

**Board of Directors Meeting**

**BD2010.40**

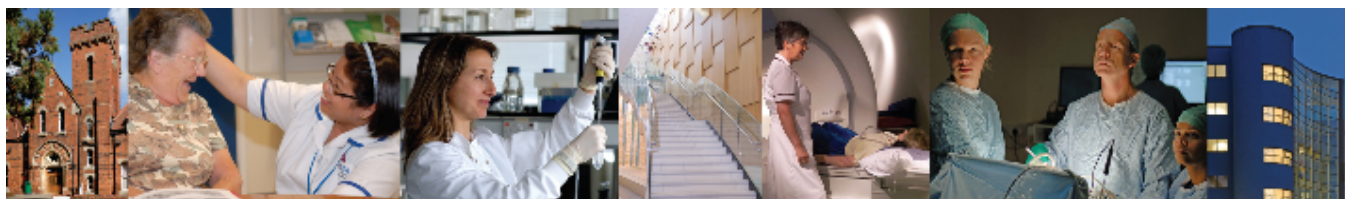
<b>Subject</b>	Trust Business Plan 2010/11			
<b>Purpose of paper</b>	To present the Trust's 2010/11 Business Plan			
<b>Board Lead(s)</b>	Andrew Stevens, Director of Planning and Information			
<b>Background papers (if any)</b>	<p>“The Operating Framework for 2010/11 for the NHS in England”, Department of Health, December 2009</p> <p>“NHS 2010-2015: from good to great”, Department of Health, December 2009</p> <p>“High Quality Care for All, NHS Next Stage Final Review Report”, Department of Health, June 2008</p> <p>“NHS Oxfordshire Strategic Plan 2009-2013,” April 2009</p>			
<b>Action/decision required</b>	Approval (Part Two has been revised since the previous meeting).			
<b>Key purpose</b>	<b>Strategy</b>	Assurance	Policy	Performance
<b>Strategic Goal(s)</b>	This paper sets out the proposed key priorities and objectives for the coming year.			
<b>Strategic Objective(s)</b>				
<b>Links to: Board Assurance Framework/ Trust Key Risks/Annual Health Check element(s)</b>	This paper sets out key risks associated with the Trust's strategic objectives for 2010/11.			
<b>Also considered by</b>	Executive Team (by circulation) Board of Directors 6 May 2010			
<b>Resource and financial impact</b>	Outlined in Sections 7 and 8.			
<b>Consideration of legal/equality/diversity/engagement issues</b>	No issues have been identified.			

## GLOSSARY

ACEI	Angiotensin-converting enzyme inhibitors
A&E	Accident and Emergency
AHSC	Academic Health Science Centre
AMI	Acute Myocardial Infarction
ARB	Angiotensin receptor blockers
BAF	Board Assurance Framework
BRC	Biomedical Research Centre
BREEAM	British Research Establishment Environmental Assessment Method
CABG	Coronary Artery Bypass Graft
CCRF	Cardiovascular Clinical Research Facility
CIP	Cost Improvement Programme
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRB	Confusion, Respiratory rate, Blood pressure
CRL	Capital Resource Limit
CRS	Care Records Service
CRUK	Cancer Research UK
ED	Emergency Department
ERP	Enhanced Recovery Programme
FT	Foundation Trust
GI	Gastrointestinal
HDU	High Dependency Unit
HF	Heart Failure
HMR	Hospital Mortality Rate
IRP	Independent Reconfiguration Panel
ITU	Intensive Therapy Unit
JR	John Radcliffe
LVSD	Left ventricular systolic dysfunction
MES	Managed Equipment Service
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
NCG	National Commissioning Group
NIHR	National Institute for Health Research
PCI	Percutaneous coronary intervention
PCT	Primary Care Trust
PN	Pneumonia
PP	Private Patients
PROMs	Patient Recorded Outcome Measures
RTA	Road Traffic Act

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SCBU	Special Care Baby Unit
SHA	Strategic Health Authority
SIRO	Senior Information Risk Owner
SLA	Service Level Agreement
SPK	Simultaneous pancreas-kidney
STEIS	Strategic Executive Information System
SUI	Serious Untoward Incident
VBAC	Vaginal Birth After Caesarean
VTE	Venous thromboembolism



## **Business Plan 2010/11**

## Foreword by the Chief Executive

I would like to say how delighted I am to have joined the Oxford Radcliffe Hospitals NHS Trust (ORH) and to share some thoughts as its new Chief Executive.



