Northern Lincolnshire and Goole NHS

NHS Foundation Trust

Operational Plan Document for 2014-16

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Together
we care, we respect, we deliver

Contents

SECTION 1
EXECUTIVE SUMMARY

1.1 Northern Lincolnshire and Goole Foundation Trust provides a comprehensive range of acute hospital services across Northern Lincolnshire and the Goole area which are augmented by the Trust providing community services primarily to the population of North Lincolnshire.

1.2 The Trust continues to be the largest provider of acute care in Northern Lincolnshire, serving a population in excess of 0.4 million. The Trust is the largest single employer across the local community employing approx. 6,400 staff.

1.3 The Trust's Forward Plan submission is built upon the Strategic Direction & Options paper prepared by the Trust in response to the commissioners' 'Healthy Lives, Healthy Futures' visioning process which was originally submitted to Monitor in early January 2014.

1.4 The Trust Board do not consider that the current configuration of services is either clinically or financially sustainable in the long term. In coming to this view the Trust Board has consistently stated that the sustainability issue is a challenge for the whole local health community and cannot be resolved by a single organisation.

1.5 Historically, services have been developed across Northern Lincolnshire which have not focussed upon a holistic view of individuals' healthcare needs; this is associated with services being fragmented across a variety of organisational boundaries, differing funding arrangements across organisations and systems which do not support seamless patient flows / service integration. The outcome of such an evolving community of healthcare providers is one which is neither clinical nor financially unsustainable. In the absence of clear commissioning strategy to address these issues it has been necessary for the Trust to take a lead co-ordinating role in forging an overall strategic vision.

1.6 The Trust will report its first financial deficit since gaining foundation trust status at the end of 2013/14 and the financial prospects set out in the Forward Plan indicate that it expects that financial deficits will be reported, albeit with potential mitigation actions yet to be transacted during 2014/15 & 2015/16.

1.7 As a consequence of the above the Trust is required to publish a Financial Recovery Plan which covers the above period and which sets the overall approach to regaining financial stability over the course of the medium term. This will require the support of both local commissioners and, in all likelihood, NHS England in order to both broker a local solution to the short term funding shortfall faced by the Trust and to invigorate the overall health community to deliver the main aims of the longer term service strategy.

1.8 The Trust had already commissioned a service improvement plan prior to being placed in Special Measures and it is an irrevocable intent of the Trust Board that the service improvements, the quality gains experienced as a consequence of them and the key themes from the Keogh Action Plan are not undermined as a consequence of the financial pressures faced by the Trust and the local health community.

1.9 The Trust is therefore embarking on a journey which attempts to streamline services the Trust provides whilst maintaining safety and quality. The Forward Plan therefore highlights a number of initiatives which support the Trust's determination to provide integrated care at its best within the resources available to the local health economy aimed at delivery the overarching objectives set out in this plan, the Financial Recovery Plan which accompanies this and the Five Year Strategic Plan which will be published in June 2014.

SECTION 2
THE SHORT TERM CHALLENGE

2.1 Given the growing pressures faced by the NHS and the challenges specific to Northern Lincolnshire, transformation of services across the whole patient journey is essential

2.2 The Strategic Options paper submitted to Monitor in January 2014 highlighted that integration across primary, secondary and community healthcare providers will deliver a more sustainable healthcare footprint both in terms of clinical and financial sustainability.

2.3 For tertiary services, the population of Northern Lincolnshire flow predominantly to Hull and East Yorkshire Hospital (adults) and Sheffield Childrens Centre (children). The boundaries between Northern Lincolnshire and Lincolnshire do place NLaG as the closest hospital for some of the East Lincolnshire population resulting in a continued growth in demand from Lincolnshire.

2.4 The North East Lincolnshire locality has two social enterprises, one providing adult health and social care services and the other delivering adult mental health services. The health structure is different in North Lincolnshire with the Trust delivering adult health and community care services and Rotherham, Doncaster and South Humber FT providing mental health services.

Key Priorities 2014-16

- Integrate Services across provider partners in order to Deliver The Best Care In the Right Location and ensuring that organisational boundaries do not work to the detriment of patients

- Following multi organisational Board meetings create the foundation for the strategic journey by formalising;-

    - an Integrated Healthcare Structure consisting of multiple providers within North East Lincolnshire building upon agreement in principle. A structure which develops a high quality, cost effective healthcare model for the population

    - the structure to be adopted with our main tertiary provider which consolidates the patient pathways between the organisations strengthening clinical sustainability

- Working alongside our clinical teams, support both North East Lincolnshire and North Lincolnshire CCG with the commissioners currently proposed Consultation process likely to take place during the summer of 2014.

- As a health community agree a prioritised work plan which does not jeopardise the quality improvements achieved during 2013/14 but delivers transformation of the service construct sufficient to reduce the financial deficit.

- Provide the Best Patient Experience To Our Patients by
    - providing the highest quality care in a safe, friendly environment
    - respecting patients' dignity
    - enhancing the patient experience

- Maximise Efficiency & Quality In Service Delivery
    - Providing services in a location most convenient and clinically appropriate
    - Working to continuously improve the Trust's organisational efficiency

SECTION 3
QUALITY PLANS

Regulatory Control

3.1 ***CQC -*** The Trust is registered with the CQC. During the final quarter of 2012/13, the Trust received its planned but unannounced inspection visit by the CQC. Whilst no major concerns were highlighted during the visit, it was identified that action was required in certain areas.

3.2 The Trust entered 2013-14 with a key aim to deliver the improvements needed. Following the CQC follow up visit in December 2013 the previous compliance action were removed.

3.3 The Trust continues to test compliance with CQC requirements via a range of on the ground testing mechanisms including CQC mock visits and monitors performance via the quarterly Trust Assurance Framework reports submitted to the Trust Governance and Assurance Committee and the Trust Board.

3.4 ***CNST Maternity Standards*** - The Trust recently achieved Level 2 Accreditation gaining an excellent score of 46 out of 50. The service received 9/10 for each domain with the exception of communication for which it received 10/10. The service was praised for the work they have done and the high quality service they provide and are being quoted as examples of best practice to other providers.

3.5 ***Patient Led Assessment of the Care Environment*** (PLACE) unannounced inspections took place between April and June 2013. The results overall were not of the high standard that we expect and there was particular criticism regarding the quality of the food. A number of Trust-wide actions and site specific actions were taken in response to the results, some of which were already underway.

3.6 The formulated action plan was monitored by the Patient Environment group and items by exception reported to the Patient Experience Group and to the Quality & Patient Experience Committee. The 2014 assessments have been completed for both DPOW and SGH at the time of writing and a date is planned for the inspection at Goole. Initial findings indicate that progress from 2013 has been maintained.

Mortality Improvement

3.7 During 2013 the Trust was identified as one of fourteen Trusts that reported higher than expected mortality rates based upon the SHMI mortality performance indicator. This led to the Trust being included in the review by Sir Bruce Keogh and the subsequent agreement of a comprehensive action plan. The Trust is delivering against the actions contained within the comprehensive plan, this is evidenced by;-

- the improvements seen within the hospital mortality performance
- outcomes of externally verified reviews undertaken

3.8 Whilst it is recognised that SHMI performance inside and outside of hospital are intertwined, the out of hospital SHMI is having a disproportionate impact on the overall SHMI performance reported for the Trust. The out of hospital SHMI continues to deteriorate whilst the in hospital SHMI continues to improve. This highlights the need for further integrated working across the community to improve performance across the whole health economy.

3.9 As a result of findings from quality evaluation work, through case note reviews and the monthly data reporting within the mortality report, specific pathway areas have being identified and where necessary quality improvement projects have been developed focussing on the pathway of care and the other key ‘action themes’ from the trigger tool review work,

3.10 The Mortality Performance Committee oversees the workstreams related to SHMI improvement and will focus on the improvement work in individual clinical areas which need to improve further through engaging with frontline clinicians, rationalise the work in respect of Trigger Tool review of patient mortality and work with the commissioner lead groups to improve out of hospital mortality.

Trust Quality Goals

3.11 The Quality Strategy and Patient Experience Strategy set out the Trust's overall approach to quality and patient experience and identifies the Trust's priorities. It describes how quality goals will be delivered and how delivery will be measured and assured and therefore provides evidence through our governance programme that risk assessment and quality improvement are embedded in everything we do.

3.12 The Quality Strategy is currently undergoing a refresh and will be relaunched in the organisation during 2014-2015.

3.13 The Trust Board has adopted the 2014-15 Quality Priorities as proposed by the Quality and Patient Experience Committee (QPEC), which is a sub-committee of the Trust Board. The priorities fall within three categories;-

Clinical Effectiveness

Mortality - Deliver mortality performance within 'expected range' and improving quarter on quarter, on a Moving Annual Total (MAT) basis at each quarterly publication date until our reported SHMI is 95 or better.

NEWS - 95% of cases with a NEWs score, appropriate action was taken.

Dementia

i. 90% of patients aged 75 and over admitted as an emergency to be asked the dementia case finding question.
ii. 90% of the above patients scoring positive on the case finding question to have a further risk assessment.
iii. 90% of the patients identified as requiring referral following risk assessment to be referred in line with local pathway.

