Northern Lincolnshire and Goole NHS

NHS Foundation Trust

Strategic Plan Document for 2014-19

Northern Lincolnshire and Goole NHS Foundation Trust

Contents

Section 1 Executive Summary: "Clinicians Working in Partnership"

1.1 **The Work Continues:** The Trust submitted its Strategic Options and Direction paper to Monitor in January 2014, and the Trust's plans were further refined and detailed in the 2014-16 Operational Plan, submitted in April 2014. This paper builds upon both of these previous submissions, and should be read alongside them.

1.2 **A Significant Challenge Ahead:** In the earlier submissions, the Trust Board reinforced previous findings that the local health services as currently configured are not sustainable in the medium to long term, under the current NHS payments system. However, no compelling case for change had been made for a radical downgrading, rationalisation or centralisation programme of the Trust's services. The Trust instead identified a programme of clinician-led integration of pathways and services, with the principal aim of controlling net demand growth, through this means limiting future cost growth and delivering sustainability. This would build on the work already underway across local providers of primary, secondary, community, social and mental health care.

1.3 **We Must Work Together with Partners:** In coming to this view the Trust Board has consistently stated that the sustainability issue is a challenge for the whole health community and cannot be resolved by a single organisation. A health and care configuration which meets the needs of the local population, delivering the quality improvements seen and expected, whilst achieving financial surplus is the ultimate aim of the Trust and local economy. The Trust strategy can and will deliver this within the next 5 years.

1.4 **Focus on Our Core Services:** The Trust strategy detailed in this document remains consistent with the recommendations contained within both the January strategic options submission and the Operational Plan submitted in April. The Trust's strategy is focussed upon a programme of redesign and efficiency improvement for the existing service profile to better deliver local services for local people. This tight focus on the core local issues across health services is designed to deliver change at the rapid pace required. The key action themes are:

- **Integration** – based on clinician to clinician work across health and care providers within Northern Lincolnshire, and on a wider footprint to include relevant tertiary centres. This will, with improved pathway design, innovative service reconfiguration and better communication, build a framework for demand growth control.

- **Efficiency** - through delivery of a robust cost optimisation programme. The Trust has a 5 year programme of savings to deliver, the majority in the first 2 years. Intensive work is already underway, under the auspices of the Trust's Financial Governance Review process, backed by external consultants PwC. This will deliver optimum efficiency across the whole of the Trust's cost base, and support the redesign process, but will also deliver clarity over the ultimate scope for efficiency savings – identifying where spend reductions will have an adverse impact of patient care.

- **Resources** – the current "Payment by Results" based resource allocation system is not fit for purpose in the form currently used across the local health economy. For providers, it means that the only route to financial stability is through increased activity volumes, at a

time when the health community needs to prioritise the elimination of excess activity. This "one size fits all" system must be significantly redesigned if the integration based strategy set out by local providers is to be delivered. The option for local flexibility is available under the current Operating Framework, and other models are being piloted elsewhere. The Trust proposes a redesign to explicitly support a more collaborative approach, with "open book" financial planning across all organisations, and the following key changes to the resource allocation system:

a) Restrictions on the use of marginal rate "part payments" for emergency activity, so that providers have the resources to meet demand safely;

b) A more flexible approach to the treatment of readmissions – the Trust performs strongly in this area, and payment reductions again simply erode the resources necessary to ensure patients are treated safely;

c) A "gain share" arrangement for activity reductions against an 'outturn plus underlying growth' base level.

d) A process to recognise for the premium cost element inherent in the Trust's site configuration. In some key service areas, delivery across two or more sites is essential, given the location of our local communities. This should be reflected in the allocation of resources;

e) A contribution from commissioners to the capital and other transitional costs of transformation. Where the Trust has to make more significant changes or improvements, the financial challenges should be treated as a "whole community" issue.

1.5 **Working Together Will Improve Patient Care and Reduce Costs**: Integration across providers delivers the greatest opportunity to control demand, alleviating the cost pressures arising from demand growth. Integration improves the quality of care provided by removing organisational boundaries, enabling clinical teams to work seamlessly across the patient journey.

1.6 **We Can Work With The Current Provider Structure:** We can operate together as long as appropriate systems are in place to support:

- Clinician to Clinician work to improve pathways and services;
- Joint financial planning to optimise the use of resources.