The ORH has much that is worth celebrating : high quality clinical services delivered in some fantastic facilities, world class innovation and research, and the high regard in which the Trust's services are held by the people of Oxfordshire. However, there is still much work to do before we can say that the Trust has truly reached its full potential.

The future goals of becoming a Foundation Trust and developing our role with our local partners as an Academic Health Science Centre are still very real and form an important part of our strategy. Achieving these ambitions when times are tough will be harder, but it also means a greater urgency to make the changes that are needed to be recognised as a high performing NHS Trust.

I can appreciate that there are mixed views about change, but as a former clinician I know that the development and delivery of services works best when led locally. We need to improve our ability to deliver services focused on the needs and expectations of our patients and ensure the quality and efficiency of the services we provide. The move later this year to the new Clinical Management Structure is fundamental to our ability to deliver this. The new arrangements will provide clinical services with devolved authority to deliver services, but also the accountability of doing so within a framework that ensures the delivery of quality, operational and financial standards. The new organisation that emerges from these changes will better equip us to achieve the ambition of delivering excellence in all that we do.

This same determination to do the right thing for our patients and the Trust as part of the NHS, will help us move forward through the immediate challenges. We must maintain and improve safety, quality and performance in a way that is sustainable, and do so whilst delivering the financial performance required of us. Unless we address all of these issues, none of our ambitions will be deliverable. Some of this short term recovery will be uncomfortable, but we must deliver operational and financial performance in a way that keeps our commitment to our patients and the quality of their care.

This business plan provides a framework for the coming year:

- Part One describes the strategic context in which the Trust is operating
- Part Two sets out the Trust's key priorities and objectives for 2010/11
- Part Three establishes the financial framework in which we must deliver our objectives
- Part Four describes how we will monitor progress
- Part Five sets out the key risks that we face over the coming year

**Sir Jonathan Michael**

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<b>Part One - Strategic Context</b>
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## 1. National Strategic Context

### “From Good to Great: preventative, people-centred, productive”<sup>1</sup>

The Department of Health has updated the NHS strategy in its document NHS 2010-2015: “From Good to Great: preventative, people-centred, productive”. The document sets out a vision for the NHS in which improvements to the quality of care provided continue, but within the context of a challenged financial outlook.

### NHS Operating Framework 2010/11<sup>2</sup>

The vision described in “NHS 2010-2015: From Good to Great” is advanced within the annual operating framework for 2010/11.

The five national priorities remain:

1.	Improving cleanliness and reducing healthcare-associated infections
2.	Improving access through achievement of the 18 week referral to treatment pledge, and improving access to GP services
3.	Keeping adults and children well, improving their health and reducing health inequalities. The four areas of focus remain: <ul style="list-style-type: none"><li>• Heart disease</li><li>• Cancer</li><li>• Children</li><li>• Maternity</li></ul>
4.	Improving patient experience, and staff satisfaction and engagement
5.	Preparing to respond in a state of emergency, such as an outbreak of a new pandemic

The operating framework also signals the challenge that will be facing the NHS as a result of the national economic outlook. For example in 2010/11 there will be a 0% uplift in national tariff prices and the uplift for the following three years will be a maximum of 0%. The uplift in 2010/11 includes an efficiency requirement of 3.5%. It is expected that the efficiency requirement will increase over the following three years.

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<sup>1</sup> “NHS 2010-2015: from good to great: preventative, people-centre, productive”, Department of Health, December 2009

<sup>2</sup> “The Operating Framework for the NHS in England 2010/11”, Department of Health, December 2009

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The operating framework seeks to set out updates to national policies and levers and a set of enablers to promote the transformation required to meet the challenges of the economic context. The framework states that a focus on three areas will be required to make this transformation possible:

1.	Improving quality while improving productivity, using innovation and prevention to drive and connect them
2.	Local clinicians and managers working together across boundaries to identify opportunities and manage change
3.	Taking action both for the short and medium term

### The Link between Payment and Quality

The NHS Operating Framework makes significant changes to the payment system to reward quality, with increases to hospitals only available by improving quality. As in 2009/10 our contracts for this year include a Commissioning for Quality and Innovation (CQUIN) scheme, linking payment to specific locally determined goals that cover the domains of quality and innovation. Appendix A sets out the proposed local goals.

The Operating Framework also introduces “best practice” tariffs in four areas:

- Cataracts
- Cholecystectomy
- Fragility hip fracture
- Stroke

If Trusts can demonstrate that they are delivering these services in accordance with best practice, as set out through agreed criteria, they will be rewarded through payment of a higher price.