NICE - Evidence Based Practice - to increase compliance with NICE guidance with 90% compliance achieved by the end of March 2015.

Expected Date of Discharge - <target to be set on receipt of baseline compliance figures>% of patients within 24 hours of admission to have an estimated date of discharge recorded

Patient Experience

Friends and Family Test - to have a response rate that achieves a response rate in the top 50% which also improves in the Quarter 1 response rate.

Complaints

i. 50% reduction in the number of re-opened complaints.
ii. 90% of action plans following a complaint to be implemented within agreed timescales.
iii. achieve a <target to be agreed> reduction in complaints relating to specific themes {To be identified as a result of outcome of deep dive review which is nearing completion}

Pain management - 95% of patients felt staff did everything they could to help control pain and improve the patient's comfort

Staff Satisfaction - 2.5% increase in morale/staff satisfaction per

Patient Safety

MRSA - 0 MRSA Bacteraemia developing after 48 hours into the inpatient stay

C.Difficile - achieve a level of no more than 30 hospital acquired C.Difficile cases over the financial year 2014/15.

Safety Thermometer

i. provide harm free care to 95% or more patients - as measured by the Safety Thermometer.
ii. provide harm free community care to 95% or more patients – as measured by the Safety Thermometer

Patient Falls - Eliminate all avoidable repeat falls - as measured via the Root Cause Analysis undertaken for every repeat faller).

Pressure Ulcers - 50% reduction in avoidable grades 2, 3 & 4 pressure ulcers

Nutrition

i. 100% of patients identified as requiring it should be commenced on the Nutrition care pathway
ii. 100% of patients should have their food record chart completed accurately and fully in line with the care pathway

Hydration - 100% of patients should have their fluid management chart completed accurately and fully in line with the care pathway

Board Assurance on the Quality of Services Provided

3.14 ***Monitor Quality Governance Framework-*** Following the Keogh review into the quality of care undertaken by the Keogh Review Team the Trust attended a risk summit and action planning event. As part of the actions required the Trust commissioned an external an external assessment of compliance with Monitor's Quality Governance Framework. This work was undertaken by KPMG who carried out an initial review in October 2013. The review considered the Trust's position against the four domains (Strategy; Capabilities and Culture; Process and Structure; and Measurement) and the ten questions that form Monitor's Quality Governance Framework.

3.15 The original review concluded in a score of 6, and made 21 graded recommendations for improvement. On the basis of this guidance the score of 6 was in excess of Monitor's threshold of 3.5 or less. KPMG conducted a follow up review during March 2014, the outcome of which allocated the Trust an overall score of 3. This improved score reflects the progress made with implementation of the 21 recommendations and the sustainability of your processes.

3.16 Crucially a score of 3 provides a level of externally verified assurance that the Trust meets Monitor's requirements for Quality Governance.

3.17 ***Quality monitoring -*** The Trust Board and its established sub committees will continue to receive the following as assurance mechanisms that the adopted Quality Strategy and Patient Experience Strategy is being delivered;-

- ***Annual Quality Account*** - this document details the clinical quality priorities the forthcoming year 2014-15 in addition to reviewing the progress made towards the previous year's objectives.

- ***Monthly Quality Report*** – this provides the Trust Board with a detailed focus on progress towards meeting the priorities throughout the year.

- ***Monthly Mortality Report*** – this provides the Trust Board with a detailed focus on the progress in relation to the mortality action plan and clinical priority work streams.

- ***Review Outcomes*** – where independent reviews have been commissioned, the outcome is received at the Trust Board and relevant Board sub-committees including proposed actions and regular feedback as actions are delivered or barriers escalated.

3.18 The Chief Nurse has the lead for quality at Board level, working closely with the Medical Director (lead for Mortality) and the Director of Clinical and Quality Assurance, and the Non-Executive lead, who chairs the Trust's Quality and Patient Experience Committee. This Committee is responsible for the following:

Quality & Patient Experience Committee responsibilities

- Overseeing the development and implementation of the Trust's Quality Strategy and Patient Experience Strategy and the agreement of annual quality objectives.
- Considering the monthly Quality Report and Annual Quality Account prior to submission to the Trust Board and publication of the Annual Quality Account.
- Ensuring that actions arising from the external assurance on the Annual Quality Account are implemented.
- Agreeing key quality performance indicators and utilising these as appropriate to assess Trust performance and improve quality and patient experience.
- Monitoring the Trust's performance in respect of the achievement of quality contract targets e.g. CQUINs/Quality KPIs and advising on remedial actions where shortfalls are identified.
- Using information from the CQC Intelligent Monitoring Report and other sources of information to identify and address issues (e.g. Mortality) which may impact on the Trust's ability to deliver a safe and effective service to patients.
- Considering the outcomes of relevant local and national audits and reports (e.g. Dementia and stroke) and recommending appropriate action to further improve quality and/or monitoring the development and implementation of appropriate action plans.
- Making recommendations for action to Directorates and the Trust Board for developing or improving standards, systems and processes for improving quality and patient experience.
- Agreeing the Annual Clinical Audit Programme and the Annual Clinical Audit Report prior to submission to the Trust Board.
- Agreeing the Trust's strategy and approach to information to improve the experience of patients.
- To consider themes/trends and learning from complaints and concerns and consider how this information might be used as part of the wider Trust approach to improving the patient experience.
- To consider the findings from Ombudsman's reports and monitor the development and implementation of appropriate action plans
- Acting as the central repository of all patient feedback in order that the intelligence from a variety of sources is considered in the round rather than in isolation.

3.19 ***Clinical Leadership -*** The Trust has redesigned its clinical leadership structure introducing five Associate Medical Directors who will assist the medical director. Each leads the strategy and operation of an individual clinical area spanning multiple clinical specialities. Within specialities there is an associated Clinical Lead. Clinical Leads are responsible for the quality related work of each specialty across all areas in the Trust. At each of these levels the medical clinical lead has an equivalent nurse lead and managerial support.

3.20 The clinician structure is designed to embed and facilitate clinical improvements being managed as close as possible to the patient. As the Trust and wider health community progress the transformational journey, the new structure will enable clinicians to drive the clinical change required.

3.21 ***Nurse Staffing Levels -*** The Trust Board received and approved a report in March 2013 that provided clear principles and processes of nurse staffing on our wards/departments, along with evidence and examples of how we monitor safe levels.

3.22 This paper proposed to the Trust Board, principles for a co-ordinated and transparent process based on the Royal College of Nursing recommendations for safe staffing levels 2010 and safe staffing for older people's wards 2012. These are framed around the point of care delivery. This was so that an accurate picture could be obtained and any variance between wards/departments could be clearly identified and addressed.

3.23 Maintaining safe staffing levels on a daily basis relies on many factors to ensure staff are deployed in an effective way. This all depends on effective management and leadership

3.24 The establishments approved by the Chief Nurse will be reviewed on an annual basis or sooner should the service need dictate either through a planned transformation scheme or resulting from acuity of demand.

3.25 ***Embedding Quality -*** Throughout 2013/14, the Trust has continued to build upon the Quality Dashboards. Dashboards draw on data already being collected for each ward from a range of systems and teams, displaying this clearly in one document. This helps to prevent 'data silos', which has been a significant issue in the past for many organisations.

3.26 The indicators used cover both quantitative data as well as "soft" intelligence from staff and patients for each ward. This provides vital triangulation of data and consequently gives an increased level of assurance around the accuracy of the data seen.

3.27 In response to the Mid Staffordshire inquiry, the healthcare landscape has swiftly been adapting in relation to openness and transparency, and there is now an increasing need for trusts to be able to demonstrate quality monitoring and compliance at service and ward level. At ward level, our Quality Dashboards are also being used to facilitate staff engagement with, and responsibility for, improving the quality of care delivered to patients. A key aim of the dashboards is to ensure every member of the team (including support staff and those involved with indirect patient care) are fully involved as part of the 'team'.

3.28 Although Quality Dashboards demonstrate clearly areas of potential concern and allow senior managers to respond quickly when issues are identified, they also demonstrate where excellent quality of care is being provided and are used by senior managers to spread good practice and lessons learned.

3.29 ***Quality Assured Cost Improvement Planning -*** The Trust has undertaken a multiple stage sign off process for its Cost Improvement Programme. This process has been undertaken with each Clinical Group and Directorate. The Trust has operated this process to provide the assurance that savings delivery will not entail adverse impact on the quality of clinical services provided to patients, and that no increased clinical risks result from any scheme. Any schemes deemed to pose an unacceptable risk to quality were removed from the programme.

3.30 Formal sign off of the plans was completed by both the Medical Director and Chief Nurse. The Quality and Patient Experience Committee and Trust Governance & Assurance Committee will have a continual focus on assuring that the in-year implementation of the CIP plans continues to pose no quality risk for the Trust

3.31 ***SHINE (Share, Help, Integrate, Nurture, Empower) -*** The Trust aspires to be the healthcare provider of choice. We can achieve this together by providing individualised, safe, forward thinking services achieved through empowering and engaging with every member of the team. The Trust established the SHINE network during 2013/14.

