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17 November 2016

[redacted]

By email [redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of 20 October 2016 in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, Monitor and the NHS Trust Development Authority are operating as an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means Monitor.

Your request

In your email you highlighted a number of documents:

1. *The Halsall Letters consist of:*
    a. *Letter from Janet Soo-Chung to Tony Halsall dated 5.5.10*
    b. *Paper prepared by NLTPCT Medical Director Jim Gardner for NLTPCT Board Meeting of 26.5.10 entitled "Patient Safety and Clinical Quality issues at University Hospitals of Morecambe Bay NHS Trust"*
    c. *'Part 2' Minutes of NLTPCT Board Meeting of 26.5.10*
    d. *Letter from Janet Soo-Chung to Tony Halsall dated 27.5.10*
    e. *Letter from Tony Halsall to Janet Soo-Chung dated 28.5.10*
    f. *Letter from Janet Soo-Chung to Tony Halsall dated 3.6.10*
    g. *Janet Soo-Chung's cautiously, but not cautiously enough, worded endorsement dated 10.6.10 of the 2009-10 UHMB Quality Account*
    h. *Letter from Tony Halsall to Janet Soo-Chung dated 14.6.10*
    i. *Minutes of the NLTPCT Integrated Governance Committee meeting of 22.6.10*
    j. *Minutes of the NLTPCT Board Meeting of 29.9.10*

Your request is as follows:

2. *With the above background, this first part of this FoI request is for the "briefing pack" and "handwritten notes" relating to the Monitor-UHMB 'Board to Board' meeting of 8.9.10, as described in Point 5.164 of 'The Report of the Morecambe Bay Investigation' published on 3.3.15.*

3. *The second part of the FoI Request is for any letter or document dated during the period June to September 2010 incl., from David Bennett, Chief Executive of Monitor during almost all of the relevant period, or Miranda Carter, Monitor Assessment Director or Adam Cayley, variously described as Monitor Portfolio Director and*

Regional Director, indicating that Monitor paid specific attention to the concerns raised in the Halsall Letters.

Decision

NHS Improvement holds some of the information that you have requested.

In relation to the first part of the request, NHS Improvement has decided to withhold some of the information that it holds on the basis of the applicability of the exemption in section 40 of the FOI Act, as explained in detail below.

In relation to the second part of the request, we do not hold any letter from David Bennett or Adam Cayley. In relation to information from and letters from Miranda Carter, NHS Improvement holds a letter dated 9 July 2010 and has decided to release this.

Section 40 – Personal data

I consider that some of the information in the Board to Board meeting pack is exempt from disclosure under section 40(2) and 40(3)(a) of the FOI Act on the grounds that it contains personal data and that the first condition under section 40(3)(a) is satisfied, namely, that disclosure would amount to a breach of the first data protection principle (personal data shall be processed fairly and lawfully). This is an absolute exemption and consideration of the public interest test is not required.

The information withheld is names of junior staff that were part of the Assessment team. The staff would have a reasonable expectation that their names would not be published.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

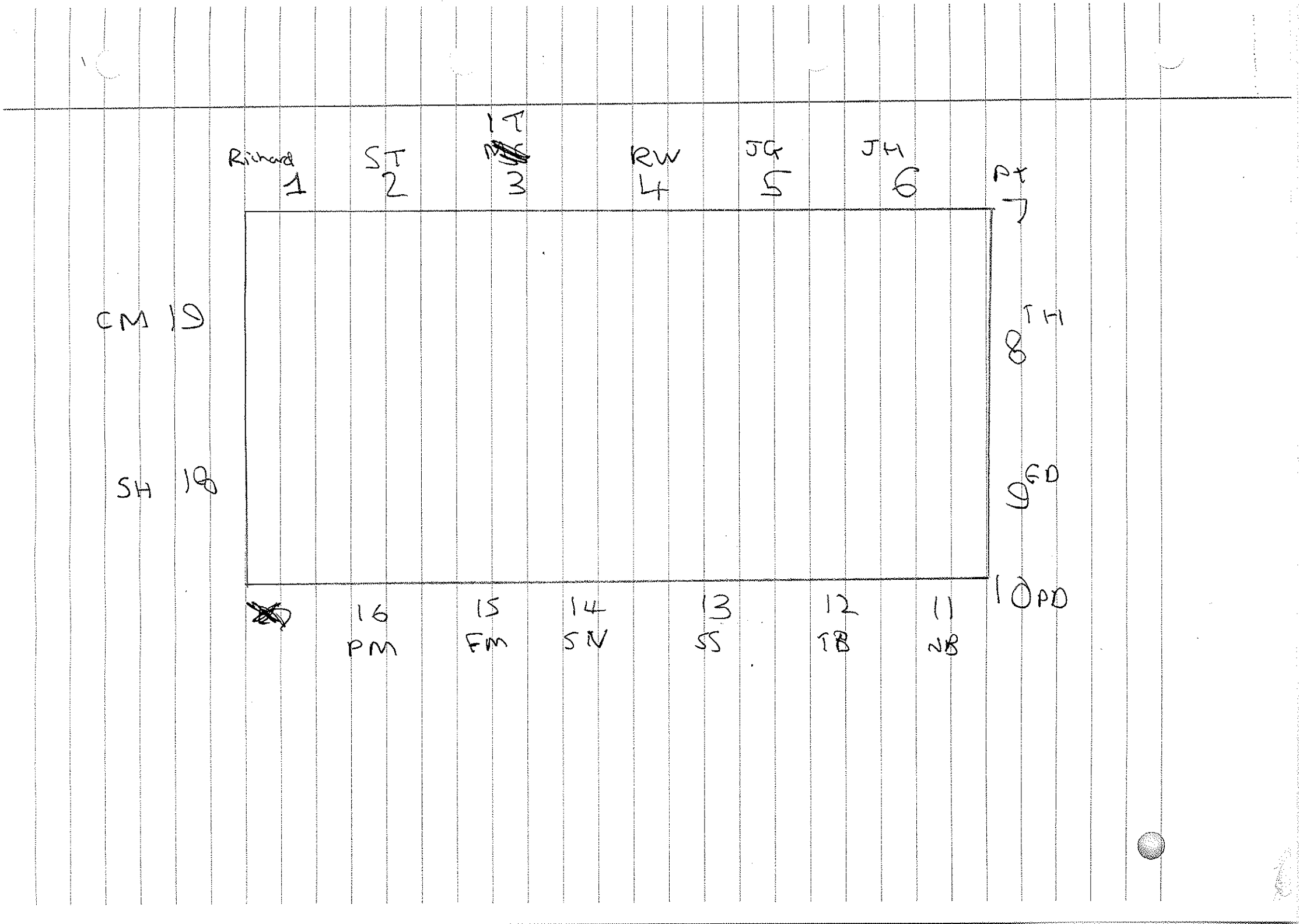
A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely

Miranda Carter
Director of M&A and New Organisational Models


Richard 1
ST 2
IT 3
RW 4
JG 5
JH 6
PT 7
TH 8
GD 9
PD 10
11 2B
12 TB
13 SS
14 SN
15 FM
16 PM
SH 18
CM 19

08/09/10 B2B meeting notes

19	Introduction
CG	Presentation
19	Q ✓
	Do what you do with 20% less people?
	Can it be delivered? W/o any impact on Q
1	CT
	M4 £0.1. Ramp-up to £2m?
12	a) Seasonal fluctuation
	b) CIP heavily geared to 2nd half of year.
	→ ward reductions
	→ paybill
9	Already closed 1 of wards. } Actions taken: not showing through
	In taken out 29 WTE. } books.
1	How do NGDs get ~~chattering~~ comfort on hockey stick?
9	→ Strategy → build finance planning through 3 principles:
	(1) Equity
	(2)
	(3) Innovative partnerships + outsourcing.
	→ Set of parameters on judgements.
	Do deliver money?
	Are they deliverable?
	Do they impair Q of clinical care?
	Are they sustainable
	→ CQSC look at in detail. This is how get assurance.

19	Does Board risk-rate delivery?
12	Noe is red at end of july. Some amber-red → ward closures. → ahead of plan. → paybill ↓. → moved to A/G. ↘ where expected @
8	Risk-rated all parts → 1-5. Look to take out 1s and 2s. → mechanisms to fill personal internally. → 40 people tomorrow on managerial → closed ward £0 (with support from commissioners).
3	From NED perspective, how comfortable on significant mgrm improvement?
11	July: good performance: surplus of £705k.: core good. NED challenge on paybill: → monitor costs → big savings on pay bill costs cumulatively. → 1° down to recruitment of consultants + doctors + Fitwise agency costs. → NEDs challenged 9 months ago: → : HR brought in line-by-line action on each vacancy. → now goes to CE Taskforce when vacancy becomes available.
5	All need better balance approved to monitor: → trad. board by division. → 164 EqIP scores by 6 workstreams. → no reds for deliverability: Ward 50 now dar. → if any discrepancy between 2; here in on hand.

18	Hear rhetoric Margin falls year on year? Why declining + why not ever will ↑.
12	past : targetted high margins : to pay off historic debt more latterly: Board taken decision & recognises falling margins; want to see improve.
18	Board decision to ↓ from 9 to 6%?
12	Board decision was to target a specific surplus, not a margin? Delivered loan payback by aggressive CIP. → then able to lower surplus. → now more challenging times.
1	Concern on 2 things: (a) more challenging job (b) more margin Key risks to surplus delivery?
5	CIP delivery : believe can deliver
18	But 75% recurrent delivery year-on-year?
5	More rigorous + rigorous now on how done. Didn't always have degree of workforce support. Change in culture: clinicians, stakeholders + local partners.

3	Reminder on delay of EQIP.
	⚠ from CIPS:
	→ all schools have clear management, very closely monitored, along with quality, impact + deliverability,
	→ very close management from EMs + rating from NEAs.
16	Some of bigger schemes have been actioned + are in place + ∴ will deliver
	∴ have confidence that in bag
9	Taking out parks + road so done?
1	What proportion in bag?
12	No red, some due to some in stm later in year.
1	What proportion in bag?
	What run-rate as of today?
12	0.5m a month → up to £1 from period 7
	→ paybill + road closures.
	Some small schemes coming in Dec + Jan.
1	Back to risks for you? CIPS first.
5	Clinical sustainability:
	→ medical recruitment at 1 hospital
	→ more confidence than 1 year ago

9	Junior doctors:
*	→ Lancaster Uni: ~~going first~~ full cohort that's fully tuned there.
	Consultants:
	→ driving very hard + accelerating. Were covered as NCPS but now improved.
	→ sessions in future: 1·5 → 0·5.
10	Identified issues on 2 staffs categories.
	Junior: new package on recruitment for Barrow:
	→ now adopted by NW Deanery.
	Consultants: working with HR: recruitment period driven down from 6 months to 1 month;
	pulled obstacles (e.g. Royal College) away.
8	Wanted not started: haematology vacancy: £300k/year
	→ now recruited + save £150k/year
	radiology thinks this needs: 7 applications
9	Both drive encapsulates challenge on NCPS
1	Back to risks.
5	3rd: restructuring for future env.
	strength of links with GPs much stronger than other areas
	→ ∴ in a better position
1	PCT demand management a risk.
	Is delivery of your plan conditional on your partners? their

16	PCT had 4 ~~have~~ year plans
	→ e.g. follow-up rates:
	→ agreeing ~~what~~ won't follow-up specialty by specialty
	→ PCTs take income out + ~~they~~ we take out costs
	∴ historically 08/09 + 09/10 activity was flat
	→ demand management doesn't deliver.
	→ ∴ taken prudent
	→ PCT receives + planning healthcare surplus.
1	Can you do additional work w/o destroying rules?
14	A+E growing, + occupancy rates dropped off
	Planning going forward:
	→ NEL more predictive than electives.
	→ lower care Nov/Dec, NEL will be impacted.
	→ working with, with PCTs + social cares.
	→ premium rates for planned care:
	→ understand risks + planned for it.
✱ 1	Concern: fluctuations in NEL. In plan?
12	Know NEL surges.
	EQIP → flexible ward programme
14	20-30 beds closed in summer.
	→ gearing up to respond.
9	Recog. brand premium rates ↓

2 | Pleased to hear emergency demand predictable from an acute.
Concern: all new players.
→ (a) risk-rating of demand-management into this?
(b) new casterers: what doing proactively?

9 | (b) Cumbria is pilot for ICO for last 3 years.
→ ∴ more complete here:
→ deal with 2.5 of GP contracts.
→ Eddie + Tony working closely on new model of integrated care.
→ ∴ Cumbria well advanced.
→ track record: ASR at WGH and explored with PCAS + secondary care model.

N Lancs:
→ PCT view is 3 groups; not shared by GPs.
1 GP group assigned + wants working with Trust.

10 | Last 3/12 years → worked v closely with GPs
(a) Cumbria / S Lakes: worked with on ASR.
(b) RLI → 30 GPs in A+E on shift basis
→ trying to ↓ admissions, + improve pathways.
by GP patient knowledge.

→ GP sit on interview panels for new consultants.
→ external reviews: Lead GPs are interviewed + take part in shaping clinical strategy
→ Meet GPs regularly (personally).

9 | Lot of effort going on helping to create, future.

16	partnership → Lancaster Constantine vision for Tribune. → demand management: Trust needs to take cost out. → SV doing work on ↓ bed base. → both parties need to work together. → sent some work on Lancaster visit.
	cutbacking → take hard-nosed approach. → e.g. only where actions can deliver real change + both sides take out cost. → e.g. consultant-to-consultant referrals. → e.g. agreeing evidence-based referrals.
19	PCG in grand: → no red-rated risks; 2 b positi on track to deliver £ 2m.
	CIPS
1	Decided headcount ↓, but payhill doesn't drop much.
5	Not taking out 20% of heads.
12	You are looking at employee benefit expense. Key drivers are consultant contract etc.
1	Taking out some heads, what is mechanism?

4	Board has principal of employment-over-earnings: → taking out parts is last resort → but doing this this year. → pay protection: down from 5 to 2 → working with divisions on skill mix. → e.g. maternity: Bank mate Plus pitching in staff. → additional capacity ↓ decreased. → saving of £60k/month removed. → covers leave: £100k/year = 3 nurses, don't need to be taken out of front line.
1	At a loss: if not taking posts out, how getting saving?
6	Need to take out staff, but need to ↓ by taking out earings. → consultants: 6.5/2.5 vs 7.5/3.5 ∴ more productive. → recruited 3 consultants with this in place. → any saved money on ward closure if take posts out. → 40 people interested in reinvestment scheme.
1	How much are you looking to ↓ wage bill by headcount ↓, benefits etc.
16	4% efficiency → 75% staff = 3% per annum. £96k = 3% per annum. WTE £500k reserve to £350 reserve = massive impact. 1 to 5 ratings → what is essential.

12 — Need to fully understand with cost/benefit lots of work
→ Broadly: net of data etc + CIP.

1 — Reverse line: ↓ slightly
Same work with significantly fewer people?
Ø. Hav covered Q won't suffer.

9 — Everything built on 3 strategic principals. [see p
1–5 ranking done with clinicians + not imposed by Board.
→ monitoring of ~~stuff~~
→ is it deliverable?
→ will it impair on CQ?
→ By Board + CQSC.

19 — Example?

5 — ① Nurse managers spend a day a week working on wards:
→ enhance work, improve morale.
→ no ↓ in relay, but ↑ in commitment to ward.

② Saving running all med staffing in Medical Division
→ AC report as benchmarking.
→ redeploying to ensure those below ↑.

③ Junior doctors.
④ BR+ : ensure safe staffing

V good ward-to-Board reporting:
→ know on a weekly basis on Q/S/PE.
→ NEDs looking at governance + monitoring of EQIP:
→ insisting on 6 month review of impact.

19 If something went wrong, how quickly would you pick it up?
How do you know what is going on on wards.

6 NQAT:
1) audit tool looking at KO standards:
→ 2x a year minimum for each ward.
→ links to performance schedule.

Set high bars: expected vols: with monthly review + improvement to order.

2) GURU: 22 measures on 3 domains;
monitor on ongoing level on ward
→ triggered by nurses at ground level.

Board gets 1/4ly reports on GURU measures from nurses in Boardroom.

Good example on early detection on deteriorating patient.
→ NED challenge at Board.

Director robotic walkrounds are very structured.

19 How sure what you wanted is quickly accessed?

6 How a data validation system (similar to HEAT).
Peer reviews.

19 How track complaints? What is actual attribute?

7 Culture should be to encourage feedback of concerns.
Concerned when see complaints down:
+ rare occasions that complaints taken seriously, lessons learned
+ what has been done.

Encourage incident reporting: rarely major ones are near misses
only 0.1% are serious
only 6 SUIs since April (2 MRSA cases)

Mortality - good + get + lot of feedback.

2 Impressed by org approach to Q.
Test Board governance: seen trees; what is road?
NEDs: 2/3 areas where made most improve improvements?
2/3 areas that keep you awake?

9 I with Jackie or Peter, visit PCT areas of concern.
with PCT medical directors
→ recently visited nursing home:
→ reborn had concerns on 3 wards on Q of care.
→ immediately visited ward + introduced some changes,
inc additional staffing.

2 Not my point. What is collective view?

5 Want to learn NEDs filtering? first piece is highlow
on QG?

15	Proud herd: ① MRSA → improved on figures. ② interventions → generated by NEDs. + part of process with Royal Colleges. ③ ↓ in paybill: everything predicated by patient robots ④ ↑ NEDs on CQSC. ↓ Got deeply into CHKS data.
2	One area of pride is ↓ in MRSA. Personally, what are you proud of? How know safe from aneurysm perspective?
6	Areas for improvement: QLS linked to 3 domains: → aim to ↓...
2	No. future.
6	① Stroke services improved. Was a time when ashamed of stroke care. → now closer to national averages. ②
2	What is recent on stroke services?
9 ~~6~~	Achievement of ~~9/10~~. 90/10.
~~8~~ 2	So, is that the currency?
6	That, + provision of rapid access treatment,
	AQ: top 2 ~~3~~ of 2 of 4 areas. Bradly of cardiac failure + cardiac arrest Pneumonia + joint replacements,

3	Awake : vacancy : not cost, but ↑ risk of locums. → recruit of new challenge is ↓ing risk.
13	Achieved 99% A+E ; struggled last year. → achieved + proud of.
9	HCAI a massive achievement.
7	-1 reason applied to be NED, : had some complaints on admin ab outpatients. → still concerned about record keeping + need to sort out ——→ [why not play in complaints?]
2	Feels dotted around + technical NED concerns. But acknowledge lot of work done + key issues.
9	Way asked question not answered. We are disappointed.
15	5 years ago, reporting not very good. IPR : ab a glance : finances / quality.
19	Do you benchmark against other orgs.
10	Part of CIKS (sample size of 25)
19	Areas for improvement?
10	Re admission rates → not other byte trying to understand.
6	NEDs asked for audit to be done.

19 Capex was surprising. Except for 1 year, lower than dep^n.
How got assurance

3 Capex on Lancaster: can really want to do, but if push comes
shove, won't do it.

19 Nice to have?

6 Is potential exverance issue.
Quality could be enhanced, but not mission critical.

18 Over life of plan, low capex. How make sure maintain Q of
asset base.

12 Historically, capex is low.
~~Over that time~~

19 ∴ Need to raise at some point?

12 Given condition + estate, high risk some down over history.

19 Is your dep^n too high then?

12 Gearing is high: on 3 sites ∴ replication across 3 sites.
↳ not used intensely.

19 So being depreciated so quickly?

18 1 : Q issue
2 : completions market } over plan, if not invested in Q of provision.

∴ mediated in terms of completion?

12 Believe as board that don't want to do, but would have to.

19 Base plan: except that for one year

12 Hard evidence that reverse is true.

19 And NEDs comfortable on that? Part of 2 day session?

Colchester: Yes

SLR

19 Not heard SLR.

12 Monthly by div; Q by specialty.

a) Shorter form for divisionally CIP programmes.
b) use it to buy + stretch CIP buy by
→ if evidence, certain areas can go further.

10 Chair SLR group; lead clinicians attend yearly;
→ receive reports + filter down to specialties.
Working on getting clinicians to understand Q and finance.

Q:

1b) What table to what not.

10) [Medical Director answers.]

b) Board sees Bubblegrams.

19) Back to low margins, timing, anything that would consider stopping doing?

10) Have to deliver mandatory service: obs, not delivering any change: will make l

19) Could someone else do it for you.

8) Ophthalmology: done work on last year is having 2 emergency wards + on 3 sites:
→ get clinicians + managers together:
→ new model of X-ray ordering
→ ∴ take out half whole tier of on-call weekend.
* → ∴ save good worked examples.

19) Do KGHs accept what linked with?

9) (a) Proactive with partners trumpet tiers on who should be providing what.
→ ∴ c. working directly with Boards.
(b) Socially responsible need to provide services: will normalise it at right as can.

White paper drives ways of looking at service provision.

(c) radiology: position in bubblegrams driven by poor provision
∴ external review.

1	Do NEDs get together + role out 5 challenges for next 6 months.
5	~~QRS~~ include strategy for next few years developed by QR NEDs with other public + partner orgs
8	Reformatted Board Sub-committee to put CQ next to finance. Real coherence in how CQSC developed over last few years.
	Good NEDs challenge: e.g. on stroke services.
10	As GD, felt strategy on NICE + how NEDs could be assured that being implemented.. ∴ nor have robust system on audit of NICE recs.
19	Italia contact than starting from good place; ∴ need to understand that can take out later.
	Dannside
1	What NEDs do on Board, typ not involved on dannside?,
13	Did 2 day session early in year → CIMS → contingency plans. Gone through rigorous assessment + order of priority.
9	Priority driven by Board discussion + driven by 3 principals Don't accept all RAG ratings → look at sample of green.

11 When look at loss-making items, look at full OTI, ∴ some may be loss-making but make contribution to margin.

10 4 years ago, Board approved clinical strategy:
→ 3 sites, unique area, but operate as network
→ can't deliver all services at all hospitals.
→ Board look at each speciality + consider:
→ ophthalmology / ENT / urology / neurosurgical / cardiology.

15 Problems in ~~strategy~~ geography + demographics.
→ ∴ not necessarily right business answer

19 wants to see Boards who challenge orthodoxy + drive innovation.
SLR creates dynamic Boards.

9 Yes, I think has driven CIP development.

2 Redesign, GP contract, conversations, previous clinical sustainability issues to avoid on dealt with →
implication of radical change + risk to delivery?
LT viability issues + what considered as Board?

8 Board having conversation on strategic risks:
→ moving forward, trying to become org that wants to challenge service delivery model
→ cardiology example
→ 2x paediatric services have ⚠ warns to external review
→ look at county-wide provision with PCT.

→ ASR: closed coronary care unit; to cable lots of work;

No-one in NH

last couple of years tried to ensure outward-looking rather than inward looking.

9 Whatever comes out of 'CSR, ...

Respect for uncertainty that Chancellor will charge':

→ Juice or lever to drive charges.

19 BM would say, never waste a crisis

19 Crack: downside scenario of non-viability.

specific issue on capex.

9 Commonly feel got on top of Q issues,

Only Trusts that at least tried to get into local negotiations on paybill.

Chair good / GDs good

Juve ver yoon.

AC Chair.

Chair → what is your Board development programme.?

~~Estate Estate planning~~

Got to get portion that believe to margin will turn round ↑

→ defer CIP programme based on 75% deliverability

± not sure on capex/dep^

Board good enough.

St → impressed with HR, and not as on FT.

→ getting tough.

→ recruitment: task division to ↓ SPAs.

Monitor

Independent Regulator
of NHS Foundation Trusts

Highly confidential

University Hospitals of Morecambe Bay NHS Trust

Board to Board meeting – 8 September 2010

Monitor Non Executives:

Chris Mellor
Stephen Thornton

Assessment team:

[redacted]

Speaking brief

Area	Discussion points
Introduction	Welcome the Trust and inform them that we will first do the introductions round the table and then let them make their presentation. [Trust presentation] Thank you, as you know our approach is to test whether you are legally constituted, well governed and financially viable. I will first ask about legally constituted and then I will pass over to [Richard] who will probe you on your finances, where there will be a number of questions particularly on your future financial viability, and we will want to understand from the Board what planning you have done to address the tightening financial environment. We will then move over to questions of governance and quality.
Legally constituted	In terms of legally constituted, I need to start by saying that we have little discretion in this area. I understand that there is one outstanding area regarding the constitution, namely the title of one of the staff constituencies, which is currently being amended in your constitution and resubmitted to our team. I do need to say if an issue does come up it must be fixed; we have little legal discretion in this area.
Financial questions [Richard Guest to lead]	I normally start with the history then current trading and move on to the financial projections. I have a number of questions to ask you particularly on your current trading position, the Trust's ability to manage in the current economic situation given that you already appear to be quite efficient, and that our sensitivities show a position which is not financially viable (and therefore not authorisable), even after taking some of your mitigations into account. (See areas to probe)
Governance and clinical quality questions	Moving on to the governance area we have a range of areas we would like to probe the Board on. (See areas to probe).
Closing Statements	We should now draw the meeting to a close, before I do can I ask whether there are any areas that were not covered today that you would like to raise? In conclusion: you have heard the concerns raised today on [current trading and financial viability in a downside scenario]. The team will continue to work on your case and the mitigation plans, and we will take our decision at the end of the month. [Depending on how the meeting goes you may wish to say if the trust wants more time to address the downside].

Areas to probe (1/2)

	Key issue	Implication
	Business plan	
History	**EBITDA margin** • EBITDA margin has declined year-on-year (from 9.5% in 2007/08 to 7.1% in 2009/10. • The Trust plan anticipates the margin falling further in 2010/11 to 6.6% (largely explained through income not being inflated and CIP not exceeding the increased cost pressures) before rising year-on-year to a peak of 9.4% in 2015/16 (year 5). • When benchmarked against other trusts, EBITDA margin is below lower quartile in 2010/11 and rises to be in line with the median margin by 2015/16.	• *To the Director of Finance:* a) *Why does EBITDA margin fall despite CIP levels above the efficiency requirement in tariff? ; and* b) *why is margin is anticipated to deteriorate further this year to 6.6%?*
Current trading	**Current trading** • As at end of Month 4 Trust had achieved £0.1m of surplus against a full year plan of £2.0m. • EBITDA margin is low YTD (6.0%) although in line with that planned. Trust that this is due to income being typically lower in April and May as a result of number of operating days and costs being spread evenly over the year. In addition, CIPs are back-ended. • Trust state CIP delivery is on track but £0.8m of 2010/11 schemes are red-rated for delivery and £1.2m are amber-red rated for delivery. • Pay overspend of £1.2m against budget and £0.5m against LTFM plan YTD primarily on medical agency locums (and to a lesser extent, bank nurses) driven by service critical vacancies. Trust states plans in place to secure appointments to vacant posts.	• *Is the Audit Committee Chair confident of delivery of surplus to plan given achievement is weighted towards latter half of year?* • *Does the Board feel EBITDA achievement is low? Do the NEDs understand the factors depressing achievement? How does the current trading picture compare with the same period in 2009/10?* • *How are the NEDS assured about delivery 2010/11 CIPs given current risk ratings assessed by the Board?* • *What plans are in place to stem agency overspend?*
	Demand management / overperformance • Trust has modelled an average of c. 50% achievement of the two main commissioning PCTs' demand management plans. While this is realistic given historical track-record, both PCTs are adamant that need to deliver their 2010/11 demand management plans and that they are not in positions to pay for significant additional activity. • Trust agreed outturn positions with the PCTs in January 10 subsequent to this £1.8m of additional activity was incurred and not paid for in 2009/10.	• *Which does Board consider the more material risk: that PCT demand management plans deliver or that they fail to deliver but Trust is not paid for activity above that planned? How would the Board mitigate these risks?*
Projections	**Future CIP plans** • Trust's future financial viability is dependent on CIP achievement. The £66.3m CIP programme (over 25% of turnover) is forecast to deliver in-year CIPs rising from 3.7% of cost base in 2010/11 to 5.3% of cost base in 2015/16. • Schemes have been developed based on a combination of external and internal benchmarking and E&Y-led review. Historical CIP achievement peaked at 5.7% in 2007/08. While budgeted CIPs levels have been achieved very year since 2006/07 a proportion has been non-recurrent (30%, 25% and 29% in FY08-10 respectively). • The CIP programme assumes a headcount reduction of 861 WTE (c. 19% of existing staff, including 18% of nursing staff, 10% of consultants and 6% of junior medical staff).	• *Given the importance of significant CIPs for financial well-being, how is the Board assured that CIP programme is deliverable? how do the NEDs monitor key milestones?* • *Do the NEDS feel 2010/11 target of 3.7% is low given Monitor and SHA downside planning assumptions?* • *What work was done to assess the level of staff that can be safely taken out?* • *What early warning indicators will the Board use to ensure that removing clinical staff is not adversely impacting quality?*
	Paybill reduction mitigation • The most significant I&E mitigation proposed relates to further headcount reduction. The Trust has completed considerable work on this mitigation including a complete review of all positions at the Trust for criticality of posts ('red pen' exercise). • On top of the paybill CIPs of £4.3m (861WTE), the Trust has submitted a further headcount reduction mitigation , delivered from 2012/13 to 2015/16, and amounting to £13m per year by 2015/16. • The Trust's existing benchmarked nurses per bed ratio is at the lower quartile.	• *The Trust has an already low nurses per bed ratio. How much further headcount reduction does the inclusion of the pay bill mitigation add to current CIP total of 19%?* • *How have the NEDs assured themselves that further headcount reductions will not adversely impact on quality especially given the constraints of three site working?* • *What assumption have been made about redundancy costs if the paybill mitigation is implemented?*
	Downside planning • The Trust has put forward an extensive programme of downside mitigations, and prioritised an order in which schemes would bwe implemented. The assessment team consider some realistic while others require further supporting evidence to be submitted by the Trust. Mitigations (other than paybill reduction) include a number of service developments in various stages of internal planning, fixed asset and land sales, and reduced capital expenditure (see below). • Breakeven mitigated CIP rises year-on-year from c. 4.6% in 2011/12 to c. 7.6% in 2015/16.	• *Can the NEDs give an overview of the board's approach to downside planning? What downside risks did the Board considered? How are NEDs assured Trust is financially viable for the future?* • *Which of the service developments do the NEDS think most credible?* • *Does the board believe it can be financially viable without the paybill mitigation?*
Other	**Capital expenditure** • The Trust is planning to spend less in total on capital expenditure, and states that this is due to plans to reduce the overall size of the estate and to reflect that both the total value of backlog maintenance and specifically the high and significant risk elements have fallen over the last few years. The only year in which capital expenditure exceeds depreciation is 2010/11 when there is a significant level of development capital. • The Trust has submitted capital expenditure reduction as a mitigation and has stated that the largest items in the proposed mitigation are reductions in scope in development capital (Lancaster Hospital reconfiguration) and an increase in charitable funds purchases of equipment.	• *Is it feasible to scale back capital expenditure on the Lancaster Hospital reconfiguration given that it has been identified by both the commissioner and the Trust's NEDs as needing to happen? Is there a cheaper alternative that is worked up as a plan?*

Areas to probe (2/2)

Key issues

Clinical governance (see slide 1.6(b) for further details)

Annual Healthcheck
- Your score for quality of service fell from 'good' in 2007/08 to 'fair' in 2008/09. Why was this, and what are you doing to resolve this?

Board reporting
- Questions to NEDs:
  - *What information does the board see on quality? How are you assured that there are no information gaps?*
  - *How does the board receive assurance on the standards of basic care and safety for patients?*
  - *How do you know which are your best and worst services, and what are you doing about the latter?*
  - *How do you intend to use GURU to drive improvement in quality?*

Robustness of data
- How is the Board assured of the robustness of quality data?
- How does the Trust use it's internal audit and clinical audit functions for quality assurance?

Engagement with stakeholders
- How does the Board take into account the views of patients and staff, other than the annual patient and staff surveys?
- How does the Trust engage with staff on the EQIP agenda?
- Why has the Trust developed a Patient and Public Involvement Strategy?
- How does the Board plan to engage the Board of Governors with the quality agenda?

Complaints
- Questions to NEDs:
  - *What information does the Board see on complaints?*
  - *What (if any) are the major trends within complaints over the last six to twelve months?*
  - *A consistent theme in complaints has been cancelled outpatients appointments. What has the Board done to address this?*

Staff survey
- You had a high response rate this year and overall good results, but in three areas you were in the bottom 20% of similar trusts. This included:
  - staff being satisfied with the quality of care they deliver (69%); and
  - percentage of staff reporting good communications between senior management and staff (20%)

  What actions are you taking to improve results?

Lessons learned
- What lessons have you learned as a result of the Mr Titcombe's complaint and the subsequent maternity investigations?
- What (if anything) do you plan to change as a Board following the findings of the Francis Report?