## 2. Local Strategy

### Oxfordshire Primary Care Trust (PCT) Strategy

Oxfordshire Primary Care Trust has reviewed its strategy. The PCT has confirmed its five strategic goals. These are to:

- |    |   |
|----|---|
| 1. | Ensure that the core services purchased from primary and secondary care providers continually improve to meet changing health needs, giving patients optimum access to satisfactory, timely, high quality care that also offers good value for money. |
| 2. | Improve health outcomes and promote independence for the following key population groups: <ul style="list-style-type: none"><li>– Older people.</li><li>– Those with long term conditions.</li><li>– People with mental health problems.</li></ul>    |

- Children and families living in areas of deprivation.
3. Improve access to health services by increasing the commissioning of integrated whole care pathways that create a proportionate and appropriate shift of activity from hospital into primary and community care settings.
  4. Help more local people of all ages to make sustainable healthy lifestyle choices.
  5. Reduce health inequalities in Oxfordshire by improving health outcomes for people living in wards with the highest mortality rates at a greater rate than for the PCT population as a whole.

### Creating a Healthy Oxfordshire

In response to the financial challenges that the local health system will be facing in the next several years, the PCT has sought to develop a whole system response. It is being projected that over the three years from 1 April 2011 the local health system will need to achieve savings of £240m. To seek to address this challenging target, a whole system programme – Creating a Healthy Oxfordshire – is being established. Within the programme there are six work streams. These are:

1.	Shaping future primary care
2.	Integrated community services provision
3.	Acute services
4.	Integrated commissioning
5.	Disinvestment
6.	Patient responsibility and engagement

The purpose of the programme is to secure the transformational change necessary in order to secure clinical and financial sustainability.

### 3. Key Contract Requirements

Appendix B sets out how the key national and local strategic priorities are reflected in the Trust's contract with its main commissioner, Oxfordshire PCT. Board leads have been identified for each contract requirement.

#### 4. The Trust's Strategy

The Trust currently has four strategic goals that were generated through a strategic review involving patient and public groups, staff and colleagues in other organisations:

1. **To be hospitals of choice for patients** by providing an outstanding environment for clinical services, with customer focused patient care that will be valued by our partners and the communities we serve.
2. **To be world leading teaching hospitals and an Academic Health Science Centre** (in partnership with the University of Oxford), with an international reputation for advancements in medicine and biomedical research, able to offer specialist expertise and outstanding teaching and treatment facilities.
3. **To achieve financial sustainability and long-term growth** by intelligent redesign of our hospital services, based on improved leadership, productivity and efficiency.
4. **To be an excellent employer** with flexible and workable policies that will encourage the recruitment and retention of quality staff

It is proposed that a major refresh of the Trust's strategy will be undertaken during 2010/11 in order to respond both to:

- The changed external environment within which the Trust is operating.
- Internal changes that are being progressed to provide clinical services with devolved authority to deliver services.

The Financial context in which this Business Plan has been developed is described in Section 7.

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## 5. Key Priorities

The Trust has four key priorities for 2010/11 which are set out in the table below.

<b>Key Priorities for 2010/11</b>	
<b>1.</b>	<b>Achieve all operational performance targets</b>
<b>2.</b>	<b>Achieve in year financial breakeven</b>
<b>3.</b>	<b>Deliver excellence in all that we do:</b>
a)	Quality of care – safety, outcomes, patient experience and customer service
b)	Efficiency, cost-effectiveness, good systems and management
c)	Teamwork, communications, relationships with partners and stakeholders, and staff relations and experience
d)	Research, teaching and training
<b>4.</b>	<b>Redefine the Trust’s future strategy</b>

A set of business objectives has been developed to deliver these priorities. These are described in the next section.

## 6. Business Planning Objectives 2010/11

The table below shows how each of the business objectives developed for 2010/11 supports the Trust's four key priorities.