1.7 **Delivering Efficiently Supports Delivering Quality**: The Trust is confident of delivering its savings targets over the period. A robust savings programme is in place, a programme which will drive efficiencies and eliminate wastage. The Trust is working in partnership with PwC, who are supporting the Trust in developing appropriate delivery arrangements, and are engaged in identifying further areas where efficiencies could be made. Early work has already identified potential opportunities for the Trust to further build on the 2014/15 programme. This is a long term project, but the next 2 years are critical and challenging. What has become

clear is that improved systems of working can deliver savings, through better focus of resources, but also support the consistent delivery of quality services to patients. The Trust will need time to deliver the full programme, but the opportunities are now clear.

1.8 **A Skilled Workforce is the Foundation of Effective Delivery:** The Trust is working hard to build an improved workforce strategy to meet the new challenges of service delivery, learning the lessons from a very difficult period over the last 18 months. The Trust has specific geographical disadvantages in recruiting senior clinical staff, and this has been a key feature of our work in this area. Key work areas include:

- Improved workforce planning to link our staffing needs to our service plans.
- More effective recruitment processes, including the use of more innovative sourcing routes for key staff.
- Building relationships with local education providers to develop the Trust as an "employer of choice" for local people.
- Developing a productive relationship with the Deanery to support the Trust in accessing the appropriate medical staff.
- Using Agenda for Change contracts more innovatively within a mixed economy of contracts, to build a more flexible team better able to meet service needs.
- Proactive development programmes for staff, to help them get the most from their careers with NLAG, and also to help the Trust get the most from its biggest asset – its committed workforce.

This is part of a wider agenda to improve engagement with staff, building the partnership working which will be essential to ongoing improvement and innovation in patient care. The Trust is pioneering techniques such as the "morale barometer" and using open door sessions with senior leaders to support this process.

1.9 **Information Technology Is Fundamental to Improvement**: The Trust has significantly increased the pace of investment in IM&T to support clinicians in better sharing of information, and to improve patient care, on wards, in clinics, and in the community. The WebV in house clinical information system continues to progress, and will be a centrepiece of future development work. Healthcare is about effective gathering of information to support clinicians in their decision making, and the Trust will continue to work with other providers to make further improvements in this area.

1.10 **Building for the Future:** The Trust continues to move forward with a programme of reconfiguration and development across its core sites, improving patient environments and supporting the modernisation of services.

1.11 **The Trust Will Be More Radical Where Needed**: If a case of need can be made, the Trust is prepared to act to improve patient care or to deliver more efficient and effective services – even where this involves difficult choices. This was evident during the past year, when the Trust took action to centralise Hyper-Acute Stroke services. This was a challenging task to undertake, but has already delivered clear improvements in patient care. Cases for change have also been developed or are under development in other areas, including ENT, where clear evidence supports reconfiguration of elements of services.

1.12 **Transformation is a Journey:** It is important that the Trust remains flexible and open to change in identifying the best means to improve services. We are in the early stages of a long journey to change fundamentally the way we deliver care - at this stage the end is not clear.

1.13 **"Healthy Lives, Healthy Futures" is a Live Process**: This transformation project across the local health community is still a key vehicle for change, and is undergoing a refocusing phase following the recent Gateway review, which identified areas for improvement. NLAG is already working actively in partnership with the other local service providers to bring the focus of the project back to the clinician to clinician debates that will deliver real innovation and progress, and to give the project more structure and robustness. The Healthy Lives, Healthy Futures process remains the best chance for the local health community to develop a joint plan for the future.

1.14 **Critical Risk – Resources Must Be Effectively Allocated To Cover Real Costs:** The integration agenda will not succeed without a redesigned resource allocation framework. A system that rewards activity increases and pays for this through large scale reductions in a one size fits all tariff system is unfit for purpose in an environment where the key objectives are joint working to reduce activity levels and deliver more effective interventions. Flexibility is possible under the current Operating Framework. The current contracting position is indicative of the position the provider sector will find itself in if an historic "activity times price" system continues, with an impasse in process, and a significant mismatch in resources and costs. Without change, the resource allocation system will eliminate real innovation and improvement.

1.15 **The Challenge is Pressing:** The case for change remains clear. The NHS faces challenges of unprecedented scale, challenges which are magnified in this health community by local health profiles, the isolated rural nature of the geography, and the issues inherent in the current service configuration. The geographical and demographic position, coupled with the scale of the future financial challenge facing this health economy, like many others, places a significant emphasis on the pace change required.