Frequency of meetings
- Question to Chair of Clinical Quality and Safety Committee:
  - *The CQSC only meets five times a year. Do you think that this is sufficient given the size of the quality agenda?*

Financial governance questions

- Are there any issues coming out of the independent accounting firm's work?
- What is the status of the contract sign-off with NHS Cumbria? Are there any further risks to your projected 2010/11 income?

Postponement issues

The Trust's application was postponed in May 2009 due to concerns around a potential CQC investigation into maternity SUIs.

Assessment team comments	Resolution
Key issue preventing authorisation – CQC concerns with the maternity services	
• As at the date of the original Board to Board, 5 of the 12 SUIs reported at the Trust related to maternity services. • Subsequent to Monitor bringing the SUIs to the attention of CQC and further information on the 4th SUI (Titcombe SUI, November 08) being received by CQC directly from the complainant the CQC risk rating was raised to 'concern' and a review instigated. • Monitor wrote to the Trust informing them that the assessment was postponed pending the outcome of the review. • In June 09 the SHA confirmed to Monitor that following their review of the initial external reports along with meetings with the Trust and PCT, they were confident the Maternity unit was fit for purpose and that the Trust has a sound process for managing and reporting SUIs • In July 09 the CQC, following the publication of the Charles Flynn report, raised the risk rating of the Trust to 'serious concern' based on the output from the Charles Flynn report and around systematic problems caused by variations in cross-site practice. • In August 09 the CQC confirmed that they were in receipt of comprehensive action plans from the Trust to address the issues in the Charles Flynn report and the Trust has been downgraded to amber risk which would remain the case until the CQC believed that the Trust was able to demonstrate the embeddedness of action plans implemented following the external reviews. • The Titcombe complainant also wrote to the Parliamentary and Health Service Ombudsman (PHSO).	• Following the Titcombe SUI the Trust commissioned a number of independent external reviews to look at maternity services form every angle including systems and processes, training, record keeping, staffing levels and multi disciplinary policy development. • These included: ○ An external review undertaken by Consultant Obstetrician and Medical Director at Wrightington Wigan and Leigh NHS FT and Chair of NW Heads of Midwifery Group; ○ NW Local Supervising Authority Review of Midwifery Practice; ○ Midwifery Unit Management Practice Review – led by Mr Charles Flynn; and ○ Workforce Planning Assessment of staffing levels (Birthrate Plus) – final report received February 10. • The above reports identified a number of shortfalls around staffing levels, multi-disciplinary working and communications between midwives and consultants which the Trust incorporated into action plans and consolidated alongside additional internal quality enhancing initiatives such as the Nursing and Midwifery Strategy (launched Winter 09 and designed to give the Board and the public assurance that quality of care is being delivered, to consolidate good practice for staff, re-energize morale and rebuild confidence while underling accountability). • CQC has commented that Trust has worked closely with them to demonstrate actions plans have been implemented and changes made to address concerns. The Trust has developed and implemented a Maternity Risk Group, Children's Safety Group, Labour Ward Forums and Obstetric Update and Issues – all of these are Trust-wide and multi-disciplinary. Minutes of groups have been received by the CQC to demonstrate forum make-up and agenda items. The Trust can demonstrate systems have been introduced for developing: ○ RAG-rated risk assessments; ○ risk reviews of staffing, theatre provision, and midwives roles; ○ review of CNST guidelines and incident analysis and lessons learnt from these. • At the regional risk panel in February 10, the SHA stated they were monitoring the Trust and were satisfied with actions the Trust had taken with regards to the Titcombe SUI and other regulators had no concerns with the Trust; this resulted in the risk rating being downgraded from amber to green. • **The Trust was registered without compliance conditions March 2010 and** CQC wrote to Monitor on April 16th to confirm that its level of concern had reduced to minor concerns. The CQC decided to carry out responsive reviews in the two specific areas where they had minor concerns: maternity and A&E • CQC indicated to Monitor 9th August that following their maternity review , which included an unannounced inspection at FGH on 29th June 2010, they are satisfied that the Trust is complaint with all required standards of safety and care in this area. Their review report highlights that a robust system for multi disciplinary working is in place, a Midwifery Action Plan for 09-12 details the vision for maternity services over the next 3 years, that the Trust has undertaken a full review of staffing and addressed identified shortfalls with action plans; that processes for learning from clinical incidents are in place and that audits are undertaken to ensure care records are completed correctly. • The SHA have informed us that there will be an inquest into the specific SUI but that they believe there are no further facts to uncover or issues to deal with. In addition, the Ombudsman has confirmed that it had decided not to investigate the Titcombe complaint.
Other issue highlighted during the original assessment	
Future financial performance – Equal Value Pay Claims • At the time of the initial Board to Board the Trust faced legal action from 1,440 claimants on ground of equal pay.	• Since April 09, 732 claims have been withdrawn and 190 claims have been struck out. • Assuming that all of the anticipated further strike outs take place, the Trust will then have 706 live claims, which is about 50% of the claims as at April 2009. • See Appendix 4.8 for further details.

Maternity concerns addressed; CQC registered the Trust without conditions, responsive review into maternity positive.

Contents

Section 1

1.1 Authorisation decision

Executive Summary

Trust type	Large Acute Trust	**RCI MFF (07/08)**	97	**Quality of services**	Fair (2008/09)	Good (2007/08)
Audited revenues	£249.3m (2009/10)			**Financial management**	Good (2008/09)	Good (2007/08)
Registration status with CQC: Unconditional						

Checklist		Key authorisation issues	Resolution
Legal compliance	O	One minor outstanding issue with constitution.	Trust is amending it's constitution post Board-to-Board.
Financial viability and sustainability			
• Working capital	O	Ongoing work with independent accountants; no major issues to date.	Report expected on 17 September 2010.
• 5 year plan	O	**LTFM forecast**: Based on declining NHS clinical revenues (1.4)% total revenue CAGR (£217.7m 2010/11 to £204m 2015/16) delivering net surplus (normalized) of £7.8m and cumulative cash balance £40.0m by 2015/16.. **Surpluses:** driven by £66m CIP programme (minor contribution from single service development - RLI reconfiguration, contributes £0.4m p.a. to EBITDA from 2012/13). CIPs based on 6 themes: Support Services (24% total), War on Waste (19% total), Cross Site working (13% total), Pay bill Reduction (8% total), Redesign Clinical Pathways (5% total) and Lorenzo (2%). Unidentified schemes account for 29% and occur predominantly in years 4-5. **CIP drivers include**: medical productivity **(**reductions in length of stay, pre-operative elective and non-elective bed days), staff savings (861 WTEs / c 20%) of workforce achieved through natural wastage; pay costs account for 73% of total expenditure), centralisation of diagnostics. CIPs increase from 3.7% in 2010/11 to 5.3% (£11.9m) in 2015/16. Historical CIP achievement peaked at 5.7% (3.9% on recurrent basis); 2009/10 achievement was 3.5% (2.5% recurrent basis). **Capital programme**: £49.0m; includes £8.0m for RLI redevelopment and £35.7m for maintenance of existing premises. All funded by retained surplus – no planned borrowing. **Trust not currently financially viable in mitigated 4.5% downside.**	Generic together with Trust specific sensitivities applied to base case to reflect risks identified including: CIP achievement, unfunded activity, agency overspend and Equal Value Claims (EVC). In addition, CQUIN (which Trust included in base case) removed in part in 10/11 and in full from 11/12 onwards. •**CIP sensitivity** £7.3m in D/C reflecting non-achievement of 15% by 2015/16; sensitised CIP peak of 4.5% (2015/16). Income generating CIPs removed. **Unfunded Activity sensitivity** in D/C of £0.9m and £0.6m in 2010/11 and 2011/12 reflecting 100% achievement of PCTs' demand management plans. **Agency overspend sensitivity in** A/C of £0.5m and £0.3m in 2010/11 and 2011/12 reflecting 2010/11 current trading pressures. **EVC sensitivity** in D/C of £3.9m assuming that100% of the known claimants and 25% of the unknown claimants are successful with the impact spread across three years from 2013/14 to 2015/16.**Service development** not sensitised; some further service developments allowed in mitigation on evidence of advanced plans and external support. **Mitigations** proposed deliver £26.9m improvement to I&E and £112.5m of cumulative cash. Work ongoing to assess credibility.Maximum CIP under the allowed mitigated downside : 5.7% of cost base in year 2015/16. Currently Trust not financially viable in mitigated downside. Most significant mitigation proposed relates to further Headcount Reduction (c.£13m improvement in I&E by 15/16) partial allowance of which would support Trust financial viability but further work required post B2B to understand full impact.
• PBC ratios	✓	No issues.	
• PPI cap	✓	No issues.	
Governance			
• FRP	O	Ongoing work with independent accountants; no major issues to date.	Report expected on 17 September 2010.
• Corporate governance	✓	08/09 Annual Health check "fair" due to: 1 core standard not met (NICE technology appraisals); 6 national priority indicators and 3 existing commitments not achieved.	
• Quality Governance	O	On work to date, the Trust score 3.5 (7 A/G). Issues: inconsistencies in divisional quality reporting, review of Board reporting, and data robustness.	Score to be finalised post B2B .
• CQC's confirmation	O	Minor concerns. CCQ responsive review into maternity (June 2010) positive; CQC satisfied Trust compliant; minor concern resolved.	Final confirmation due from CQC on 17 September 2010.

✓: satisfactory. O: open issues. ✖ significant concerns.

1.2 Trust overview

Executive Summary

Trust basics

- Trust operates from three main hospital sites plus various community facilities. Royal Lancaster Infirmary ("RLI" or "Lancaster Hospital") is largest (c.507 beds) and oldest (site developed in phases and comprises a mix of listed and newer buildings) while both Furness General Hospital ("FGH") in Barrow (c.349 beds and most geographically isolated site) and Westmorland General Hospital ("WMG") in Kendal (c.139 beds) are newer builds. Each site provides a similar range of services including outpatient, day case and impatient surgery, diagnostics and therapies although following an Acute Services Review' in 2006 the Trust, with support of PCTs, concentrated acute medical care in RLI and FGH leaving a primary care assessment service at WMG (since transferred to Cumbria).
- Services primarily provided to the residents of South Cumbria (NHS Cumbria) and North Lancashire (the two accounting for 97% of 09/10 income). Catchment population is c.363,000 spread across area of 1000 square miles with additional seasonal activity driven by tourists. Journey time of c.47 miles (in excess of 1 hour) between 2 main hospital sites.
- A largely new management team was put in place in 2007 and 2008, including new Chief Executive (clinical background, previously led a successful FT application) and Chair (clinical background and significant experience within NHS at senior level). The Board has 3 EDs who are accountants and one NED (AC Chair) who is an accountant.
- The Trust is the leading acute trust for implementation of the LORENZO electronic patient record system which went live in May 10. Non-recurrent costs of £3.3m were incurred, funded by the DH/SHA, in 2009/10 and 2010/11 (payment in advance). LORENZO will drive significant benefits for the Trust e.g. multi-resource scheduling for staff and integrated systems for beds, theatre and outpatients.

Turnover (2009/10 audited)	£249.3m	**Total assets (March 10)**	£172.5m
Employees WTE (March 10)	4,304	**Beds (March 10)**	995

Target achievement 2009/10	**Actual**	**Target**
National requirements		
MRSA	12	12
C.Difficile	85	292
Minimum standards		
MRSA screening	92%	100%
A&E - 4 hours	98.1%	98%
Thrombolysis (Call to Needle)	60%	68%

Cancer targets

During 2009/10 the Trust met all standards, including the new standards introduced in year (e.g. Symptomatic Breast Screening).

- The Trust is rated **FAIR** for Quality of Services and **GOOD** for Financial Management in 2008/09 (Good and Good in 2007/08 respectively).
- The Trust is **AMBER/GREEN** rated for governance. All compliance framework targets were met in 2009/10 with the exception of thrombolysis (call to needle).

- **Trust's vision: "The needs of our patients will drive everything we do".** Strategy focuses on performance consolidation, enhancing reputation and ensuring sustainability. Trust-wide intensive focus on quality in 2009/10 has resulted in: Efficiency & Quality improvement Programme (EQIP) aimed at improving quality of care via taking out unproductive costs and ensuring all service improvements are made with the full engagement of staff and clinician; launch of Nursing & Midwifery Strategy (impacting 70% of staff) to ensure fundamental practices of care are consistent and high across all sites and establishment of 'GURU, a ' 'Ward to Board' assurance framework of real time performance data. Trust awarded £0.2m for performance in pneumonia and hip & knee in 09/10 under under NW Advancing Quality Initiatives
- Sole LTFM service development is redevelopment of RLI (contributes £0.4m to EBITDA by 2014/15). Reconfiguration is discretionary but represents significant qualitative gain enhancing patient experience and boosting staff morale. Improved clinical pathways will improve patient flow. Internal plans also recognize potential to grow service base e.g. development of a satellite radiotherapy unit at WGH; repatriation of out of area activity and retraction from loss-making diabetes service
- In-year CIPs rise from 3.7% to 5.3% of cost base by 2015/16. Major themes: reducing LoS, consolidation of support services (pathology/radiology) and cross-bay working as Trust addresses economic and clinical challenge of running services in duplicate/triplicate across sites. Plans include bed reductions (995 to 840,16%) and WTE (861, c.20% of staff).
- After some delays, driven by disputes around future impact of demand management schemes and marginal rates for over activity, contract signed with NHS North Lancashire and financial envelope agreed with NHS Cumbria. NHS Cumbria recently settled a £20m arbitration with N.Cumbria NHS Trust.
- Trust has included £49.0m of capital expenditure in the base case (excluding service development spend, £8.0m) of which £35.7m is maintenance capex.

	10/11	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**
I&E (base case)	£2.0m	£2.8m	£4.9m	£5.1m	£6.2m	£7.8m
Capex	£10.3m	£8.6m	£8.2m	£7.3m	£7.3m	£7.3m

Income sources (2010/11 plan)	£m	£m
Elective	46.9	
Non-Elective	71.5	
Outpatient	38.3	
A&E	7.7	
Non-tariff income / other NHS clinical	53.3	
NHS clinical income		217.7
Education and training		8.7
Research & development		0.6
Other income		22.4
Total income		**249.3**

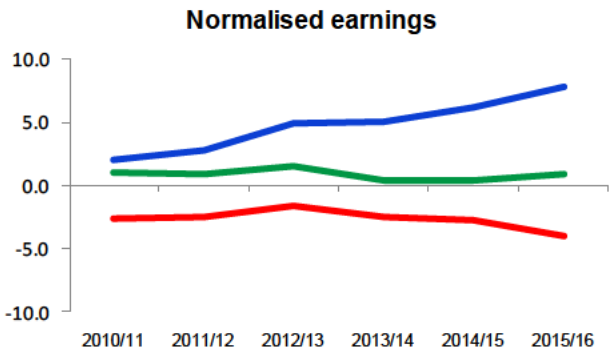
Historical financial performance

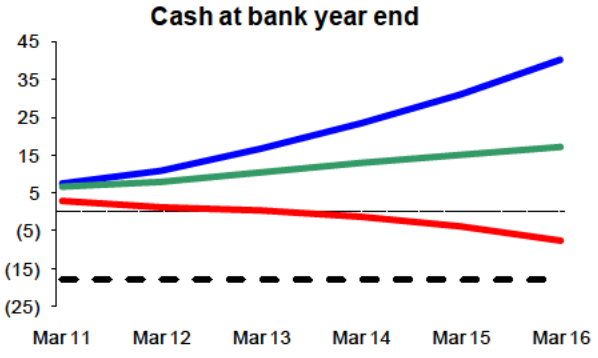
	07/08	**08/09**	**09/10**
Normalised I&E	£3.3m	£1.1m	£2.1m

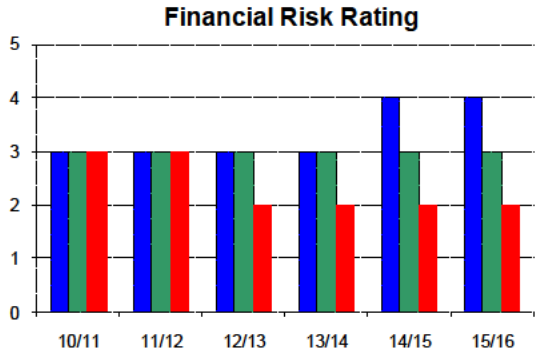
The Trust was placed in turnaround in 2005/06 by NHS North West. Following c.£23m cost improvement programme Trust considered financially stable exited turnaround in August 08.

Commissioning PCTs	**Contract value**	**Relations**	**Financial position 2009/10**	**2008/09**
NHS Cumbria	£124.5	Transition to ICOs	Breakeven	£0.3m
NHS North Lancashire	£84.1m	Pragmatic	£1.5m	£2.0m

1.3 Financial scenario analyses







Base case | Assessor | Downside | WCF = £18m

1. The Trust's base case is predicated on achievement of significant CIPs with no service developments modelled and an implied efficiency of c.4% from 2011/12.
2. Currently the Trust remains not financially viable in the downside mitigated case.
3. Trust would be viable if paybill mitigation is allowed (see slide 1.5). **Further work to be performed post B2B**.
4. Cash position in the assessor case strong, due to high levels of cash in the base case, in part driven by low maintenance capex at 55-65% of depreciation in each year.

Assessor Case

£m		I&E Impact (£m)						Cash Impact (£m)					
		10/11	11/12	12/13	13/14	14/15	15/16	10/11	11/12	12/13	13/14	14/15	15/16
Base case		**2.0**	**2.8**	**4.9**	**5.1**	**6.2**	**7.8**	**7.5**	**10.9**	**16.6**	**23.3**	**30.9**	**40.0**
Tariff Income and costs	4% efficiency	-	0.0	(0.4)	(0.5)	(0.3)	(0.1)	-	0.1	(0.3)	(0.5)	(0.7)	(0.7)
CIPs	95% achievement in 10/11, 90% from 11/12	(0.5)	(1.7)	(2.9)	(4.1)	(5.4)	(6.8)	(0.5)	(2.1)	(5.1)	(9.2)	(14.6)	(21.4)
Agency	Overspend on agency costs	(0.5)	(0.3)	-	-	-	-	(0.5)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)
Assessor Case		**1.0**	**0.9**	**1.5**	**0.4**	**0.5**	**0.9**	**6.5**	**8.1**	**10.5**	**12.9**	**14.8**	**17.1**

Downside Case

£m		I&E Impact (£m)						Cash Impact (£m)					
		10/11	11/12	12/13	13/14	14/15	15/16	10/11	11/12	12/13	13/14	14/15	15/16
Assessor Case		**1.0**	**0.9**	**1.5**	**0.4**	**0.5**	**0.9**	**6.5**	**8.1**	**10.5**	**12.9**	**14.8**	**17.1**
Tariff Income and costs	4.5% efficiency	(1.1)	(1.2)	(2.5)	(3.7)	(4.8)	(6.0)	(1.1)	(2.3)	(4.8)	(8.4)	(13.1)	(19.1)
Activity	Monitor generic assumption for unfunded activity	(1.1)	(1.3)	(0.6)	(0.2)	-	-	(1.1)	(2.4)	(3.0)	(3.2)	(3.2)	(3 2)
Activity	100% demand management in 10/11 and 11/12	(0.9)	(0.5)	-	(0.0)	(0.0)	(0.0)	(0.9)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)
CIPs	15% non-achievement in 15/16, and 15% non-achievement for additional CIPs identified buy Trust during assessment	(0.5)	(0.6)	(0.9)	(1.3)	(1.7)	(2.3)	(0.5)	(1.1)	(2.0)	(3.3)	(5.0)	(7.3)
CQUIN	20% costs in 10/11, removed from 11/12	(0.3)	(1.2)	(1.1)	(1.0)	(0.9)	(0.8)	(0.3)	(1.4)	(2.5)	(3.5)	(4.4)	(5.3)
EVC	Equal value claims estimated payment in 13/14	-	-	-	-	-	-	-	-	-	(1.3)	(2.6)	(3 9)
Mitigations	Refer to summary mitigation slide	0.2	1.4	1.9	3.3	4.3	4.2	0.2	1.6	3.5	6.8	11.1	15.3
Mitigated Downside Case		**(2.6)**	**(2.5)**	**(1.7)**	**(2.4)**	**(2.7)**	**(4.0)**	**2.9**	**1.0**	**0.2**	**(1.4)**	**(3.9)**	**(7.8)**

* *The efficiency assumption in 2010/11of £1.1m should cumulate – to be adjusted post Board-to-Board.*

Trust is not currently viable in the downside case – further work required on paybill mitigation.

1.4 Business plan summary

	Key area	Summary	Sensitivity
Activity	Commissioning	• Trust has assumed that population growth of 4% over 5 years will mostly be offset by PCT demand management plans. • LTFM assumes broadly 50% of demand management is achieved (Trust has used PCT contract intentions for their calculations and then assumed that that NHS Cumbria will deliver 50% of plans and NHS North Lancashire 25% in the early years rising to 100% in later years). • This was based on a Trust review of all PCT demand management schemes to assess feasibility of deliverability; Trust points to poor historical performance to support their lack of confidence. • In addition, the Trust commented that to reduce capacity in line with PCT predictions carried too much associated risk if activity was not reduced i.e. Trust takes out capacity but demand continues. • While PCTs stated that the Trust has not taken into account the current transition to GP-led commissioning a review of demand management plans from PCTs indicated that were not materially different from the Trust's figures, with some outer years figures assumed by the Trust to be more prudent than PCT plans. • PCT commissioning intentions modelled were based on PCT strategic plans provided in March 10 in connection with 2010/11 contract negotiations. While PCTs have made subsequent changes to plans these have negligible impact. • Demand management and its impact was an area of debate in contract negotiations. • Trust finally agreed marginal rates for over-performance. • With NHS North Lancashire :1% above 2009/10 outturn @ 30%; 1-2% @ 50% and above 2% at full tariff. • With NHS Cumbria: up to £0.5m above contract is no payment; £0.5m to £1.0m above contract @ 30%, £1.0m to £1.5m @ 50% and above £1.5m at full tariff. • In 2009/10 £1.8m of over performance was not paid for.	Generic assumptions applied for unfunded activity, and additional sensitivities applied in 2010/11 and 2011/12 – the years in which Trust assumed <100% achievement of PCTs' demand management plans.
	Competition	• The Trust faces limited competition due to the geographical spread of its population. • There is a small BMI hospital in Lancaster with limited facilities. The Trust believes BMI are looking to close the site as wards are currently only open every other week. The PCT does not consider this to be a threat to the Trust. • While a Ramsay Healthcare centre opened on the Kendal Hospital in June 08 offering Orthopaedics, General Surgery and ENT (5 year contract c. £5m), the local GPs, public and NHS Cumbria have not been supportive believing that to do so will threaten future of Kendal Hospital. The trust has stated that Ramsay is actively looking to work with the Trust to boost their low volumes and the Trust anticipate Ramsay will leave at or before contract expiry. • In addition, £3.3m of activity for the Trust population currently flows to neighbouring Trusts. The Trust is planning to repatriate 25% of this activity through working with local GPs is included in the base case, amounting to £0.8m in total.	No competition sensitivity applied.
	Readmission	• Revisions to the Operating Framework 2010/11 highlights that from December 10, further income will not be paid on patients readmitted within 30 days of discharge. The Trust does not believe that this will have any material effect on them - the current patient readmission rate is c. 3% (excluding births and regular or planned visits).	No sensitivity applied.
	Service developments	• The Trust has one service development within the base case - the reconfiguration of Lancaster Hospital, which is assumed to have no impact on income, but is an enhancement to the Lancaster hospital site. • The site requires remodelling to improve patient flows and enhance quality operational efficiency. • £8m of capital expenditure over a three year period is planned, however the outline business case has yet to be finalised and presented to the Trust Board for approval • A further nine service developments, in varying stages of internal planning, proposed as mitigation. Trust has RAG-rated these and assessors reviewed evidence of advancement of plans, local need and external support.	No sensitivity applied.
	Tariff changes and tariff inflation	• No inflation has been modelled for 2010/11 and the Trust has assumed deflation of 1% p.a thereafter. • These assumptions are broadly in line with Monitor's, however from 2012/13 onwards the generics assume deflation of 1.5% in the downside case.	Generic assumptions applied. Impact of £5.2m by 2015/16 in DC.
	CQUIN	• The Trust estimate £3.3m CQUIN revenue for 2010/11 and assumes 38% contribution (i.e. £1.3m). • The Trust received £1.5m of CQUIN in 2009/10 and met all its quality targets during the year. • From 2011/12 the Trust has assumed £3.3 for CQUIN, contributing £1.3m p.a.	Removed all income and associated costs from 2011/12 in DC and 20% contribution from 2010/11.

1.4 Business plan summary

	Key area	Summary	Sensitivity
Cost base	Employee benefits expense	• Inflation of 2.0% in 2010/11, 1.9% in 2011/12 and 1.5% p.a. thereafter. The inflation assumption is based on the A4C pay awards and include the 1% National Insurance increase. • Consultant contract 0.7% 2010/11 and 0.8% p.a. thereafter; incremental drift 1.4% 2010/11 and 1.1% p.a thereafter. • AfC varies between 1.2% p.a. and 2.2% p.a. depending on staff category - the assumption is based on actual costs incurred in 2009/10.	Generic pay assumptions applied. Trust benefits by £4.1m by 2015/16 as a result of prudent assumptions, however low cost inflation assumptions net off this benefit.
	Drugs and other costs	• Drug inflation of 5% p.a. from 2010/11 onwards. In addition the Trust has modelled additional inflation for NICE guidance of between 5.2% and 4.3% within its base case. This is broadly in line with the generic assumptions. • Other expenses inflation of 2.5% in 2010/11 and 1.5% from 2011/12 onwards (compared to Monitor's generic assumption of 5% from 2011/12 onwards). • Monitors generic assumptions assume an implied efficiency of 4.5% in the downside case from 2011/12. The Trust's implied efficiency is c.4% from 2011/12.	Trust drug inflation rate raised to Monitor generic assumption - results in £0.2m adverse impact by 2015/16. Clinical supplies and other cost inflation adversely impacts by £6.4m in 2015/16.
	CIP	• The Trust has assumed CIPs of up to 5.3% in the outer years of the LTFM. • The planned savings will be driven by the Trusts Efficiency and Quality Improvement Programme (EQIP) programme. EQIP was developed in early 2010 and identified savings by grouping them into six workstreams. • Workstreams have varying degrees of backing detail with outer years plans being less defined, however all the schemes for 2010/11 have been risk rated for delivery. • All the schemes within the workstreams have had a 'Quality Impact Assessment' (QIA) performed which risk rate the impact of the schemes against the three domains of safety. • Larger schemes in the workstreams include efficiency gains through reducing length of stay (c. £4m); a review done by Better Care Better Value (BVBC) highlighted £16m of potential productivity gains from a 25% improvement in key BCBV indicators . Rationalisation of pathology and radiology contribute £5.7m, the Trust has plans to rationalise support services from three sites to two sites. ○ While £19.6m of total CIP programme equates to unidentified schemes Trust has only included a small proportion of BVBC productivity gains in plans. E.g. of the £8.6m identified by BCBV under the LoS indicator, Trust identified £3.2m in its EQIP programme.	CIPs reliant on successful implementation of all work streams. Sensitivities applied to reflect risk of slippage and non- achievement. Total sensitivity of £6.8m (10% of total) by 2015/16 in AC and a further £2.3m (total 14%) in downside with CIPs reduced to a peak of 4.5% in 2015/16 in latter. All income generating CIPs removed.
	Current trading	• As at month four 2010/11, the Trust's current trading position had improved with a surplus of £0.1m against a planned break even position. The Trust comment that the deficit in the first two months was a planned as costs are profiled evenly during the year and majority of CIP achievement is planned for the latter half of the year • As at month four, the Trust has overspent on agency costs by £1.2m (against budget), although some of this has been recouped with lower medical staffing spend of £0.5m. This is viewed by the Director of Finance as the most critical expenditure issue facing the Trust.	Agency overspend sensitivity applied of £0.5m and £0.3m in the AC in 2010/11 and 2011/12 respectively.
	Capital programme	• The Trust has included £41.0m of capital expenditure in its base case (excluding service development spend), of which £35.7m is maintenance capex. The Trust has prioritised all capital spend to ensure all critical backlog maintenance is performed. • No inflation has been assumed on the capital expenditure.	No sensitivity applied.
	Working capital	• Balance sheet assumptions are in line with historical trends. • £18m working capital facility planned. Trust is reviewing draft terms from Barclays.	No sensitivity applied.
	Other	• At the time of the previous B2B, the Trust had received 1,440 Equal Pay Claims (75% Stefan Cross, remainder the unions). The latest position is 381 known claims. • The Trust's estimate does not include legal costs and estimates £3.3m for paying out on known claims (in a downside scenario) appears reasonable. The calculation is based on the methodology used in Cumbria Partnerships FT's assessment.	Sensitised 100% of known cases and 25% of unknown cases. Downside case cash impacted in across three years from 2013/14 to 2015/16 by £3.9m.

1.5 Summary of mitigations

- In the event of downside scenarios Trust has considered a range of mitigating actions and ranked these according to priority of implementation. Over the 5 year period these produce a maximum of £26.9m improvement in I&E performance. Assessment team divided these into those allowed in full/in part in the first instance (average of 20%; deliver £3.6m improvement in I&E performance and £16.7m of additional cash) and those disallowed as a result of requiring more robust supporting evidence or not viewed as realistic.
- The most significant mitigation proposed relates to further headcount reduction ("red pen exercise: pay") delivering a c.£13m improvement in I&E by 2015/16.Headcount reductions are based on a Trust exercise under which all posts were ranked for criticality. This identified up to £24.3m of savings (based on removal of all posts ranked 1 or 2 out of 5).
- Trust included £4.3m of headcount reductions in its CIP progarmme and submitted implementation of a further £13m as a further headcount reduction mitigation. Partial allowance of this mitigation would support Trust financial viability but further work required post B2B to understand feasibility of contemporaneous roll-out and safety impact.

	Trust priority	Mitigations	Explanation	Monitor's assessment	I&E impact 10/11	11/12	12/13	13/14	14/15	15/16	Cash impact 10/11	11/12	12/13	13/14	14/15	15/16
Accepted and Applied	=1	Service developments	• Service developments allowed as part of mitigations (see slide 2.4 for further details): o MoHs surgery o Wet age-related macular degeneration (AMD) o Diabetes o Ambulatory cancer care centre	• Considered realistic. o 100% contribution. o 100% contribution. o 100% contribution. o 75% contr bution.	-	1.1	1.5	1.5	1.5	1.5	-	1.1	2.6	4.1	5.6	7.1
	=1	Lorenzo related benefits	• Lorenzo went live in May 10 and implementation of the system has been considered successful. Benefits include various schemes to support customer service, minimise waste and standardize best medical practice: savings on medical secretaries, medical records, outpatient efficiency and prescribing.	• Base case Lorenzo savings are understated/ • Proposed mitigation discounted by 25%.	-	0.2	0.5	1.9	2.9	2.9	-	0.2	0.7	2.6	5.5	8.4
	5	'Red-pen exercise': non-pay	o As part of "red-pen" exercise below Trust has identified non-pay elements within divisions which could be removed in downside scenario e.g. removal of non-mandatory training.	o Considered realistic. o 100% contribution.	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.4	0.6	0.8	1.0	1.2
Total mitigations applied *(difference between these numbers and slide 1.3 is inflation and rounding)*					0.2	1.5	2.2	3.6	3.6	3.6	0.2	1.7	3.9	7.5	12.1	16.7
Total Trust Mitigations Proposed					1.1	5.0	11.9	19.0	24.8	26.9	1.1	6.1	18.0	41.0	73.7	112.5
Total % applied at B2B stage					18%	30%	18%	19%	15%	13%	18%	28%	22%	18%	16%	15%

	Priority	Mitigations	Explanation	Monitor's assessment
Further evidence required	=1	Service developments	• Further service developments (see slide 2.5).	• Further evidence needed on some developments.
	=1	Revisions to the Operating Framework 2010/1	• Relates to local pay arrangements and reducing amount paid for waiting list initiatives. • I&E impact of £0.5m p.a. in 2010/11 and £1.0m p.a. from 2011/12 onwards.	• Further evidence on basis of calculation to be provided by Trust.
	3	Reduction in sites	• Trust to cease work at an old hospital, Queen Victoria Centre and stop leasing space from NHS Cumbria at Ulverston Health Centre. • I&E impact of £0.4m p.a. (reduction in capital costs and overheads) from 2011/12 onwards. Cash impact of land sale would be c.£3.6m	• Further evidence needed on ability to cease work at Queen Victoria Centre in 2010/11 and that the Trust could stop leasing the PCT space by April 11.
	6	'Red-pen exercise': further headcount reduction exercise on top of existing CIP	• Trust undertaken a "red pen" exercise, whereby all staffing posts have been reviewed to identify which posts could be removed in a downside scenario. • Post reduction scheme provides opportunities for savings should they become essential for financial viability.	• **Not included within mitigated position, but considered as being potentially deliverable in part, c. 50%, subject to further work post B2B.** • Redundancy costs of 7.5% of allowable pay bill reduction would be applied as part of the DC sensitivities were this mitigation to be partially allowed.
Not considered realistic	2	Reduced capex	• Trust to reduce capex by 25% in 10/11, 30% 11/12 and 35% p.a. thereafter. • Total I&E impact of £1.1m and cash impact of £13.1m.	• Not considered realistic as levels of maintenance capex are already low in the LTFM.
	4	Implementation of Core Business Review	• Trust has identified services it is providing (to both commissioners and social care authorities) that do not attract tariff and are unpaid for. • Trust will withdraw these services if they are not paid for • Total I&E impact of £0.5m in 2011/12 and £1.8m p.a. from 2012/13.	• Not considered realistic given non-payment for overperformance in 2009/10.
	N/A – cash mitigation	Land sales	• £8.3m of surplus land identified. • Nine discrete areas of land across three sites.	• £11.9m is at NBV (valued on a modern equivalent asset basis). Trust is currently obtaining a commercial valuation for one of the nine areas of land following challenge from the assessment team.. • Mitigation not considered credible at this stage given lack of commercial valuations, analysis of site usage, sale method etc..