Key Priorities		1	2	3	4
<b>Objectives</b>		Operational Performance	Financial Breakeven	Excellence	Future Strategy
	1.	To continue to implement the cancer services marketing action plan.	✓		✓
	2.	To implement the cardiac services marketing action plan.	✓		✓
	3.	To implement the bowel screening programme.		✓	
	4.	To continue to work with the PCT to achieve strengthened demand management plans.	✓	✓	
	5.	To contribute to the Creating of a Healthy Oxfordshire Programme.	✓	✓	✓
	6.	To continue to contribute fully to the Better Healthcare Programme.			✓
	7.	To explore the possibility of transferring work into primary care where it is clinically and financially effective.		✓	✓
	8.	To rationalise services.	✓	✓	✓
				Quality of Care	
				Efficiency, cost effectiveness, good systems & management	
				Teamwork, communications, relationships, staff relations & experience	
				Research, Teaching & Training	

## Oxford Radcliffe Hospitals NHS Trust

Key Priorities		1	2	3			4
		Operational Performance	Financial Breakeven	Excellence			Future Strategy
				Quality of Care	Efficiency, cost effectiveness, good systems & management	Teamwork, communications, relationships, staff relations & experience	Research, Teaching & Training
<b>Objectives</b>							
9.	To continue to implement the strategy for the stroke pathway.	✓		✓			✓
10.	To reduce the number of patients who are medically fit to discharge within the Trust's beds.	✓		✓		✓	✓
11.	To continue to strengthen the urgent care pathway.	✓	✓	✓			✓
12.	To work with commissioners to repatriate activity from London providers.		✓	✓			
13.	To develop the clinical network for vascular services.			✓			
14.	To advance the strategy for Neonatal Intensive Care Unit (NICU) services.			✓			✓
15.	To progress the business case for the laboratory component of the Trust's strategy for infection control.	✓		✓			✓
16.	To progress actions to strengthen the efficiency of the Trust's clinical support services.	✓		✓	✓		
17.	To contribute to the establishment of the Thames Valley Health						✓

Key Priorities		1	2	3			4
		Operational Performance	Financial Breakeven	Excellence			Future Strategy
				Quality of Care	Efficiency, cost effectiveness, good systems & management	Teamwork, communications, relationships, staff relations & experience	Research, Teaching & Training
<b>Objectives</b>							
Innovation and Education cluster.							
18. To continue to lay the foundations for the development of an Academic Health Science Centre.							✓
19. To continue to reduce the number of healthcare acquired infections.		✓		✓			
20. To implement the Trust's patient safety strategy.				✓			
21. To become a high reliability organisation.				✓			
22. To meet key access targets on a sustainable basis.		✓		✓			
23. To continue to strengthen patient feedback.				✓			
24. To provide effective training in customer care.				✓		✓	
25. To strengthen GP/primary care collaboration.				✓		✓	
26. To strengthen clinical networks.				✓		✓	
27. To contribute to the strengthening of emergency planning.					✓		
28. To strengthen the Trust's contribution to the wider public health agenda.						✓	

## Oxford Radcliffe Hospitals NHS Trust

Key Priorities		1	2	3			4
		Operational Performance	Financial Breakeven	Excellence			Future Strategy
				Quality of Care	Efficiency, cost effectiveness, good systems & management	Teamwork, communications, relationships, staff relations & experience	Research, Teaching & Training
<b>Objectives</b>							
29.	To strengthen stakeholder relationships and the Trust's public engagement activities.					✓	
30.	To develop a culture of openness, transparency and positive staff engagement.					✓	
31.	To implement a clinically led organisation.	✓	✓	✓	✓		✓
32.	To introduce service line management.	✓	✓		✓		✓
33.	To develop and maintain a high quality, flexible workforce.						
34.	To develop and implement the Trust's recovery programme.		✓		✓		
35.	To lay the foundations for a successful application for NHS Foundation Trust status.	✓	✓	✓	✓	✓	
36.	To implement the Care Records Service.			✓	✓		✓
37.	To strengthen management information.	✓	✓	✓	✓		
38.	To redefine the Trust's future strategy.						✓

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## 7. Financial Plan

A further paper seeks the approval of the Board of Directors to the proposed financial plan and budgets for 2010/11.

### Context and Trust Financial Strategy

The Trust enters 2010/11 with an underlying deficit of £11.6m. To this must be added:

- The annual efficiency targets included in the determination of the national tariffs
- Agreed changes in commissioning intentions in the local health economy
- Unavoidable costs not covered by the national tariff and cost improvement target
- The impact of any other non recurrent elements
- The need to deliver annual surpluses from 2011/12 onwards to recover the accumulated historic deficit.

Furthermore, work commissioned by the SHA indicates that, in view of the difficult national economic situation and its impact on the finances for the NHS over the next few years, in line with other health economies, Oxfordshire must take action to avoid the financial gap between needs and affordability increasing further.

The Trust must therefore expect real term reductions in income over the next few years as commissioners implement their own plans to reduce expenditure and live within their budgets.