1.16 **The Challenge Can Be Successfully Met:** The strategic direction delivers a programme of cultural change, stakeholder engagement, demand and cost control which can meet the challenges faced. Working together, clinicians can lead the change required. As a local health community, we need to create the space and process so that they can transform pathways and deliver improved efficient and effective services for patients.

1.17 **Governance – Declaration of Sustainability:** The Board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years' time.

The Board is making the above declaration on the basis that the health community wide actions identified through recent submissions by the Trust to Monitor are delivered. The submissions referred to include the January Strategic Options Paper, the Operational Plan submitted in April and this Strategic Plan.

The Trust Board have indicated to Monitor that it does not consider the current configuration of services within Northern Lincolnshire to be either clinically or financially sustainable in the medium to long term. This reinforces the finding of a number of previous reviews since 1996 and the view that the Trust Board have held for some time. 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.

Northern Lincolnshire and Goole NHS Foundation Trust Vision and Values

The Trust vision and values have been created with the input of staff from all levels of our organisation. They reflect our shared values, ideals and principals and strengthen our commitment to putting patients first. For our patients, it sets out what they can expect from the Trust at every step of their journey; whether that is on the phone, in writing or face-to-face. For staff, it represents a set of standards and ideals for them to work by with a renewed emphasis on teamwork.

Together we care

We care about quality and patient safety

We care about positive experiences for patients, carers and staff

... and we care about doing the right thing, each time, every time.

Together we respect

We respect the dignity and individuality of each person in our care

We respect the professionalism, diversity and skills of each person in our team

... and we respect the dedication and commitment of those delivering healthcare.

Together we deliver

We strive to deliver first-class services through listening, learning, and empowering

We aim to deliver forward thinking healthcare services that set us apart from the rest

... and we will deliver safe, compassionate services to exceed our patients' expectations.

Section 2 Market Analysis and Context

2.1 As a three site Trust, Northern Lincolnshire and Goole covers a population of approximately 382,000 residents. Referencing Monitor's 'Facing the future: smaller acute providers' publication June 2014, a population this size would place the Trust in its totality in between the classifications of a small and a large hospital. On an individual hospital basis however, each site would be classified as within the 'smallest' hospital bracket.

2.2 Public Health England published health profiles which indicate a significantly worse than the England average position across a number of areas, depicted on the table below;-

R = Significantly worse than England average

A = Not significantly different from the England average

G = Significantly better than the England average

Indicator	North Lincolnshire	North East Lincolnshire	East Lindsey	East Riding
Deprivation	G	R	R	G
Statutory homelessness	G	A	G	R
Violent crime	A	R	G	G
Smoking in pregnancy	R	R	R	A
Starting breast feeding	R	R	A	R
Obese children (Year 6)	A	A	A	G
Alcohol-specific hospital stays (under 18)	G	A	A	G
Teenage pregnancy (under 18)	R	R	R	G
Adults smoking	R	R	A	G
Obese adults	R	R	A	R
Incidence of malignant melanoma	G	G	G	A
Hospital stays for alcohol-related harm	R	R	G	G
People diagnosed with diabetes	R	R	R	R
Hip fractures (65 and over)	A	A	R	A
Smoking related deaths	R	R	R	G

Indicator	North Lincolnshire	North East Lincolnshire	East Lindsey	East Riding
Early deaths: heart disease and stroke	A	R	R	A
Early deaths: cancer	R	A	A	G
Road injuries and deaths	R	R	R	R

2.3 In addition to delivering across three small rural sites, the health profiles above show a significant number of areas deemed significantly worse than the England average with deprivation differing between the Trusts two main sites.

2.4 The Trust has the majority share within the 10 mile radius of both of its main sites. The Goole site is very different due to the nature of services provided from that site.

2.5 National publications have indicated optimal population sizes needed to sustain Tertiary Centres. The population currently receiving care from Hull and East Yorkshire (HEY) is on the margins of the size needed. This includes the activity referred from Northern Lincolnshire and Goole Foundation Trust including the Lincolnshire population who choose to receive their care from the Trust. To sustain Tertiary provision relatively close to Northern Lincolnshire, clinical integration with HEY to maintain current activity volumes is critical.

2.6 The Trust has a number of clinical alliances in place with Hull and East Yorkshire NHS Trust predominantly cancer services. The alliances were increased following the National direction for specialist services provided by a tertiary centre, major trauma and vascular services being the key changes for the Trust.