Further work required post-B2B on mitigations to determine financial viability.

1.6a Governance summary

Key area	Summary	Resolution / Conclusion	Risk
Statutory requirements Membership. Board structure	• Legal sign-off received at time of postponement. No material changes since original assessment. • No issues with membership. • No issues with Board structure.	Final sign-off required from legal team.	●
Organisational capacity	• Chief Executive (clinical background, previously led a successful FT application) is highly regarded by staff as a visible and accessible presence while Chair (clinical background and significant experience within NHS at senior level) has driven more external focus in particular building and sustaining relationships. EDs include Director of Service & Commercial Development, a qualified accountant who has previously held Turnaround posts. Director of Nursing praised by CQC and SHA as innovative and focused on driving real improvement. • Board benefits from mix of longer term NEDs with considerable background knowledge and newer appointees. NED Chair of CQSC has a clinical background while 2 most recent NEDs appointments (December 08 and April 09) have respectively have Strategic IT and Legal/Ombudsman backgrounds respectively. • Following introduction of Clinical Quality and Safety Committee ("CQSC") in 09/10, Board agenda has become more focused on Quality and Governance and the structures supporting the patient safety and care emphasis increasingly embedded and sustainable. SHA comment that Trust has been responsive and open in dealing with operational issues and that team working has improved as a result. • Significant work undertaken by Board during regular development sessions. Areas covered include: External Audit workshop on Board's attitude to risk management and governance, future environment (quality/ people /money), RLI redevelopment, key messages from Francis Inquiry, Monitor's Quality consultation and Trust Quality Improvement Strategy. NEDs also organised two internal workshops (EQIP and CHKS data scrutiny).	No further issues.	●
Performance management	• Integrated Performance Report (incorporating service quality, clinical targets and finance measures) is used to discuss issues at each monthly Board/Financial Performance and Scrutiny Committee. Trends are shown graphically. Minor concerns over 'information overload' and duplication of reporting.	IPR is under regular review.	●
Risk management & controls	• Risk management policies and processes appear comprehensive and embedded throughout organisation. • Trust has secured CNST II accreditation for Maternity Services and NHSLA II for all services which gives assurance that systems for managing risk have a degree of robustness.	No further issues.	●
Financial reporting procedures	• To date no significant issues raised by independent accountants or by Internal Audit and External Audit.	PwC's FRP opinion expected 17 September 10.	●
Compliance Framework / Healthcare targets and standards	• Current performance is amber-green with a score of 1.0 (thrombolysis and MRSA screening targets). Trust is working with North West Ambulance Service to improve the call to needle time.	No further issues.	●
Clinical quality	• SHA comment that Trust is continuing to improve range and strength of its incident reporting; latest Patient Safety Incident Report (March 10) places Trust in middle 50% for reporting incidents. Trust has also moved to an e-reporting system which has hugely speeded up reporting times. • Number of serious incidents during 2009/10 was 9 (compared to 12 in 2008/09 and 4 in 2007/08) which represents 0.1% of all reported safety incidents for the year. Trust established a knowledge, education, learning and development directorate in 2009 to develop the concept of the learning organization and support work undertaken to get a robust approach to lessons learnt. Trust published a summary of lessons learned from SUIs in its Quality Account. • Trust has Quality Improvement Strategy supported by a number of developing tools for assessing quality of care. These include real time Board to Ward Assurance reports (GURU) which are discussed at every Board meeting and Nursing and Midwifery Quality assessment tools which complement Nursing and Midwifery Strategy (launched 2009/10) to ensure fundamental practices of care are consistent and high across all sites.	No further issues.	●

● Low risk ● Medium risk ● High risk

1.6a Governance summary

Executive Summary

Key area	Summary	Resolution / Conclusion	Risk
Clinical quality cont.	• Each CIP scheme is assessed within Trusts EQIP progarmme for its quality impact on patient safety, clinical effectiveness patient experience and staff engagement and RAG rated; Trust monitors ongoing impact on quality through benchmarking, external reviews, IPR and KPIs. • In the CQC Annual Health Check the Trust scored 'Fair' for Quality of Service and 'Good' for Quality of Financial Management in 2008/09 ('Good' and 'Good' respectively in 2007/08). Movement from "Good" to "Fair" was due to one core standard not being met (NICE technology appraisals), failure to meet the 2008/09 MRSA target (met in 2009/10) and data submission issues in respect of cancer target data. In terms of the NICE technology appraisal - all NICE recommendations are audited and a report is presented to the Trust Board twice a year. There is a report to each CQSC about NICE and the same report goes to the Clinical Audit and Effectiveness sub-committee.	No further issues.	●
Service quality	• Trust scored on average the same as all other trusts (i.e. in median range) in 2009 staff and patient satisfaction surveys with no particular areas of concerns identified. • Trust undertook their own staff satisfaction survey in 2009 results of which demonstrate they have improved on their scores and perceptions since the survey of 2008/09. The Trust has robust communications plans to help staff understand the implications of new strategies and have developed managers to ensure they understand their roles in terms of involving and engaging their staff within their local work areas. Trust states that they have one of the lowest absence figures for the whole of NHS North West. • IPR includes overall complaint numbers and split by site, complaints by specialty areas and the themes arising from complaints. It also incorporates Ombudsman contacts and lessons learned. • A total of 473 formal complaints were received in 2009/10 (compared with 482 in 2008/09) with no particular trends relating to locations or services. However, the Trust identified two themes "Outpatient appointment arrangements" including cancellations /and postponements and "Communication / Information Issues" including outpatient and discharge letters. • Some concerns were also raised with Trust by NHS North Lancashire in relation to the above areas. The Trust has put in place action plans to address concerns: further guidance issues internally on discharge summaries; with full rollout of Lorenzo Clinical Documentation (by March 2011) these will move to electronic format (via e-mail link to practices). Trust has a policy that all patients are clinically reviewed prior to being cancelled to ensure patients are not put at risk but review of this is on-going' they also recognize that current performance for Choose & Book requires improvement and in conjunction with SHA and PCT are looking at learning lessons from Warrington -a best practice site	No further issues.	●
CQC Report	• The Trust was registered without conditions. • CCQ responsive review into maternity (June 2010) positive in outcome and minor concern resolved. • CQC have indicated that following their maternity review, which included an unannounced inspection at FGH on 29th June 2010, they are satisfied that Trust is complaint with all required standards of safety and care. Their review report highlights that a robust system for multi disciplinary working is in place, a Midwifery Action Plan for 09-12 details the vision for maternity services over the next 3 years, that the Trust has undertaken a full review of staffing and addressed identified shortfalls with action plans; that processes for learning from clinical incidents are in place and that audits are undertaken to ensure care records are completed correctly. • Follow-up on minor long standing issue regarding suspected subarachnoid haemorrhage in A&E due Sept.10.	Awaiting final sign-off.	●
Quality governance	On basis of work to date Trust score 3.5 (7 A/G). Main issues: inconsistencies in divisional quality reporting, a review of Board reporting, and robustness of data. Trust has action plans in place to address concerns identified.	Score to be finalised post B2B .	●

● **Low risk** ● **Medium risk** ● **High risk**

1.6b Quality Governance overview (1/2)

Executive Summary

Board Monitoring of Quality

- Integrated Performance Report to the Board includes sections on quality and patient safety ; the Clinical Quality and Safety Committee meetings (now attended by all NEDs) provides key link to clinical data. Staffing agenda items include CHKS, Patient Experience, Clinical Audit, SUIs and Quality Dashboard.
- Every CIP is assessed under Trust's EQIP scheme; all plans require clinical signoff and support and are RAG rated for quality impact; process includes an opportunity for staff at every level to comment.
- EDs conduct formal workarounds by (each does one per month) with similar programme of NED workarounds to be rolled-out (some NEDS already do this informally and value continuing to do so).
- Evidence of active NEDs challenge on consistency of cross-divisional scheme ratings under EQIP ; and that they need to be confident that increases in ward intensity and turnover (as a result of reduced LOS) have no adverse impact; NED have also requested enhanced insight into patient experience , further and more regular information on recruitment delays and safety of staffing levels (at FGH).
- CQGC review incidents by site, number, severity and tends and cross reference these with complaints. Dissemination of lessons learned viewed as critical; in 9/10 6m project required all lessons learned – internal and external- be collated in one place and made available to all in form of guidance and feedback.

Quality Improvement Strategy 2010-13

- Trust's proposals for quality improvement based on :*saving lives by reducing hospital mortality rates*; *preventing harmful events*; *reducing variations in fundamental aspects of basic care* and *continuously improving patient satisfaction and outcomes.*
- Trust engaged widely in setting its priorities (focus groups with governors, consultation with 120 managers; Board event; members input and analysis of complaints and incident reporting) before signing up to and developing a suite of national and local quality initiatives to continuously improve standards.
- **Trust has 10 Quality Improvement Projects. Each projects is grouped under one of domains of safety, effectiveness and experience, and delivered through multi Trust-wide Quality Groups.**
- **Each Quality Group includes:executive leadership sponsorship and support and lead clinicians; patient involvement.; clear aims with defined measures to monitor improvement and agreed timescales; agreed reporting mechanisms via quality sub-committees through to CQSC.**
- Quality Improvement Projects complement Trust's 6 work streams in EQIP programme and agreed measures provide demonstrable evidence of positive impact on quality e.g. a Quality Improvement Project to deliver more timely discharge will support the EQIP programme objective to reduce variations in LoS. Other projects includes VTE and a falls collaborative group aimed at reducing falls by 20%.
- Trust has a training structure to ensure staff are focused on delivering service improvement with four levels of clearly-defined roles (from 'expert' to 'generalist') and a description of how each role will deliver training.

Nursing / Midwifery Quality Assurance Tool (NQAT/MQAT)

- Developed to allow wards to monitor 15 essential care standards, act on the findings and demonstrate continuous improvement in care. Based on original Essence of Care Standards (DH, 2007), Confidence in Care (DH, 2008) and aligned to CQC, NHSLA, Saving Lives Campaign and Hygiene Code Standards.
- **Assessment tool provides for a RAG rating for each of the standards and an overall score for each ward. Trust has an escalation policy for amber and red-rated ward with three stages of escalation up through the Patient Experience Sub-Committee, CQSC and the Chief Executive Group. Regardless of rating DoN meets directly with every ward manager once per quarter.**
- Areas of strength will be celebrated through the Trust's system for learning lessons and those areas that require improvement will be reported via action plans through to the Divisional Governance Forums, Senior Divisional Nurses and Director of Nursing. The results will be displayed on GURU – the ward based dashboard (see right).

GURU Dashboard

- Through the Productive Ward programme Trust identified a series of measures to track and monitor improvements. As a result Trust developed a dashboard of KPIs to demonstrate ward performance in relation to safety, effectiveness and patient experience and general ward management and organisation. This 'GURU' dashboard includes a series of measures to monitor overall performance and provides evidence for NQAT/MQAT (see left).
- GURU Ward to Board Assurance is a standing item at each Board meeting and supported by Boardroom presentation on quality directly form Nurses
- GURU sits on all PCs within the Trust and is accessible to Ward Managers, senior management and Executives. There is also the facility to interrogate performance at Trust, Divisional and ward level.
- GURU allows staff to gain real-time and historical picture of' performance in areas such as: direct patient care, infection prevention, staff sickness, patient/staff satisfaction, falls, complaints and compliments. Other options include the ability to peer review and mark a specific event that may impact on service provision and standards. Performance can be benchmarked against expected standards and thresholds.
- Staff at Trust state GURU has been empowering; emphasised accountability and ability to drive quality from the front line.
- Evidence that GURU has been used to identify problems e.g. last year on ward 35 at RLI ward manger was removed and matron changed following review of trends.

Working with patients

- As part of reviewing how performance data is displayed and communicated to patients and the public the Trust has worked with patients and Shadow Governors to design the way in which the information is made available to them.
- This work has transformed the way Trust communicates and shares information about infection prevention and increased the quantity and quality of information.

Further development

- Future plans include the direct link and feed between GURU and other electronic databases such as the incident reporting system and the electronic record sickness data.

CHKS dashboard

- Set of high level indicators for mortality, quality and outcomes, safety and efficiency is being developed for Trust overall and for each clinical division (already in use in Family Services Division).
- Board held a dedicated development day on CHKS, its usefulness in identifying risk and what it includes/excludes.

GURU along with the NQAT/MQAT has enabled the Trust to establish a 'Ward to Board' assurance framework of useful and meaningful performance data about the nursing and midwifery impact on quality. This framework now being embedded.

1.6b Quality Governance summary (2/2) (work in progress)

Executive Summary

Strategy

1A: Does quality drive the Trust's strategy?

- The Trust's quality vision is supported by a Quality Improvement Strategy 2010-13 aligned to four overall aims (save lives, prevent harmful events, reduce variations in fundamental standards, increase patient satisfaction and outcomes). The Strategy will be delivered through a series of Improvement Projects aligned to the overall aims. Strategic objectives are reinforced through divisional business plans.
- Improvement projects clearly align to 2010/11 priorities in quality accounts. There are various local and national initiatives to improve quality (CQUIN, Patient Safety First Campaign, Advancing Quality, PROMS, Vital signs cards, NQAT, GURU). 2010/11 targets are specific and measurable and timely.
- Patients and public can view the Trust Business plan on the internet. A Patient and Public Involvement Strategy has recently been developed. Quality objectives are reinforced to staff through regular team meetings and 'Weekly News' publications.

1B: Is the Board sufficiently aware of potential risks to quality?

- All 2010/11 schemes have Quality Impact Assessments (see slide 4.4 for further details). Evidence of Board challenge on EQIP schemes (e.g. paybill reduction and Ward 50).
- Evidence provided of internal and external benchmarking on operational efficiency metrics.

Capabilities and Culture

2A: Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?

- The Trust has a strong Executive team in place, with the CE promoting a quality-focussed culture through the Trust. NEDs chair the Audit Committee, Financial Performance and Scrutiny Committee and Clinical Quality and Safety Committee.
- Some of the NEDs were unable to clearly articulate the best/worst performing services. NEDs recognised this and all now sit on the Clinical Quality and Safety Committee (which is chaired by a NED with clinical experience).
- The Trust has a detailed Board Development Plan (recent topics include Monitor's Consultation on quality governance, and Key Messages from the Francis Inquiry). In addition , NEDs have organised two internal workshops on EQIP and CHKS data scrutiny. Board observation and Clinical Quality and Safety Committee evidenced direct challenge from NEDs to Executive team on quality issues.

2B: Does the Board promote a quality-focused culture throughout the Trust?

- Structured programme of Executive walkarounds is in place but is only now being introduced for NEDs.
- Board encourages a high-reporting and open culture. Good evidence of culture of learning lessons from incidents throughout organisation, particularly in relation to maternity services improvement. Trust provided evidence of a quarterly Lessons Learned Report going to the Integrated Risk Sub-Committee.

Processes and Structures

3A: Are there clear roles and accountabilities in relation to quality governance?

- The Trust Board is ultimately accountable for the quality governance of the organisation. The Medical Director an Director of Nursing provide clinical leadership at Board level.
- The Clinical Quality and Safety Committee is responsible for examining quality issues. The subcommittees of this committee reflect Darzi's three domains of quality (i.e. Integrated Risk, Clinical Audit and Effectiveness, and Patient Services and Experience).
- All managers are made aware via training that they are respons ble for quality (as well as HR and finance). Divisional reporting on quality matters is not consistent and action plans are in place to address this.

3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?

- Trust has a formal performance management process in place with a clear escalation policy. Trust has a whistleblowing policy in place and had provided an example of it being used in practice.
- Both internal audit and clinical audit assess quality issues, a beit clinical audit in a less structured way. Plans are in place to address this. Internal Audit completed a review on the effectiveness of the Clinical Quality and Safety Committee in2010/11 which found no major concerns.

3C: Does the Board actively engage patients, staff and other key stakeholders on quality?

- A Patient and Public Involvement Strategy has recently been developed. Feedback from patients is regularly sought through a variety of methods. Patients are represented on sub-committees. Meeting with shadow governors (including staff governors) indicated good relationship with Trust Board. There appear to be good communication channels with staff and appraisal and training rates are good.
- Following the CQC's review of maternity services, there is evidence that the Trust Board made a substantial effort to engage with staff and that this led to a re-energising of staff.

Measurement

4A: Is appropriate quality information being analysed and challenged?

- The integrated Performance Report includes a number of key metrics (e.g. safety, clinical efficiency, incidents, complaints) but not necessarily in one place. NEDs stated that they would like to review this in the near future.
- Dashboard reporting is increasingly being utilised and reported to the Board via the GURU system.
- The Trust Board have commissioned additional reviews on quality where it felt necessary (e.g. maternity services, where a significant improvement has been achieved with Board focus).
- Sub-committee structure ensures that quality information is analysed at the appropriate level.

4B: Is the Board assured of the robustness of the quality information?

- Internal Audit assessed Board reporting in 2009/10 and gave full assurance.
- The Trust achieved Level 2 performance against the requirements of the Information Governance Statement of Compliance.
- Action plans and recommendations from both Internal Audit and Clinical Audit are followed-up on.
- Some scope for Internal Audit to do further work on the assurance of quality data.

4C: Is quality information used effectively?

- The Trust board has a variety of sources of quality information (e.g. IPR,BCBV indicators, GURU, productive ward). The Trust has also developed a Nursing Quality Assessment Tool to measure standards of care on a ward by ward basis. Evidence of these being used effectively provided by assessment team wa karound and Board and committee observations.
- Significant scope for Board reviewing all sources of quality information and ensuring that it can see in a clear fashion (in one document) what the quality of services is.

Overall score of 3.5 meets Monitor's authorisation criteria. Further work and calibration to be completed post-B2B.

Section 2

2.1 Base case – summary normalised financials

£m	Actual Mar - 08	Actual Mar - 09	Actual Mar - 10	Outturn Mar - 11	Forecast Mar - 12	Forecast Mar - 13	Forecast Mar - 14	Forecast Mar - 15	Forecast Mar - 16	CAGR Mar - 08 Mar - 11	CAGR Mar - 11 Mar - 12	CAGR Mar - 12 Mar - 16
Income												
NHS clinical revenue	202.0	210.8	220.4	217.7	215.4	212.7	209.9	206 9	204 0	2.5%	(1.0%)	(1.4%)
Other income	23.7	25.4	29.6	31.7	32.0	32.3	32.7	32.9	33.2	10.1%	1.1%	0.9%
Non-recurring income	(1.1)	(1.5)	(3.0)	(1.8)	(0.8)	(0.7)	(0.7)	(0.6)	(0.7)	19.1%	(54.6%)	(5.4%)
Total income	**224.7**	**234.7**	**247.0**	**247.5**	**246.6**	**244.3**	**241.9**	**239.2**	**236.5**	**3.3%**	**(0.4%)**	**(1.0%)**
Expenses												
Employee benefits expense	(148.7)	(157.9)	(167.6)	(169.5)	(168.8)	(167.2)	(166.4)	(166 3)	(165 0)	4.5%	(0.5%)	(0.6%)
Non-pay costs	(55 6)	(58 5)	(64.0)	(62.8)	(60.2)	(57.5)	(55.1)	(51.7)	(49.3)	4.2%	(4.2%)	(4.9%)
Non-recurring costs	0.9		2.2	1.1						5.7%	(100.0%)	-
Total Expenses	**(203.4)**	**(216.4)**	**(229.4)**	**(232.4)**	**(228.9)**	**(224.7)**	**(221.5)**	**(218.0)**	**(214.3)**	**4.4%**	**(1.0%)**	**(1.6%)**
Normalised EBITDA	**21.3**	**18.3**	**17.6**	**16.3**	**17.7**	**19.7**	**20.4**	**21.2**	**22.3**	**(8.5%)**	**8.9%**	**5.9%**
EBITDA margin (%)	*9.5%*	*7.8%*	*7.1%*	*6.6%*	*7.2%*	*8.0%*	*8.4%*	*8.9%*	*9.4%*			
Normalised Net Surplus/(Deficit)	**3.3**	**1.1**	**2.1**	**2.0**	**2.8**	**4.9**	**5.1**	**6.2**	**7.8**	**(15.4%)**	**43.4%**	**28.7%**
Reported net surplus margin (%)		***0.5%***	***0.8%***	***0.8%***	***1.2%***	***2.0%***	***2.1%***	***2.6%***	***3.3%***			
Cashflow from operations		18 3	19.4	14.1	17.7	19.6	19.9	21.0	22.1			
Capital expenditure		(8.6)	(8.2)	(10.3)	(8.6)	(8.2)	(7.3)	(7.3)	(7.3)			
Cashflow before financing		9.7	11.2	3.8	9.1	11.4	12.6	13.7	14.8			
Net cash inflow / (outflow)		0.2	4.4	(1.8)	3.4	5.7	6.7	7.6	9.1			
Year end balance sheet cash position		4.8	9.2	7.5	10.9	16.6	23.3	30.9	40.0			
Net current assets / (liabilities)		0.1	3.3	3.6	7.0	12.8	19.9	27.8	37.0			
Financial risk rating					4.0	4.0	4.0	4.0	4.0			

Historical position

1. The Trust was placed into turnaround by NHS North West in 2005/06 in recognition of its poor underlying financial position, with formal monitoring commencing in August 06. The Trust had a net deficit of £5.4m at March 06 which improved to a surplus position of £1.9m at March 07 and £3.3m at March 08. This turnaround was mainly achieved by growth in NHS clinical revenue due to increased activity, offset by only modest cost growth enabled by significant cost improvement savings (including the removal of c.340 WTEs). The net surplus declined in 2008/09 to £1.1m, largely driven by the increased staffing costs required to achieve the EWTD and agency costs at Furness General Hospital. The cashflow from operations in 2006/07 and 2007/08 were impacted by the DH cash regime which restricted the Trust from keeping excess cash at March 07 but was relaxed by March 08.
   - A working capital loan of £6.5m was drawn down from the DH in March 07. In addition £0.8m of support from the PCT was received in 2008/09 towards clearing the historical debt. The debt has now been paid off.
2. The increase from 2008/09 to 2009/10 clinical income includes £3.8m of overperformance. The Trust went to arbitration with NHS Cumbria for the income £2m was settled and £1.8m was not paid for. The increase in other income is largely offset by the decrease in clinical income as £4.7m of income from Trust activity is taken over by the PCT, the Trust receives income of £4.7m for overheads and staff from the PCT.
3. EBITDA Margin declines from 2007/08 to 2009/10 largely due to CIP as a % of cost base (declining from 5.7% in 2007/08 to 3.9% in 2008/09 to 3.5% in 2009/10) and increasing pay costs as % of income. Margin movement between 2009/10 and 2010/11 is largely explained through income not being inflated in 2010/11 and CIP not exceeding the increased cost pressures.

Current and future position

4. As at Month four the Trust has achieved £0.1m of the £2m surplus. This is due to the Trust planning a deficit in the first 2 months of the year. The Trust has overspent on agency costs and CIP achievement is largely backended.
   - The Trust's original strategy of activity growth coupled with maintaining high CIPs has been replaced with a sustainability strategy of flat activity growth (population growth offset by demand management) and significant CIPs – 3.7% of cost base in 2010/11 to 5.3% of cost base in 2015/16.
5. One service development , the reconfiguration of Lancaster Hospital, is included in the plans. The development will not impact income and assumes a cost benefit gained from the efficiency of the reconfiguration of £0.4m per annum.
   - A low level of capital expenditure has been planned from 2010/11 to 2014/15, with the majority of spend on the Lancaster Hospital reconfiguration (£8m over three years).
6. The Trust plan to build cash reserves, ensuring sufficient cash is maintained for any equal value claims made against the Trust. Current estimate of equal value claims is £3.9m (downside) - see slide 4.8 for further details.

Base Case predicated on sustainability; flat activity coupled with CIPs sustain surpluses

2.2 Local health economy: Commissioning intentions

Demographics

- Trust covers large geographical area (approximately 1,000 square miles) with limited road infrastructure due to location of the Trust across the lake district and surrounding areas (refer to map on next slide). This results in relatively long drive times between Trust sites (average between Barrow and Lancaster c.1 hour).
- Serves a population of c. 363,000. Significant seasonal activity for A&E driven by tourists to the Lake District. c.97% of Trusts income is commissioned from two PCTs: NHS North Lancashire (commissions for population of c.145k) and NHS Cumbria (c.205k population spread over largest geographic area in the country between North and South Cumbria).
- ONS population projections suggest a forecast increase in population of 4.2% in the next five years, with a disproportionate percentage of this being in the over-65 age range.
- Trust's catchment area consists of a mix of relatively prosperous areas (South Lakeland and Lancaster) and socioeconomically deprived areas (Barrow and Furness), with variations in the average life expectancy between the South Lakeland and Barrow of 3.4 years and 2.2 years for men and women respectively.
- NHS North Lancashire and NHS Cumbria are in joint discussions on the reconfiguration of services in the area that the Trust serves. Cumbria is planning a "Big Conversation" public engagement process in South Cumbria during 2010, running for a period of 6-12 months, around specific themes e.g. long-term conditions.

NHS North West

- View on Trust - SHA has confidence in the Trust Board - leadership is good, finances well managed and there are no significant clinical concerns. Trust scores 6-7/10 (vs. 2/10 3 years ago) in terms of where it is at on it's 'quality journey'; it is actively engaged with SHA's 'Energise for Excellence in Care' movement and Director of Nursing is "excellent"; very open and keen to achieve improvement.
- Performance - Trust has demonstrated key improvements: reporting moving into the high, timely and improving category; Trust is signed up to patient safety critical care campaigns and are posting data on leadership; HCAI numbers are below trajectory and continuing to drop and patient safety ,experience and care is being actively managed and monitored via Trust's GURU real time system.
- Going forward - Trust has successfully delivered CIP plans in the past, but will need to demonstrate that it can take out costs and capacity. SHA thought Trust downside planning was not particularly harsh. Key risk to the business plan will be having to deliver PCTs' demand management plans in full. While they recognise demand management plans have not been delivered in the past future plans have more effective input and more credibility in delivery; the PBC consortia in Cumbria is good.

NHS North Lancashire

- Finance - Budget of c. £550m and achieved a surplus of c. £1.5m in 2009/10. At mid-year, the projection was closer to £10-12m deficit driven by activity in acute sector and overspend on continuing care and specialist services so the PCT elected to put itself in turnaround. As a result of inherited recurring problems from 2009/10 the PCT sees itself as operating with flat cash in 2010/11 despite 5.7% uplift.
- PCT believes that activity should not be delivered in secondary care if it is not needed or can be done in the community. Increased productivity and decreased capacity are both required to ensure sustainability of LHE.
- Demand management – the PCT produced its updated Strategic Plan 2008-13 in January 10. Utilising demand management to reduce secondary care use is planned to produce savings of around £4m over the period 2010/11 to 2012/13.
  The PCT believes the Trust's assessment of expected income impact based on historic precedent and assumes that it will fail to be delivered in full; in 2009/10 the PCT planned £1.5m of demand management for the Trust, none of which was delivered.
  The PCT says it must deliver future plans - it is investing £6m to support delivery of 2010/11 schemes that were previously tentative and outline only. They emphasise that the move to PBC is transformational; the local GPs aligned and empowered are well placed to drive community primary care and reduce unplanned emergency care.
- Performance – the PCT raised a number of concerns including quality and timeliness of discharge letters, deferment of hospital appointments and A&E processes. The assessment team raised these issues with the Trust and CQC; the Trust provided copies of written correspondence with the PCT which addressed each concern.
- Service Development – the PCT is supportive of the Lancaster Hospital reconfiguration as it believe service models and bed usage need to be reviewed in context of LHE-wise solution including use of community and GP beds.
- Trust Board – the PCT believe the Trust has a strong operational team but could do more to develop external relationships and they have not been proactive in developing relationships.

NHS Cumbria

- Finance - Prior to 2007/08 the PCT was in financial deficit. In 2009/10 it achieved a breakeven position (albeit with £4m of brokerage from the SHA to fund continuing care and specialist care). The PCT put itself into voluntary turnaround in 2009/10
- Contract – The 2010/11 contract not to date been signed. The PCT may go to arbitration with North Cumbria NHS Trust over c. £20m of disputed activity from 2009/10. The Trust has proposed a contract with marginal rates for small amount of over-performance identical to that signed by other PCT. SHA believes the contract will get signed by the end of summer.
- Demand management – the PCT produced a revised Strategic Plan 2008-13 in February 10 and its QIPP Strategy in March 10. Both documents outline it's 'Closer to Home' Strategy with an emphasis on the transfer of services from hospital to community settings. In terms of scale, it envisages shifting around £13-£14m of services (in income terms) over the period 2010/11 to 2013/14.
  The Trust's assessment of expected income impact is based on historic precedent and assumes that it will fail to be delivered in full (although NHS Cumbria been more successful than North Lancashire PCT historically).
  The PCT commissioned a piece of work from a management consultancy firm to query the realism of the Trust's assumptions e.g.Trust is assuming 4 p.a. % increase in population in South Lakes, which the PCT assumes it is 1% across the whole population (with a large increase in elderly people).
- Performance – the PCT believes that the Trust engaged well on the historical Acute Services Review (ASR) for South Lakes but in the last 12 months the PCT has found it more challenging to effectively engage with the Trust. The PCT believes that complex clinical engagement is needed to change model and pathways of care across the LHE, particularly at Barrow Hospital. The Trust has sound clinical services; some are very good particularly at Lancaster Hospital, but Barrow Hospital is probably not as good, with one or two exceptions - general surgery is good, elderly care good and diabetes are excellent; poor areas include rheumatology and paediatrics.

DC sensitivity applied as Trust has modelled different assumptions to the PCTs' demand management assumptions in 2010/11 and 2011/12.

2.3 Local health economy: competition

Competition

- The road infrastructure of the area, and the resultant drive times between towns, means there is little competition from neighbouring trusts except at the boundaries of the Trust's catchment areas.

Foundation Trusts

- *Royal Preston Hospital* (part of Lancashire Teaching Hospitals NHSFT) is situated to the south of the Trust, closest to the Lancaster site. Currently c.£1.1m of activity from the Trust's catchment population flows to Preston.
- *Blackpool Victoria Hospital* (part of Blackpool, Fylde and Wyre Hospitals NHSFT)is closest to the Lancaster site. Currently attracts c.£0.1m of activity from Trust catchment area.
- *Wrightington Hospital* (part of Wrightington, Wigan and Leigh NHSFT), south of Preston and is closest to the Lancaster site. Attracts c.£0.8m of activity from the Trust catchment area.

NHS Trusts

- *West Cumberland Hospital* , Whitehaven (part of North Cumbria University Hospitals NHS Trust, "NCUHNHST") is closest to the Barrow site. This hospital is likely to lose it's A&E which could generate activity for Furness Hospital Barrow.
- *Cumberland Infirmary Hospital,* Carlisle (also part of NCUHNHST) is and closest to the Barrow site.
- In total around £0.2m of Trust area activity flows to NCUHNHST.