### Outline Financial Plan

The table below sets out the Trust's outline financial plan for the next four years.

	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000
Income	631,846	625,556	619,329	613,165
Cost Improvement Programme	47,000	48,592	40,530	40,430
Expenditure	631,846	618,040	611,813	605,468
Surplus (before impairments)	0	7,516	7,516	7,697
Impairments	5,000	5,000	5,000	5,000
<b>Surplus/(deficit) after impairments</b>	<b>-5,000</b>	<b>2,516</b>	<b>2,516</b>	<b>2,697</b>

### Commissioner Income

The majority of the Trust's predicted income will come from contracts with commissioners. This income is budgeted for at £512m in total. Service Level Agreement (SLA) negotiations are still ongoing at the time of writing. The table below summarises the levels of income currently proposed from each of the Trust's main commissioners.

## Oxford Radcliffe Hospitals NHS Trust

Oxfordshire PCT	287,800
South Central Specialist	79,950
Other	144,250
<b>Total</b>	<b>512,000</b>

### Divisional Budgets

The table below sets out how the financial plan has been translated into draft budgets at Divisional level. These budgets will be updated as the detailed cost improvement programme is developed and as service level agreements are signed.

	Comm and RTA Income	PP and Overseas Income	Other Income	Total Income	Pay	Non-Pay	Total Expense	Net
A	180,768,118	1,967,928	4,632,317	187,368,363	-74,882,866	-52,067,886	-126,950,752	60,417,611
B	192,021,516	3,965,199	6,141,936	202,128,651	-116,317,363	-48,206,952	-164,524,315	37,604,336
C	127,922,175	2,873,751	15,135,269	145,931,195	-104,862,635	-26,675,100	-131,537,735	14,393,460
D	0	3,129,576	15,702,343	18,831,919	-36,688,210	-50,939,640	-87,627,850	-68,795,931
E	0	0	14,516,886	14,516,886	-11,887,177	-2,629,709	-14,516,886	0
F	11,288,191	129,000	48,761,620	60,178,811	-20,990,726	-27,375,505	-48,366,231	11,812,580
G	0	0	2,890,092	2,890,092	0	-58,322,148	-58,322,148	-55,432,056
<b>Total</b>	<b>512,000,000</b>	<b>12,065,454</b>	<b>107,780,463</b>	<b>631,845,917</b>	<b>-365,628,977</b>	<b>-266,216,940</b>	<b>-631,845,917</b>	<b>0</b>

### Cost Improvement Programme (CIP)

The Trust's financial plan contains an overall savings target of £47m in 2010/11, with further targets of £48.5m, £40.5m and £40.5m in 2011/12, 2012/13 and 2013/14 respectively. The table below provides a summary of the proposed savings programme for 2010/11.

Cost Improvement Programme	2010/11	2011/12
	£000	£000
FYE of 2009/10 schemes	3,050	-8,150
Workforce cost reduction programme	20,500	17,500
Improved use of hospital capacity	4,500	2,500
Infrastructure costs	8,300	9,000
Additional Income	2,500	1,000
Clinical Services Strategy	tba	tba
Total Recurrent	38,850	21,850
Balance to be identified		26,750
Non Recurrent	8,150	0
<b>Total</b>	<b>47,000</b>	<b>48,600</b>

The Cost Improvement Programme will be delivered through a series of workstreams which are set out in the table below, together with the nominated lead director for each.

Workstream	Lead Director
Theatre utilisation	Chief Operating Officer
Inpatient utilisation and productivity	Chief Operating Officer
Outpatient utilisation and productivity	Chief Operating Officer
Medicines management	Chief Operating Officer
Procurement	Director of Finance and Procurement
General efficiency	Director of Finance and Procurement
Estates utilisation	Director of Estates and Facilities
Private patient income	Chief Operating Officer
Research income	Director of Finance and Procurement
Clinical services strategy	Director of Planning and Information
Workforce cost reductions	
• Division A	Chief Operating Officer
• Division B	Chief Operating Officer
• Division C	Chief Operating Officer
• Division D – clinical areas	Chief Operating Officer
• Estates and Facilities	Director of Estates and Facilities
• Finance and Procurement	Director of Finance and Procurement
• Human Resources	Director of Human Resources
• Medical Director	Medical Director
• Nursing/midwifery	Director of Nursing and Clinical Leadership
• Planning and Communications	Director of Planning and Information
• Absence management	Director of Human Resources
• Vacancy management	Director of Human Resources

## 8. Proposed Capital Programme 2010/11

The size of this year’s capital programme is constrained by the fact that funding for it is limited to internally generated funding (depreciation). The Trust’s underlying deficit and inability to repay loans means that the Trust is unable to bolster the internal funding by external borrowing. The proposed capital programme is set out in the table below. Further work will be undertaken to prioritise the available sums, taking into account clinical and non-clinical risk issues and the need to invest in change in order to deliver the required efficiency savings.