Concluding comments

The provider environment set alongside the health needs of the populations served provides the context upon which the Trust strategy is based.

Monitors report into small hospitals drew a number of conclusions and the Trust will utilise its findings to support decision making going forward.

Whilst the Trust strategy aims to maintain its current market share overall, the Trust will be strengthening its position in certain specialties to deliver a competitive focus. Maintaining current market share is crucial to maintaining relatively local Tertiary provision.

Section 3 Risk to Sustainability and Strategic Options

Risks to Sustainability

3.1 The key risks to sustainability facing the Trust are detailed below.

Workforce

3.2 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.

3.3 One of the largest challenges faced is the recruitment and retention of a skilled workforce, a workforce that can be flexible and responsive to both current and future demand. Given the Trusts previous reliance on premium rate staff to cover vacancies, the ability to recruit and retain a skilled workforce is pivotal to service sustainability.

3.4 For a significant period of time NLAG has operated with a clinical vacancy rate of approximately 10%. The reason for this is multifactorial. National shortages in many areas of medicine such as Accident & Emergency and radiology are compounded by the geographical location in which the Trust operates. Doctors favour large city locations or areas more densely populated with prime transport links. On a national scale, acute providers of healthcare, particularly in coastal locations have problems recruiting and retaining doctors.

3.5 The Yorkshire and the Humber Deanery, responsible for all post qualifying doctors below the grade of consultant, have reduced the number of trainees in many acute specialities. These reductions are nationally led and applied in all areas of the country with the rationale being that reducing training numbers in acute roles will stimulate interest in mental health and general practice. As these reductions are applied uniformly it has served to compound recruitment problems with the Trust having little option but to fill such vacancies with locum doctors thus applying significant financial pressure.

3.6 The Trust is working to improve recruitment and has several projects in the process of delivery, some of which are starting to deliver results, although the overall picture is currently unchanged and vacancies remain at 10%. The Trust has made significant progress by;

- adopting alternative mechanisms to attracting staff eg international recruitment opportunities
- delivering a marketing plan to attract healthcare talent from outside of its immediate labour markets
- holding seats on local strategic partnership forums with local authorities, providers of education etc.
- working closely with Jobcentre Plus (JCP)and other providers to shape the local labour market
- developing relationships with schools, colleges of higher education and universities to influence those approaching working age to consider careers in healthcare.

3.7 Recruitment into the Trust and the wider NHS continues to be a significant challenge and a potential risk to delivering the Trust strategy.

Financial Environment

3.8 Monitor has commenced the longer-term redesign of the NHS payment system and its operation. The current system presents opportunities for commissioners to pay below tariff for actual activity through the application of marginal rates, non-payment mechanisms, fines and CQUINs clawbacks. The current system creates an unbalance between the costs of service delivery and provider income for the activity delivered. The redesigned system must be one which supports the new and sustainable patterns of care needed to deliver the challenges facing the NHS. The changes are anticipated to commence in 2015-16. The Trust will face further financial risk should the new system not address the in-balance described.

3.9 The current NHS payment system doesn't recognise a consistent tariff approach for therapy and other community services. Given that this is an area of significant transformation and investment as an enabler to acute reconfiguration there is a significant risk that 1) 2015-16 system continues to ignore such services and 2) where services remain as block contracts there is a potential for unmet need, as identified in some community pilot sites, to overwhelm the services.

3.10 The Trust is aware of the proposed changes to the process of resource allocation to CCGs. Whilst timescales are to be confirmed initial indications are that both North and North East Lincolnshire will see a material reduction in allocation. This places further risk to the level of funding that will be available for the local economy and places greater emphasis on the pace and scale of change needed.

3.11 The financial deficit faced by Specialist Commissioning was confirmed to be approximately £31m for 2014/15 rising to £62m for 2015-16 for the South Yorkshire and Bassetlaw Area Team. The Trust is aware that funding has been provided to support this deficit position and subsequently diminished Commissioners ability to offer to the Trust. There is a significant risk that this will continue as the size of the deficit increases in 2015/16.

3.12 This Operational plan set out the plan for the two years 14/15 and 15/16. A deficit projection was forecast for 14/15 of approx. £6.0m, with a much reduced deficit of £0.5m in 15/16.