3.32 The SHINE network includes Quality Mentors who are staff from a range of areas who hold significant occupational expertise and the personal enthusiasm to support others to achieve

their ideas. This may include mentoring, the provision of expert advice, coaching or unblocking obstacles.

3.33 Value champions represent their team and support the delivery of the Trusts Vision and Values in their team. Values champions support the integration of the values in everyday activities as well as work on dedicated projects to enhance the contribution the vision and values make to:

- Enhancing the patient experience
- Increasing staff satisfaction
- Improving organisational performance

3.34 The Trust has developed a Morale Barometer which is a quarterly survey offered to all staff to complete to gauge morale and to determine the progress being made regarding moving the culture forward. Importantly it tracks the workforces' sense of job satisfaction and links this to areas such as Trust communications. Starting from September 2013 the Morale Barometer also became the means of conducting a quarterly friends and family test check and will be used from April 2014 for Staff FFT CQUIN process.

3.35 To date the Morale Barometer has evidenced improvements across all of the above indicators and importantly has demonstrated a 10% increase in job satisfaction, which in itself is a major component in assessing the workforce improved morale.

Key Quality Priorities 2014-16

- Deliver against the Quality Priority thresholds
- Continue to embed the progress made in relation to the comprehensive action plan compiled in response to Keogh.
- Continued focus on our relative position and absolute performance in relation to mortality which is a key influencing factor in relation to the quality strategy
- The Trust has implemented a number of actions during 2013-14 aimed at delivering high quality care for people with dementia. Actions include providing dignity rooms, developing a dementia friendly bay, educating staff. These will be embedded and built upon as we progress into 2014-15.
- Continue to undertake root cause analyse on all pressure ulcers graded 2/3/4 and all repeat fallers
- Continue to provide the training programme with respect to pressure ulcer care
- Develop and maintain a skilled and competent workforce where dementia care is a focus
- Continue to learn from the patient stories received at Trust Board
- Continue to learn from complaints and concerns and ensure that the process for patients and relatives to raise such issues is accessible and responsive
- Continue to embed both the unannounced Director visits and mock CQC visits implemented throughout 2013/14
- Continue to embed the SHINE network incorporating all its components

SECTION 4
OPERATIONAL REQUIREMENTS AND CAPACITY

Current Demand Assessments

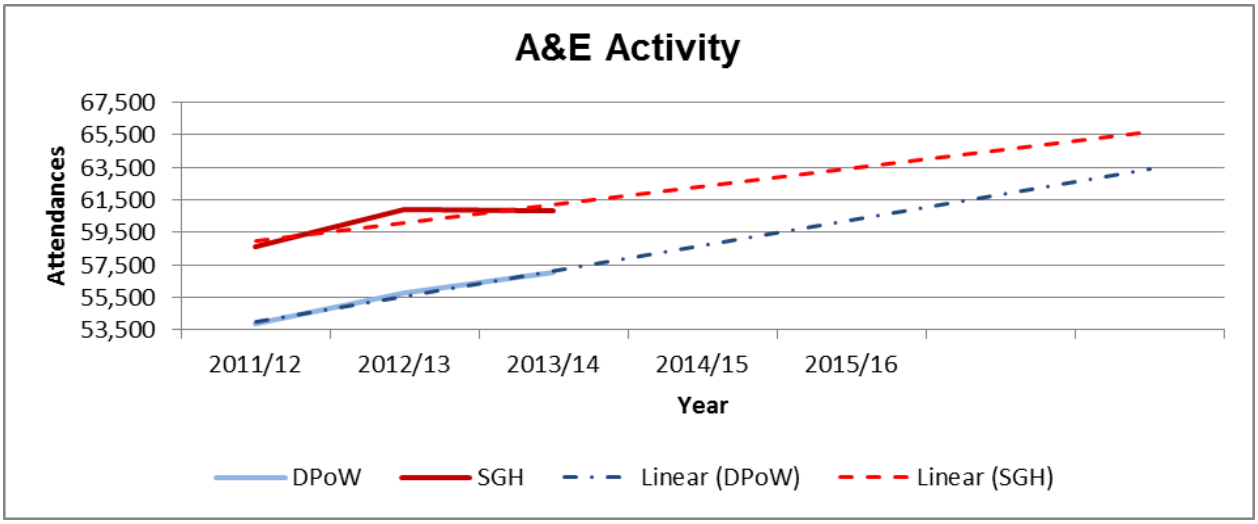
4.1 The activity and demand forecasts which have underpinned commissioner plans previously assumed broadly flat line demand growth. Historically it was assumed that elective activity would initially grow as a consequence of the move toward the 18 week waiting time guarantee with the initial growth being reduced as demand and diversionary measures reduced elective demand to the acute sector.

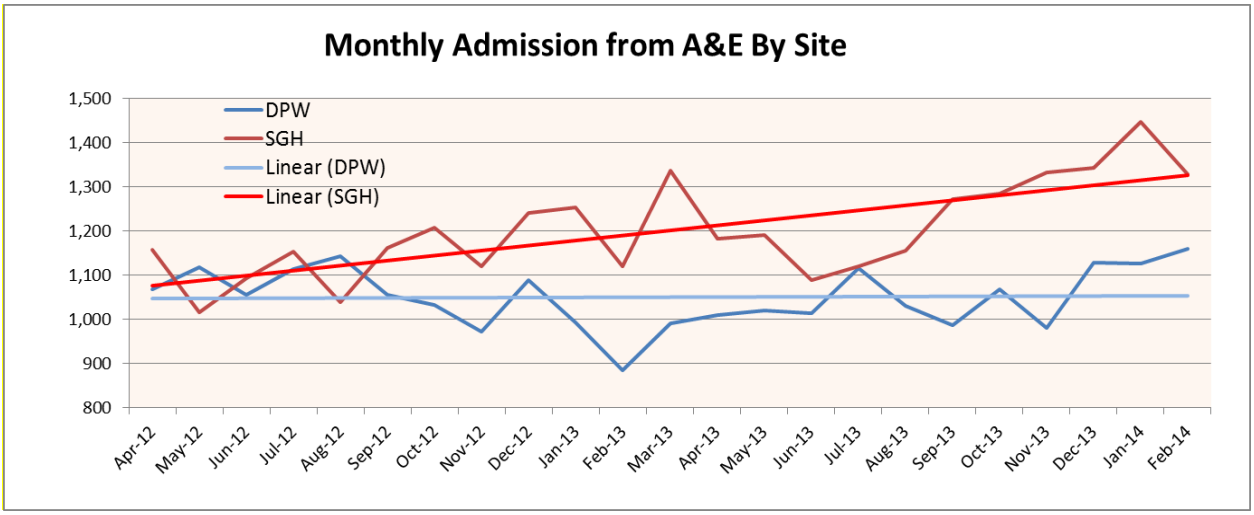
4.2 Emergency admissions were assumed to reduce over time as demand management schemes to be implemented by commissioners would mitigate the demographic impact of population growth and the increase in elderly patients.

4.3 The actual activity trends experienced over the longer period are significantly different to those originally set out and have impacted upon the Trusts ability to progress with major transformation due to the need to treat the current demand.

4.4 The funding gap currently experienced across the whole NHS calls for greater creativity, innovation and transformation which requires a significant shift in activity and resource from the hospital into community.

4.5 ***Accident & Emergency Attendances -*** Both our main Accident and Emergency services have been under pressure to deliver a high quality service within national performance parameters given both the demand and acuity levels. Due to variations in commissioner approaches at each of North East and North Lincolnshire, the service models for Accident & Emergency have progressed at different paces.





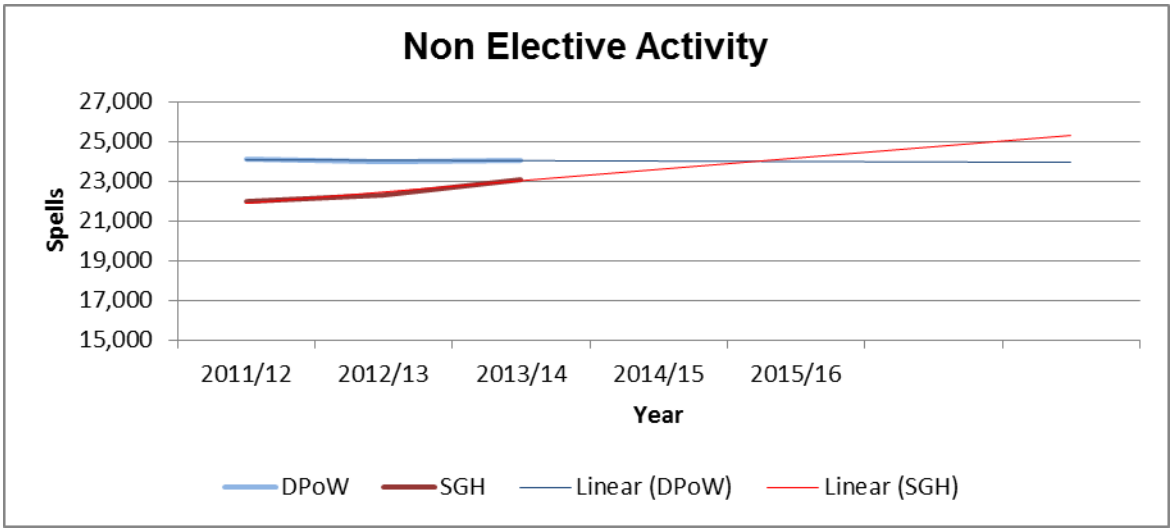
4.6 Within the Grimsby site, a pilot has been in operation which has placed GPs at the front of Accident and Emergency 24/7. This pilot has demonstrated that approximately 25% of activity could be cared for by a GP as a minor injury and not utilise the resource attributed to majors. This has supported delivery of robust performance for North East Lincolnshire population against the 95% seen within 4hrs threshold. The pilot needs to progress to the next phase to understand whether or not a reduction in emergency admissions can be delivered thus providing a mechanism for the Trust to reduce its cost base.