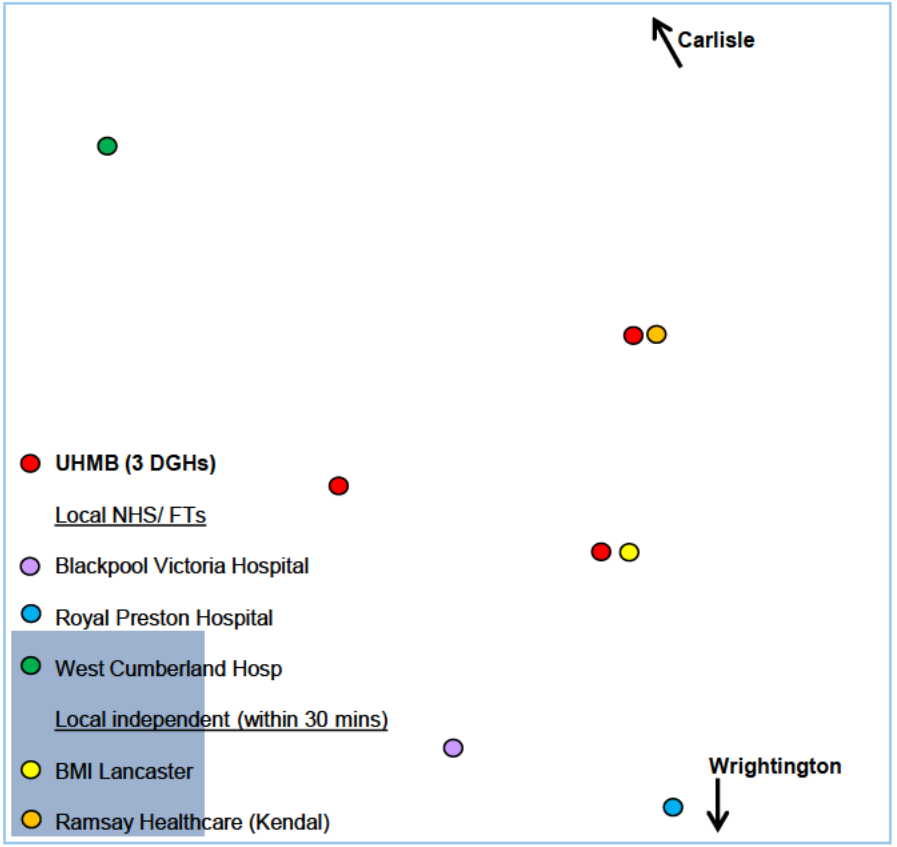
Independent Providers

- *BMI Lancaster* – a 27 bed (all en-suite) hospital. While being an established hospital it has low occupancy rates. North Lancs. PCT does not believe this poses a threat to the Trust as long as the Trust does not move services used by Lancaster residents (e.g. ophthalmology or ENT) to Kendal. The Trust has no plans to do so.
- *Ramsay Healthcare* – a 19 bed elective treatment centre opened in Kendal in June 2008, co-located on Kendal site. Provides Orthopaedics, general surgery and ENT. SHA provided £6m 5-year contract in place which steps down over time. Per discussions with NHS Cumbria, neither GPs nor public are supportive because they think support will lead to further closures, to date had little impact on the Trust's activity. NHS Cumbria has confirmed that Ramsey only received 500 GP referrals from South Cumbria in the nine month period August 08 to April 09.

- In addition to the main competitors identified above the Trust is monitoring the proposals of a number of smaller providers considering setting up services in the Trust's catchment area, these include:
  - *Spine Care UK* – A company providing spinal pain and pain management services.
  - *Assura* – A company that sets up new provider companies in partnership with local GPs to provide a limited range of Tier 2 services e.g. minor procedures, outpatients, diagnostics etc.
- As at April 10 neither of these companies have developed services to compete with the Trust in its catchment area.

Impact of Choice

- The Trust has assessed that currently c.£3.3m p.a. (based on HRG 3.5) of activity that could be provided locally is currently going to other providers. This is largely driven by referral patterns from specific GPs. No sensitivity applied – Trust has demonstrated action plan.



Distances - Drive Times

Competitors	Closest UMBH Site	Distance (miles)	Drive Time (mins)
Royal Preston Hospital	Lancaster	25	30
Blackpool Victoria Hospital	Lancaster	38	45
Wrightington Hospital	Lancaster	40	45
West Cumberland Hospital	Furness	50	75
Cumberland Infirmary Hospital	Furness	50	60
BMI Lancaster	Lancaster	1	5
Ramsay Healthcare	Kendal	0	0

GP Relations & PBC

- Cumbria is one of the national Integrated Care Pilots involving horizontal integration of GP and community services. There are six geographical groups in the county, with GPs leading on commissioning for each area with devolved budgets in place for 2010/11. Two of these localities (Furness – Barrow Hospital; South Lakes – Kendal Hospital) impact the Trust materially.
- **Sensitivity applied relating to PCT's demand management plans (see slides 1.4 ('commissioning') and 2.2).**

Given the geography of the region, competition is not a significant issues for the Trust.

2.4 Service development schemes

Business Plan

ADVANCED SERVICE DEVELOPMENTS: Business cases approved by Trust Board. Contribution and capex included within the financial model.

No	Description and assumptions	Comments on assumptions (including commissioner view)	Risk level and sensitivity	£M	10/11	11/12	12/13	13/14	14/15	15/16
1	**Reconfiguration of Lancaster Hospital** • The site requires remodelling to improve patient flow and to separate elective and non elective care. • The Lancaster site includes 5 nightingale wards in the old wing of the hospital with up to 22 beds in each. The wing is accessed via a long underground corridor from the remainder of the hospital.	• **Plan**: Reconfiguration of Lancaster Hospital in order to create physical separation of elective and non elective activity. • **Timing**: The Trust has yet to draft an OBC. • **Capital funding**: £8.0m over 3 years has been modelled. • **Status**: The Board has yet to approve any formal capital build plans.	**Trust view** Achievement of Trust objectives are not dependent on this development. **Assessment team view (sensitivity)** • No sensitivity applied	Revenue	-	-	-	-	-	-
				Cost	-	(0.3)	(0.4)	(0.4)	(0.4)	(0.4)
				Contribution	**-**	**(0.3)**	**(0.4)**	**(0.4)**	**(0.4)**	**(0.4)**
				Marginal contribution	-	-	-	-	-	-
				Capex	(3.0)	(3.0)	(2.0)			-

SERVICE DEVELOPMENTS NOT IN BASE CASE – ALLOWED AS PART OF MITIGATIONS: Business cases not approved by Trust Board. Contribution and capex not included within the financial model.

2	**MoHs Surgery** • Provision of microscopically controlled surgery for common types of skin cancer, limited number of specialists in the country	• Supported by both PCTs and specialist commissioner. • Final business case to be approved by Board.	**Trust rated green for delivery** **Assessment team view:** • Allow as mitigation. • Allowed 100% of the contribution. • Evidence on commissioning intention provided by NW specialist commissioner.	Revenue	-	0.4	0.4	0.4	0.4	0.4
				Cost	-	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
				Contribution	**-**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3)**
3	**Wet AMD** • Ophthalmic treatment to reduce risk of blindness in older people.	• Business case taken to Hospital Management Team in June 09. • Commissioner support confirmed from Trust meeting notes. • Business case to be reworked and finalised with new tariffs.	**Trust rated green for delivery** **Assessment team view:** • Allow as mitigation. • Allowed 100% of the contr bution. • Commissioner support evidenced by meeting minutes.	Revenue	-	2.6	2.6	2.6	2.6	2.6
				Cost	-	(2.0)	(2.0)	(2.0)	(2.0)	(2.0)
				Contribution	**-**	**0.6**	**0.6**	**0.6**	**0.6**	**0.6**
4	**Diabetes** • Currently the Trust makes a loss on diabetes service provision. • NHS Cumbria is proposing to decommission the service commencing 1 October. • The transfer of services to the PCT will be cost neutral in 2010/11 and the Trust will recharge at full cost from 2011/12 onwards (it currently makes a £0.2m loss on the service).	• SLA for provision of services between organisations still to be agreed.	**Trust rated green for delivery** **Assessment team view:** • Allow as mitigation. • Allowed 100% of the contribution. • Evidenced by email from NHS Cumbria confirming intention to decommission service in 2010/11.	Revenue	-	-	-	-	-	-
				Cost	-	0.2	0.2	0.2	0.2	0.2
				Contribution	**-**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**
5	**Ambulatory Cancer Care Centre** • Development of "satellite site" for cancer services at Kendal Hospital run by Lancashire Teaching Hospitals NHSFT (LTHNHSFT).	• **Plan**: Business case to be developed in 2010/11. This is supported by both PCTs. • Trust is assuming that it will expand to 6 cardiologists.	**Trust rated amber for delivery** **Assessment team view:** • Allow as mitigation. • Allowed 75% of contribution. • NHS Cumbria verbally confirmed need for expansion but were unable to confirm that six cardiologists would be required.	Revenue	-	-	0.7	0.7	0.7	0.7
				Cost	-	-	(0.2)	(0.2)	(0.2)	(0.2)
				Contribution	**-**	**-**	**0.5**	**0.5**	**0.5**	**0.5**

SERVICE DEVELOPMENTS NOT IN BASE CASE – NOT ALLOWED AS PART OF MITIGATIONS: Business cases not approved by Trust Board. Contr bution and capex not included within the financial model.

6	Trust has submitted a further six service developments which were not included in the base case as mitigations.	• cardiology expansion, dermatology, primary care and GP contracts, Transforming Community Services and ISTC.	**Assessment team view:** • Four require further evidence from the Trust and two are not considered realistic.	**Total contribution**	**0.1**	**0.8**	**1.5**	**2.4**	**2.4**	**2.4**

2.5 Activity and price inflation assumptions

	Actual			Outturn	Forecast				
	Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16
Activity Growth									
Elective									
Demographic change		0 9%	0 8%	0.9%	0 9%	0 8%	0.7%	0.7%	0.7%
Changes in underlying demand		(0.2%)	(0 9%)						
Additional activity as a result of achievement of 18 weeks									
Demand management				(0.8%)	(1.0%)	(1.0%)	(1 0%)	(1 0%)	(1 0%)
Repatriation of work from other providers to Trust				0.3%	0 5%	0 5%	0 3%		
Impact of HRG4			5 5%						
Other				(0.0%)					
Adjustment									
	-	0.7%	5 5%	0.4%	0.4%	0 3%	0 0%	(0 3%)	(0 3%)
Non-Elective									
Demographic change		0 9%	0 8%	0.9%	0 9%	0 8%	0.7%	0.7%	0.7%
Changes in underlying demand		3.1%	(1 9%)	(0.3%)	(0.7%)	(0.7%)	(0 6%)	(0 6%)	(0 6%)
Langdale Wards (Kendal Hospital)				(0.4%)					
Impact of HRG4			7.7%						
Other				(0.1%)					
	-	4 0%	6.7%	0.1%	0 2%	0.1%	0.1%	0.1%	0.1%
Outpatient									
Demographic change		0 9%	0 8%	0.9%	0 9%	0 8%	0.7%	0.7%	0.7%
Changes in underlying demand		3.7%	1.4%						
Additional activity as a result of achievement of 18 weeks									
Demand management				(3.5%)	(2.2%)	(2.2%)	(2 2%)	(2 3%)	(2 3%)
WGH									
Impact of HRG4			1 6%						
Other		(5.1%)		0.8%					
	-	(0.5%)	3 8%	(1.8%)	(1.2%)	(1.4%)	(1 5%)	(1 6%)	(1 6%)
A&E									
Population		0 9%	0 8%	0.8%	0 9%	0 8%	0.7%	0.7%	0.7%
Changes in underlying demand		1 0%	1 6%						
Transfer of PCAS (Kendal Hospital)			(2 8%)	(15.7%)					
Other				0.1%					
	-	1 9%	(0.4%)	(14.8%)	0 9%	0 8%	0.7%	0.7%	0.7%

Inflation - Base Case						
Tariff	0 0%	0 0%	-1.0%	-1 0%	-1 0%	-1.0%
Non-Tariff	0 0%	0 0%	-1.0%	-1 0%	-1 0%	-1.0%
Non-NHS Clinical Income	0 0%	0 0%	-1.0%	-1 0%	-1 0%	-1.0%
Education & Training	0 0%	1 0%	1.0%	1 0%	1 0%	1.0%
Research & Development	0 0%	1 0%	1.0%	1 0%	1 0%	1.0%
Other Income	0 0%	1 0%	1.0%	1 0%	1 0%	1.0%
Monitiors Assessor case inflation	-	0 0%	-1.0%	-1 0%	-0 3%	-0.3%
Monitiors Downside case inflation	-	0 0%	-1.5%	-1 5%	-0 8%	-0.8%

Activity growth

- ***Demographic change:*** The Trust has assumed that population growth will be 4% over the next 5 years. This assumption is based on population growth statistics.
- ***Demand management:*** Both NHS North Lancashire and NHS Cumbria have written strategic plans outlying their demand management plans over the next five years. The Trust has considered these plans and on the basis of prior experience have assumed broadly a 50% delivery (although prior experience of delivery of plans is less than 50%).The Trust's clinical divisions are of the opinion that a 50% delivery is optimistic and are still experiencing higher than expected activity. Payment for overperformance is based on the rates set out below. The Trust has agreed a financial envelope with NHS Cumbria but has not yet signed the final contract.
  Discussions with the PCTs indicate that if they do not deliver their demand management plans as budgeted for, they have insufficient reserves to pay for significant contract overperformance. As such, an additional DC sensitivity has been applied in 2010/11 and 2011/12 for non-payment for overperformance.
- ***Repatriation*:** The Trust has assumed that 25% of work performed out of area can be repatriated. The Trust have various schemes planned to repatriate the work including MoHs and Wet AMD (see slide 2.4)
- ***Langdale Wards / transfer of PCAS:*** These movements relate to the transfer of Langdale wards and primary care ambulatory services (PCAS); NHS Cumbria has taken over the services and the Trust provides the PCT with accommodation and support services. Trust staff are planned to be TUPE'd across to the PCT in September 10.
- **Overall activity growth** : Overall, the Trust's forecast activity growth is relatively flat. Currently the PCTs have agreed the following to fund overperformance:
  - NHS North Lancashire : 1% above 2009/10 outturn @ 30%; 1-2% @ 50% and 2% and over at full PBR.
  - NHS Cumbria: up to £0.5m above contract is no payment; £0.5m to £1.0m above contract @ 30%, £1.0m to £1.5m @ 50% and above £1.5m at full tariff.

Inflation

- Prudent inflation assumptions for clinical income; however non-clinical income inflation assumptions are optimistic in comparison to Monitor's generic assumptions.

Implied efficiency	10/11	11/12	12/13	13/14	14/15
	3.4%	4.1%	3.9%	3.9%	4.0%

Assessor Case	Mar-11 £m	Mar-12 £m	Mar-13 £m	Mar-14 £m	Mar-15 £m	Mar-16 £m
Commissioning intentions	-	-	-	-	-	-
Competition	-	-	-	-	-	-
Service developments	-	-	-	-	-	-
Sensitivity for activity	-	-	-	-	-	-

Downside Case	Mar-11 £m	Mar-12 £m	Mar-13 £m	Mar-14 £m	Mar-15 £m	Mar-16 £m
Monitor generic - unfunded activity	(1.1)	(1.3)	(0.6)	(0.2)	-	-
Additional unfunded activity risk	(0.9)	(0.5)	-	-	-	-
Competition	-	-	-	-	-	-
Service developments	-	-	-	-	-	-
Sensitivity for activity	(2.0)	(1.8)	(0.6)	(0.2)	-	-

Generic unfunded activity DC sensitivities applied. Additional DC sensitivity applied in 2010/11 and 2011/12 assuming 100% delivery of PCT demand management plans in these years.

2.6 Expenditure assumptions

£m	Actual Mar - 08	Actual Mar - 09	Actual Mar - 10	Outturn Mar - 11	Forecast Mar - 12	Forecast Mar - 13	Forecast Mar - 14	Forecast Mar - 15	Forecast Mar - 16	CAGR Mar - 08 Mar - 11	CAGR Mar - 09 Mar - 10	CAGR Mar - 10 Mar - 14
Employee benefits expense	(148.7)	(157.9)	(167.6)	(169.5)	(168.8)	(167.2)	(166.4)	(166.3)	(165.0)	4.0%	-	(1.0%)
Drug costs	(11.6)	(12.8)	(13.7)	(14.2)	(14.6)	(15.1)	(15.8)	(16.2)	(16.5)	7.0%	3.0%	3.0%
Clinical supplies	(20.6)	(20.9)	(22.7)	(22.5)	(21.3)	(19.8)	(18.8)	(17.6)	(16.2)	3.0%	(5.0%)	(7.0%)
Non-clinical supplies	(23.4)	(24.7)	(27.6)	(26.1)	(24.3)	(22.6)	(20.6)	(17.9)	(16.5)	4.0%	(7.0%)	(9.0%)
Other operating expenses	-	(0.1)	0.0	-	-	-	-	-	-			
Total	**(204.3)**	**(216.4)**	**(231.6)**	**(232.4)**	**(228.9)**	**(224.7)**	**(221.5)**	**(218.0)**	**(214.3)**	**4.0%**	**(1.0%)**	**(2.0%)**

CAGR
Decreasing CAGR reflects CIPs in excess of inflationary pressures in future years.

Total activity growth	%	-	0.5%	3.3%	(4.1%)	(0.6%)	(0.7%)	(0.8%)	(0.9%)	(0.9%)
Total number of beds (inc. service developments)		1,004	974	995	879	853	840	840	840	840

Implied efficiency	10/11	11/12	12/13	13/14	14/15
	3.4%	4.1%	3.9%	3.9%	4.0%

Employee benefit expenses

		Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16
Average staff numbers (non agency)	*WTE*	4,110	4,140	4,246	4,227	4,093	3,910	3,740	3,598	3,431
Employee benefit expenses inflation	%	-	-	-	2.0%	1.9%	1.5%	1.5%	1.5%	1.5%
Staff costs per bed	*£k*	148	162	168	193	198	199	199	198	197
Nurses per bed	*WTE*	1.81	1.87	1.86	2.06	2.08	2.05	1.97	1.89	1.80
Agency costs	%	1.6%	2.7%	3.1%	2.2%	2.1%	2.1%	2.2%	2.2%	2.3%

- The Trust has assumed 2% pay inflation in 2010/11 based on the national pay award and AfC. From 2012/13 a 1% pay award plus NI increase has been forecast.
- Headcount reduction over plan is 815, representing 95% of all staff (see slide 2.7(2)).
- The Trust has secured a number of permanent post positions in 2009/10 and believes less reliance can be placed on agency staff.
- As at the end of Month 4 the Trust had overspend on agency costs by £1.2m against budget and £0.5m against plan.

Drug costs

		Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16
Activity growth	%	-	-	-	-	(0.2%)	(0.1%)	(0.1%)	(0.1%)	(0.1%)
Inflation	%	-	-	-	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
NICE guidance	%	-	-	-	-	5.2%	4.9%	4.7%	4.5%	4.3%

- Activity decline reflects the Trust's assumptions that population growth will largely be offset by the PCTs' demand management schemes.
- Drug inflation has been assumed at 5% and c.5% for NICE guidance from 2010/11. These assumptions are broadly in line with Monitor's generic assumptions (10% inflation from 2010/11).

Clinical supplies

		Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16
Activity growth	%	-	-	-	-	(0.3%)	(0.5%)	(0.4%)	(0.5%)	(0.5%)
Inflation	%	-	-	-	2.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Quality and reform	%	-	-	-	-	-	-		-	-

- The Trust has assumed relatively low clinical supplies inflation based on historical data and RPI.

Other expenses

		Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16
Inflation	%	-	-	-	2.5%	1.5%	1.5%	1.5%	1.5%	1.5%

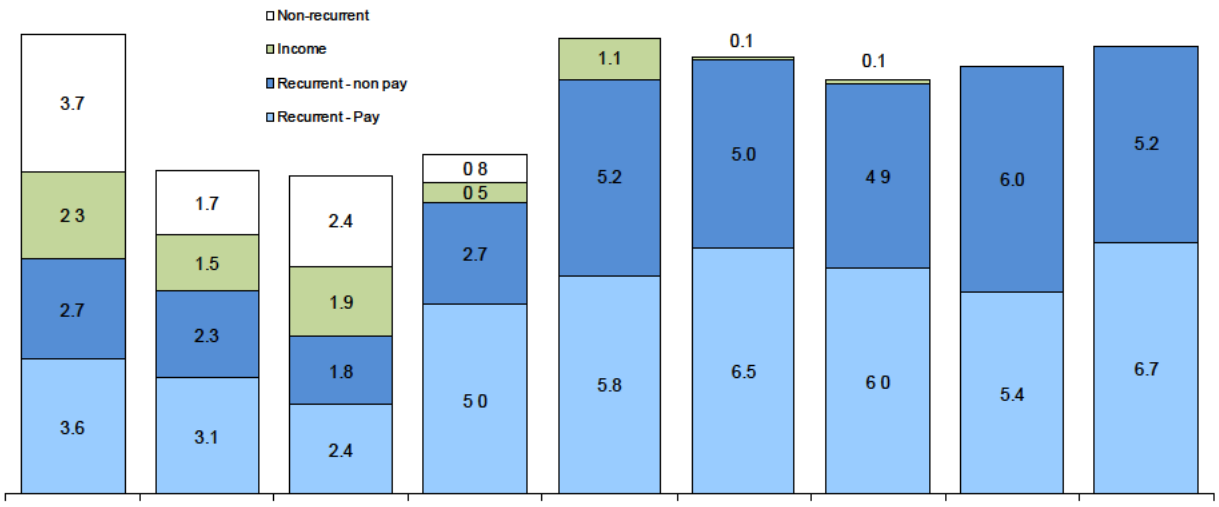
- Inflation is based the Trust's historical data and RPI.

The Trust has made prudent assumptions – Monitor's generic sensitivities applied. Specific sensitivity applied in AC for agency overspend in 2010/11 and 2011/12.

2.7 (1) CIP achievements to date and future projections

Historical performance (2007/08 to 2009/10)

- Management believe prior to 2006/07, Trust was not effective in setting targets. In 2005/06, CIP target of £10.5m was missed by a significant margin (£6.5m achieved in-year). Processes put in place as part of turnaround to improve target setting.
- Target of £12.1m in 2007/08 was exceeded by £0.2m but included £3.7m of non-recurrent savings. Where non-recurrent CIPs contribute to target level, Trust subsequent replaces these with new schemes to ensure that CIP target is achieved on recurrent basis overall.
- Trust achieved £8.7m of CIPs in 2008/09, against a recurrent target of £9.2m. £2.8m of these savings were non-recurrent, largely achieved through holding vacancies.
- In 2009/10 Trust achieved 92.6% of £9.2m target, 26% of this was achieved through non recurrent savings, mostly holding vacancies (£0.6m),releasing some reserves (£0.4m) and income (£0.6m). Trust's Medicine Division unable to achieve savings largely due to Trust being unable to close Ward 50 at RLI and delays in oncology reconfiguration.



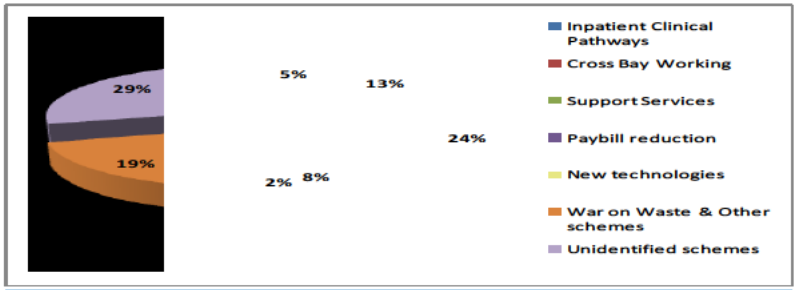
	Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16
Total CIP achieved/planned (£m)	**12.3**	**8.7**	**8.5**	**9.0**	**12.1**	**11.6**	**11.0**	**11.4**	**11.9**
CIP as a % cost base in year	5.7%	3.9%	3.5%	3.7%	5.0%	4.9%	4.7%	5.0%	5.3%
Sensitised CIP as a % of cost base				2.8%	4.0%	4.3%	4.1%	4.4%	4.5%
Mitigated CIP as a % of cost base				2.8%	4.1%	4.5%	4.9%	5.6%	5.7%
Mitigated CIP as a % of cost base				2.8%	4.1%	5.4%	6.6%	8.2%	8.7%
Recurrent achievement versus target	**70.8%**	**75.1%**	**71.9%**						
Cumulative impact on I&E position (£m)				9.0	20.3	32.0	43.0	54.4	66.3
Recurrent total CIP (inc. income)as a % of cost base (in year)	3.9%	3.1%	2.5%	3.4%	5.0%	4.9%	4.7%	5.0%	5.3%

Outturn performance (2010/11)

- Trust Board are currently monitoring a CIP target of £12m but Monitor have reflected a target of £9m in the analysis as income CIPs were removed. These included £1.3m CQUIN, £0.4m Lorenzo, £0.5m depreciation and £0.8m other.
- Trust states CIP delivery is on track- end M4 Trust achieved £2.8m out of target of £12m, £23k below plan; £0.8m of schemes are red-rated for delivery and £1.2m amber-red rated. CIPs in 2010/11 are largely back-ended.

Forecast (2011/12 to 2015/16)

- Under EQIP (Trusts' Efficiency and Quality Improvement Programmed each CIP is allocated 1 of 6 work streams. Each scheme has a lead manager and a lead clinician with an ED taking an overall responsibility of a work stream.
- Trust used external benchmarking to inform some EQIP schemes. Better Care, Better Value Indicators (BCBV) and CHKS benchmarking highlighted potential for productivity gains e.g. Reducing Length of Stay-Trust position 132/167; productivity opportunity £7.5m; Reducing pre-operative Non-Elective bed days - Trust position 138/167; productivity opportunity £5.8m.
- All the schemes have had a QIA (Quality Impact Assessment) and are RAG rated. NEDS in recent CQSC meeting challenged inconsistencies in how QIA's were rated and asked for a number of schemes to be re-assessed. All schemes have a Project Overview Document detailing how scheme should be delivered. (Refer to 4.4 for details). Board reports CIPs by division and separate EQIP team.
- CIPs sensitivity assumes 95% achievement in 10/11 and 90% thereafter in the assessor case . In downside it assumes 90% achievement 2010/11; 15% non- achievement of additional CIP schemes years 2-4 Trust originally submitted plans for total programme of c.£50m) and 85% achievement in 2015/16.



- Largest 3 work streams are Support Services (24% total), War on Waste (19% total) and Cross Site working (13% total).
- Unidentified schemes account for 29% and occur predominantly in years 4-5.

Sensitivity applied for non-achievement: 5% in 2010/11 and 10% from 2011/12 onwards in AC and 15% in DC

2.7 (2) CIPs – workforce impact

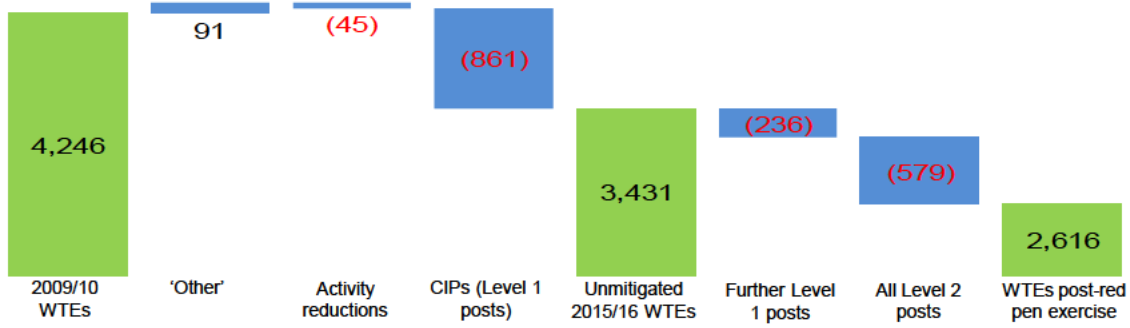
Executive Summary

Overview

- The Trust plans an overall reduction in staffing levels from 4,246 WTE in 2009/10 to 3,431 WTE in 2015/16; an overall reduction of 19%. The most significant reductions are in nursing staff (327 WTE, 18%); a large reduction is also planned for scientific, therapeutic and technical and non clinical staff (155 WTE, 27%). Agency staff employed is planned to fall by 50%. Consultant staff will fall by 10% and junior medical staff by 6%.
- Paybill CIP programme totals £4.3m (£1.5m 2010/11, £0.8M 2011/12 and £0.5m p.a. thereafter). A further £13m has been proposed as part of Trust downside mitigations (see below).
- Trust believes CIP reduction can be achieved via natural wastage (16.5% workforce is 55+ and average retirement age is 59.5 years) and other staff turnover and assess there is no significant risk of redundancy or severance payments.

Paybill reductions (downside mitigation)

- Paybill reduction review commenced in 2009/10 and included a ranking process ('red pen exercise' - under which divisions were asked to rank all posts 1-5, 1 being the least critically important to the organization and 5 being the most critically important) as well as internal presentations and discussions with Staff Side colleagues, regarding options relating to the freezing of increments and the standing down of national pay award from July 10.
- Board had wished to adopt core principle of 'Employment over Earnings' maintaining employment for as many staff as possible while recognising that to do so would impact on individual earnings.
- Directors and CE gave up their pay award of 2.25% in April 10.
- Proposal to withdraw 2010/11 AfC uplift was blocked by Regional Staff Side union representatives.
- Plan B – the ranking /'red pen' exercise - resulted in identification of up to £24.3m of savings (based on removal of all posts ranked 1 or 2) of which only £4.3m were included in the paybill element of the CIP programme and a further £13m as part of Trust downside mitigations.
- 2010/11 refresh of ranking exercise included all Divisions and Corporate functions invited to dedicated session regarding posts to be removed to meet 2010/11 paybill reduction target. All identified posts are subject to Quality Impact Assessments.
- Alongside this review concurrent analysis undertaken of:
  - Vacancies across Divisions and Corporate Departments (Split by Clinical & Non-Clinical) including review of vacancies not recruited to / vacancies out to advert; posts where resignations are live; fixed term / temporary posts; Agency posts and expected Retirement
  - Turnover of Staff (Split by Clinical & Non-Clinical and by division)
  - Mutually Agreed Resignation Scheme (Split by (Clinical & Non-Clinical)
  - Long Term Sickness (Split by Clinical & Non-Clinical)
  - New starters since November 2009 and November 2008
- Delivery of paybill reduction in 2010/11 is supported by an internal clearing house for displaced staff – linked to Trust Organisational Change policy and Regional Clearing House operational policy; enhanced internal communications with all staff and HR-run drop-in sessions to discuss implications, within each division – with the option to include staff side colleagues.
- Trust states that through this process they have been able to address some long-standing inefficiencies and also re-focus on cross-bay working practices.



People Strategy 2007-2012

- People Strategy, launched in 2007, sets out Trust plan to build a flex ble, responsive, efficient, productive and motivated workforce.
- Strategy has discrete phases; phases 1- 2 are complete; phase 3, current, was approved by Board in March 10. Progress against Strategy is monitored against KPIs quarterly at FPSC.
  - Phase 1 contained critical targets (e.g. 100% appraisal coverage, 95% mandatory training completion, 100% induction attendance) in order to anchor sound people management principles. These metrics are reported within a discrete 'workforce' section in Trust's IPR.
  - Phase 2 maintained scrutiny of metrics while driving improvement through mix of leadership and organization development. It also focused on areas of development from previous staff surveys.
  - Phase 3 focuses on leadership development to demonstrate Trust has attributes of a 'learning organisation'. Plan focuses on making divisional management teams more fluid increasing freedoms and responsibility to drive the organisation forward for all key management tiers and individuals within those tiers.

Staff engagement

- Trust structured approach to workforce engagement in Engagement Framework aimed at ensuring staff understand issues, their scale and impact, options to raise and address concerns and effect change at a local level. Channels of communication also include Team Brief and Weekly New; a poster campaign was used to launch 'War on Waste' CIP initiative.
- Trust performed well in 2009 staff survey (see slide 3.6) and is part of a project in the North West to allow benchmarking on workforce metrics. Based on current data, the Trust is ranked sixth-best (out of sixty-three trusts) in the region for sickness absence.

Medical staffing issues

- On-going issues with medical staffing vacancies, particularly at FGH leading to NEDs request for monthly report to Board/FPSC on all medical vacancies and associated agency/locum costs. Situation appears improved with appointments into key roles; all new consultant contracts signed are for cross-bay workings.

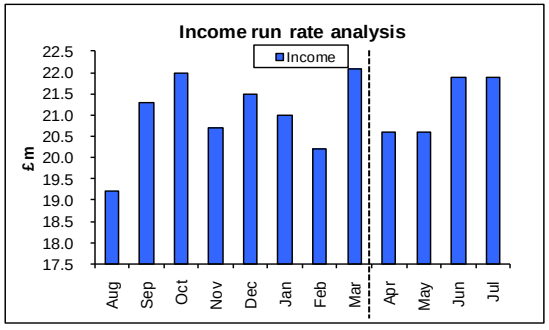
Medical Staffing – Audit Commission benchmarking

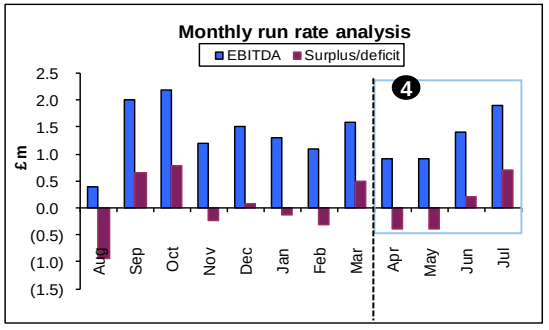
- In 09/10 Trust's External Auditors (EA) completed a pilot benchmarking exercise, with comparative 2008/09 data collected from 12 acute hospital trusts. Information was collected and analysed at the level of 40 sub-specialities.
- EA strongly highlighted to assessors 1) that comparator group was very small and therefore it was difficult to make strong judgements based on the data and 2) Trust's participation in exercise emphasised skill mix as an area under consideration at Trust and with the potential to deliver savings in some areas.
- Preliminary findings: at an overall Trust level, 'productivity' above average, however throughput in 'supporting' specialities (e.g. anaesthetics, radiology and pathology) was low; number of trainees supervised by consultants lower than elsewhere; in 08/09 Trust made comparatively little use of non-consultant career grade doctors.
- Trust uses a significant number of locum doctors to deliver activity and comply with EWTD. This may add additional costs and present concerns about the quality of care. EA note that location of Trust, may drive challenges to recruit into some specialities. A 09/10 review with comparative data from 50 acute trusts; expected September 10.