## Oxford Radcliffe Hospitals NHS Trust

Resources available	Sub total	Total	Leasing or non cash	Purchase
	£m	£m	£m	£m
Available CRL				
Purchase		15.00		15.00
Leasing strategy		3.00	3.00	
2nd MRI Churchill lease (if case approved)		2.40	2.40	
Managed equipment service (MES) FOR 2010-11		1.08	1.08	
Income:				
University General recharge	1.20			
University - Cardiac CCRF	0.98			
PCT repayment re ward 5E Community Hospital	0.17	2.35		2.35
<b>"Available" for capital spend</b>		<b>23.82</b>	<b>6.48</b>	<b>17.35</b>
<b>Schemes in progress</b>				
JR MRI replacement	0.01			0.01
Projects team (revenue to capital transfer of expenditure)	0.70		0.70	
BREEAM assessment	0.05			0.05
JR Window repair	0.30			0.30
Care Records service	1.90		1.90	
Fibre Optic Link to Churchill	0.08			0.08
Cancer Centre medical equipment	0.20			0.20
Cancer Centre "legacy" requirements	0.70			0.70
GOMLA patient-level costing system	0.25		0.25	
Renal home adaptations	0.01			0.01
Near-patient testing in ED	0.01			0.01
JR Lab Accreditation	1.32			1.32
Paediatric mortuary	0.31			0.31
NICU interim plan	0.10			0.10
Misc. retentions	0.07			0.07
E-rostering	0.19		0.19	
Cardiac Expansion	1.30	7.50		1.30
<b>MES equipment (technical definition of "capital")</b>				
Ultrasound scanners	0.17		0.17	
CT simulator	0.85		0.85	
Analogue mammography equipment	0.05	1.07	0.05	
<b>Third party funding already received for specific purposes</b>				
Biomedical research centre (remaining allocation)	1.97			1.97
Experimental cancer Medical Centre	0.50			0.50
NIHR grant for Clinical Biomanufacturing Facility	1.83			1.83
CRUK grant	0.10	4.41		0.10
<b>2nd Churchill MRI (if going forward)</b>		<b>2.40</b>	<b>2.40</b>	
<b>Total committed expenditure</b>		<b>15.38</b>	<b>6.51</b>	<b>8.86</b>
<b>Maintenance of the existing asset:</b>				
Medical equipment & replacement theatre instrumentation	2.50			
Maintenance of existing estate	1.30			
IT	1.60			
Contingency re breakdown of existing asset	0.50	5.90		5.90
Conitngency/Invest to Save/Clinical Governance		2.55	-0.04	2.58
<b>Total suggested programme</b>		<b>23.82</b>	<b>6.48</b>	<b>17.35</b>

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## **9. Governance Arrangements**

The Trust will review its governance arrangements in 2010/11 as part of the implementation of the new Clinical Management Structure. On 1<sup>st</sup> April 2010 the Trust was successfully registered without conditions under the Care Quality Commission's (CQC's) new registration system. This registration demonstrates that the CQC was satisfied that the Trust meets essential standards of quality and safety. The CQC will continue to monitor these and the Trust's governance arrangements will need to ensure that they are maintained.

## **10. Key Performance Indicators**

The Trust will continue to prioritise the monitoring of nationally and locally determined indicators of quality and feedback from patients using our services. In addition to the indicators specified in our contracts with commissioners (set out in Appendices A and B) the Trust will need to ensure that it monitors performance against existing national commitments and the national priorities set out in the 2010/11 Operating Framework. The Board report that is presented to each meeting of the Board of Directors will be revised to ensure that these are incorporated. Key performance indicators for the 2010/11 objectives, including the financial plan, cost improvement plan and workforce plan will also be developed and incorporated.

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<b>Part Five - Risk Analysis</b>

## 11. Key Organisational Risks

The table below sets out the principal risks which have been identified against each of the Trust’s strategic objectives. These risks, together with mitigation/control plans are included within the Board Assurance Framework (BAF) reviewed regularly by the Board of Directors. In addition, the Executive Board and Board of Directors will review the Trust’s Risk Register (which the BAF is referenced to) twice a year, drawing on the risk mitigation plans in place across the Trust.