4.7 At the Scunthorpe site, 1st October saw the commencement of the Unplanned Care Service. This service now incorporates a Single Point of Access which is based within the Scunthorpe A&E department encompassing a variety of acute, primary and community services. Whilst early indications show that the number of attendances since 1st October is lower than the first six months of the year by 1.2% (366 attendances), the acuity of those patients and therefore the subsequent increase in admissions (8.2% compared to 2012/13 or approx. 1,100 patients) has placed a significant pressure on the Scunthorpe medical wards.

4.8 ***Non Elective Activity -*** The Grimsby site is in the midst of a transformational journey incorporating other North East Lincolnshire providers. Historically the Diana Princess of Wales site has seen an increasing demand on emergency activity, however the following actions have delivered a level of mitigation to previously forecast growth

- With the emphasis on specialist services being delivered from Tertiary centres only, the Grimsby site saw a significant reduction in Vascular services and a slight reduction in Major Trauma due to activity moving to Hull and East Yorkshire hospitals.

- Up to 2010/11 the Trust saw a gradual but significant shift in demand from Lincolnshire residents, since 2011/12 whilst the Trust continues to experience demand growth from the Lincolnshire population, investments within Louth County hospital have gone some way to mitigate the extent of that growth.

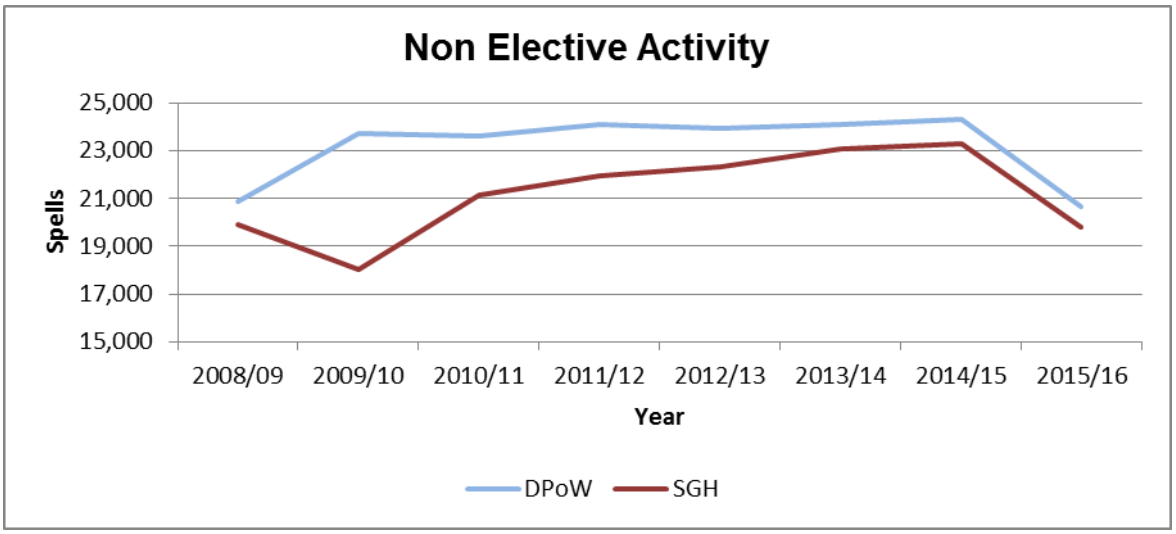


4.9 Some Trust services are provided from the Scunthorpe site only, these include Percutaneous Coronary Interventions (PCI) and Hyper Acute Stroke (on a temporary basis) services. These contribute to the increase in demand on the Scunthorpe site.

4.10 ***Planned Activity -*** The Payment by Results Framework contains a marginal rate payment for non-elective activity, utilising 2008/09 as the activity baseline. Payment at 30% in the face of significant growth in non-elective demand has proved a very challenging balance and has contributed to a material number of cancellations of elective activity to accommodate emergency demand. Where clinically appropriate the Trust has delivered planned activity in a day case setting and reports day case rate performance on par with its peers.

Forecast Demand and Capacity Planning

4.11 Introduction of the Better Care Fund has the potential to trigger significant transformation. National Planning Guidance states an aim of reducing hospital emergency admissions by 15%. The graph below depicts the impact this could have on demand should the local health community be able to redesign services enough to deliver the national planning assumptions surrounding Better Care Fund.



4.12 The priority work streams identified across the Health Community to support delivery of the non-elective activity reduction are

- Frail Elderly
- End of Life / Palliative Care
- Care in the Right Place
- Unplanned Care
- Complex Care

Incorporating seven day services where appropriate.

4.13 Actions have been taken during the latter half of 2013/14 across providers within North East Lincolnshire who have worked in collaboration to reconfigure some service processes/ models. The pilot included;-

- Acute and community teams working side by side on the wards regardless of which organisation they are employed by. The aim of this being to enable more efficient discharge further reducing delayed transfers of care, length of stay and medical outliers.

- Expansion of patient equipment services across 7 days again to enable discharge at the weekends as evidence showed inability to access equipment was a barrier

- Utilisation of community transport to take patients back to their place of residence when fit for discharge as awaiting transport is a cause for delay

4.14 A reduction in non-elective activity through the work above needs to drive a service configuration going forward which provide the ability to reduce medical outliers. The actions taken during 2013-14 need to be formalised and embedded to ensure that planned surgical services are not disrupted.

4.15 Working closely as providers has highlighted the current nursing bed base in operation within the community. In addition to the 19 bedded step-down unit on the Diana, Princess of Wales site, an additional 45 beds have been opened during 2013 in the community. Providers have agreed that this is not a cost effective service model and operationally proves difficult to continually staff and deliver high quality services due the small bed numbers at each location.

4.16 Providers have agreed in principle that should a patient need a nursing bed that providers will look to that provision to come from the Diana Princess of Wales site. Providers have commenced a piece of work to confirm the most effective and efficient bed base footprint for the population of North East Lincolnshire. Ultimately for the Trust this will enable robust and flexible capacity planning to enable delivery of both elective and non-elective demand as we progress through 2014-15 and beyond.

4.17 Providers have been working to understand the patients who continually attend A&E and/or are frequently admitted into the hospital due to a complex need. Patients who are confused / potentially undiagnosed dementia are a cohort of patients who we all need to ensure are cared for in the most appropriate setting. Providers are exploring the possibility of delivering a 'Home from Home' service from the Diana, Princess of Wales site

4.18 CCGs continue to push the Trust towards a new to review ratio which goes further than the Trusts peer group. Clinical engagement across acute and primary care is crucial to the success of this. Redesign of service models where clinically appropriate may support the Trust to redirect its workforce and reduce its reliance on premium rate locums / agencies. Whilst there have been pockets of progress during 2013/14, further work is required to deliver sufficient change in volumes which would enable the Trust to reduce its cost base. As resource will be removed primary care will need to provide the assurance that patients will not re-enter acute care via a new referral.

4.19 All of the above aim to ensure that patients receive the right care in the right place from the right person. By integrating services into the one location clarity of provision should be improved. The pilots discussed above provide convincing evidence that by working together providers can enact beneficial change. They also suggest integration will remove barriers and supports delivery of a seamless, more efficient transfer of patients across all elements of the healthcare journey.

4.20 As the health community progresses with the programme of transformation, an alternative mechanism to the current tariff will need to be agreed to provide a 'sustainability premium'. This is reflected within the financial recovery plan. The Trust is aware that Monitor are reviewing the existing tariff structure and the Trust will work with this as it develops. The work described above introduces service models which are not reflected in the current tariff structure.