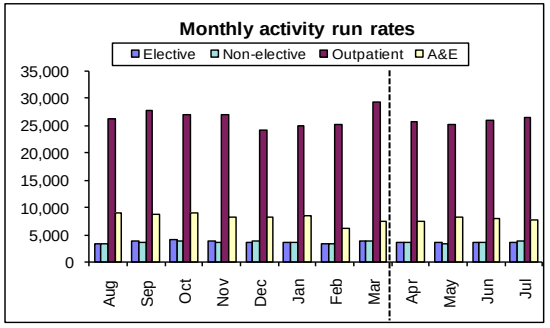
Pay CIPs represent £4.3m (6.5%) of the overall CIP target, with c. 19% of the workforce being removed

2.8 Base case – current trading

£m	2010/11 to month 4 YTD 4 months Actual	YTD 4 months LTFM	Variance to LTFM	% Variance	Latest Forecast YTG 8 months	Forecast outturn
Total Income	**85.1**	**84.0**	**1.1**	**1.3%**	**164.2**	**249.3**
Total Costs	**(80.0)**	**(79.0)**	**(1.0)**	**1.3%**	**(152.3)**	**(232.3)**
EBITDA	**5.1**	**5.0**	**0.1**	**0.0**	**11.9**	**17.0**
EBITDA margin %	*6.0%*	*6.0%*	*0.0%*	*0.7%*	*7.2%*	*6.8%*
Surplus/(deficit)	**0.1**	**0.0**	**0.0**	**0.0**	**1.9**	**2.0**
Surplus/(deficit) margin %	*0.1%*	*0.0%*	*0.1%*	*n/a*	*1.2%*	*0.8%*
Activity						
Elective	14,418	14,875	(457)	(3.1%)	30,384	44,802
Non-elective	14,454	14,694	(240)	(1.6%)	29,507	43,961
Outpatients	103,647	102,781	866	0.8%	205,937	309,584
A&E	31,450	29,520	1,930	6.5%	56,868	88,318







Comments

Surplus

1. As at the end of month four the Trust had achieved £0.1m of surplus against a full year plan of £2m.
   The Trust was £1.1m ahead of planned income, this is largely to due to non-recurring income overperformance of £0.9m - this relates to Lorenzo income and additional funding that the Trust has received to fund in-year costs.
   Additional costs incurred to deliver additional income include overspends on agency costs of £1.2m against budget and c. £0.5m against LTFM plan.
2. The Trust had planned a low EBITDA margin for the first quarter of the year. This is due to income being typically lower in April and May due to number of operating days and costs being spread evenly over the year. 30% of full-year EBITDA achieved by month four.
3. Elective and non-elective activity was less than planned by month four, with no specific reason for this given by the Trust. Increased outpatient admissions were required to keep abreast of demand and growing waiting lists and the explanation for A&E being above plan involved school holidays and unusually attractive weather leading to attendances being above those planned.

4. **Surplus/deficit monthly run rates**
   The Trust's net income and expenditure position varies each month. The in-month deficits are as a result of less working days in the month.
   Income in August 09 is significantly lower, due to bank and school holidays.
   The number of operating days in the months August, December and May are 19; March and July have 23 working days.

Breakeven position at month 4 against full-year plan of £2.0m

2.9 Operating KPIs (acute)

Business Plan

		Actual			Outturn	Forecast					2010/11 Benchmarking		
		Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16	Upper quartile	Median	Lower quartile
Average Length of Stay (Elective)	*days*	1 0.8	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	1.7	1.4	0.7
Average length of stay (exc Day Cases)	*days*	2.7	2.8	3.3	3.0	2.8	2.8	2.8	2.8	2.8	4.0	3.4	3.1
Average Length of Stay (Non Elective)	*days*	5.7	5.5	5.4	5.0	4.8	4.5	4.5	4.5	4.5	6.0	5.0	4.5
Bed Occupancy	%	2 82.7%	84.8%	85.9%	84.8%	85.9%	85.9%	85.9%	85.9%	85.9%	87.9%	85.0%	82.0%
Theatre Utilisation	%	90.3%	3 84.7%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	90.0%	85.0%	81.8%
Day Case Percentage (Day Cases/ Spells)	%	69.1%	73.8%	77.9%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	79.0%	77.4%	64.9%
New to follow up outpatient ratio	%	180.9%	177.7%	169.3%	160.1%	154.5%	149.0%	143.5%	138.0%	132.6%			
Number of consultant PA sessions per week		11.2	10.9	11.0	11.0	11.0	4 10.5	10.5	10.5	10.5	Benchmarking data not available		
Number of beds		5 1,004	974	995	879	853	840	840	840	840			
Local population	*000*	323	326	329	332	335	337	340	340	340			

Comments

1
- As part of the Acute Services review, the Trust has carried out service re-design to reduce ALOS e.g. less pre-operative days, and improved discharge processes.
- The Trust attributes the improvement in LOS to a number of factors, including:
  - A review of emergency flows and the completion of some site reconfiguration following the Acute Services Review.
  - Rapid Access Case Management. The Trust has a Short Term Intervention Service, linking with community case managers working from Kendal hospital, in addition to revamped multi-disciplinary team working.
  - The movement of some long-term patients to nursing homes (facilitated by joint work with commissioners, with intermediate care & community based models of care being introduced).

2
- The Trust reduced bed occupancy between 2005/06 and 2007/08 as a result of improved monitoring of bed availability and patient flow management. The Trust increased occupancy from 2008/09 to 2009/10 due to changes in case mix.

3
- In 2007/08, the Surgical Division undertook a concerted effort to ensure all sessions in the timetable ran and fewer were cancelled due to consultant leave, training etc. This took place at a cost as re-utilised sessions were undertaken at premium rates and was therefore not sustainable. In 2008/09 the Surgical Division used far fewer premium sessions. In 2009/10, theatre utilisation was again increased as a deliberate strategy to increase the volume of activity per session. This allowed the generation of additional income.

4
- The reduction in planned consultant PA sessions reflects one of the Trust's CIP programmes to improve medical productivity and reduce duplication of rotas and on-call commitments. The Trust will continue to improve its consultant job planning process with a view to changing the ratio of DCC to SPA's (8.5:1.5 = 10 PAs),. The Trust has already implemented this for new consultants.

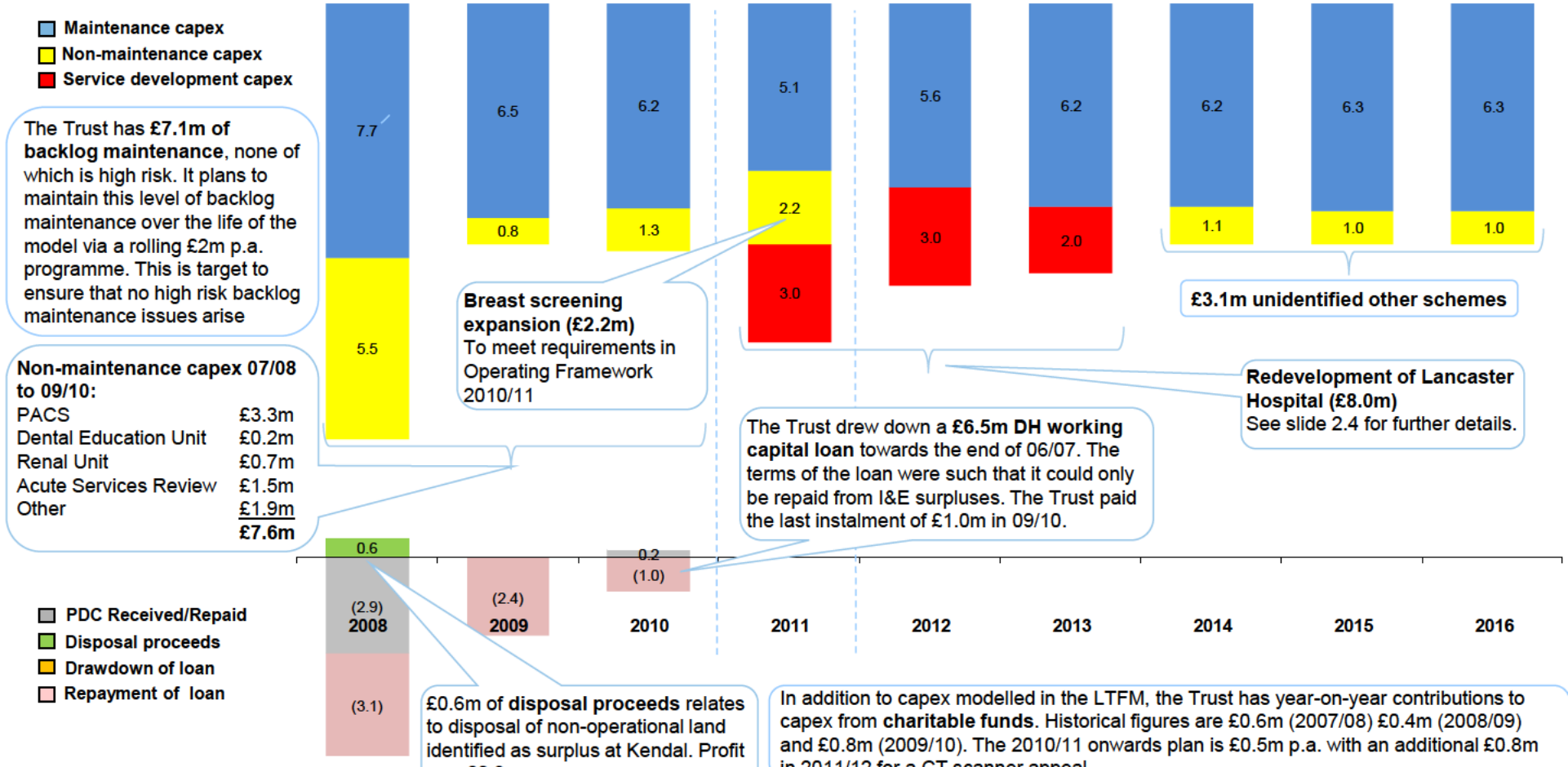
5
- Beds reduced by 109 between 2005/06 and 2009/10. This was driven in part by the Acute Services Review. In addition, a range of beds were closed within Medicine & Surgery at all three sites. These bed closures reflected reduced length of stay and improved bed occupancy.
- The Trust plans to take out a further 155 beds over the next three years (c. 16% of Trust's beds as at March 10).
- For 2010/11, the total planned reduction of 116 beds includes 51 beds being transferred to NHS Cumbria (Langdale wards) and a further 44 beds included in the Trust's EQIP programme (inc. Ward 50 and oncology beds). Of the remaining 21 beds, the Trust believes that 16 beds can be taken out by closing a ward of winter contingency beds at Barrow Hospital.
- For 2011/12 and 2012/13, the Trust plans to close two further wards with a FYE in 2012/13 of a further 48 beds.

The trust believes it can drive a reduction in bed numbers by improving (mostly non-elective) lengths of stay.

2.10 Capital expenditure and funding

Business Plan

Total capital expenditure	£m 12.8	£m 7.3	£m 7.5	£m 10.3	£m 8.6	£m 8.2	£m 7.3	£m 7.3	£m 7.3



The Trust has **£7.1m of backlog maintenance**, none of which is high risk. It plans to maintain this level of backlog maintenance over the life of the model via a rolling £2m p.a. programme. This is target to ensure that no high risk backlog maintenance issues arise

Non-maintenance capex 07/08 to 09/10:

PACS	£3.3m
Dental Education Unit	£0.2m
Renal Unit	£0.7m
Acute Services Review	£1.5m
Other	£1.9m
	£7.6m

Breast screening expansion (£2.2m)
To meet requirements in Operating Framework 2010/11

£3.1m unidentified other schemes

Redevelopment of Lancaster Hospital (£8.0m)
See slide 2.4 for further details.

The Trust drew down a **£6.5m DH working capital loan** towards the end of 06/07. The terms of the loan were such that it could only be repaid from I&E surpluses. The Trust paid the last instalment of £1.0m in 09/10.

£0.6m of **disposal proceeds** relates to disposal of non-operational land identified as surplus at Kendal. Profit was £0.3m.

In addition to capex modelled in the LTFM, the Trust has year-on-year contributions to capex from **charitable funds**. Historical figures are £0.6m (2007/08) £0.4m (2008/09) and £0.8m (2009/10). The 2010/11 onwards plan is £0.5m p.a. with an additional £0.8m in 2011/12 for a CT scanner appeal.

Operating cashflow	£m 27.8	£m 18.3	£m 19.4	£m 14.1	£m 17.7	£m 19.6	£m 19.9	£m 21.0	£m 22.1
Maintenance capex / dep'n	(63%)	(61%)	(61%)	(54%)	(56%)	(64%)	(61%)	(66%)	(67%)
Total capex / dep'n	(108)%	(68)%	(74)%	(109)%	(86)%	(84)%	(72)%	(76)%	(78)%
Total capital expenditure	13.3	7.3	7.5	10.3	8.6	8.2	7.3	7.3	7.3
Long Term Borrowing Limit				49.5	49.1	48.7	48.2	47.6	47.1
PBC breached				No					

Trust has restricted capital spend to build up cash reserves for potential equal value claims. No capex sensitivity applied.

2.11 Financial risk rating based on Trust's base case

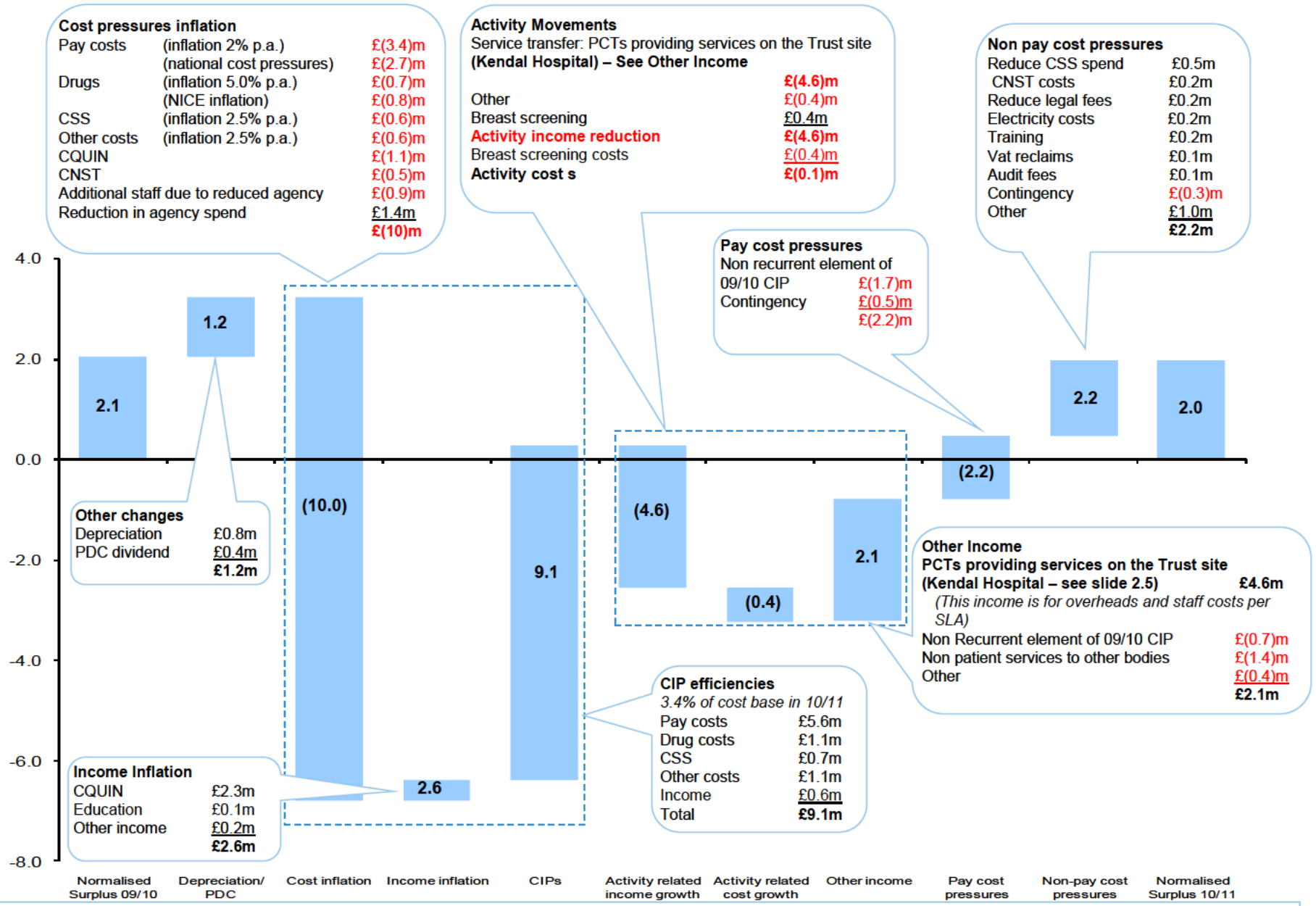
Business Plan

Criteria	Metric	Weight	Bands					CY Outturn	Year one
			5	4	3	2	1		
Underlying Performance	EBITDA margin	25%	11%	9%	5%	1%	< 1%	6.8%	7.5%
Achievement of Plan	EBITDA, % achieved	10%	100%	85%	70%	50%	< 50%	100.0%	99.5%
Financial Efficiency	Return on assets	20%	6%	5%	3%	-2%	< -2%	4.4%	4.8%
	I&E surplus margin	20%	3%	2%	1%	-2%	< -2%	0.8%	1.1%
Liquidity	Days costs	25%	60 days	25 days	15 days	10 days	< 10 days	30 days	30 days
Average		100%	5	4	3	2	1	3.3	3.4
Overall rating					3				

- **N.B. The Trust is negotiating a working capital facility of £18m.**

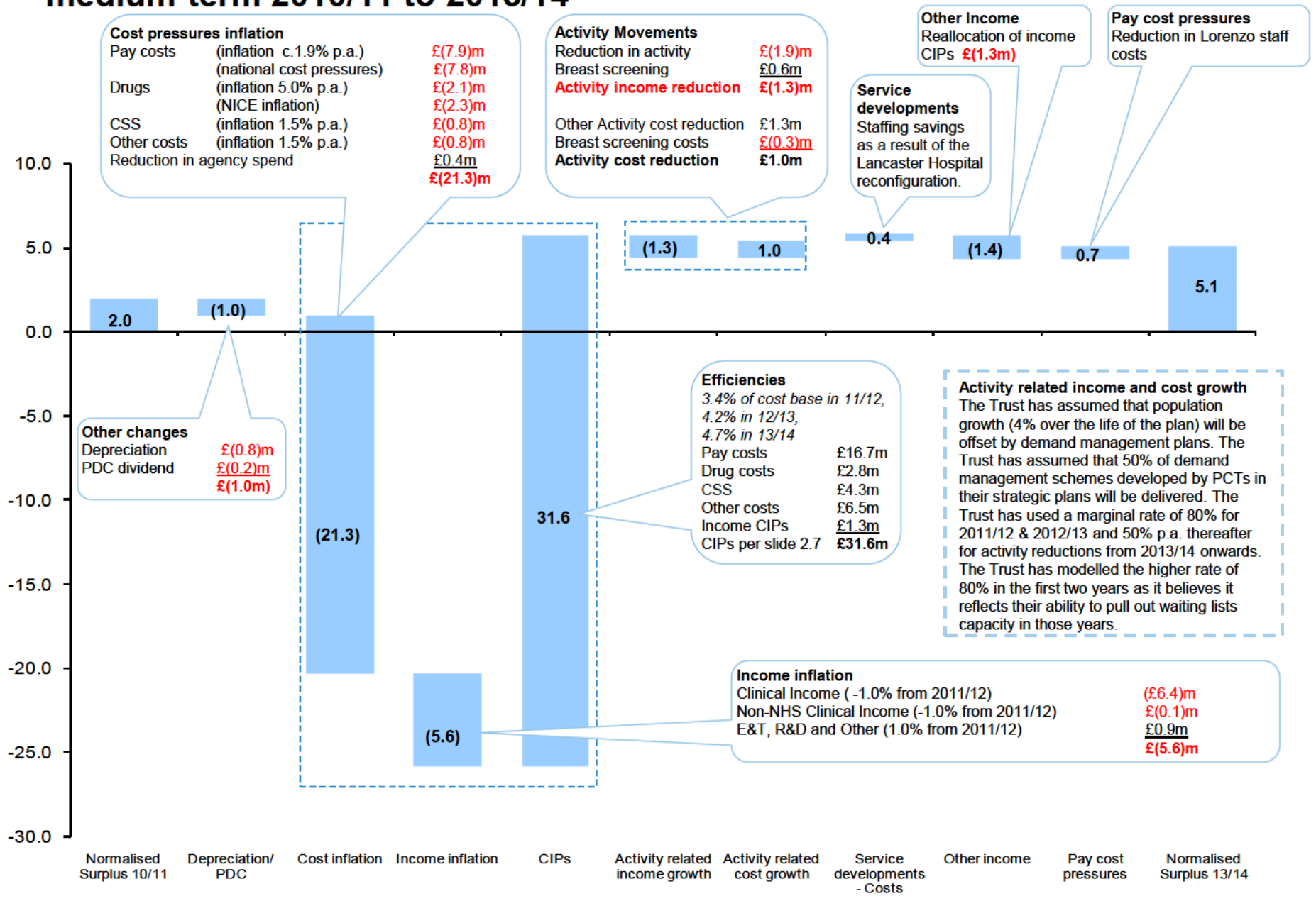
Trust has an FRR of 3 in outturn year. FRR remains at 3 in first two quarters in both base case and AC.

2.12 Bridge analysis – base case normalised net surplus; short-term 2009/10 to 2010/11



Cost pressures exceed CIPs in 2010/11

2.12 Bridge analysis – base case normalised net surplus; medium-term 2010/11 to 2013/14



Surplus improvement driven by CIPs rising to 5.3% of cost base in 2015/16

Section 3

3.1 Non-executive directors

Professor Eddie Kane
Current career: Retired

Chair — **Appointed May 2008**

- *Other current roles:* Director at the National Institute for Personality Disorder Research (Nottingham University), Professor roles at Nottingham University and Imperial College.
- *Prior to retiring:* Career involving numerous positions in senior NHS management including Principle Advisor to the DH on High Security and Personality Disorder services (including overseeing the Fallon inquiry), Regional Director of MH in the Northwest and Midlands, Regional Director of NHS Services and Performance in West London, NHS Trust Unit Director for North West (where he worked with David Nicholson).

Niven Ballantyne
Current career: Semi-retired. Owns an investment company operating two public houses in Yorkshire.

Chair of the Audit Committee — **Appointed April 2008**

- *Prior experience:* Background in the leisure industry: Corporate Development Director for Luminar Leisure Group PLC (an organisation employing over 3,000 people, running entertainment venues). Property and Commercial Director and Financial Director of Northern Leisure PLC (acquired by Luminar Leisure Group PLC in 2000). Finance and Development Director of Bass Leisure Entertainments.
- *Qualifications*: Qualified as a Chartered Accountant in 1968.

June Greenwell
Current career: Retired

Chair of the Clinical Quality and Safety Committee — **Appointed April 2004**

- *Other current roles:* Chair of Trustees (local voluntary sector care home), Chair of Lancaster District Older People's Partnership.
- *Prior to retiring:* Career, spanning 20 years, as an independent researcher (mainly focused in healthcare). She was also an honorary research fellow and lecturer in Lancaster University's social science department.
- *Qualifications*: Holds a PhD (Bristol University) for her research examining approaches to hospital restructuring.

Frank McLaughlin
Current career: Semi retired. Some consultancy work.

Appointed January 2006

- *Other current roles*: Occasional commercial consultancy roles to develop and produce Stratospheric Airships.
- *Prior experience*: Background largely in the aerospace and defence industries: Commercial Director of several divisions of QinetiQ Plc (formerly MoD DERA), engaged to transform DERA into a new Plc and to change the culture from a Civil Service environment. Previously, Commercial Director within a division of GEC Marconi. Began career at British Aerospace working on contract negotiation.

Steve Smith
Current career: Faculty Manager, Faculty of Science and Engineering, University of Liverpool.

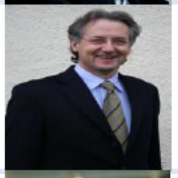
Appointed March 2007

- *Current role*: Faculty Manager for the University of Liverpool's Faculty of Science and Engineering. Prior to this was a Senior Administrator in the University's Faculty of Medicine.
- *Prior experience*: Professional engineer, spending bulk of his career at Unilever in various management roles. Moved into the academic environment in 2002 following redundancy.
- *Qualifications*: Corporate Member of the Institution of Mechanical Engineers (1991)

Ian Tomlinson
Current career: Retired

Appointed December 2008

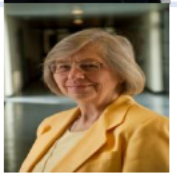
- *Prior to retiring:* Background in the IT industry. Sales Director 747 Solutions Inc (spin off from Compaq, focused on developing mobile commerce solutions for financial institutions and mobile operators). Provided sales consultancy to IT businesses seeking consultancy and support projects within the NHS NPfIT programme.
- Previously various sales manager and business development manager roles for Tandem Computers.



Pat Thomas
Current career: Retired

Appointed April 2009

- *Other current roles: Currently:* sits on the Administrative Justice and Tribunals Council (2005 onwards, approx. 45 days per year commitment)
- *Prior experience:* Had a career in law academia (1962-1985) and the Local Government Ombudsman (1985-2005, Vice-Chair from 1993-2005).
- *Qualifications:* Fellow, University of Central Lancashire



1 x NED vacancy upon authorisation. Job description has been drafted based upon recruiting someone from a corporate finance background.

3.2 Executive directors

Tony Halsall	**Chief Executive** — **Appointed March 2007** • Led the successful foundation trust application for Clatterbridge Centre for Oncology Foundation Trust (Wave 2). • Previously held executive director posts at Wrightington, Wigan and Leigh NHS Trust (Director of Nursing and Operations) and Stockport NHS Trust (Director of Nursing and Midwifery). • *Qualifications:* RGN (1983), Currently studying for an MA in Leadership and Learning (Lancaster University).	
Tim Bennett	**Finance Director and Deputy Chief Executive** — **Appointed April 2005** • Previously held executive director roles at Cardiothoracic Centre Liverpool (FD), Wigan and Bolton Health Authority (FD and Director of Modernisation) and Bolton PCT (FD). • Chair of Healthcare Financial Management Association (northwest branch) – a leading industry voice on NHS finance matters. • *Qualifications:* CIPFA (1990); MBA (2008 – Lancaster University).	
Peter Dyer	**Medical Director** — **Appointed April 2006** • Consultant in Oral and Maxillofacial Surgery (practices 1 day per week). • Fellow of the Royal College of Surgeons in Ireland. • Held post of Clinical Director for surgery for two years prior to being appointed as Medical Director. • Member of the DH's 'NHS Clinical Pathways Steering Group'. • *Qualifications:* BDS (1979 – London), MBBS (1988 – London), MA (2000 – Lancaster).	
Jackie Holt	**Director of Nursing and Modernisation** — **Appointed August 2008** • Previously held Director of Nursing and Governance and FT Programme Director posts at The Walton Centre. • Qualified as a nurse in 1982 and has spent career working in acute DGH's, gradually moving into general management. • Expert advisor to the DH in the development of the National Framework for Long Term (neurological) Conditions. • *Qualifications:* Registered General Nurse (1982), MA in Management (1996 – Manchester Metropolitan University).	
Steven Vaughan	**Director of Operations and Performance** — **Appointed October 2007** • Previously held acting Director of Operations role at Burton Hospital NHS Trust. • Worked in the NHS since 1989 in various management roles. • Appointed Honorary Senior Lecturer at University Of Central Lancashire.# • *Qualifications:* Recently completed the NW Leadership Academy Aspiring Chief Executive development programme, CIMA (1996), Postgraduate certificate in Health Operational Research and Management Science (2006 – Uni. of Keele).	
Roger Wilson (Non-voting Director – to become voting on achievement of FT status)	**Director of Human Resources and Organisational Development** — **Appointed July 2007** • Previously held Director of Workforce and Learning role at the 5 Boroughs Partnership NHS Trust. • Joined NHS in 1987 as a graduate finance trainee at Mersey Regional Health Authority. • Joint Chair – Cumbria and Lancashire HR Network. • *Qualifications:* Diploma in Strategic Human Resource Management (2005)- Manchester Business School), Fellow of the Chartered Institute of Personnel and Development (2007).	
Patrick McGahon (Non-voting Director – to become voting on achievement of FT status)	**Director of Service and Commercial Development** — **Appointed July 2007** • Previously held post of Turnaround Director for the Trust (seconded to the Trust in October 2006). • Previously held executive director roles including North NHS Cumbria (FD and acting CE), North Cumbria Mental Health and Learning Disabilities NHS Trust (FD and acting CE), Cumbria Ambulance Service NHS Trust (acting CE). • Worked within the NHS, local government and not-for-profit organisations since 1987. • *Qualifications:* MBA (1994 - Edinburgh Business School), CIPFA (1991)	

3.3 Governance checklist

Governance

Statutory requirements	
Is the proposed constitution compliant with the Act and otherwise appropriate?	**O** One area outstanding, regarding the name of one of the staff constituencies. The Trust is currently amending the constitution to remedy this issue.
Has the statutory consultation been held?	✓ Yes, consultation commenced in October 07 and ended in January 08. A formal consultation has not been re-run since then; however, the Trust has maintained engagement with it's members and shadow Board of Governors.
Have the elections been held in compliance with the Act?	✓ Elections were held in May 09 and were overseen by the Electoral Reform Society. All seats were filled.
Membership strategy	
Has the Trust taken steps to secure representative membership?	✓ Yes, the Trust has developed a Membership Strategy, and currently has 5,709 public members which represents 1.5% of the general population. Members are broadly reflective of the population (analysis of membership by race, gender, age and socio-economic group has been provided) The minimum number of members in each category specified in the constitution has been filled. There are 5,273 (84%) staff members and 19 staff members have opted out.
Will the Board and Governors reflect the composition of the membership; are the affiliations and financial interests of the council known?	✓ The Trust is operating a shadow Board of Governors comprising 30 governors. This is made up of 6 staff members, 7 stakeholder members and 17public members. The public governors are split between constituency based on populations which was considered the most appropriate way of allocating governors positions representatively.
Board structure	
Are there clear structures and comprehensive procedures for the effective working of the NHSFT Boards?	✓ Yes. Trust Board meetings take place every two months and receive suitable reports. The Finance and Performance Scrutiny Committee (which is attended by the full Board) meets in the intervening months. The Trust has a Company Secretary. The shadow Board of Governors has three sub-committees focusing on strategy, patient experience, and membership. Meetings held with the shadow staff governors confirmed that the shadow Board had good working relations with the Chair and Executive team.
Does the Trust has an effective Board & Subcommittee structure and reporting mechanism. Is there NED representation on key committees?	✓ The Trust Board and sub-committees are embedded and effective. There are clear terms of reference for all committees and a structured reporting lines from divisions to Trust Board. Official Board sub-committees are Audit and Remuneration & Terms of Service (NEDs only), Charitable Funds (full Trust Board membership), Finance & Performance Scrutiny ('FPSC'; NED chair, full Trust Board membership), Clinical Quality and Safety ('CQSC'; NED chair plus three other NEDs and Medical Director and Director of Nursing membership). In addition, the Executive team meet on a monthly basis at the Hospital Management Team meeting. Minutes and other quarterly reports flow from the committees to the Board. Audit Committee effectiveness has been confirmed by Internal Audit and External Audit. A review of Board reporting was carried out by Internal Audit in 2009/10 which gave significant assurance.
How do clinical governance issues flow through the committee structure? Does one particular NED focus on / take responsibility for this area?	✖ Clinical governance issues flow through the CQSC which meets five times per year. This committee is chaired by June Greenwell. Initially two other NEDs also attended (Ian Tomlinson and Frank McLaughlin) and Pat Thomas joined in February 10. The terms of reference have recently been amended to allow full NED representation. A number of sub-committees report their minutes to the CQSC (Clinical Audit and Effectiveness, Integrated Risk, Patient Service and Experience, and Medicines Management). Some concerns on the duplication of quality information reported to the CQSC and over-reliance on June Greenwell.
Is the Board assured of the effectiveness of its formal sub-committees, if so how?	✓ A review of the effectiveness of the CQSC was carried out by Internal Audit in 2009/10 which gave significant assurance.