### Principal Risks to the delivery of the Trust’s Strategic Objectives

Principal Risks to the delivery of the Trust’s Strategic Objectives		
SO1.	To consolidate and advance the international status of the Trust’s defining services.	
Principal Risks		
<b>Cancer Services</b>		
1.1	Capacity issues in the Cancer Intensive Care Unit and Day Surgery and theatres are insufficient for workload. High risk of patients requiring HDU being placed on wards, compromising safety.	Chief Operating Officer
1.2	Split of services and staff between Churchill and JR impacts on quality and safety of care.	Chief Operating Officer
1.3	There is a need to resolve the location of Head and Neck cancer services.	Chief Operating Officer
<b>Cardiac</b>		
1.4	There is a need to respond to the Safe and Sustainable review of Paediatric Cardiac Surgery.	Chief Operating Officer
<b>Neurosciences</b>		
1.5	There is a need to respond to the Safe and Sustainable review of Paediatric Neurosurgery.	Chief Operating Officer
<b>Gastroenterology</b>		
1.6	Bed pressures mean that GI patients may be in unfunded beds. GI wards not staffed to take these patients.	Chief Operating Officer

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Transplant		
1.7	Insufficient bed capacity risks loss of the NCG contract due to inability to maintain activity levels for SPK/ Intestinal transplants and risk of loss of >£5m Trust income. Impact on patient safety with patients returning to ward following major surgery.	Chief Operating Officer
<b>SO2.</b>	<b>To provide high quality, efficient and innovative core services that meet the needs of local patients and the challenges of the local health community.</b>	
	<b>Principal Risks</b>	
2.1	Failure to deliver performance improvement and cost reduction programme compromises financial performance, standing, reputation, services (particularly core services), patient experience and FT application.	Chief Operating Officer
2.2	Reductions in management capacity may impact on performance.	Chief Operating Officer
2.3	Workload pressures on management impinge on capacity and capability.	Chief Operating Officer
2.4	Horton General Hospital: Sustainability of safe services for maternity, paediatrics, gynaecology and anaesthetics post IRP decision while PCT develops long term vision for services.	Director of Planning and Information
2.5	Sustainability of emergency general surgery challenging. The general surgical and trauma junior medical on-call rota is combined overnight and this could impact on quality and safety of services.	Director of Planning and Information
2.6	Failure to develop effective collaborative working, e.g. with PCT and GPs, compromises improvements to emergency care pathways and care of patients with long term conditions.	Chief Operating Officer
2.7	Potential to compromise activity/ finances and reputation through lack of collaborative demand management.	Director of Planning and Information
2.8	Failure to meet emergency access target compromises patient care, patient experience and overall performance.	Chief Operating Officer
2.9	Delayed transfers of care remain a challenge to performance and to the appropriate placement of patients within alternative accommodation.	Chief Operating Officer

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2.10	Commissioners will be unable/unwilling to fund current levels of activity.	Director of Planning and Information
2.11	Stroke unit admission not available to all stroke patients with impact on service, performance and reputation of Trust.	Chief Operating Officer
<b>SO3.</b>	<b>To continue to strengthen the Trust's portfolio of specialist services and to consolidate and extend the catchment area from which patients for specialist services are drawn.</b>	
	<b>Principal Risks</b>	
3.1	Problems with the coding, recording and reporting of information will lead to a loss of income and misreporting of income within the Trust. Information/data issues also impact on 18 week waiting times.	Director of Planning and Information
3.2	Risk arising from imbalance between funding and standards of service required and capital/revenue funds to support Trust strategies and business cases (capacity, environment, performance).	Director of Finance and Procurement
<b>SO4</b>	<b>To identify, evaluate, prioritise and nurture emerging services</b>	
	<b>Principal Risks</b>	
4.1	Failure to build on opportunities (including commercial opportunities) afforded by the BRC for translational research compromises agreement on strategies for a) identifying and evaluating new emerging services b) new technologies in the genes and pathology services c) specific service developments.	Medical Director
4.2	Failure to ensure long term funding for BRC compromises ORH's ability to continue to develop its vision as an Academic Health Science Centre.	Medical Director
<b>SO5.</b>	<b>To ensure that the development of platform services parallels and advances the strategy for clinical services, ensuring that platform services contribute to optimising the efficiency and customer care focus of the Trust.</b>	
	<b>Principal Risks</b>	
5.1	Achievement of diagnostic access targets.	Chief Operating Officer