Key Operational Priorities 2014-16

- Working alongside all organisations in North East Lincolnshire deliver integrated roll out of the planned Single Point of Access due to become operational with phase 1 in May 2014.
- Continue to embed the Single Point of Access within North Lincolnshire during 2014 with warm call transfers on target for commencement 1st June 2104.
- Working with Core Care Lincs and North East Lincolnshire CCG, deliver the next phase of integration of GPs within A&E
- Embed the increased resource invested in Community services within North Lincolnshire ensuring planned outcomes of investment are delivered, predominantly providing care within a persons place of residence where clinically appropriate.
- Whilst the Trust overall is on par with peer group for day case rates, a priority for the Trust to improve productivity is to work with clinical teams to understand if we can go further in specialties which are not consistent either across the sites or with peer group.
- Work across health and social care to implement the new models of care (eg Diabetes Sigma 6) and new pathways which would reduce the volume of outpatient follow up appointments
- Evidence the capacity planning work described above to better inform the strategic direction which will be described in the June Plan submission to Monitor.
- Embed service developments which have been delivered during 2013/14;-
  - Step down facility opened November 2013
  - Surgical Assessment Unit opened November 2013
  - Redesigned Women & Childrens services effective November 2013
  - Palliative Care Services commenced early 2014
  - Decant Ward opened in readiness for the winter 2013/14
  - Locality teams within North Lincolnshire particularly into the Single Point of Access as that develops
  - Service models which demonstrated reduction in admissions, Paediatric Assessment Unit and Acute Oncology rota

Workforce Plans & Requirements

4.21 The Trust firmly believes that its success is determined by the skills and professionalism of its workforce. This belief underpins the Organisational Development and Workforce Strategy (April 2012). The Trust's newly established Workforce Planning Team contributes to delivery of this strategy and the Trust's Vision – *Together we care, we respect, we deliver* - by ensuring the Trust has suitable access to appropriately skilled teams to deliver its business goals.

4.22 The Trust has placed an increase focus on the collection, evaluation and provision of accurate workforce data (including demographics, staff group make-up and equality and diversity) as part of its response to the Keogh Action Plan during 2013. The Trust will further enhance the robustness of the workforce planning and control systems during 2014 as it embeds clear workforce KPIs throughout the internal performance management and control systems. The Trust has a long established Workforce Review Group – this group, and the internal oversight arrangement arrangements associated with it, will be further strengthened during the course of 2014 in order to give the Trust Board greater line of sight in relation to all workforce planning, control and development matters.

4.23 The appointment of a dedicated workforce planning post has been incorporated into the operational plan in order to allow the Workforce function to support this process.

4.24 The Trust's existing workforce plans have been extensively reviewed during the course of 2013 with a particular, but not exclusive, focus on the nursing establishments. These revised establishments have been signed off and embedded in the financial plans which are set out in

this report. The review of establishments is accompanied with a greater focus on internal workforce metrics which will form part of the internal performance management process throughout the organisation.

4.25 Workforce planning methodologies will be firmly integrated into all business planning meetings. In addition the Trust aims to bolster its participation on local strategic partnership forums, forge closer working relationships with Jobcentre Plus and other providers to help shape the local labour market and externally strengthen its position as the local employer of choice. Furthermore by working with those approaching working age The Trust will aim to encourage them to consider careers in healthcare, and from this work with Health Education England to commission courses of higher education.

4.26 The workforce planning function has been reviewed in order to support operational managers to consider and, where appropriate, implement alternatives to traditional approaches to filling vacancies and think differently. As such constructing innovative establishments and applying role redesign techniques are crucial strategies and skills within workforce planning teams. The Trust is presently critically evaluating a range of potential opportunities in order to provide greater flexibility within the workforce, although within a strict criteria in order to ensure that innovations in workforce recruitment and planning do not undermine the quality or safety of patients and staff. The following opportunities are currently being evaluated:

- Medical Staff 'Group Job-Planning' – this approach seeks to align the services' commissioned activity and acuity of patients to the skills of the medical staffing team. Consequently group job-planning maps the needs of the service onto the medical establishment skills base, in turn aligning each doctor's PAs with the needs of the service.

- Clinical Apprenticeships – linking to above the Trust is investigating whether any skills gaps identified as part of the Trust job-planning could be supplemented either through further developments to the existing workforce or alternatively via the introduction of CAs. The construction of CAs would require the input and endorsement in medical education and the Deanery. The Trust is assessing whether CAs could be utilised initially within emergency medicine and general medical specialties to overcome recruitment difficulties.

- Advanced Nurse Practitioners (ANPs) – Akin to CAs ANPs have been used to up-skill nurses to support medical rotas. This is done in partnership and with the support of the respective medical/consultant body and facilitated through Fellowships with universities. The use and rollout of ANPs has been a key feature of the existing workforce plan and further expansion of these roles to support medical and other aligned rotas is envisaged during 2014.

4.27 Technical and Therapy Staff: The Trust continues to be able to attract new staff to these posts, however, reviewing the current situation reveals retention can be problematic. As such rolling job adverts are being used so the Trust can maintain a presence in the jobs market in the short term.

4.28 Nursing Staff: As stated above, the Trust has extensively reviewed the nursing establishments during the course of 2013. Additional nursing posts have been recruited during 2013 and these posts have been incorporated recurrently into the Trust's financial plans. Although the overall ward structures will be reviewed as part of the Trust's on-going transformational planning process, whilst these wards are retained the revised nursing establishments have ensured that they are adequately, and safely, staffed.

4.29 With the current high demands across the NHS for nursing staff the local, regional and national talent pools are growing dry. Consequently the Trust has turned to the EU labour markets to recruit cohorts of nurses as a short-term solution, whilst supporting activity through the Trust Nurse Bank and by using costly agency solutions. Nursing stability across wards and clinics is critical to maintaining quality and safety of services as well as the performance, loyalty and retention of the current workforce.

4.30 To successfully support the delivery of the Trusts mid to long term succession plans the creation of internal talent pools should be achieved through the processes outlined above.

However, the Trust also recognises the above skills escalator models of home-growing own talent must not be restricted to the development of clinical skills or professions. Leadership development and clinical leadership also hold strategic importance in generating and maintaining flow of new leaders and managers through the structures.

4.31 To achieve the Trust vision for its future leadership the Trust has now commenced a series of leadership courses aimed at improving mental, personal and team resilience, staff engagement and feedback techniques, motivational, influencing and human factors training and virtual team/distance leadership skills (to support managers of mobile and community teams – a potential growing necessity under the sustainable service review). These leadership courses have been strategically applied at senior leader levels, including medical leaders, in an attempt to continue the culture transformation and delivery of Francis and Keogh work streams.

4.32 The Trust draws its workforce from local, regional, national and international labour markets. Each provides different skills and occupations and therefore the correct strategic interventions are required to influence the make-up of each talent pool.

- Local Labour market - The Lincolnshire and immediate neighbouring labour markets adequately meets the needs of the bulk of administration, estates/ancillary and additional clinical professions. Linked to this, and to contribute to the Trusts partner in the community agenda, the Trust should seek to home grow staff into these professions through work experience for schools, apprenticeship programmes for 16+ year olds, NLG Employability schemes for those disadvantaged in the labour market and NHS careers showcase events encourage young adults to consider a career in the NHS and healthcare. Such activities may include NLG led hospital open days and careers fairs, supported by affiliated universities and with inspirational guest speakers. Additionally the Trust is considering the implementation of Student Bursary Contracts to support local talent through university and secure their professional service for c.3years post-graduation.

- Regional and National Labour markets – The Trust is seeking to form relationships with universities where it can proactively market itself to the students early on in the course so they see NLG as their employer of choice. To build this relationship with the students it will require investment of both time and no doubt require a multifaceted marketing approaches (portraying Lincolnshire as a life style choice, NLG as a provider of excellence etc) and must be seen as a mid to longer term return. These relationships can be formalised through various means such as clinical attachments and research placements, all designed in a way to showcase the Trust and the lifestyle available from Lincolnshire.

- International Labour market - Clearly given the current demands for nursing and medical staff the Trust needs to move much more into international markets. Although this has started with the launch of the overseas recruitment website, identification of potential talent pools for medical staff the Trust is starting to undertake a thorough valuation of the international market takes place to target markets which have qualified job ready professional staff within the Trust hard to fill occupational categories and develop relationships with overseas educational establishments.

4.33 The Trust forecast base sickness rate as at 31st March is 4.1% which broadly in line with national averages. Average sickness levels now form part of the internal performance management process in order to ensure that operational managers are clear on their present sickness levels, the factors which have contributed to this and have plans in place in order to ensure that, where they are an outlier, mitigation plans are in place in order to prevent potential detrimental impacts to patient care or operational efficiency.

4.34 The Trust is reporting a forecast vacancy rate across all staff groups of 3.9% as at 31st March 2014. Focus is needed as we enter 2014-15 on medical staff vacancies levels to enable the Trust to reduce its reliance of premium rate payments. The Trust is presently reviewing capacity plans across all operational areas in order to ensure that substantive establishments are sufficient to meet operational demands and thus minimise the need for ad hoc capacity solutions.

SECTION 5
FINANCIAL PLAN

5.1 The Trust's financial plan for 2014/15 and 2015/16 is constructed, at the time of writing, in the absence of an agreed contractual income framework with either of the Trust's two main local commissioners. The Trust Board adopted a financial framework for 2014/15 which also sets the foundation for the financial plan for 2015/16 at its March Trust Board meeting. This framework therefore underpins this plan, although it is recognised that, following the eventual agreement of a final income framework with commissioners the Trust Board will potentially need to review its approach to internal and cross-community risk management and mitigation during the course of the year.