✓: satisfactory. **O**: open issues. ✖: some concerns. ✖: significant concerns

3.3 Governance checklist

Organisational capacity		
Self certification Has Trust self-certified that it is confident that the collective experiences /qualifications of the Board and management team are sufficient to perform roles of a NHSFT?	✓	Self-certification was received on 22nd July 2010. The Trust has self-certified that it is confident that the collective experiences/qualifications of the board and management team are sufficient to perform the roles of an NHSFT and discussions with Board members have demonstrated that all necessary areas to support the self-certification have been considered.
Evidence showed by applicant		
Has the Trust in its interactions with Monitor shown satisfactory evidence that the collective experiences and qualifications of the Board and management team are sufficient to perform the roles of a NHSFT?	✓	The Chief Executive (clinical background and previously led a successful FT application) and the Chair (clinical background and significant experience within NHS at senior level) appear to operate effectively, with the Chief Executive leading on implementation of strategy, engagement with specific internal and external stakeholder groups. and management of his Executive team and the Chair operating effectively as an ambassador for the Trust and leading and supporting a constructive dynamic within the Board while holding the Chief Executive to account. The Trust has a stable and experienced Executive team, EDs have previous NHS Board level experience and the Director of Service and Commercial development previously held a Turnaround post and is a qualified accountant. The NEDs provide broad and relevant experience. Ian Tomlinson's significant IT experience has been utilised effectively for assurance by the Board during the roll-out of the Lorenzo project. June Greenwell's clinical background has provided useful background I her role as Chair of CQSC. In Board and Committee observations the NEDs demonstrated that they provided challenge to the Executive team on performance.
Is there sufficient evidence of the ability of the Board and management team to clearly articulate the business plan as evidenced through: • The quality of the business plan • Board-to-Board meetings and assessor meetings	✖	The Trust submitted a good quality IBP, although both NHS Cumbria and NHS North Lancashire expressed concerns that the Trust had 'refreshed' the IBP rather than rewriting it to reflect the changed health landscape since the previous assessment. In meetings the Executive team, divisional management, and clinical representatives were able to describe the strategy and the impact on their areas of work. During the course of the assessment meetings it became clear that most of NEDs have a detailed understanding of the EQIP programme. Some reservations on robustness of downside planning. [Board-to-Board meeting to be held on 8 September 2010].
Did the Board and management team have a clear view on the key risks facing the Trust?	✓	Assessment meetings with the Executive team, NEDs and divisional management revealed consistent and articulate views on the short-term operational risks and the risks to the objectives set out in the business plan.
Were the Board and management team able to sufficiently outline the contingencies in place?	✓	Yes. The Executive team and NEDs were aware of the actions the Trust could take should it face less favourable market conditions.
Did any unexpected other issues come to light during meetings?	✖	Both NHS Cumbria and NHS North Lancashire stated that the Trust's demand assumptions were based on outdated PCT plans and that their demand management requirements were higher than stated in the IBP. Cumbria commissioned external consultants to review IBP (June 2010); key issues: lack of sufficiently detailed vision for clinical service developments over next 5 years linked to PCTs future plans and in particular the future operation of FGH, the commissioning impact of the formation of ICOs in South Cumbria, some key financial assumptions are not aligned to the NHS Cumbria financial plans. Trust stated that activity assumptions were based on 10/11 contract negotiations (March 10); that downside planning assumed full delivery of demand management schemes, that both PCTs have significant levels of reserves and that it is unclear what the impact of move to ICOs is in practice.
Third party evidence Have any concerns been raised by any third party (for example: Healthcare Commission; SHA; Accounting firm) through the assessment process on organisational capacity?	**O**	There was positive feedback from meetings with NHS North West, Internal Audit and External Audit on their working relationships and capabilities of the Trust Board. Both NHS Cumbria and NHS North Lancashire expressed the view that the team was a good operational team, but both had concerns on the team's ability to think strategically and engage in partnership working. This view was not echoed by NHS North West. Ongoing updates between Assessment team and independent accounting firm firm – no significant issues highlighted to date.

✓: satisfactory. **O**: open issues. ✖: some concerns. ✖: significant concerns

3.3 Governance checklist

Performance management	
For Finance, Clinical access, Clinical Governance, Organisational / HR and Long Term Strategy	The Trust reorganised the divisional structure at the Trust in 2007/08 from a structure of 9 clinical directorates to 3 clinical divisions (Medicine, Surgery & Critical Care, and Core Clinical Services. This was done to drive efficiency in the Trust, with each division, a "mini-Trust", having accountability for meeting targets and living within resources in the same way that the Trust overall has to. The Trust reviewed this in 2009/10, and set up a new division for 'Family Services' (previously in Medicine division).
•Are the targets/measures identified reasonable? •Are the correct targets/measures being monitored? •Is performance against the targets managed appropriately?	✓ *Finance* The monthly Integrated Performance Report (IPR) (which includes finance sections) is discussed at the Board and, in months where there is no Board meeting, at the FPSC(full Board membership). It includes the summary I&E position to date and for the month against budget, detailed costs (pay costs by staff type and non-pay costs by type) for the year to date and month against budget, capital spend against budget, income and expenditure variances by division, CIP achievement against budget by division, the balance sheet position and cash flow forecast (incl. rolling 12 months). The divisional financial position is also discussed within divisions on a monthly basis.
•Are the reporting lines clear and appropriate? Are arrangements in place and effective to respond to adverse performance? i.e. have mitigating actions been identified in case of adverse performance? Are arrangements in place to continually review and update targets to ensure continual improvement?	✓ *Clinical Access / Clinical Governance* Clinical access and clinical governance issues are included within the monthly IPR ('National Targets' and 'Patient Safety and Quality Metrics' sections). The specific metrics monitored include all national targets (including MRSA and C. Diff by site), last minute cancellations, hand hygiene compliance, incidents by type and complaint response times. In addition, clinical governance is monitored via the Clinical Quality and Safety Committee (CQSC) which is chaired by a NED and now has full NED membership. This committee meets quarterly. It is informed by a number of sub-committees (Patient Experience, Clinical Audit and Effectiveness, Integrated Risk and Medicines Management) ach of which are chaired by either the Medical Director or Nursing Director and meet either monthly or bi-monthly. These sub-committees are informed by a number of groups relating to specific areas, such as the Cancer Clinical Quality Group, the Patient Information Group and the Maternity Risk Group etc. The sub-committees and groups are attended by divisional representatives. The role of each committee and group is clearly defined in the relevant terms of reference.
Activity monitoring and reporting	✓ *Organisational / HR* Organisational and HR issues are included in the monthly IPR ('Workforce' section). The specific measures monitored are the Trust sickness rates, staff turnover % and appraisals compliance. Agency spend is monitored separately. In 2009/10, each division was allocated a HR representative who reviews specific issues within each division. The divisional monthly report also includes key organisational/HR KPIs such as staff appraisal rates and attendance at mandatory training, in addition to those included in the IPR.
	✖ *Long term strategy* The Trust's strategic objectives are set out in the IBP. SMART outcome measures are in place for 2010/11 for each strategic objective. The Trust monitors performance against national, quality and finance targets on a monthly basis via the IPR and provides quarterly updates on the Business Plan to the Board / FPSC. Some concerns raised by PCTs on Trust Board's ability to think long-term / strategically.

✓: satisfactory. **O**: open issues. ✖: some concerns. ✖: significant concerns

3.3 Governance checklist

Risk management and controls	
Does the Statement of Internal Control confirm that the organisation has an effective system of internal control in place for the whole year?	✓ Yes the 2009/10 SIC confirms the Trust has an effective internal control system. The Head of Internal Audit's 2009/10 opinion concluded that significant assurance could be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Is the Statement of Internal Control supported by appropriate risk management, control and review processes that are embedded in the organisation?	✓ Yes, there is an embedded risk management, controls and review process from division to Trust level which is supported by a Trust-wide Risk Management Strategy (updated in July 09, annual review planned for July 10).
Does the risk management strategy cover all areas in the SIC guidance?	✓ Yes, the 2009/10 opinion on the effectiveness of the SIC did not note any gaps in the coverage of SIC guidance.
Is there clear identification of the context in which the risk is managed?	✓ Yes. For each risk, key controls are identified at a ward and divisional level. Action plans are developed to mitigate risk or to reduce risk to an acceptable level, with each action being allocated a lead and reviewer. Action plans are followed up and reviewed regularly within the divisions. Risks are allocated a risk score based the likelihood and consequence both before and after the mitigating actions have been put in place. The top eighty risks are included within the assurance framework and risk register, which summarises the action plans in place for each risk.
Are the appropriate controls in place in relation to each risk?	Yes. Within divisional level risk registers, each risk is allocated a lead and reviewer. Each risk has a consideration of the adequacy of controls. All risks are recorder in a central risk register which is maintained by the Trust's risk department. All risks captured in the AF include current controls and mitigating actions. There are action leads and timescales allocated to each action plan which is monitored by the AC to ensure timely implementation of action plans.
Are there appropriate review and assurance mechanisms in place?	✖ The Integrated Risk sub-committee which reports to the CQSC leads the review of the risk register. This sub-committee is attended by the Medical Director and Director of Nursing and meets every six weeks. The Board receives a report relating to the top 10 risks facing the Trust, controls in place on these risks and any actions plans. Review of Board papers indicates that the most recent report to Board had some incorrect information included in terms of movements of risk scores, and some concerns that the risks are not clearly linked to the Trust's strategic objectives as described in the Trust's business plan. The Risk and Assurance Framework (RAF) is approved by the Board and the FPSC annually. However, while the FPSC reviews and approves the RAF, the AC has responsibility for the review and maintenance of an effective system of integrated governance, risk management and internal control. As such, there are some concerns on lack of clear ownership and management of the RAF. The Board has not had a formal discussion on it's risk appetite.
Are risks identified and evaluated in a structured way?	✓ Yes. risk registers are populated at corporate, divisional and ward level and any individual may suggest a risk to include on the risk system. All risks identified are scored on a 5x5 matrix for likelihood and impact. The process for the identification of risk at a ward level appears embedded within the organisation with guideline on this included in the induction for all staff.
Is the Board Assurance Framework embedded in the organisation?	✓ Yes. The Head of Internal Audit's 2009/10 opinion concluded that an Assurance Framework had been established which is designed and operating to meet the requirements of the 2009/10 SIC and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.
Are there significant control issues/gaps in assurance and control identified in the assurance framework or SIC?	✓ The 2009/10 SIC noted that important further improvements be made to some key existing to ensure: • authorisations of payments are only made within delegated limits; and • the quarterly staff in post lists circulated to budget holders are consistently reviewed, signed and returned to financial management.

✓: satisfactory. **O**: open issues. ✖: some concerns. ✖: significant concerns

3.3 Governance checklist

Risk management and controls	
Audit Committee (AC)	
Does the AC (as a group) have the appropriate skills and experience to adequately fulfil their responsibilities?	✖ Yes. The AC Chair is a qualified accountant (Niven Ballanytne) with commercial experience. Prior to his appointment, the committee was chaired by June Greenwell (now Chair of the CQSC). JG was replaced as Chair as it was thought by the Trust that this role would be more appropriately filled by an accountant. Both Internal Audit and External Audit have expressed that NB is developing well as a Chair (he was appointed in January 2009), and that JG still has a strong role on the AC. All NEDs (excluding the Chair) are members of the AC.
Does the AC carry out an annual self assessment of its effectiveness?	Yes. The AC performs a self assessment as part of its annual report from the committee to the Trust Board.
Is the AC confident that its recommendations to the Board are implemented in a timely and robust manner?	✓ Yes. AC Chair stated that recommendations are cleared on a timely basis. The AC reviews outstanding recommendations via a tracker which is reviewed at each AC meeting. This details the responsible director and the date the recommendation was made. Meetings with other AC members, EA and IA confirmed that the AC as challenging.
Internal Audit and External Audit	
Have any issues/concerns been raised by either internal or external audit?	✓ No major issues raised in the assessment team meetings with the EA and IA and annual reports to the Trust. In 2009/10, IA gave limited assurance for: • Payroll feeder systems (portering staff): now assured. • S4BH – Medicines Management. In the ALE scores in 2008/09 the Trust scored 4/5 in two areas and 3/5 in three areas, an improvement on 2008/09 (five being the best score).
Are recommendations implemented in a timely and robust manner?	✓ EA and IA confirmed that the Trust is receptive to their recommendations and acts on them on a timely manner.
Fraud	
Has the Trust encountered any serious fraud in the last two years?	✓ Meeting with Counter Fraud raised no material issues with fraud. Overall strong counter-fraud procedures in place and appropriate focus from Trust Board.
If yes, are procedures and controls now in place and effective?	✓ N/A
Shared Services	
Does the organisation rely on shared services in order to deliver its agenda?	✓ No. The Trust does not have any material shared services.

✓: satisfactory. **O**: open issues. ✖: some concerns. ✖: significant concerns

3.3 Governance checklist

Financial reporting procedures	
Are there adequate controls over key cost categories?	✖ Costs are managed at a divisional level via monthly finance meetings. Each division has an allocated accountant within the finance team. Key costs are reported within the IPR The Trust's clinical divisions experienced overspends in 2009/10. A Financial Accountability Framework has subsequently been approved and issued to budget holders.
Are there any issues/concerns in relation to:	
• Financial reporting to the Board	✓ No. Financial reporting to the Board is done through the IPR which includes a section on finance and an appendix detailing additional financial information. The report includes forecast outturn position and a rolling 12 month cashflow forecast. The financial information is presented by the Director of Finance to the Board.
• Capacity and capability of Finance department	✓ No. A 'Fitness for Purpose' review of the finance department was carried out by RSM Robson Rhodes LLP (now merged with Grant Thornton) in June 07. This resulted in a restructure of the roles within the finance team and, following this, a follow up review in Summer 08 found no major areas of concern. No issues around the capacity and capability of the finance department were raised by Internal Audit, External Audit or the independent accounting firming firm FRP report.
• Accounting systems	✓ No. The accounting system used by the Trust is Oracle. It uses the standard package with no Trust specific variations. No issues with the accounting systems were highlighted by Internal Audit, External Audit or the independent accounting firm FRP report.
• Treasury management	✓ No. The independent accounting firm FRP report commented that the treasury management policy, which was compiled in line with the requirements of the FT regime, needed Board approval. This was approved at the January 09 Board meeting.
• IT controls	✓ No. No issues relating to IT controls were raised by Internal Audit, External Audit or the independent accounting firm FRP report.
Are the budgeting procedures thorough and well defined?	✓ Budget setting commences in November each year. Prior this, the budget setting process is agreed by the FPSC. Budgets are reviewed by dirvisions and signed off at the March Board meeting. The Trust does not currently fully zero base its budgeting assumptions, but is gradually moving to this approach. The independent accounting firm FRP phase report raised no concerns with the budget setting process.
How significant have budget variances been over the last three years?	✓ Budget variances have not been significant. Where variations have arisen they have been managed well internally (during period of financial recovery) and externally (good relationships with PCTs mean Trust historically has received payment for additional activity).
How well has the Trust managed its budget variances?	✓ The independent accounting firm FRP phase report raised no concerns with budgetary control process. Performance against budget is monitored by the FPSC at a detailed level and by the Trust Board at a more high level.
How does the Trust manage and report its central reserves?	✓ The Trust holds a central general reserve of £0.5m (the minimum required to be held by the SHA) and specific contingencies. This is held within the 'other' costs line as part of the budgeting process and costs allocated against this line as incurred. The reserve is predominantly used for non-recurrent cost pressures, for example the FT development costs were allocated against here. The Trust does not separately report the central reserve to the Board, but given the size of the reserve this has not been raised as a concern.

✓: satisfactory. **O**: open issues. ✖: some concerns. ✖: significant concerns

3.4 Healthcare targets and rating (acute)

Governance

Rating for 2010/11 Compliance Framework

Relates to	Priority	Target (see comments)	Period	Threshold	Weighting	Trust expectation of target (per self certification)
Acute	1	C. Difficile year on year reduction (to fit the trajectory for the year, as agreed with PCT)	Quarter	15% reduction[1]	1.0	Achieved
Acute	1	MRSA - Meeting the MRSA objective [(2)]	Quarter	Full target	1.0	Achieved
Acute	1	Maximum waiting time of 31 days for second or subsequent treatments: surgery	Quarter	94%	1.0	Achieved
Acute	1	Maximum waiting time of 31 days for second or subsequent treatments: anti cancer drug treatments	Quarter	98%		Achieved
Acute	1	Maximum waiting time of 31 days for second or subsequent treatments: radiotherapy - From Jan 2011	Quarter	94%		Achieved
Acute	1	Maximum waiting time of 62 days for first treatment from urgent GP referral to treatment: all cancers	Quarter	85%	1.0	Achieved
Acute	1	Maximum waiting time of 62 days for first treatment from consultant screening service to treatment: all cancers	Quarter	90%		Achieved
Acute	2	Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Quarter	95%	0.5	Achieved
Acute	2	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	Quarter	96%	0.5	Achieved
Acute	2	Cancer : Two week wait from referral to date first seen comprising either : - All cancers - for symptomatic breast (cancer not initially suspected)	Quarter	93% 93%	0.5	Achieved
Acute	2	People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	Quarter	68%	0.5	0.5
Acute	2	Screening all elective in-patients for MRSA	Quarter	100%	0.5	0.5
All	2	Self certification against compliance with requirements regarding access to healthcare for people with a disability	Annual	n/a	0.5	Achieved
All	2	Any core standards	By exception		0.4	0
						1.0

Trust is amber-green-rated for governance with a score of 1.0 (due to breaches of thrombolysis and MRSA screening minimum standards).

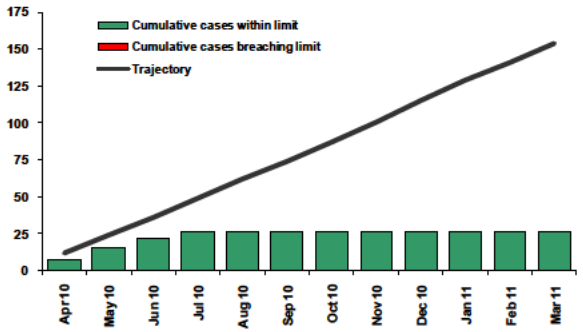
3.5 Healthcare target performance (1/2)

Governance

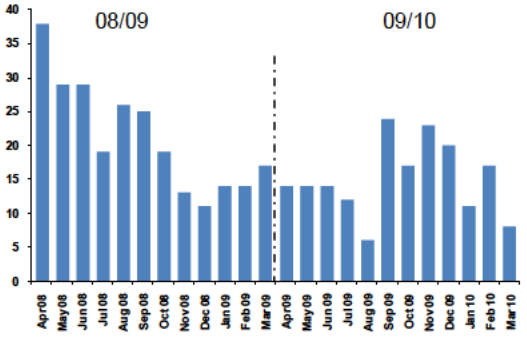
● ***Clostridium difficile* year on year reduction** (target of *154 cases for 2010/11)*

- 26 cases in 2010/11 as at month four.
- During 2009/10, the Trust had 85 cases. A ceiling a 292 cases was set by the PCT; the Trust internally stretched this target to 154 cases and the stretch target was comfortably achieved.
- Unannounced infection prevention spot checks were started in August 2009. Reports are issued to ward managers and matrons, an action plan is generated and progress is monitored by the Infection Prevention Committee. Sixty-five clinical areas were inspected in 2009/10. Ten areas were judged to be green, 44 were amber and 11 areas red. The areas judged as red required immediate improvement; they have since been re-assessed and have improved to amber or green.

2010/11 *C.diff* target trajectory



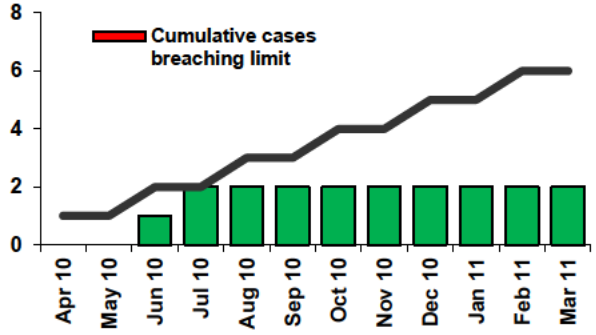
***C.diff* cases by month – Apr 08 to Mar 10**



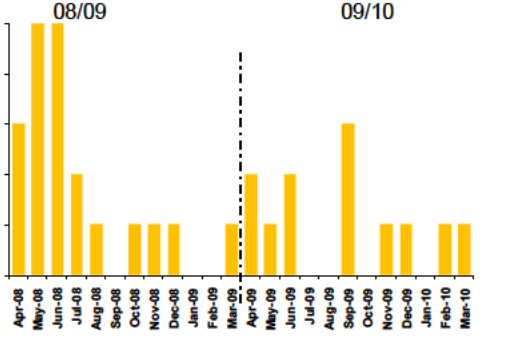
● **MRSA Bacteraemia** *(ceiling of 6 cases for 2010/11)*

- 2 cases in 2010/11 as at month four.
- Trust exceeded their full year target of 12 in 2007/08 and 2008/09 with 20 cases in each year. During 2009/10 the Trust achieved the target for the first time with 12 cases (against a ceiling of 12 cases), of which 8 were post-48 hour cases.
- As the MRSA rates were not falling quickly enough during 2007/08, the Trust was supported by the DH improvement team. The improvement team felt that good progress had been made by early 2009 and therefore signed the Trust off.
- As the Trust has an annual MRSA objective which meets Monitor's de minimus limit, the MRSA objective does not apply for the purposes of Monitor's Compliance Framework (provided the Trust does not exceed the de minimus level).

2010/11 MRSA target trajectory

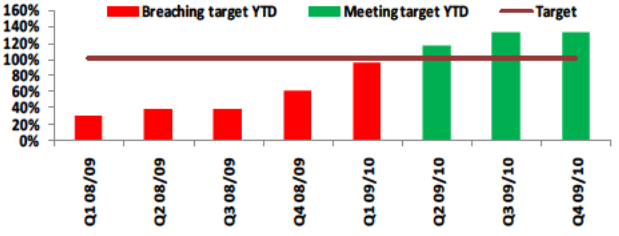


MRSA cases by month – Apr 08 to Mar 10



● **Screening all elective inpatients for MRSA** *(target =100%)*

- DH guidance on screening is to count the number of screening samples received in the lab compared to the number of admissions. This fails to take into account that some patients may have 4-5 screens but others may be missed – thus more than 100% is possible (see right) but does not provide any assurance that 100% of the admissions have been screened. 2010/11 performance to month four is 120% using this methodology. **Using this methodology the Trust would be compliant with Monitor's Compliance Framework.**
- The Trust's approach for internal reporting is to randomly select 200 elective and 200 emergency admissions each
- month and audit the screenings carried out on those patients to provide assurance to the PCTs (The PCTs are
- happy with this approach). **Using this methodology, the Trust is non-compliant (at month three of 2010/11)**
- **with only 92% for elective admissions being screened.**



3.5 Healthcare target performance (2/2)

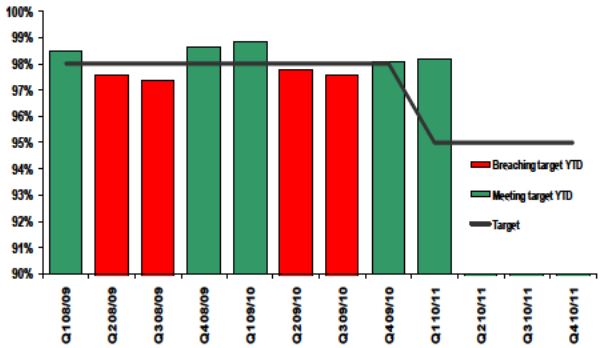
Governance

National cancer targets

- The Trust is historically a strong performer against the three national cancer targets 2 weeks outpatient wait, 31 day diagnosis to treatment and 62 day referral to treatment).
- The Trust underachieved on 31 day diagnosis to treatment in 2007/08 due to an issue in one speciality that has now been resolved .
- In 2008/09 whilst the standards were achieved for all measures, data submission issues led to the CQC not recording performance in the Healthcare Ratings. This was corrected for 2009/10 .
- During 2009/10 the Trust met all standards, including the new standards introduced in year (e.g. Symptomatic Breast Screening).

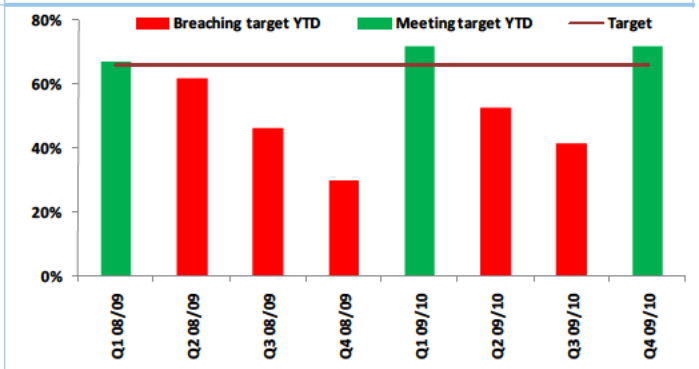
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge

- YTD performance as at month 3 is 98.71%, without PCT A&E attendance mapped back which will further improve performance
- The Trust has delivered the year-end target consistently in 2007/08, 2008/09 and 2009/10 (98.06%). However, the Trust struggled to consistently achieve the target in-month in 2009/10, with the Trust failing to achieve the in-month target in six of the twelve months. A&E breaches take place almost entirely at Lancaster Hospital.
- At the request of the Trust (with the support of the NHS North Lancashire), the Emergency Care Intensive Support Team (ECIST) visited the Trust in Autumn 09 to review emergency care provision and the impact on the A&E target. A detailed action plan was drawn up which was performance managed through divisional performance reviews.
- The Lancaster health community has an Urgent Care Board , which the ECIST reviewed noted had 'excellent clinical and managerial representation and the Trust believes it has a reasonable number of achievable aims. ECIST are continuing to provide consultancy support to the Trust.



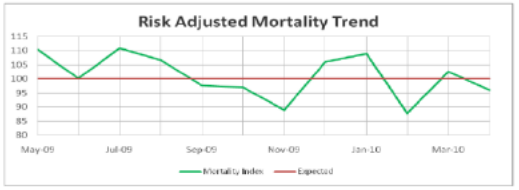
Thrombolysis

- Historically the Trust has struggled to meet the 60 minute call-to-needle standard mainly due to geography with many call-to door times > 60 minutes, thus patients require pre-hospital thrombolysis.
- Every breach of the standard is investigated in detail and the Trust is working with the North West Ambulance Service to improve the call-to-needle time.
- 2010/11 performance as at month four was 56%.
- The Trust consistently meets achieves the door-to-needle minimum standard of 75%.



Mortality (using CHKS)

- Compared with the previous year, 2009/10 saw a reduction in the number of patients who died in hospital. There is a seasonal peak in the winter months, but this was lower than in previous years.
- The Trust tracks its monthly mortality rate using CHKS. The rate is reported at Board level as part of the IPR.
- The index value for April 10 is 96 (4% less than predicted).
- The annual average for the period April 09 to March 10 was 102 (2% more than predicted).



3.6 (1) Other performance measures

Governance

Board information	Findings	
CQC report	• The Trust was registered without conditions. • The CQC decided to carry out responsive reviews in two specific areas where they had minor concerns: maternity and A&E • Maternity - CQC have indicated that following their maternity review , which included an unannounced inspection at FGH on 29th June 2010, they are satisfied that trust is complaint with all required standards of safety and care. • Their review report highlights that a robust system for multi disciplinary working is in place, that their is a Midwifery Action Plan for 09-12 which details the vision for maternity services over the next 3 years, that the Trust ahs undertaken a full review of staffing and addressed identified shortfalls with action plans; that processes for learning form clinical incidents are in place and that audits are undertaken to ensure care records are completed correctly. • A&E -The review of Lancaster Hospital will occur in September 10. This is a direct response to a complaint to CQC (and Monitor) by a former consultant radiologist at the Trust regarding lumbar punctures not being performed for patients with subarachnoid haemorrhages following negative CT scans. • CQC Healthcare Assessor for the Trust commented that Trust are responsive to concerns and that both the Director of Nursing and MD are very open.	●
SUIs	• The number of serious incidents during 2009/10 was nine (compared to twelve in 2008/09 and four in 2007/08) which represents 0.1% of all reported safety incidents for the year. • Serious patient safety incidents are formally investigated by a senior member of staff. When any investigation is complete, recommendations are reported to the Chief Executive and Executive team. Actions plans and changes are monitored by the CQSC and reported through to the Board. The commissioning PCTs scrutinise the outcomes of all serious patient safety investigations and monitor the changes made. • The following 4 serious incidents have occurred in 2010/11 (CQC is aware of these): ○ Junior Doctor found to have TB. Contacts have been dealt with appropriately. The incident involves agencies external to the Trust e.g. Health Protection Agency and the UK Immigration Authority. Internal Audit have been asked to complete the Root Cause Analysis. ○ Patient had three admissions to the hospital over a space of three days with a diagnosis of meningococcal bacteraemia. Concerns raised by his family around the experience in the Emergency Department and transfer to different wards. A further issue was the notification to the Health Protection Agency. The Root Cause Analysis has been completed and an action plan is being implemented. ○ One 'never event' reported in May 10. This was a late report from an incident in December, initially marked up as Amber as no harm had been caused. This was a retained swab spotted when the patient was in recovery. The patient was informed, returned to theatre to have the swab removed and made a complete recovery. No further action was taken and this is not subject to a complaint. Medical Director to chair a lesson learned meeting. ○ Patient deemed medically fit, had already been assessed by Crisis team as at risk of self harm if discharged; planned to place him in a mental health bed. Patient stated he had not hurt himself, no evidence of injury. Staff closely observed patient until Crisis Team came to collect him.	●
CQC Review of Maternity Services 2007	• The Trust was rated as "better performing" in this review. • The Trust was in the top 75% of trusts in England with regard to the number of midwives per 1000 births (35.48 WTE) and is fully compliant with the recommendation of having at least 40 hours of consultant presence in each obstetrics unit per week. • The Trust scores in the top 75% of trusts in England for training of midwives in core maternity skills. • In 2010, the Trust requested that "Birthrate Plus" perform a review of staffing, skill mix etc across the three maternity units to ensure that the Trust will have the appropriate staffing mix across its footprint. The Trust has found that the staffing gap between the Birthrate Plus report and the 2010/11 budget for relevant grades of staff is 8.48 WTEs; of this 1.08 WTEs are attributable to the Trust. The Trust is in discussion with the PCTs as to how fund these additional posts as some of the posts required are community midwifes. Additional costs of £0.2m per year are not included in the LTFM.	●
CNST Maternity	• The Trust achieved CNST Level 2 for maternity across all sites in April 08. It was rated as 'better performing' by the HealthCare Commission in its "Review of Maternity Services 2007". This is the second highest rating for the quality of maternity services. • Following an informal review with the CNST Assessor, the Trust's maternity service has applied to be assessed at Level 2 standards (using the revised standards issued in March 09) in February 11. In preparation for the assessment the Maternity Services have formed a CNST Project Group, with additional dedicated hours, to assist with the implementation process. In line with best practice informal visits by the NHSLA assessor will take place twice yearly, allowing the Maternity Service to identify issues to be addressed before the formal assessment.	●
NHSLA – General standards	• The Trust achieved Level 1 compliance in December 07 and Level 2 in September 09. • A Risk Manager has been appointed to the post of NHSLA project lead. An NHSLA working group has been established. In line with best practice, informal visits by the NHSLA assessor will take place twice yearly allowing the Trust to identify issues to be addressed before the formal assessment.	●

● **Low risk** ● **Medium risk** ● **High risk**

3.6 (2) Other performance measures

Governance

Board information	Findings	
2009 Staff survey	• Trust had a response rate of 65% which is in the top 20% of trusts nationally. Of the 40 key findings, the Trust was in the top 20% of acute trusts for 12 measures, the middle 60% for 25 measures and the bottom 20% for 3 measures. • Improvements were around percentage of staff experiencing physical violence from staff, and staff feeling valued by their work colleagues. • The Trust's performance has not deteriorated in any of the key findings. • The four areas to address are around team working, communications between senior managers and staff, satisfaction with the quality of work and patient care, and staff experiencing physical violence from patients / relatives.	●
Complaints	• As at month 2 2010/11, the Trust had received 78 complaints (c.f. 74 for the same period in 2009/10). • A total of 473 formal complaints were received in 2009/10 (compared with 482 in 2008/09). The Trust has no trends relating to particular locations, services or personnel. In 2009/10 the Trust received a substantial number of complaints regarding outpatient appointment cancellations. • The introduction of the Nursing Quality Assessment Tool (NQAT), a group of about 15 standards of fundamental nursing care with actions to be taken if a satisfactory standard is not achieved, is expected to contribute to a reduction in 'inadequate treatment and care' complaints. NQAT was launched in May 10. • Many PALS contacts relate to communication and information with patients seeking clarity about treatment, diagnoses, results etc. PALs officers facilitate these requests and ensure that patients are satisfied with the information received before closing the case. PALS provide feedback to the Trust groups looking at patient correspondence and patient information. • Two Ombudsman investigation reports were received in 2009/10 – one relating to a 2003 breast screening complaint (the complaint was not upheld) and one relating to a 2005 complaints about care post-miscarriage (the complaint was upheld but the service had already been reviewed and improvements made a considerable time before receipt of the report).	●
Patient safety incidents	• As at month 4 2010/11, 3034 incidents had been reported, of which c. 35% relate to slips/trips/falls. • 8,237 patient incidents were reported in 2009/10 (3,697 patient safety incidents, 3,036 patient accidents, 1,060 staff/visitor incidents and 440 other incidents). Of this total, 7,221 (88%) were 'near misses' meaning they caused no harm or required simple first aid. • The most common types of incidents in the Trust are slips/trips/falls, violence and verbal abuse on staff (by both patients and visitors), manual handling and needle stick injuries. • The Trust is compliant with NPSA guidelines. The Trust's latest Patient Safety Incident Report (March10) puts the Trust in the middle 50% for reporting with 4.8 incidents reported per 100 admissions (median = 5.4).	●
Inpatient Survey 2009	• Trust had a response rate of 52%, compared with a national average also of 52%. • Of the 64 questions, the Trust was in the top 20% of acute trusts for 17 questions, the middle 60% for 38 questions and the bottom 20% for 9 questions. • Good areas of performance included admission to hospital and patients' care and treatment. Areas where the Trust did not perform as will included explanations of operations/procedures and leaving hospital. • Compared to the 2008 Survey, the Trust was significantly better on no questions, and significantly worse in 9 questions.	●
Outpatients Survey 2009	• Trust had a response rate of 52%, compared with a national average of 50%. • Of the 73 questions, the Trust was better than average for 9 questions, average on 59 questions and worse than average on 5 questions. • Compared to the 2004 Survey, the Trust scored better on 4 questions, and worse on 7 questions. • The one area where the Trust scored lower than other surveyed trusts and which showed a decrease in response compared with the 2004 results was 'patients not fully involved in decisions about care or treatment'. The survey's authors attended the Hospital Management Team meeting in June 10 to present detailed results by speciality and site. This information has now been disseminated to all departments to produce targeted action plans.	●
Core standards	• The Trust has declared full compliance for 2009/10. In 2008/09, The Trust was rated 'Almost Met' as it was not fully compliant on 1 of the 44 indicators (NICE Technology Appraisals, a core standard).	●
Dr Foster data	• Dr Foster's Quality Account for 2008/09 concluded that patient safety was in line with expectations. For clinical effectiveness measures, the Trust's performance was below expectations for the proportion of day-case patients end up staying longer for treatment. For patient experience measures, the Trust's performance was below expectations in two areas – not having a specialist palliative care team available 24/7 and lack of provision of overnight stay facilities for relatives.	●
Press search	• Press articles from the last 12 months focus on a variety of different issues including wrongly telling a family that a relative had died, a woman and new-born baby dying at Barrow Hospital. Both of these were SUIs at the Trust, and the CQC is aware of the SUIs. Recent articles have focussed on the local MP lobbying the SofS regarding the potential new cancer centre at Kendal Hospital.	