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5.2	Maintenance of plain film reporting and introducing 'hot reporting' for urgent inpatient and ED referrals. Insufficient medical staff hours to maintain timely reporting service. Films not being reported and patient safety/ treatment/ performance compromised.	Chief Operating Officer
5.3	Risks associated with current multiple laboratory IT systems.	Chief Operating Officer
<b>SO6.</b>	<b>To develop the Trust's role as an academic health science centre of international standing working in partnership with the University of Oxford and the Nuffield Orthopaedic Centre and other partner organisations</b>	
	<b>Principal Risks</b>	
6.1	Failure to agree timetable and process for FT application compromises ORH reputation and standing, particularly with key partners including Oxford University and PCT, resulting in reputational damage.	Director of Planning and Information
6.2	Failure to deliver credible long term financial model in current and long term financial situation compromises successful FT application.	Director of Finance and Procurement
<b>SO7.</b>	<b>To provide demonstrably excellent clinical outcomes and indicators of patient safety.</b>	
	<b>Principal Risks</b>	
7.1	Improvements in patient safety not delivered and safety and patient experience compromised.	Director of Nursing and Clinical Leadership
7.2	Financial situation could divert attention from the safety agenda.	Director of Nursing and Clinical Leadership
7.3	Failure to address actions in external reports compromises safety and quality in all areas.	Director of Nursing and Clinical Leadership
7.4	Failure to manage all aspects of healthcare associated infection – meet MRSA and <i>Clostridium difficile</i> targets, introduce MRSA screening, address environmental concerns etc. poses risk to continued registration with Care Quality Commission (CQC).	Medical Director
7.5	Medicines Management risks across a number of areas, including controlled drugs.	Director of Nursing and

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		Clinical Leadership
7.6	Failure to meet core standards, existing and new national targets and criteria for registration with CQC – potential impact on patient experience and reputational damage.	Director of Nursing and Clinical Leadership
7.7	Risks associated with filing into and access to health records.	Director of Planning and Information
7.8	Lack of capital funding for requirements associated with statutory standards, enhancing the patient environment, control of infection and carbon reduction strategy.	Director of Finance and Procurement
7.9	Loss of portable media containing patient identifiable data.	Director of Nursing and Clinical Leadership
<b>SO8.</b>	<b>To improve the overall patient experience by offering excellent customer care.</b>	
	<b>Principal Risks</b>	
8.1	Failure to implement an appropriate End of Life pathway for all appropriate patients could impact on quality of care.	Director of Nursing and Clinical Leadership
8.2	Failure to continue improvements in single gender accommodation compromises the privacy and dignity of patients.	Director of Nursing and Clinical Leadership
8.3	Failure to develop and maintain public membership through delays in FT application compromises patient and public engagement and future election process.	Director of Planning and Information
<b>SO9.</b>	<b>To maximise the Trust's contribution to the health and wellbeing of the local community.</b>	
	<b>Principal Risks</b>	
9.1	Trust is not prepared for the impact of a pandemic flu outbreak and all aspects of performance (including financial) are compromised.	Chief Operating Officer and Medical Director

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<b>SO10.</b>	<b>To become a strategic, high performing and agile organisation supported by efficient and patient focused clinical processes, modern systems and business processes.</b>	
	<b>Principal Risks</b>	
10.1	Tensions between access targets and quality and safety requirements compromise performance, particularly at time of significant financial and capacity pressures.	All
10.2	Current and long term financial position of the ORH and across the health economy compromises financial stability of the Trust.	Director of Finance and Procurement
10.3	Scale of required cost improvement programme impacts on foundation trust application.	Chief Executive
10.4	Staffing constraints and workload pressures impact on service provision and quality.	Director of Human Resources and Chief Operating Officer
10.5	Inability to meet the stringent requirements for cash management required for successful FT application.	Director of Finance and Procurement
10.6	Ageing equipment across the Trust compromises service delivery, performance, quality and safety.	Director of Finance and Procurement
10.7	Insufficient capital for maintenance of estate.	Director of Finance and Procurement
10.8	Failure to achieve private patient income targets, e.g. because of lack of theatre and bed capacity.	Chief Operating Officer
10.9	Lack of management focus and funding jeopardises the successful implementation of the Care Records System (CRS).	Director of Planning and Information
10.10	Lack of clarity over roles and responsibilities within Clinical Management Structure.	Chief Operating Officer