5.2 The Trust will also enter 2014/15 after reporting an in-year financial deficit in 2013/14. This factor, combined with the fact that the Trust has stated that, as presently configured, the Trust Board do not believe that the existing service structure is clinically or financially viable without significant longer term transformation, has resulted in this plan being supplemented with the submission of a Recovery Plan to Monitor in accordance with the letter to the Trust Board Chairman dated 7th March 2014. The financial strategy section should therefore be read alongside with Financial Recovery Plan submission made to Monitor on 4th April 2014.

5.3 The local community established a Sustainable Services Review (SSR) in 2011, and this process continued to evolve and is now incorporated into a 'Healthy Lives, Health Futures' title which commissioners intend consulting the local public on during 2014.

5.4 The Trust expects to receive feedback as to which options have been identified by commissioners as suitable for further analysis although the latest assessment of commissioner plans suggest that, at this stage, they do not envisage consulting on any significant change to the existing service configuration.

5.5 The Trust is therefore not anticipating any material change to service configuration through this process which would impact upon the 2014/15 service delivery plans. The financial assessments made for 2015/16 and beyond have been constructed upon the basis that commissioners adopt service configuration proposals which have been set out in the Strategic Direction & Options paper submitted to Monitor on 6th January 2014 as part of the Enforcement Undertakings Process as set out in Monitor's letter to the Trust Board Chairman on 17th October 2013.

5.6 A financial assessment of the potential medium term financial impact of implementing each of the options set out in the Strategic Direction & Options paper was subsequently submitted to Monitor on 13th January 2014.

5.7 This financial assessment provides the basis for the 2015/16 financial plan although certain aspects of this assessment – mainly the income assessment and the CIP dependence – have been updated in order to take account of the latest assessment of contract income prospects.

Financial Performance 2013/14

5.8 During 2013/14 the Trust is expected to report a deficit of between £4.20mil and £4.80mil; non-recurrent contingencies which have supported the Trust's financial position during the course of this year are now exhausted which means that the underlying financial position facing the Trust is likely to be significantly higher that this sum.

Financial Projections 2014/15-2015/16

5.9 The Trust, like most of the acute sector, faces an extremely challenging financial position for 2014/15 due to the following factors:

- the fact that the Trust will report a deficit of between £4.20mil and £4.80mil in 2013/14 and that the non-recurrent contingencies used to support the underlying deficit have now been exhausted;

- the fact that the Trust will have not made any material inroad into an underlying deficit which, at the commencement of 2014/15, is estimated to be approximately £14.0mil;

- the costs of investment in clinical front services due to the Trust's mortality position, and increased sensitivities to clinical quality risks associated with the recommendations within the Francis Report have not, thus far, been accompanied with any material increase in income in order to fund them.

5.10 The Trust submitted options for longer term sustainable services to Monitor in early January, with an accompanying potential financial planning framework, as part of the Trust's enforcement undertakings. These documents set out a basis for a longer term strategic vision.

5.11 Thus far, the strategic options have not been translated into a contractual settlement with commissioners, and therefore the income which was expected to be generated in order to support the delivery of the strategic vision has not been forthcoming. Unless there is a significant shift in commissioner planning intentions, there is little prospect of the Trust being in a position to report a balanced financial plan without significant clinical infrastructure reductions. Given present demand levels, and the Trust's intent to maintain the quality improvements delivered since being placed under Special Measures, this is an extremely unpalatable option.

5.12 It should be noted therefore that, as a direct consequence of the above position the Trust will not be in position to report either an in-year or recurrently balanced plan over the course of the next two years. The Financial Recovery Plan which accompanies this report sets out how the Trust envisages reconfiguring its services, income and cost base in order to allow the Trust to gain financial sustainability of the course of the medium term.

5.13 The Trust originally set out a contractual prospectus for the forthcoming year based upon the following key planning principles:

1) Forecast Outturn from 2013/14, plus;

2) Full year effect of the investments agreed by commissioners during 2013/14, plus;

3) Net increase in income of 1.5% linked to the initial activity model, plus;

4) A contract baseline realignment which equates to approximately £8.0m which relates to the removal of a variety of technical underpayments which mainly stem from the application of the non-elective marginal rate, plus;

5) A temporary, non-recurrent package of funding of £2.0m to support capital elements of the transformational journey for 2014/15 only.

5.14 In addition to this are the income impacts of further service developments set out as part of the net savings programme for 2014/15 – primarily repatriation of work into the Trust from other local acute providers.

5.15 It was recognised that this was a risk laden income strategy. However, given that the two local CCGs reported an overall surplus for 2013/14 of approximately £10mil based upon present spend levels with the acute trust, and were to receive net allocation growth, it was judged that this was ultimately affordable. In the light of the investments made by the Trust to secure quality improvements following the Keogh review, the income growth plan was judged a reasonable assumption. In relation to the two local CCGs the Trust set out an initial funding exposition which formed the main body of the income expectations in the Monitor submission in early January.

5.16 Feedback from both commissioners now suggest that their access to the 2013/14 surpluses is not guaranteed, and therefore the levels of potential commissioning power for 2014/15 will be lower than previously assumed. For the purposes of the initial construction of the financial framework the Trust has decided it prudent to reduce the initial income assessment which, when taken into account would result in the following income and expenditure position for the next two financial years:

	2013/14	2014/15	2015/16
	£mil	£mil	£mil
Income - Clinical	284.44	299.16	301.22
Income - Other	32.49	33.80	35.12
Income - Donations	0.10	0.48	0.72
Expenditure – Pay	224.98	230.43	228.28
Expenditure – Non Pay	85.42	97.86	98.46
EBITDA	**6.64**	**5.16**	**10.40**
Post EBITDA Items	11.10	11.10	10.86
Trading Surplus/(Deficit)	**(4.47)**	**(5.94)**	**(0.46)**
Exceptional Items	(3.28)	(2.50)	(2.80)
I&E Surplus/(Deficit) – post technical items	**(7.75)**	**(8.44)**	**(3.26)**

5.17 In the absence of an evidenced based activity plan from commissioners the Trust has used its own assessments of projected levels, again founded upon an outturn based model with growth specific to activity types used. Net activity growth on outturn is calculated at 1.5%, with the historic underlying growth rate of 2.5 to 3.5% mitigated by some anticipated success in reduction of activity through improved pathway management. Activity growth is therefore biased towards diagnostic services and high cost drugs, and away from outpatient activity.

5.18 In arriving at the above figures, the Trust has used inflation assumptions based not on the national model, which assesses inflation across the board at 2.5%, but instead uses local modelling suggesting real inflationary pressures of 3.4%. The specific rates used are as follows:

Inflation	2014/15	2015/16
	%	%
Pay Awards (based on recent adjusted profile)	0.45	0.48
Incremental Pay Drift	0.95	0.80
Agency Staffing Inflation	4.00	4.00
Drugs Inflation	4.50	4.50
Clinical Non Pay Inflation	2.80	2.80
Energy Inflation	8.00	8.00
Services Inflation	1.50	1.50
Other Non-Pay Inflation	2.50	2.50

Cost Improvement Planning – 2014/15 & 2015/16

5.19 The Mid-Year Review published in October 2013 set out a cost improvement planning target which was broadly based upon an assumption that the Trust delivers a programme of cost reduction which meets the minimum efficiency challenge of 4% established for the service as a whole.

5.20 The potential for a higher programme of savings which could, if delivered, reduce or even close the forecasted financial deficit which was anticipated in 2014/15 was considered although this was initially discounted as a planning option for the following reasons:

- The fact that this would inevitably have to be focused on the clinical front line which could, in the absence of a coherent demand reduction strategy by commissioners, place patient care at a significant risk;

- That this could impact on the clinical quality improvement programme undertaken since the Trust was placed under Special Measures;

- That commissioners ultimately had a responsibility to contribute to the increased clinical costs incurred by the Trust, particularly in relation to rectifying the funding imbalances brought about by the impact of the marginal rate tariff and other contractual non-payment mechanisms.

5.21 The cost reduction package proposed in the Mid-Year Review therefore represents the maximum deliverable savings package which has presently been assessed as able to be delivered within the quality impact assurance process. The Trust, as part of the risk mitigation process outlined within the Financial Recovery Plan may wish to revisit this.

5.22 The total cost improvement plan over the period contained within the plan is therefore as follows:

COST IMPROVEMENT PLANS	**2014/15**	**2015/16**
Income Generation	1.62	0.91
Medical Staffing	2.42	2.15
Nursing and AHPs	1.72	2.23
Non Clinical Support Services	1.37	0.89
Support Staff Redesign	0.66	0.45
Clinical Supplies Procurement	1.99	2.15
Non Clinical Non Pay Spending	0.61	1.46
Energy Savings	0.45	0.45
Terms and Conditions	0.68	0.95
Central and Commercial Schemes	1.74	1.86
Total	**13.26**	**13.50**

Investment Programme – 2014/15 & 2015/16

5.23 The Trust has now completed work on its opening plan for the Investment Programme in 2014/15, as part of a full five year plan. The plan is constructed to meet the following objectives:

1) Supporting on-going business operations;

2) Supporting the quality improvement actions taken and planned in patient services;

3) Enabling the wider service transformation process starting to emerge for the Healthy Lives Healthy Futures process, and from elsewhere;

4) The plan must live within the parameters set by the wider financial plan.