● **Low risk** ● **Medium risk** ● **High risk**

Appendices

4.1 Financial reporting procedures report

Appendix

PwC – report dated May 2009 (from prior assessment)

	Action required (from FRP report)	Action taken (from Trust action plan)
Corporate governance and management	• None	• N/A
High level controls	• Internal Audit performed two reviews of payroll in 2008/09 – one provided 'significant assurance' on the Trust's payroll office systems, but only 'limited assurance' was provided on systems for providing information to payroll. The Trust should follow-up on Internal Audit's recommendations from this review (timescale: 0-3 months).	• Internal Audit is satisfied that all recommendations have been followed up and implemented.
	• For 08/09 the Trust exceeded it's MRSA target of 12, with 20 cases during the year. The Trust should continuously monitor and drive down HCAI (timescale: ongoing).	• The Trust met it's MRSA target for 2009/10 with 12 cases against a target of 12 cases.
Risk management	• The Trust's intentions is to achieve Level 3 scores for CNST. A mock assessment took place in February 09 to identify any improvements needed prior to a formal assessment in September 09. The Trust should finalise and implement action plans to achieve Level 3 for CNST (timescale: 3-6 months).	• During 2009/10 the Trust achieved Level 2 of the NHSLA risk management standards for acute trusts for the first time.
	• An interim Estates Strategy was approved by the Board in March 09. part of this strategy was to establish an estates rationalisation team to look at space utilisation and perform occupancy reviews. A more detailed Strategy was planned following a review of Lancaster Hospital - expected to take nine months. The Trust should review the Lancaster Hospital site and formalise a revised Estates Strategy (timescale 9-18 months).	• A revised Estates Strategy was approved by the Board in March 10. The Lancaster Hospital site is being reviewed by a Trust Reconfiguration Group and the Trust has issued a Pre-Qualification Questionnaire to potential construction firms for a new wing.
	• There are currently 1,400 equal pay claims against the Trust. The Trust has quantified a downside scenario which puts a potential obligation at £11.5m. The Trust should continue to monitor and develop action plans to fund any potential downside obligation (timescale: ongoing).	• See slide 4.8 for current position on equal pay claims.
Management reporting framework	• Ratio performance in relation to some operational efficiency metrics (e.g. theatre utilisation and bed occupancy days) are not included within the Trust's IPR to the Board. The Trust should consider whether it would be beneficial to include more operational metrics within its Board reports (timescale: 3 months).	• Operational efficiency metrics are now included as an appendix to the IPR.
	• The Board reviewed itself against *The Intelligent Board* report and the *NHS Foundation Trust Code of Governance*. The Trust should complete the only outside action from the review which is the appointment of a Company Secretary (timescale: 3 months).	• Upon review of the recommendation the Trust concluded that the role of a Company Secretary is covered through the existing Company and Membership Secretary.
Financial controls and reporting	• None.	• N/A
Audit arrangements	• The Trust should continue to consider the recommendations from both internal and External Audit and implement appropriate recommendations (timescale: ongoing).	• The Audit Committee has a standing agenda item which reviews progress made against audit recommendations.
IM&T arrangements	• None.	• N/A
Standards and Targets	• None.	• N/A

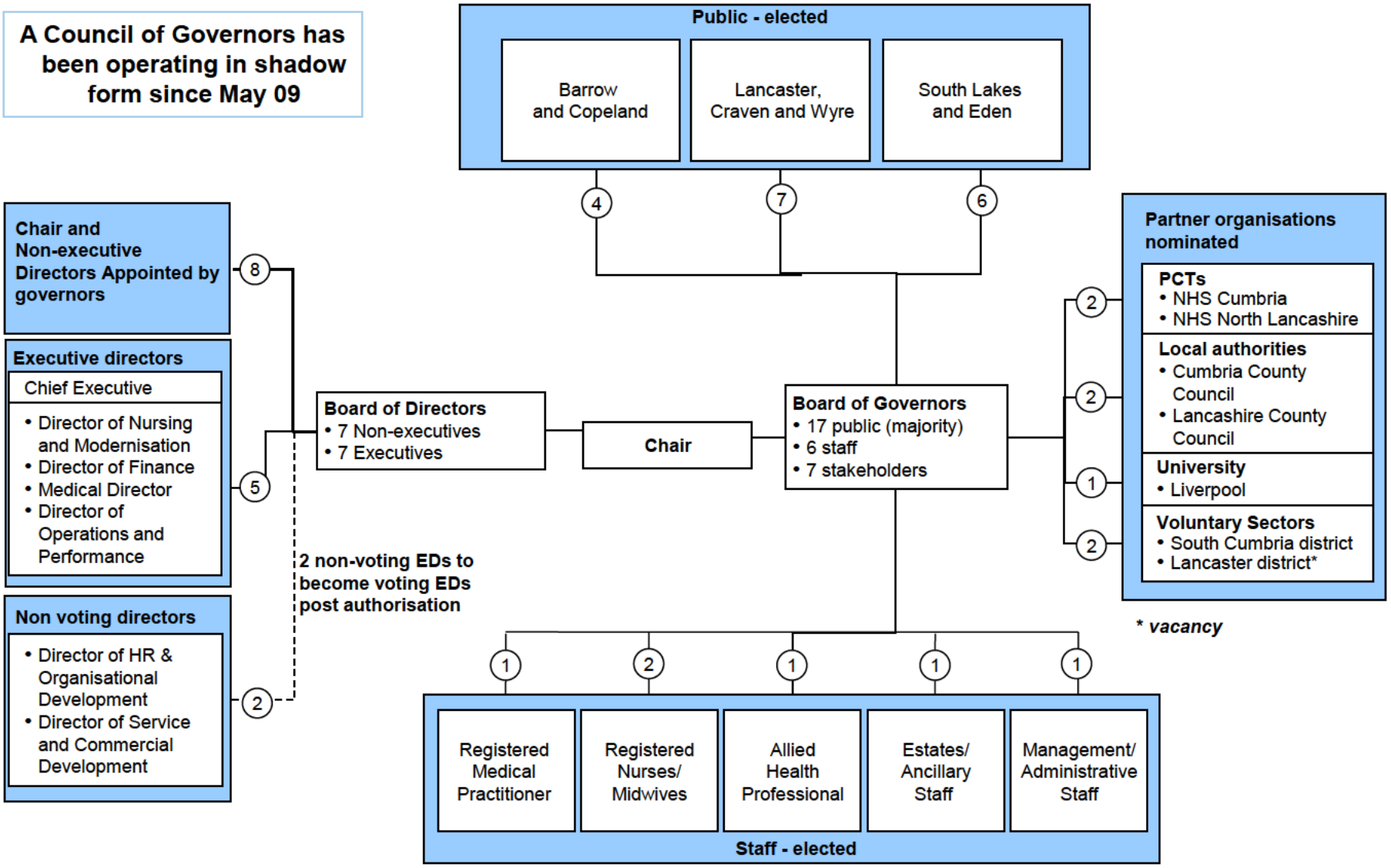
Trust has implemented recommendations. FRP opinion due in September 2010.

Appendices

4.2 Governance arrangements

Appendix

A Council of Governors has been operating in shadow form since May 09



Public governor majority	✓
At least 3 staff governors	✓
Balance of EDs/NEDs	✓

4.2 Membership and elections

Appendix

Consultation and recruitment activity

- Consultation carried out from 15 October 2007 to 13 January 2008.
- Over 2,500 consultation documents were distributed at the start of the consultation process including to MPs, local authorities, patient forums, overview and scrutiny committees, local NHS organisations, GP practices, parish councils, voluntary and community groups, libraries and hospital wards and departments.
- As the Trust has not proposed any changes to the FT governance regime including constitution or its strategic direction it was deemed by the Trust Board to determined that a further consultation was not required.
- The Trust has kept the public informed about progress with the FT application by communicating with the FT Membership via a quarterly newsletter, information included within weekly Staff Newsletters, press releases at key points in the FT process, the Trust website and standard operational stakeholder engagement.
- The Shadow Council of Governors have also been performing a feedback/information sharing role with the FT membership whilst operating in shadow format.

Staff constituency

- Eligible staff automatically become members unless they opt out (currently 17 members of staff have opted out).
- Awareness raised via Trust newsletters, team briefings, Trust notification system, CE briefings and FT drop in sessions.
- The Trust has decided staff governors should be based on staff groups as opposed to site based governors to ensure they have representative staff governors.

Public constituency

- Anyone aged 16 and over and living in within the defined Trust catchment areas is eligible to join. The Trust decided not to have a patient constituency as patients will be able to join the public membership.
- C.50% of the current membership were recruited in 2004 (the Trust had originally considered applying for FT status as a wave 1 applicant, but was not successful at that time in gaining SoS approval due to its financial difficulties). The Trust has obtained positive confirmations from these members that they still wish to retain their membership under the current application.
- The allocation of public governors across geographic locations is based on the population living within those areas.
- The Trust plans to have 10,000 public members by 2014/15. A membership secretary has been appointed to drive this and an external company - Oz Promotions, has been recruited.
- The 16-24 years category remains under-represented. Based on targets for increasing membership in 2010/11, the Lancaster, Craven & Wyre constituency is the Trust's focus.

Membership for constituencies with elected stakeholders as at 27 August 2010

Constituency	Population	Actual	%	Minimum	Ballots Counted	Council members Candidates	Council members Posi ions
Nursing & Midwifery	2,044	1,592	77 9%	100	432	4	2
Medical & Dental	355	313	88 2%	100	-	1	1
Allied Health Professionals	1,922	1,601	83 3%	100	292	3	1
Estates & Ancillary	716	704	98 3%	100	130	2	1
Management & Admin	1,364	1,095	80 3%	100	-	1	1
Staff	**6,401**	**5,305**	82 9%			**11**	**6**
Barrow & Copeland	85,867	1,553	1.8%	100	415	6	4
Lancaster, Craven & Wyre	172,971	2,377	1.4%	100	560	22	7
South Lakes & Eden	125,605	1,865	1.5%	100	667	19	6
Public	**384,443**	**5,795**	1.5%			**47**	**17**
Total		**11,100**					**23**

Maintaining Membership: Action Plan.

The Trust has in place a membership strategy which clearly sets out the goals for the Board of Directors and Council of Governors over the first 12 and 18 months of becoming an FT which relate to:

Building the membership base:

- Developing an action plan for maintaining and building the membership;
- Raising the profile of the membership across the population;

Managing active membership

- Identify the information needs of members;

Communicating with members

- Develop an effective communications strategy for members and establish a information communication infrastructure to support communications between members, governors and the Board of Directors;
- Existing communication streams include a regular membership newsletter, feedback and information sharing via shadow governors, and FT membership health events where shadow governor an meet members.
- With effect from authorisation, the Trust plans to undertake targeted mailshots from governors to their relevant constituencies and also hold annual member meetings within each constituency.

Playing a key community role

- Identify and investigate opportunities for the Trust to participate with partners in the community served;

Working with other membership organisations

- Establish opportunities to network with other FTs.

Pubic membership has increased by 16% since postponement.

Appendices

4.3 Historical accuracy of budgeting

Appendix

	08/09 Budget	08/09 Actual	Variance (Actual vs Budget)		09/10 Budget	09/10 Actual	Variance (Actual vs Budget)	
	£m	£m	£m	%	£m	£m	£m	%
Operating income								
SLA Income	203.3	❶ 210.5	7.2	4%	219.2	❻ 220.6	1.4	1%
Other Income	6.1	6.1	0.0	0.0%	6.1	6.1	0.0	0.0%
Total income	**209.4**	**216.6**	**7.2**	**3.4%**	**225.3**	**226.7**	**1.4**	**0.6%**
Operating expenditure (by business unit)								
Medicine	-50.1	❷ -52.5	-2.4	4.8%	-54.4	❼ -56.0	-1.6	2.9%
Surgery, Critical Care & Family Services	-69.2	❸ -75.3	-6.1	8.8%	-56.3	-57.7	-1.4	2.5%
Family Services	n/a	n/a	n/a	n/a	-19.9	❽ -20.4	-0.5	2.5%
Core Clinical Services	-34.5	-34.5	0.0	0.0%	-38.5	❾ -38.0	0.5	-1.3%
Facilities	-20.7	❹ -21.4	-0.7	3.4%	-20.6	-20.6	0.0	0.0%
Corporate Services	-15.6	-16.0	-0.4	2.6%	-18.5	-18.5	0.0	0.0%
Education / R&D	-0.5	-0.2	0.3	-60.0%	-0.4	-0.4	0.0	0.0%
Other	0.2	❺ 2.5	2.3	1150.0%	2.1	❿ 3.3	1.2	57.1%
Total Expenditure	-190.4	-197.4	**-7.0**	**3.7%**	**-206.5**	**-208.3**	**-1.8**	**0.9%**
EBITDA	**19.0**	**19.2**	**0.2**	**1.1%**	**18.8**	**18.4**	**-0.4**	**-2.1%**
EBITDA %								
Gain/(loss) on asset disposals	0.0	0.0	0.0	n/a	0.0	0.0	0.0	n/a
Interest expense on overdrafts and working capital facilities	0.5	0.4	-0.1	-20.0%	0.1	0.0	-0.1	-100.0%
Interest expense on loans and leases	-0.2	-0.2	0.0	0.0%	-0.1	-0.1	0.0	0.0%
Depreciation and Amortisation	-10.1	-10.1	0.0	0.0%	-10.2	-10.2	0.0	0.0%
PDC Dividend	-7.4	-7.4	0.0	0.0%	-6.5	-6.0	0.5	-7.7%
Impairment Losses (Reversals) net	0.0	0.0	0.0	n/a	0.0	-0.2	-0.2	n/a
Surplus / (Deficit)	**1.8**	**1.9**	**0.1**	**5.6%**	**2.1**	**1.9**	**-0.2**	**-9.5%**

Comments

2008/09

❶ **SLA Income** - the variance is due to overperformance against the SLA and the receipt of additional non recurrent support from NHS Cumbria, due to the delay in NHS Cumbria implementing "Closer to Home" initiatives (£1.6m).

❷ **Medicine** - The overspend is largely due to the costs involved in order to deliver the additional activity. £ 0.3m relates to non recurrent spend arising from the Acute Service Review (see slide 2.2).

❸ **Surgery** - The variance in surgery is largely due to delivering additional activity and the cost of implementing EWTD compliance rotas for junior medical staff (£1.1m). Agency overspend amounted to £0.2m.

❹ **Facilities** - Overspend related to the energy price increases at the beginning of 08/09.

❺ **Other** - Underspend primarily due to overachieved CIP target (£0.6m), review of provisions for management restructure (£0.8m) and depreciation underspend (£0.5m).

2009/10

❻ **SLA Income** – the variance is due to overperformance against the SLA.

❼ **Medicine** – the variance is largely due premium costs of locums covering vacancies in A&E and haematology combined with the costs of delivering additional activity.

❽ **Surgery and Family Services**– overspend due to delivery activity above plan, maintaining EWTD rotas, the use of agency staff where unable to recruit substantively.

❾ **Core Clinical Services –** Underspend due to consultant vacancies only some of which were covered with agency.

❿ **Other –** The Trust released unused contingency and pay reserves (£0.9m) and had an over recovery of lease income (£0.3m)

Overspends in 09/10 largely due to agency staff

Appendices

4.4 CIP programme – 2010/11

Appendix

	Workstream	Summary	Schemes	Workstream savings 2010/11 (at 2010/11 prices) £m		Delivery (as at M4) Plan YTD £m	Delivered YTD £m	Difference £m
1	Inpatient Clinical Pathways	Review on the LoS and methods of working within UHMB and how this can be streamlined to make it more efficient and effective. Emphasis is on making the hospital fit for purpose in terms of bed capacity.	Bed reductions - Oncology	0.1		0 2	0.0	(0.2)
			Bed reductions - Ward 50	0.4				
			Bed reductions - Further ward	0.4				
			Bed reductions - Review HD FGH	0.3				
			Other schemes	0.3	1.5			
2	Cross Bay Working	Areas where there is overlap across the Trust, areas around centralising and making more efficiencies around some of the functions.	Clinical skill mix review	0.2		0 3	0.2	(0.1)
			Specialist Nurses	0.2				
			Support services	0.7	1.1			
3	Support Services	This workstream includes schemes which support the workings of the hospitals core functions. This workstream includes procurement and estates & facilities as well as prescribing and back office.	Prescribing savings	0.4		0.4	0.4	0.0
			Procurement	1.0				
			Back office functions	0.1				
			Estate rationalisation	0.2				
			Other schemes	0.1	1.8			
4	Paybill reduction	Work around reducing the paybill element. Ensuring that the headcount is what it should be and the most appropriate way of doing this.	Paybill reduction	1.5		0 0	0.0	0.0
			Medical productivity	0.2				
			Other schemes	0.1	1.8			
5	New technologies	Planned from 2011/12 onwards.			0.0	0 0	0.0	0.0
6	War on Waste & Other schemes	This workstream includes tactical schemes brought forward from the previous year as well as schmemes suggested by staff and reduction of waste.	Tactical schemes	2.2		0 9	1.2	0.3
			Core Business Review	0.1				
			Other	0.5	2.8			
			Total (10/11 prices)	9.0	9.0	1 8	1.8	0.0

2010/11 achievement

- The Trust Board are currently monitoring a CIP target of £12m , Monitor have reflected a target of £9m in the analysis as income CIPs were removed,
- As at month four the Trust had achieved £2.8m out of the Trust Board target of £12m, £23k below plan. CIPs in 2010/11 are largely backended.
- As at month four, £0.8m of 2010/11 schemes are red-rated for delivery by the Trust and £1.2m are amber-red rated for delivery by the Trust.

CIP Process

Budgeting and delivery

- The six workstreams identified above each have a lead Executive Director and a named lead manager. The lead manager will complete the following documents for each scheme:
  - a Project Overview Document (POD) which details the steps that need to be taken for the efficiency to be realised; and
  - a Quality Impact Assessment (QIA) which risk rates the impact of the scheme against the three domains of safety (patient safety, clinical effectiveness and patient experience), engagement with front line staff, ongoing assessment of impact on quality post-rollout and sign-off by the appropriate lead clinician.
- Completed POD's and QIA's initially go to the Performance Optimisation Group (POG) for evaluation against the EQIP criteria (see overleaf) and sign-off. These will then go to Hospital Management Team (HMT) for review or deliverability and ultimately to the Board for approval. Once reviewed and approved the schemes move to POG monitoring.

Monitoring

- POG monitoring ensures that the agreed actions and milestones within each scheme are managed effectively and delivered. Lead managers are responsible for delivery of their particular schemes; Lead Directors are responsible to the Trust Board for delivery.
- The Clinical Quality and Safety Committee review the QIA risk scorings at each (quarterly) meeting. Any schemes with a potential moderate or major impact on quality are reviewed in some detail by the CSC. The 10 schemes with the most risk are reviewed by the Trust Board.

AC sensitivity of 5% non-achievement assumed in 2010/11.

4.4 Planned CIP programme – 20011/12 to 2015/16

Appendix

	Workstream	Summary	Schemes	Workstream savings 2011-12 £m	2012-13 £m	2013-14 £m	2014-15 £m	2015-16 £m	Total £m	
1	Inpatient Clinical Pathways	Review on the LoS and methods of working within UHMB and how this can be streamlined to make it more efficient and effective. Emphasis is on making the hospital fit for purpose in terms of bed capacity.	Bed reductions - Oncology	0.1					0.1	
			Bed reductions - further ward productivity improvements	0.8	0.5	0.5			1.8	1.9
2	Cross Bay Working	Areas where there is overlap across the Trust, areas around centralising and making more efficiencies around some of the functions.	Service reconfigurations (outpatients skillmix, pathology, radiology and	0.9	0.2	0.2			1.3	
			Pathology/radiology centralisation	0.7	3.0	2.0			5.7	
			Other service reviews	0.3	0.2				0.5	7.5
3	Support Services	This workstream includes schemes which support the workings of the hospitals core functions. This workstream includes procurement and estates & facilities as well as prescribing and back office.	Prescribing savings	0.6	0.5	0.5	0.5	0.5	2.6	
			Procurement	1.0	1.0	1.0	1.0	1.0	5.0	
			Back office functions	0.3	1.0	1.0			2.3	
			Estate rationalisation	0.4		1.0	2.0		3.4	
			Theatre & out-patient productivity			1.0			1.0	14.3
4	Paybill reduction	Work around reducing the paybill element. Ensuring that the headcount is what it should be and the most appropriate way of doing this.	Paybill reduction	0.8	0.5	0.5	0.5	0.5	2.8	
			Sickness/absence	0.5					0.5	
			Other	0.4					0.4	3.7
5	New technologies	Included in this scheme is the benefits realisation from Lorenzo, and the potential benefits the full application of Lorenzo would bring.		0.6	0.7				1.3	1.3
6	War on Waste & Other schemes	This workstream includes tactical schemes brought forward from the previous year as well as schmemes suggested by staff and reduction of waste.	Tactical schemes	2.0	2.0	1.1	1.1	1.1	7.3	
			CNST level 2 and 3	0.4					0.4	
			Rental income	0.6					0.6	
			Other	1.2	0.1	0.1			1.4	9.7
			Unidentified schemes	0.5	1.9	2.1	6.3	8.8	19.6	19.6
			Total (10/11 prices)	12.1	11.6	11.0	11.4	11.9	58.0	58.0

EQUP is about three things for the Trust
- ensuring that the Trust continuously improves clinical outcomes for patients;
- being recognised as a top performing healthcare provider; and
- Providing excellent value for money.

The Trust has three main principles around EQIP:
- how clear and measurable gains in the quality of services and/or outcomes will be improved (or at least maintained);
- How net cash-releasing efficiencies will be achieved (once additional costs have been taken out) or how increases in service productivity will be achieved (with a consideration of ho this will be converted into net cash releasing efficiency; and
- How efficiencies will be realised over a set timescale.

- A total of almost £19.6m needs to be identified for the four year period 2011-2016.
- The Trust plans to address this shortfall through schemes which embrace the Better Care Better Value (BCBV) indicators.
- A 25% improvement in the 5 key BCBV indicators, if translated into efficiency or productivity savings would result in a saving of £15.5m vs. required £19.6m.
- Of the £8.6m identified by BCBV under the LoS indicator, The Trust already have £3.2m as identified in its EQIP programme. This still leaves £10.9m as potential savings in the LoS and reduced pre-operative bed days components of the BCBV indicators

Theme	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	Total
Inpatient Clinical Pathways	44%	26%	15%	15%	0%	0%	100%
Cross Bay Working	13%	22%	40%	26%	0%	0%	100%
Support Services	11%	14%	16%	28%	22%	9%	100%
Paybill reduction	33%	31%	9%	9%	9%	9%	100%
New technologies	0%	46%	54%	0%	0%	0%	100%
War on Waste & Other schemes	22%	34%	17%	10%	9%	9%	100%
Unidentified schemes	0%	3%	10%	11%	32%	45%	100%
Total	13%	18%	17%	16%	17%	18%	100%

CIP phasing
- Total CIPs phased broadly equally over plan.
- However, significant proportion of schemes in 2014/15 and 2015/16 are as yet unidentified.

Efficiency and Quality Improvement Programme (EQIP)

- In Summer 08, the Trust employed Ernst and Young to perform a review of the services at the Trust in order to drive the future direction of the CIP programme. It also looked at the governance structure around CIPs to ensure this was appropriate to drive future CIPs. This review resulted in a list of more than 600 'tactical schemes' being identified, a review of ALOS stay by consultant and A core business review' (which identified areas where the Trust should potentially be divesting or aiming to secure additional income from the PCTs).
- Following the economic downturn and in anticipation of the likely impact this will have on the future funding of the NHS, the Trust Board held a Timeout session in mid-January 10 to consider the impacts of the economic downturn and reduced public spending forecasts; it also considered options on how the Trust could move process to ensure that it was proactive in meeting the efficiencies needed. A further timeout was arranged for late-January 10 ,chaired by the CE and involving the Executive team and senior managers. This timeout resulted in schemes being identified which would realise the efficiency savings needed for 2010/11 and the creation of the Trust's **Efficiency and Quality Improvement Programme (EQIP)** and the six workstreams described above.

AC sensitivity of 10% non-achievement assumed in year 1 to 5. Additional DC sensitivity of a further 5% non-achievement (15% total) assumed in year 5.

Appendices

4.5 Base case – Normalised earnings

Appendix

£m	Actual			Outturn	Forecast				
	Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16
Net Surplus/ (deficit)	**2.9**	**1.9**	**1.9**	**2.0**	**2.8**	**4.9**	**5.1**	**6.2**	**7.8**
Less: non-recurring income									
Digital hearing aids income	(0.3) [1]								
PCT and SHA support		(0.8) [2]	(2.3) [3]	(1.1)					
	(0.3)	**(0.8)**	**(2.3)**	**(1.1)**					
Add: normalising adjustments									
Profit/(loss) on asset disposals	(0.3) [4]								
Non-current asset impairment			0.2 [5]						
Digital hearing aids cost	0.9 [1]								
Non-recurring Lorenzo expenditure			2.2 [3]	1.1					
Normalised Net Surplus	**3.3**	**1.1**	**2.1**	**2.0**	**2.8**	**4.9**	**5.1**	**6.2**	**7.8**
Add									
Transfers from Donated Asset reserve	(0.8)	(0.7)	(0.7)	(0.7)	(0.8)	(0.7)	(0.7)	(0.6)	(0.7)
Total Depreciation & Amortisation	12.3	10.7	10.2	9.4	10.0	9.8	10.1	9.6	9.4
Total interest receivable/ (payable)	(0.6)	(0.4)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.1)
Total interest payable on Loans and leases	0.3	0.2	0.0						
PDC Dividend	6.8	7.4	6.0	5.6	5.7	5.8	5.9	6.1	5.9
Normalised EBITDA	**21.3**	**18.3**	**17.6**	**16.3**	**17.7**	**19.7**	**20.4**	**21.2**	**22.3**

Comments

[1] The Trust was given additional funding of £0.3m to contribute to the additional cost in 2007/08 for the change in accounting rules regarding digital hearing aids. The additional costs relating to this change in policy were £0.9m.

[2] Non-recurrent contribution from NHS Cumbria towards both clearing Trust's historical debt. The PCT has confirmed in writing that the £0.8m is non-repayable by the Trust.

[3] The Trust received income to fund Lorenzo expenditure. This income is wholly offset by expenditure.

[4] £0.3m of profit in 2007/08 relates to £0.6m of disposal proceeds for non-operational land identified as surplus at Kendal Hospital.

[5] The impairment is as a result of the asset revaluation undertaken in 2009/10. The £0.3m was not covered by the revaluation reserve.