5.24 The Trust has taken out material loans in 2013/14 to support its energy improvement initiatives, and the plan includes further borrowing to support development of residential services at both DGH sites. This brings with it and element of interest expenditure. Loans confirmed in 2013/14 will incur interest charges of £0.21m, and a further £0.08m is set aside for charges relating to in year loans included within the plan. This is treated as recurrent, as is the charge of £0.39m linked to the cost of capital of the Investment Programme.

5.25 The programme for 2014/15 & 2015/16 is summarised as follows:

Investment Programme	2013/14 Actual £mil	2014/15 Plan £mil	2015/16 Plan £mil
Major Equipment Purchases:	0.00	0.20	2.50
DPoW Reconfiguration:	1.46	2.82	2.20
S&G Reconfiguration:	0.06	0.68	1.30
Community Equipment Services Redevelopment:	0.01	1.15	0.00
DPoW Estates Rationalisation:	0.09	0.16	0.43
Residences Redevelopment:	0.00	4.80	6.40
Energy Partnership Programme:	0.50	4.43	1.5
Planning and Feasibility Fees	0.08	0.10	0.10
Total Major Schemes	**2.19**	**14.34**	**14.68**
Total Facilities & Estates Management	**1.58**	**1.50**	**1.50**
Total IM&T Programme	**1.38**	**2.46**	**0.97**
Total Equipment	**2.65**	**2.23**	**2.00**
Total Capital Expenditure	**7.80**	**20.52**	**19.15**
Total Revenue	**0.40**	**0.82**	**0.82**
Total Programme	**8.20**	**21.34**	**19.97**

5.26 The revenue element of the programme is expanded, primarily due to key aspects of the IM&T agenda falling outside capital definitions, as more flexible management models take shape in areas such as licencing.

5.27 The programme in 2014/15 is funded as follows:

Investment Programme Funding Envelope	£mil
Depreciation	7.60
Donations target	0.50
Loan funding	9.50
Safer Wards Safer Hospitals funding (PDC)	1.60
Cash balances	2.24
Total	**21.34**

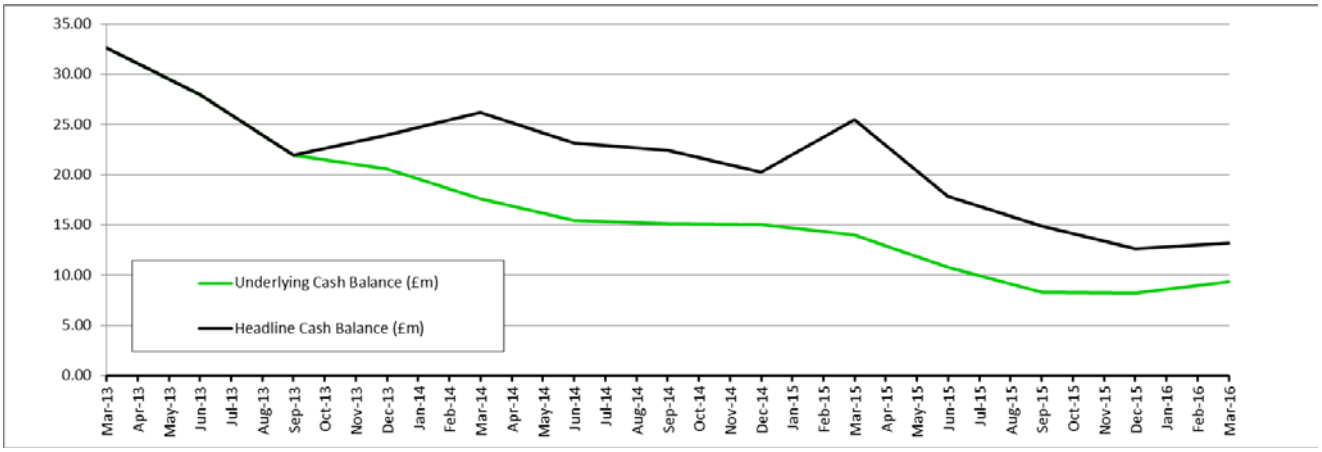
5.28 The programme is large primarily because of the impact of loans funded schemes – energy and residential developments in particular. The loans funding is a critical enabler for the residential development plans. At best only a small element of this part of the plan could be carried out without external loan funding. This plan remains contingent on success in securing loans via the FTFF, once plans are finalised.

Cash Projections – 2014/15 & 2015/16

5.29 The Trust has sought to maintain a liquidity position sufficient to remain in the highest band under Monitor's Continuity of Services rating. The plan as constituted does this.

5.30 The cash balance position at quarter end, both in headline terms and net of any committed loans funds held at each point, is highlighted below, with a graphical timeline. Loan inflows and outflows are the principal cause of volatility in the headline cash position:

	Mar-14	Jun-14	Sep-14	Dec-14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16
Headline Cash Balance (£m)	**26.17**	**23.15**	**22.43**	**20.27**	**25.51**	**17.83**	**14.84**	**12.66**	**13.22**
Committed Loan Funding	(5.15)	(7.04)	(8.51)	(8.53)	(13.35)	(7.05)	(6.58)	(4.43)	(3.90)
Underlying Cash Balance (£m)	**17.61**	**15.41**	**15.11**	**15.01**	**13.97**	**10.78**	**8.26**	**8.23**	**9.32**



5.31 The in-year deterioration of cash balances, net of loans held, can be tied back to the underlying operating deficit and the net cash funding played into the Investment Programme. The working capital position is projected to remain stable, though with marginal improvements in normal working capital management.

5.32 Liquidity will be critical in maintaining control of the Trust's operations, and as such will be the key determinant of any need to adopt mitigation actions in the event of any deviation form plan due to any of the identified risks.

Continuity of Services Ratings

5.33 Under Monitor's new Continuity of Services rating system, the Trust is judged broadly in terms of its nearness, or otherwise, to technical insolvency. This is to support Monitor as a regulator in identifying potential central support requirements, their key trigger for significant intervention.

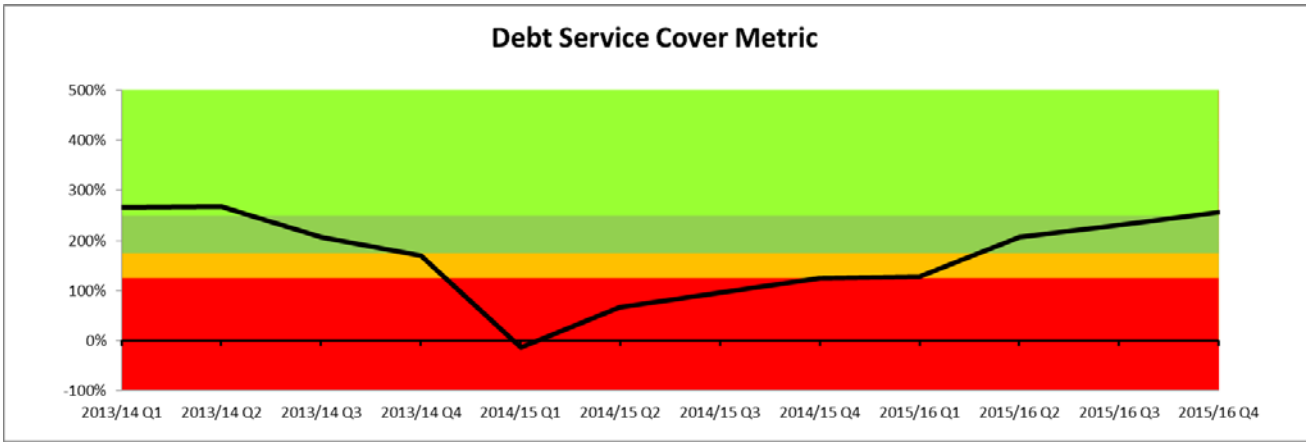
5.34 The rating is a two part rating, with each element rated from 1 (worst rating/highest risk) to 4 (best rating):

1) Debt Coverage (a cash-flow based assessment of underlying profitability)
2) Liquidity (the organisation's capacity to manage negative cashflow without default)

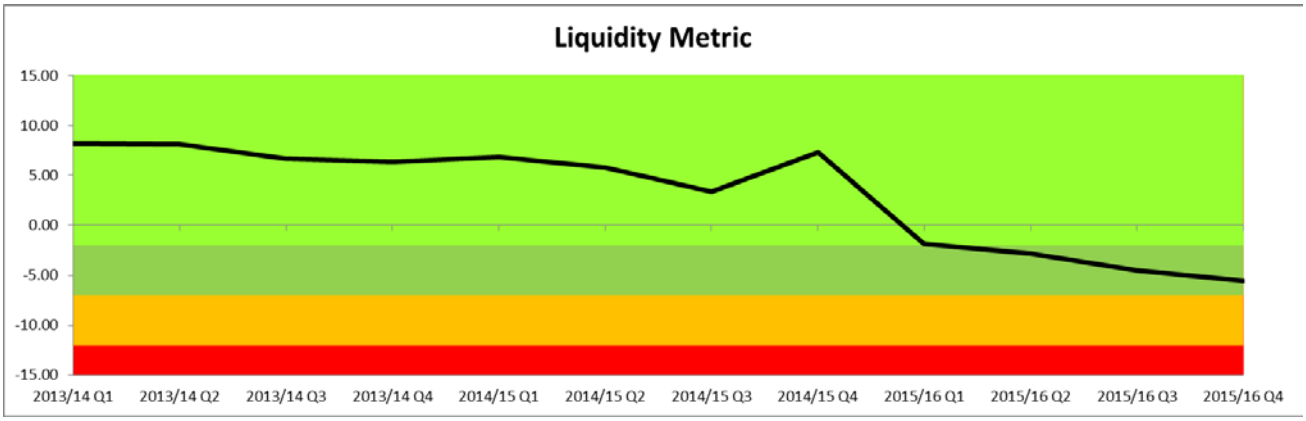
5.35 The two ratings are combined in a single rating for the organisation on an average and round up basis.