4.5 Base case – Income and expenditure

Appendix

£m	Actual Mar - 08	Actual Mar - 09	Actual Mar - 10	Outturn Mar - 11	Forecast Mar - 12	Forecast Mar - 13	Forecast Mar - 14	Forecast Mar - 15	Forecast Mar - 16	CAGR Mar - 08 Mar - 11	CAGR Mar - 11 Mar - 12	CAGR Mar - 12 Mar - 16
NHS Acute Activity Revenue												
Elective revenue (long and short stay)	44.1	45.0	46.4	46.9	46.3	45.8	45.1	44.2	43.4	2.0%	(1 2%)	(1.6%)
Non-Elective revenue	71.7	73.1	74.5	71.5	70.4	69.5	68.6	67.7	66.7	(0.1%)	(1 5%)	(1.3%)
Outpatient	34.5	35.6	33.8	38.3	37.7	37.1	36.4	35.7	35.1	3.5%	(1 6%)	(1.8%)
A&E	7.7	8.2	8.4	7.7	7.7	7.7	7.7	7.7	7.6	(0.0%)	(0.1%)	(0.3%)
Other NHS	44.4	48.9	57.2	53.2	53.2	52.7	52.2	51.6	51.1	6.3%	(0 0%)	(1.0%)
Sub Total	*202.4*	*210.8*	*220.4*	*217.7*	*215.4*	*212.7*	*209.9*	*206.9*	*204.0*			
PBR (Clawback)/ Relief	(0.4)	-	-	-	-	-	-	-	-	2.4%	(1 0%)	(1.4%)
Total	**202.0**	**210.8**	**220.4**	**217.7**	**215.4**	**212.7**	**209.9**	**206.9**	**204.0**	**2.5%**	**(1.0%)**	**(1.4%)**
Non NHS Clinical Revenue												
Private patient revenue	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	(7.6%)	(1 0%)	(1.0%)
Other non-NHS clinical revenue (incl. CRU)	1.2	1.5	1.5	1.5	1.5	1.5	1.4	1.4	1.4	7.9%	(1 0%)	(1.0%)
Total	**1.3**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	**1.5**	**1.5**	**1.5**	**6.6%**	**(1.0%)**	**(1.0%)**
Research and Development income	0.3	0.3	0.7	0.5	0.6	0.7	0.9	0.9	0.9	24.4%	20 0%	8.2%
Education and Training income	9.2	9.0	8.7	8.7	8.8	8.9	9.0	9.1	9.1	(1.9%)	1 0%	1.0%
Other Operating Income	13.0	14.5	18.6	20.9	21.0	21.1	21.3	21.4	21.7	17.2%	0 9%	0.8%
Total	**22.4**	**23.8**	**28.0**	**30.1**	**30.5**	**30.8**	**31.2**	**31.4**	**31.7**	**10.3%**	**1.3%**	**1.0%**
Total Operating Revenue and Income	**225.7**	**236.2**	**249.9**	**249.3**	**247.5**	**245.1**	**242.6**	**239.8**	**237.2**	**3.4%**	**(0.8%)**	**(1.1%)**
Operating Expenses												
Employee benefits expense	(148.7)	(157.9)	(167.6)	(169.5)	(168.8)	(167.2)	(166.4)	(166.3)	(165.0)	4.5%	(0 5%)	(0.6%)
Drug expense	(11.6)	(12.8)	(13.7)	(14.2)	(14.6)	(15.1)	(15.8)	(16.2)	(16.5)	6.8%	3 0%	3.2%
Clinical supplies	(20.6)	(20.9)	(22.7)	(22.5)	(21.3)	(19.8)	(18.8)	(17.6)	(16.2)	3.1%	(5 5%)	(6.6%)
Non Clinical Supplies	(23.4)	(24.7)	(27.6)	(26.1)	(24.3)	(22.6)	(20.6)	(17.9)	(16.5)	3.7%	(7.1%)	(9.1%)
Other Operating expenses	-	(0.1)	0.0	-	-	-	-	-	-	-	-	-
Total Operating Expenses	**(204.3)**	**(216.4)**	**(231.6)**	**(232.4)**	**(228.9)**	**(224.7)**	**(221.5)**	**(218.0)**	**(214.3)**	**4.4%**	**(1.5%)**	**(1.6%)**
EBITDA	**21.4**	**19.8**	**18.3**	**17.0**	**18.5**	**20.4**	**21.1**	**21.8**	**22.9**	**(7.4%)**	**9.2%**	**5.5%**
EBITDA margin	*9.5%*	*8.4%*	*7.3%*	*6.8%*	*7.5%*	*8.3%*	*8.7%*	*9.1%*	*9.7%*			
Non-Operating income, Total	0.3	-	-	-	-	-	-	-	-	(100 0%)	-	-
Total Non-Operating income	**0.3**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(100.0%)**	**-**	**-**
Non-Operating expenses												
Interest expense on overdrafts and working capital facilities	0.6	0.4	0.0	0.0	0.0	0.0	0.1	0.1	0.1	(66.1%)	(25.1%)	51.6%
Interest expense on loans and leases	(0.3)	(0.2)	(0.0)	-	-	-	-	-	-	(100 0%)	-	-
Depreciation and Amortisation	(12.3)	(10.7)	(10.2)	(9.4)	(10.0)	(9.8)	(10.1)	(9.6)	(9.4)	(8.6%)	6 6%	(1.7%)
PDC Dividend	(6.8)	(7.4)	(6.0)	(5.6)	(5.7)	(5.8)	(5.9)	(6.1)	(5.9)	(6.1%)	1 3%	0.8%
Impairment Losses (Reversals) net	-	-	(0.2)	-	-	-	-	-	-	-	-	-
Total Non-Operating expenses	**(18.8)**	**(17.9)**	**(16.4)**	**(15.0)**	**(15.7)**	**(15.5)**	**(16.0)**	**(15.7)**	**(15.1)**	**(7.3%)**	**4.7%**	**(0.9%)**
Net surplus/(deficit)	**2.9**	**1.9**	**1.9**	**2.0**	**2.8**	**4.9**	**5.1**	**6.2**	**7.8**	**(11.7%)**	**43.4%**	**28.7%**
Net margin	*1.3%*	*0.8%*	*0.8%*	*0.8%*	*1.1%*	*2.0%*	*2.1%*	*2.6%*	*3.3%*			

Comments

1. Historically, elective revenue has increased due to increased activity to achieve the 18 week target. The impact of HRG4 in elective and non-elective amounted to £2.3m and £3.2m in 2008/09 and 2009/10 respectively.
2. The Trust assumes that elective and non-elective income will decline over the life of the plan, largely due to PCT demand management plans assumed to take effect from 2010/11 coupled with tariff deflation of 1.0% year on year from 2011/12.
3. A&E income is forecast to decline due to minor injuries being dealt with in primary care.
4. Increase in non-tariff revenue of £8.3m between 2008/09 and 2009/10 is largely due to the unbundling of outpatient radiology revenue (£4.2m), patient transport services (£1.8m) and CQUIN (£0.9m).The outpatient radiology revenue is transferred to tariff revenue in 2010/11 (no financial impact on the Trust).
5. The bulk of the increase between 2008/09 and 2009/10 was due to an increase of £1.2m relating to income received for the provision of staff at the PCT facilities at Barrow Hospital and Lancaster Hospital.
   The increase between 2009/10 and 2010/11 is primarily due to charges to NHS Cumbria for two Langdale wards at Kendal Hospital previously managed by the Trust (£4.1m).
6. Employee benefit expense increases of £18.9m between 2007/08 and 2009/10 is attributable to pay inflation (£7.9m) and pay reform (£6.8m). Pay is assumed to decline between 2010/11 and 2015/16 , due to a large headcount (796 WTE) reduction driven by planned CIPs, offset by low pay inflation of 1.5% from 2012/13.
7. Non-clinical supplies increased in 2009/10 principally due to increased CNST costs (£1.8m).
8. Decrease in non-clinical supplies expenditure from £26.1m in 2010/11 to £16.5m in 2015/16 reflects the impact of the Trust's CIP programme over the life of the plan.

4.5 Base case – Cash flow

£m	Actual			Outturn	Forecast				
	Mar - 08	Mar - 09	Mar - 10	Mar - 11	Mar - 12	Mar - 13	Mar - 14	Mar - 15	Mar - 16
EBITDA		**19.8**	**18.3**	**17.0**	**18.5**	**20.4**	**21.1**	**21.8**	**22.9**
Other increases/(decreases) to reconcile to profit/(loss) from operations		(0.7)	(0.7)	(0.7)	(0.8)	(0.7)	(0.7)	(0.6)	(0.7)
Operating cash flows before movements in working capital		**19.1**	**17.6**	**16.3**	**17.7**	**19.7**	**20.4**	**21.2**	**22.3**
Movement in working capital:									
(Increase) / decrease									
Inventories		(0.2)	(0.1)	-	-	-	-	-	-
NHS Trade Receivables	❶	1.7	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Non NHS Trade Receivables		(0.1)	0.2	(0.2)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)
Other Receivables		-	-	-	-	-	-	-	-
Other financial assets (e.g. accrued income)		(0.1)	(0.0)	-	-	-	-	-	-
Prepayments		0.3	(0.0)	(0.4)	-	-	-	-	-
Other assets		(0.3)	(0.3)	(0.1)	-	-	-	-	-
Deferred Income & Payments on account		(0.1)	1.5	(1.5)	-	-	-	-	-
Provisions		(0.7)	0.0	0.0	-	-	-	-	-
Trade Payables	❷	1.2	(0.6)	(0.0)	(0.1)	(0.0)	(0.5)	(0.3)	(0.2)
Other Payables	❸	(1.0)	0.3	(0.1)	-	-	-	-	-
Accruals		(1.7)	0.7	-	-	-	-	-	-
Increase/(decrease) in Non Current Provisions		0.1	0.1	-	-	-	-	-	-
CF from operations		**18.3**	**19.4**	**14.1**	**17.7**	**19.6**	**19.9**	**21.0**	**22.1**
Capital expenditure				❹					
Property, plant and equipment expenditure		(8.6)	(8.2)	(10.3)	(8.6)	(8.2)	(7.3)	(7.3)	(7.3)
Proceeds on disposal of property, plant and equipment		-	-	-	-	-	-	-	-
CF before financing		**9.7**	**11.2**	**3.8**	**9.1**	**11.4**	**12.6**	**13.7**	**14.8**
Public Dividend Capital received		-	0.2	-	-	-	-	-	-
Public Dividend Capital repaid		-	-	-	-	-	-	-	-
Dividends paid		(7.4)	(6.0)	(5.6)	(5.7)	(5.8)	(5.9)	(6.1)	(5.9)
Interest (paid) on Loans and Leases		(0.2)	(0.0)	-	-	-		-	-
Interest (paid) on bank overdrafts and working capital facilities		-	-	-	-	-	❺ -	-	-
Interest received on Cash and Cash equivalents		0.4	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Drawdown of Loans and Leases	❻	-	-	-	-	-	-	-	-
Repayment of Loans and Leases		(2.4)	(1.0)	-	-	-	-	-	-
Net cash inflow / (outflow)		**0.2**	**4.4**	**(1.8)**	**3.4**	**5.7**	**6.7**	**7.6**	**9.1**

Comments

The cash regime as at March 07 restricted the Trust from keeping excess cash at year-end and drove working capital movements. This restriction was relaxed in 2007/08.

❶ Trade receivable days were 13.9 in March 08 largely due to overperformance as demand management plans were not successful. These declined to 10.4 in 2008/09 and are forecast to remain at 10 over the life of the plan.

❷ Historical movements in trade payables is due to year end cash management. The Trusts performance in "Better Payment Practice Code" at the end of 2009/10 was 83%. For the first two months of 2010/11 it was c.90%.Trade payable days have been forecast to remain at 2009/10 levels over the life of the plan.

❸ The movements in other payables from 2007/08 to 2009/10 is largely due to timing of receipts and payments and the Trust managing its cash position.

❹ Low capital expenditure has been planned, with the majority of spend relating to the Lancaster Hospital reconfiguration (£8m from 2011/12 to 2013/14). No outline business case has been drafted for this spend. Its is expected to be presented to the Trust Board in July 10.

❺ Despite building up a £40m cash balance by 2015/16, the Trust has prudently modelled £0.1m of cash interest p.a. in years 3 to 5.

Historical turnaround

❻ To facilitate the Trust's turnaround it drew down a £6.5m working capital loan (with the NHS Bank) in March 07. All three instalments have been paid to repay the loan.

4.5 Base case – Balance sheet

Appendix

£m	Actual Mar - 08	Actual Mar - 09	Actual Mar - 10	Outturn Mar - 11	Forecast Mar - 12	Forecast Mar - 13	Forecast Mar - 14	Forecast Mar - 15	Forecast Mar - 16
Assets, non current									
Net Property, Plant and Equipment and intangible assets	228.4	196.9	170.1	171.4	171.3	170.2	167.9	166.1	164.5
Other Assets	0.5	0.8	1.0	1.1	1.1	1.1	1.1	1.1	1.1
Total Non Current Assets	**229.0**	**197.7**	**171.1**	**172.6**	**172.4**	**171.3**	**169.0**	**167.2**	**165.6**
Assets, current									
Inventories	1.9	2.1	2.2	2.2	2.2	2.2	2.2	2.2	2.2
NHS Trade Receivables	7.8	6.1	6.1	6.0	6.0	6.0	5.8	5.7	5.7
Non NHS Trade Receivables	2.1	2.1	1.9	2.1	2.1	2.1	2.2	2.2	2.2
Other Financial Assets (e.g. accrued income)	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Prepayments	1.1	0.8	0.8	1.2	1.2	1.2	1.2	1.2	1.2
Cash and Cash Equivalents	4.7	4.8	9.2	7.5	10.9	16.6	23.3	30.9	40.0
Assets, Current, Total	**17.6**	**16.1**	**20.4**	**19.2**	**22.6**	**28.3**	**34.9**	**42.4**	**51.5**
Total Assets	**246.6**	**213.8**	**191.5**	**191.7**	**195.0**	**199.6**	**203.9**	**209.7**	**217.1**
Liabilities, current									
Interest-Bearing Borrowings (incl. accrued interest)	-	-	-	-	-	-	-	-	-
Deferred Income	(0.5)	(0.3)	(1.8)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
Provisions	(1.0)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)
Trade Payables	(4.6)	(5.8)	(5.3)	(5.2)	(5.2)	(5.1)	(4.6)	(4.3)	(4.1)
Other Payables	(7.1)	(6.1)	(6.4)	(6.3)	(6.3)	(6.3)	(6.3)	(6.3)	(6.3)
Capital Payables	(3.4)	(2.1)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)
Accruals	(3.1)	(1.4)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)
Total Current Liabilities	**(19.6)**	**(16.0)**	**(17.1)**	**(15.6)**	**(15.5)**	**(15.5)**	**(15.0)**	**(14.7)**	**(14.5)**
Net current assets / (liabilities)	**(2.0)**	**0.1**	**3.3**	**3.6**	**7.0**	**12.8**	**19.9**	**27.8**	**37.0**
Liabilities, non current									
Interest-Bearing Borrowings	(3.4)	(1.0)	-	-	-	-	-	-	-
Deferred Income	-	-	-	-	-	-	-	-	-
Provisions	(1.7)	(1.8)	(1.9)	(1.9)	(1.9)	(1.9)	(1.9)	(1.9)	(1.9)
Total Non Current Liabilities	**(5.1)**	**(2.8)**	**(1.9)**	**(1.9)**	**(1.9)**	**(1.9)**	**(1.9)**	**(1.9)**	**(1.9)**
Total assets employed	**221.9**	**195.0**	**172.5**	**174.3**	**177.6**	**182.2**	**187.1**	**193.1**	**200.8**
Taxpayers' equity									
Public dividend capital	125.9	125.9	126.1	126.1	126.1	126.1	126.1	126.1	126.1
Retained Earnings (Accumulated Losses)	(3.4)	(0.4)	1.6	3.6	6.5	11.3	16.4	22.6	30.4
Donated asset reserve	6.5	5.3	5.0	4.8	5.2	5.0	4.8	4.7	4.5
Revaluation reserve	92.9	64.2	39.7	39.7	39.7	39.7	39.7	39.7	39.7
Total taxpayers' equity	**221.9**	**195.0**	**172.5**	**174.3**	**177.6**	**182.2**	**187.1**	**193.1**	**200.8**
Total funds employed	**221.9**	**195.0**	**172.5**	**174.3**	**177.6**	**182.2**	**187.1**	**193.1**	**200.8**
KPIs									
NHS Trade Receivable Days		10.4	9.9	10.0	10.0	10.1	10.0	10.0	10.0
Non NHS Trade Receivable Days		34.0	26.6	27.0	27.1	26.9	27.0	27.0	27.0
Trade Payable Days		35.9	29.5	30.0	31.0	32.2	30.0	30.0	30.0
WC Facility level		-	-	18.0	18.0	18.0	18.0	18.0	18.0

Comments

1. £28.6m of the £32.6m movement between 2007/08 and 2008/09 is due to revaluation of fixed assets following a District Valuer's valuation required for IFRS reporting. There was no impact on the I&E.
2. The Trust plans to build cash reserves over the life of the plan to find any future capital plans and the remaining equal value claims liability (currently estimated at £3.9m – downside)
3. £1.2m of the £1.8m deferred income balance consists of income received to fund the Lorenzo project.
4. The reduction in provisions largely relates to the utilisation and reversal of provisions for outstanding AfC banding reviews and the management restructure.
5. Capital creditors increased in 2007/08 due to the timing of projects with a number of small projects commencing at the end of 2007/08 financial year. In addition, payments in advance of invoice terms were not necessary at March 08, as had been the case in the previous year, due to cash restrictions being lifted.
6. No revaluations of the Trust's fixed assets have been assumed.

Historical turnaround

7. Liability relating to the £6.5m DH working capital loan drawn down in March 07. Repayments made were : £3.1m in 2007/08, £2.4m in 2008/09 and the remaining £1m in 2009/10.

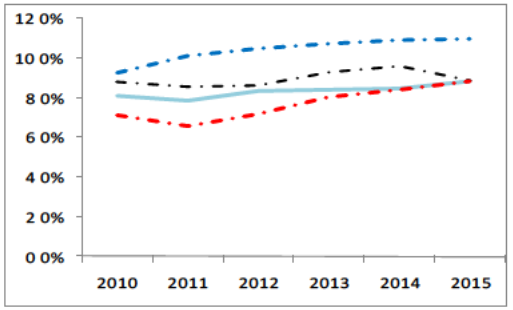
Appendices

4.6 Benchmarking long term model assumptions

Benchmarked against other non PFI acutes within the tool with outturn year of 08/09 and 09/10

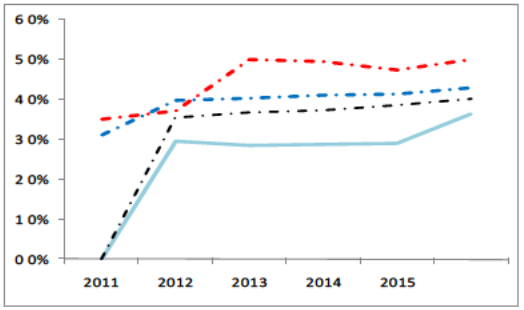
EBITDA margin (normalised)

Future surpluses are driven by CIPs in excess of inflationary pressures in the base case. By year five, the Trust aims to achieve a 9.4% EBITDA margin.



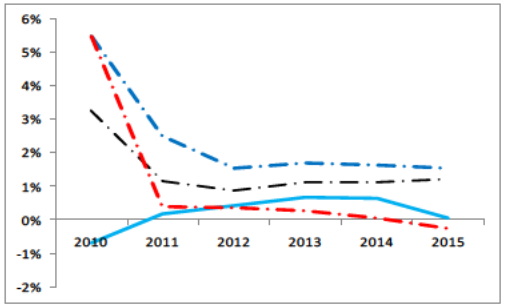
CIP as a % of cost base

From 2012/13, the Trust exceeds the upper quartile due to the high planned CIPs. An assessor case sensitivity to reduce anticipated CIPs has been applied in all years and a further downside sensitivity has been applied in years three to five.



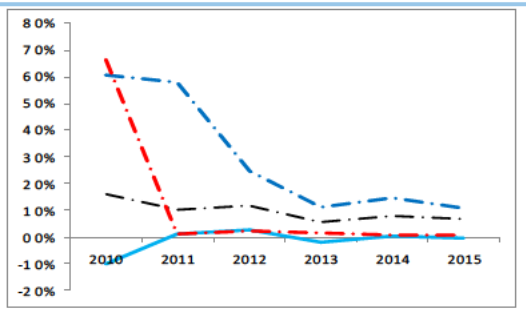
Activity growth – elective

Trust is projecting flat elective activity growth (population growth offset by demand management). The peak in growth in 2009/10 largely reflects the impact of HRG4.



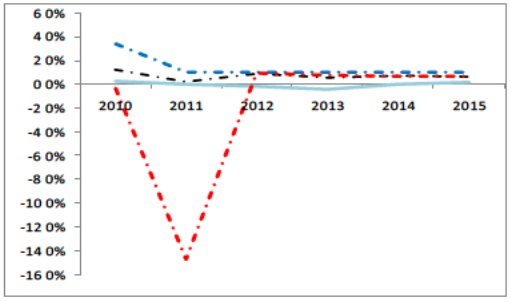
Activity growth – non-elective

Trust is projecting flat activity growth (population growth offset by demand management). The peak in growth in 2009/10 largely reflects the impact of HRG4.



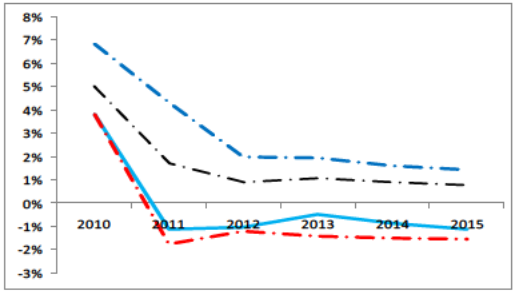
Activity growth – A&E

Trust is projecting flat activity growth (population growth offset by demand management). The decline in activity in 2010/11 reflects the transfer of the Primary Care Ambulatory Service to NHS Cumbria.



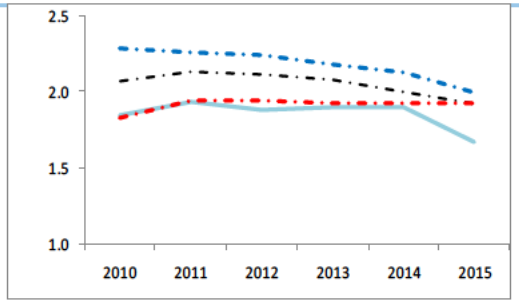
Activity growth – outpatients

Trust is projecting flat activity growth (population growth offset by demand management). The peak in growth in 2009/10 largely reflects the impact of HRG4.



Nurses per bed

Nurses per bed are broadly in line with lower quartile from 2010/11 onwards, until 2015 when they become in line with the benchmarked median.



Staff costs per bed

Staff costs per bed are broadly in line with lower quartile from 2010/11 onwards.

Lower quartile | Median | Upper quartile | University Hospitals of Morecambe Bay

Appendices

4.7 Contract risk

Appendix

Length	3 years from 2009/10			
Notice period	12 months			
Associate Commissioners	**Value 2010/11 £m**	**CQUIN**		**Local penalty clauses (quality requirements) – same for both main commissioners**
NHS Cumbria	£124.5 m (not yet signed)	National VTE Patient experience SHA schemes Six regional schemes Local schemes No avoidable pressure ulcers Reduction in falls Stop inappropriate weight loss Die in place of choice Increase nurse discharge Improve coordination of care **Total**	 £176k £176k £70k £1,337k **£1,759k**	A financial penalty remains in respect of a single quality requirement as follows: • Indicator: discharge summaries • Timeliness: the provider shall issue the patient's discharge summary to the patient's GP within 24 hours of the patient's discharge from the provider's premises, where the patient is discharged by the provider on or after 1 April 10. • Threshold: Action plan to be developed by Trust in Q1 in response to the 2009/10 discharge summary audit. Working group to be formed with NHS North Lancashire representation to agree actions and requirements. Delivery of the actions as agreed in the action plan to be delivered from Q2 onwards. • Method of Measurement: compliance to be assessed by joint Trust and PCT Discharge Working Group • Consequence of Breach: £25k penalty to be applied on failure to deliver actions form the action plan in Q2, 3 & 4.
NHS North Lancashire and associates • NHS North Lancashire • NHS North Yorkshire and York • NHS Blackpool • NHS East Lancashire • Blackburn with Darwen Teaching Care Trust Plus	£84.2m £3.8m £0.1m £0.4m £0.1m	National VTE Patient experience SHA schemes Six regional schemes Local schemes No avoidable pressure ulcers Reduction in falls Stop inappropriate weight loss Die in place of choice Increase nurse discharge Improve coordination of care Occupancy levels at RLI **Total**	 £124k £124k £50k £946k **£1,244k**	
Total	**£213.1m**		**£3.0m**	

Contract with NHS North Lancashire signed. Contract with NHS Cumbria <u>not</u> signed, but financial envelope agreed.

Appendices

4.8 Equal Value Claims

Appendix

Background to equal value pay claims (EVCs)

- The majority of equal pay claims in the NHS were lodged with Stefan Cross on a "no win no fee" basis; the remainder are represented by Thompsons on behalf of the unions.
- Claimants believe that either prior to the introduction of AfC and/or as a result of assimilation into AfC pay bands, they have previously been or are being paid less than an employee of the opposite sex undertaking similar or comparable jobs (a "comparator"). In cases where there are a large number of EVCs "lead claimants" are identified as representative of other claimants in the same job group. Claims may backdate for up to 6 years prior to date of the claim and can include both pay and employment benefits

Background to EVCs at the Trust – position as at April 2009

- As at April 09, The Trust faced legal action from c.1,440 claimants on grounds of equal pay, 75% of these claimants were represented by Stefan Cross. The Trust has instructed Dickenson Dees, the legal firm that provided advice to the North Cumbria Acute NHS Trust, to act on its behalf.
- In the last assessment we assumed that 25% of the claimants withdrew their claims and this resulted in a downside worst case sensitivity of £9.3m in 2011/12 with cash impact spread evenly from 2011/12 to 2013/14.

Legal developments since previous assessment

- In *Hartley v. Northumbria Healthcare NHS FT, Secretary of State for Health & Others* (April 2009) the Newcastle Employment Tribunal rejected the claimants' contention that AfC breached anti-discrimination legislation. Essentially any pay differences between men and women since October 04 are legally justified and any claims will be limited to losses up to October 04 only. The case may also affect claims relating to the pre-A4C equal value period as the Tribunal found nothing to show that AfC was implemented on the back of historical gender-related pay inequalities.
- A further challenge to the principles established in Hartley (in the case of *McGarry v. University Hospitals of Morecambe Bay NHS Trust*) was determined in favour of the Trust. If this decision is not appealed or if any appeal is unsuccessful the remaining claimants will only be able to recover in respect of the pre-AfC period, unless they can establish local conditions which would allow them to pursue a claim in respect of the post-AfC period. We are currently unaware of any such local conditions.

Position as at May 2010

- Following the *Hartley* decision the assessment team understand from both the Trust and the SHA that claimants have received a letter from Stefan Cross that they have three options on their cases going forward: 1) continue claims on a paying basis - estimated to be c.£2,000 per person (it appears that challenge here would be in line with the unions approach which focuses on the pre AfC period); 2) seek new legal advisors to continue with their claims; or or 3) withdraw their claim.
- Since April 2009 ,732 claims have been withdrawn and 190 claims have been struck out.
- As at May 2010, Thompson's were representing 300 claimants (221 former Stefan Cross claims and 79 original Thompson's claims). Thompson's have lodged objections to some of the dismissals, stating that their clients did not intend that these were to be withdrawn when Stefan Cross decided no longer to act for them. The details of the objections have not yet been provided and a hearing will be scheduled to deal with these cases.
- As at May 2010, there were approximately 903 live cases, of which:
  - 366 are represented by Thompson's, other representative or themselves;
  - 197 are potential strike outs; and
  - 340 are currently unaccounted for – these claims will either be struck off or transferred to Thompsons.

  Assuming that all of the strike outs take place, the Trust will then have 706 live claims, which is about 50% of the claims as at April 2009.

Financial impact

The Trust has assessed the financial impact of the claims using the same assumptions as those in the Cumbria Partnerships successful FT application. On this basis the Trust estimates its downside financial impact to be £3.2m (see below, based on known cases). The Trust's solicitors have reviewed this methodology and believe it to be a "reasonable approach".

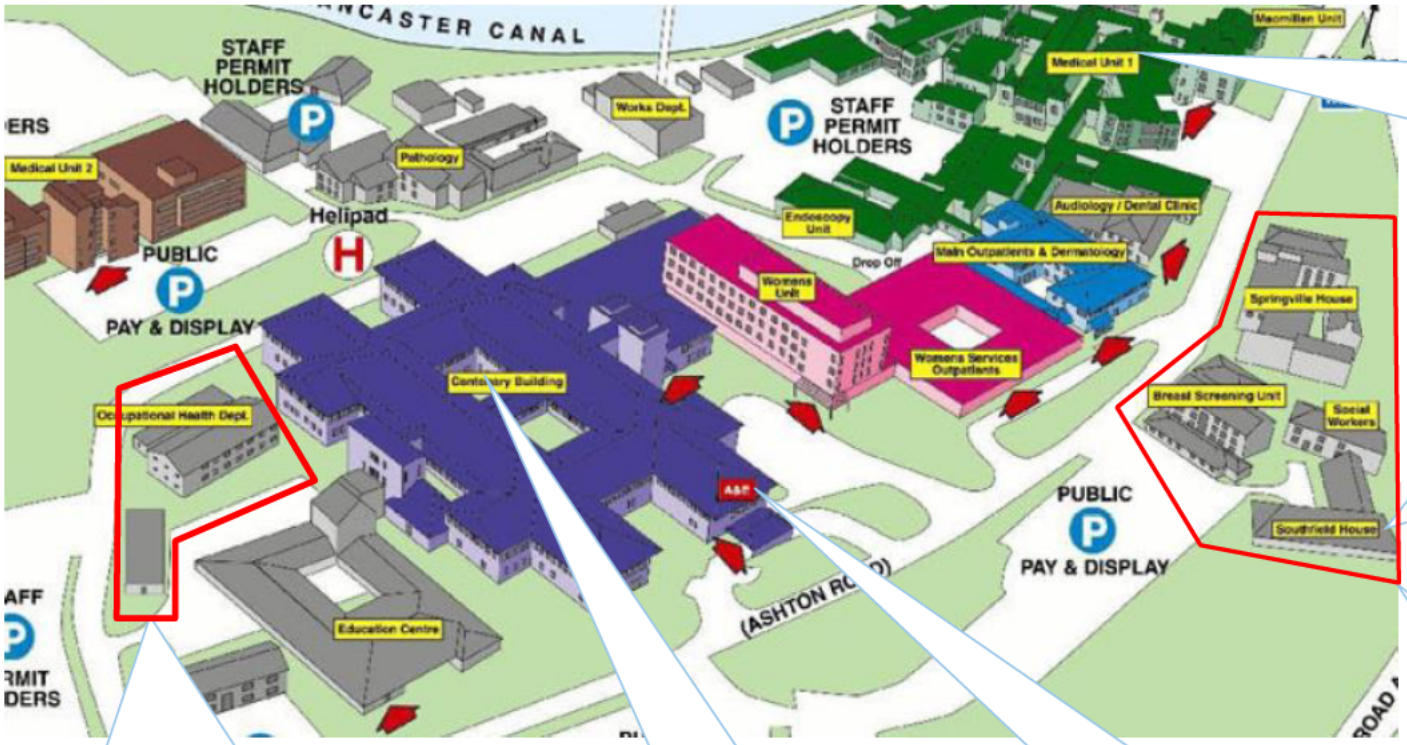
	Known cases	Known and Unknown cases
Estimated cost of settlement :	£2.5m	£4.4m
Employer's NIC and pension contributions assumed to total 25%:	£0.6m	£1.2m
Compound interest at 4% on gross amount due:	£0.1m	£0.1m
Financial Impact	**£3.2m**	**£5.7m**

We have assumed 100% of the known claimants and 25% of the unknown claimants are successful. This results in a downside worst case sensitivity of £3.9m in 2013/14 with cash impact spread evenly from 2014/15 to 2015/16.

Appendices

4.9 Royal Lancaster Infirmary

Appendix



Medical Unit 1
- Currently houses a combination of five inpatient medical wards, outpatients, therapies, day surgery, oncology, pathology lab and offices.
- Proposal is to relocate wards (c. 108 beds currently) into new build adjacent to Centenary Building.

Ward 50
- Nurse led inpatient ward (medical cover provided by GPs – do have consultant access).
- **See slide 4.4 - planned CIP for 2010/11.**

Proposed area for new build (see slide 2.4 - service development schemes)
- The Trust is proposing to demolish three current buildings (1 x office block, 1 x accommodation block, 1 x combination of offices & accommodation block).
- The Trust is proposing to build a two-storey modular construction building containing c. 100 beds. The new building will like to the Centenary Building via the main corridor.
- Combined assessment (i.e. merging Medical Assessment Unit and Surgical Assessment Unit). Short stay wards will stay on the ground floor and speciality medical wards on the first floor.
- **Capex estimated at £6m.**

Centenary Building
- Some reconfiguration of ward areas (non -capital) as part of new build proposals (see left).
- The Medical Assessment Unit will become an acute cardiology/stroke unit.
- In longer term, the trust believes that there will need to be some capital reconfiguration, this will be part of wider site reconfiguration business case.

A&E development (see slide 2.4 - service development schemes)
- Proposing to split into 3 phases
  1. Extend to expand and integrate minor injuries with primary care
  2. Extend to expand resuscitation area
  3. Refurbish remaining department
- Business case linked to ward new build, decision will be made on affordability of total scheme.
- **Capex estimated at £1m to £1.5m**

Ashton/South Road Buildings
- Includes Springville House (offices), Breast Screening Unit and social work offices (connected to Ward 50).
- Potential area for disposal. Will be looked at as part of wider site reconfiguration business case

Monitor
Independent Regulator
of NHS Foundation Trusts

9 July 2010

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Tony Halsall
Chief Executive
University Hospitals of Morecambe Bay NHS Trust
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Dear Tony

Monitor's Assessment Process: Quality Governance

In February this year, Monitor consulted on proposed changes to its publication, *Applying for NHS Foundation Trust Status: Guide for Applicants* (Guide for Applicants), with respect to the assessment of Quality Governance at applicant NHS foundation trusts.

The consultation document indicated that if adopted, the enhanced Quality Governance approach would apply to applicant trusts referred to Monitor after 1 June 2010.

Monitor has now updated the Guide for Applicants incorporating Quality Governance criteria. This update is available at http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-applicants/amendments-applying-nhs-foundation-trust-s.

In light of the responses received to the consultation and careful consideration of them, Monitor's board has decided to revise its position so that the Quality Governance criteria will apply to all applicant trusts with an authorisation decision after 1 August 2010.

As you are aware from our recent telephone conversation, this means that the new requirements are applicable to your application. The team will now work with you to agree any further submissions and meetings required to allow us to complete the enhanced Quality Governance work.

However if you have any questions or require further clarification of the revised process, please do not hesitate to contact me.

Yours sincerely

Miranda Carter
Assessment Director

Direct Line: 0207 340 2460

cc. Professor Eddie Kane, Chair
Victoria Woodhatch, Monitor