5.36 The Trust wishes to maintain a rounded rating of 3 out of 4 through the year, by maintaining Liquidity at a rating of 4, and debt coverage at 2, on a full year basis. The plan, if delivered in full, will meet these objectives in 2014/15, and remain compliant with the wider rounded rating objective in 2015/16 despite a reduction in liquidity rating to 3 as a consequence of reduced cash balances. By the end of the period bith ratings will have established a positive trajectory, as demonstrated in the charts below.

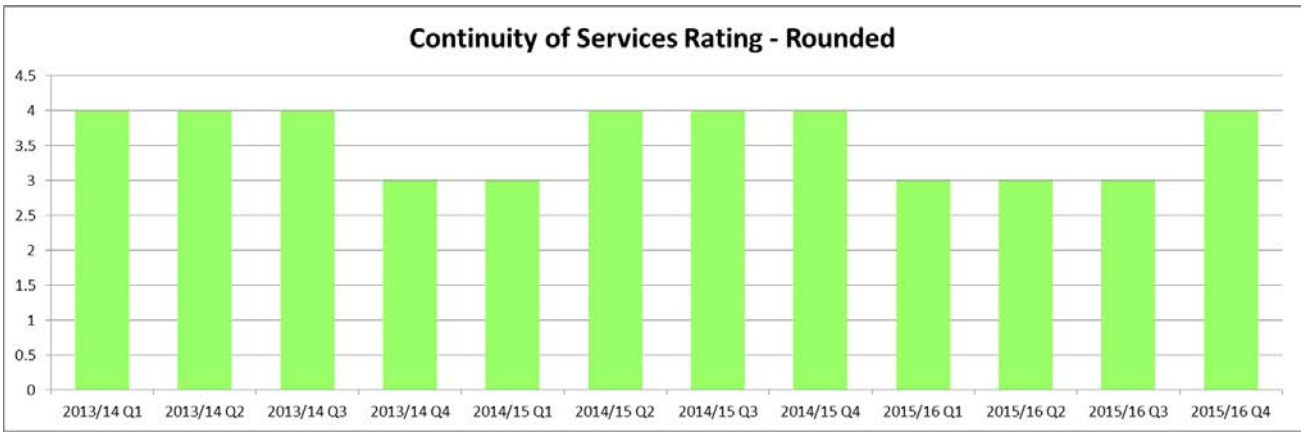
Debt Coverage:



Liquidity:



Continuity of Services Overall Rating (Rounded):



SECTION 6
KEY RISKS

External Relationships

6.1 ***CCGs*** - The Trusts contracting strategy for 2014-15 included the principle for CCGs to pay for the demand currently entering the Trust. This included the need to agree a revised baseline upon which to calculate the non-elective marginal rate baseline, based upon the significant growth in activity the Trust has experienced since 2008/09. This equated to an opening income value of approximately £6.20m although the final outturn value is likely to be significantly higher. This strategy also incorporated the need for real service change on the ground as opposed to a technical QIPP scheme. This would then enable the Trust to

i. create a financial framework which ensured the safe delivery of services as they are currently constructed including the quality investments made during 2013/14 as a result of the Francis and Keogh work

ii. use 2014/15 as the foundation to progress the wider transformational work across providers which will inevitably incur double running costs, piloting of new service models, utilisation of the Trust cash resource to configure all three site according to their required footprint as we progress into 2015/16 and beyond.

Whilst at the time of writing, the Trust hasn't agreed a 2014/15 contract with any of its local CCGs, progress with each is at differing stages, with one agreeing to the principles above.

High Risk	Inability to agree has the potential to - damage the relationship between the provider and CCG commissioner - detract resources from the work needed to progress 2014-15 in readiness for 2015-16 - if the Trust needs to utilise its cash resource to cover the running costs as currently configured, it will not have sufficient cash to cover the capital programme or to support ii. above

6.2 ***Key Stakeholders*** – The health community will be faced with significant change to the current construct of healthcare services over the next 5 years, commencing in 2014-15. This has the potential to impact key stakeholders as follows

i. staff may work in a different location, be employed by a different organisation
ii. members of the public may need to travel further for the more specialist elements of their healthcare
iii. GPs may need to refer to an organisation not within their town for some services, needing to build relationships with multi organisations
iv. The political body could be faced with proposals which move services out of their constituency.

High Risk	Inability to take our stakeholders with us has the potential to - damage the relationship and reputation of the Trust with its service users - delay and/or prevent the proposed changes *Mitigation action* – communication and involvement are essential, organise stakeholder events, ensure those involved directly are part of the decision making process, **quality of care must take priority**

6.3 ***Other Providers -*** Since the Trust submitted the strategic options paper to Monitor in January, providers within North East Lincolnshire have come together as organisational Boards to identify and develop a future construct of services which in one form can deliver the integration needed to progress the wider transformational change. This is a significant development, one which other surrounding localities are struggling to achieve.

Due to the complexity of organisational constructs within North East Lincolnshire there is a risk that as work progresses, relationships may falter causing a delay to the transformation programme.

Low Risk	Success of the developments to date including winter pilot schemes detailed in 4.13-4.17 above place this as a low risk *Mitigation action* – keep the channels of communications open across providers, ensure multi organisational workshops continue as work streams progress

Financial Position

6.4 As detailed in section 5 above, the Trust will not be in position to report either an in-year or recurrently balanced plan over the course of the next two years. The Financial Recovery Plan which accompanies this report sets out how the Trust envisages reconfiguring its services, income and cost base in order to allow the Trust to gain financial sustainability of the course of the medium term. Delivery of the financial recovery plan and its associated mitigation actions are vital to the continuity of services position of the Trust.

High Risk	The Trust will be reporting a deficit position for the first time since becoming a Foundation Trust *Mitigation action* – delivery of the Transformational Programme / Financial Recovery Plan

Performance

6.5 Should the Trust and CCGs be unable to conclude an acceptable contractual position the Trust may open discussions with the CCGs regarding shared ownership of key performance targets. At no point will the Trust jeopardise the quality of care it delivers to its patients. Should CCGs be in a position where they cannot afford to commission the infrastructure which supports the current level of demand, the Trust will not be able to continue to deliver services which accommodate the demand.

Medium Risk	Contract negotiations have not yet concluded, all parties continue to negotiate. *Mitigation action* - A number of actions have been identified which will be built upon during the first quarter.

Timescale of Change

6.6 The life cycle from planning through to delivery of the proposed service change can be significant especially if some form of reconfiguration of environment is required. Whilst the Trust has made significant progress in forming relationships and identifying priorities, given the scale of the challenge there is a significant risk that we will not see sufficient wide-scale change quickly enough as the NHS enters 2015-16.

High Risk	Ability to deliver change efficiently whilst delivering safe, quality services as demand continues at current levels *Mitigation action* – dedicated support from a newly formed Strategy and Planning Team working to the priority work streams set. Continuous liaison with key stakeholders and escalation if needed through the Chief Executive Forums (across providers) and/or Contract Boards

Unmet Need

6.6 There is the potential that as services are reconfigured, a previously unmet health need is identified. As the scale of change will impact across both health and social care there is the risk that currently there isn't any provision which meets the need of the patient/person and as a result their only option has been acute care.

Medium Risk	Work streams explored to date have identified areas were resources need to be deployed differently, the risk is the ability to adapt resources appropriately to meet the health need whilst still meeting the affordability challenge *Mitigation action* is to continue to operate multi organisational workshops to work through both current and proposed service configurations step by step. This proved successful for those workshops held during 2013 and informed the priority work streams detailed above

SECTION 7
CONCLUDING COMMENTS

Pressure across the NHS continues to grow significantly. The challenges facing the NHS over the next two years including the introduction of the Better Care Fund place a vital reliance upon transformational change. Change which for Northern Lincolnshire & Goole Trust and its local partner organisations must

- ensure do not impact adversely on the quality of care people receive
- redesign services and processes sufficiently to meet the affordability challenge faced
- involve all key stakeholders in the process to ensure integration and consequently more robust and sustainable delivery
- deliver efficiencies where opportunities exist

Pam Clipson
Interim Director of Strategy & Planning
April 2014