3.13 This plan delivered an acceptable cash position through the period, despite a relatively large capital programme, and maintained a compliant Continuity of Services rating throughout. By the end of the period, a firm basis would have been set to deliver ongoing sustainability based upon the Trust's strategy of integrated working with local providers to control demand growth rates going forward.

3.14 This performance was dependent upon delivery of savings plans equating to just in excess of 4% in each of the first two years. Delivery of this programme was identified as a risk, with the support of PwC through the Financial Governance Review identified as a mitigating factor, along with the potential to trim capital spend to support liquidity in the event of slippage.

3.15 The position was also dependent upon a resetting of income levels to better reflect activity and delivery costs – using the freedoms potentially available under the Operating Framework. This was identified as a further and more significant risk, with mitigation based upon elimination of all capacity improvements outside of funded service levels

3.16 Three key changes have been made to 15/16:

a) Income has been subjected to a downsiding adjustment, with 2015/16 income reduced by a total of £5.0m. This is treated as a non recurrent issue.

b) The capital programme has been curtailed to support the liquidity position in response to this revised income forecast.

c) The spend and loans profile has been adjusted to reflect the smaller development programme now planned on staff residential accommodation.

3.17 The Trust is facing different challenges with its two main commissioners and has led to an unresolved contractual position. As such, income risks are significantly more pronounced than they were in late March when the original plan was produced.

3.18 With these threats to income now more apparent, and further risks in 2015/16 arising from the impact of the Better Care Fund, a reduction in income forecasts has been built into the Trust strategy and reflected in the templates appended to this document.

3.19 The Trust has projected forward an evolutionary model based upon current configuration but is dependent upon:

a) Integrated working will allow for controlled demand.

b) Commissioners will fund inflation, at the levels modelled for expenditure by the Trust.

c) Income and contract values will be determined by projected commissioner allocation growth, not directly by activity levels and tariffs.

d) The Trust will be able to deliver a maximum of 2% savings plan rates from 2016/17 onwards.

3.20 There are obviously major difficulties projecting these periods when the following issues remain unclear:

a) The payment system to be used in contracting.

b) The activity levels and service models anticipated by commissioners.

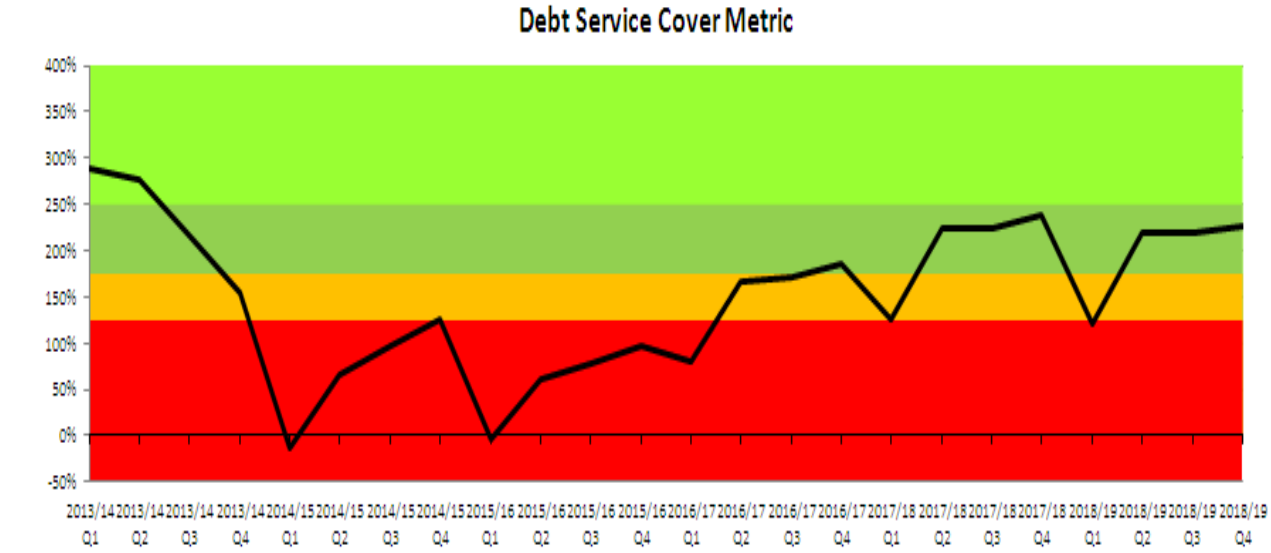
c) The likely direction in commissioner allocations and structures/responsibilities.

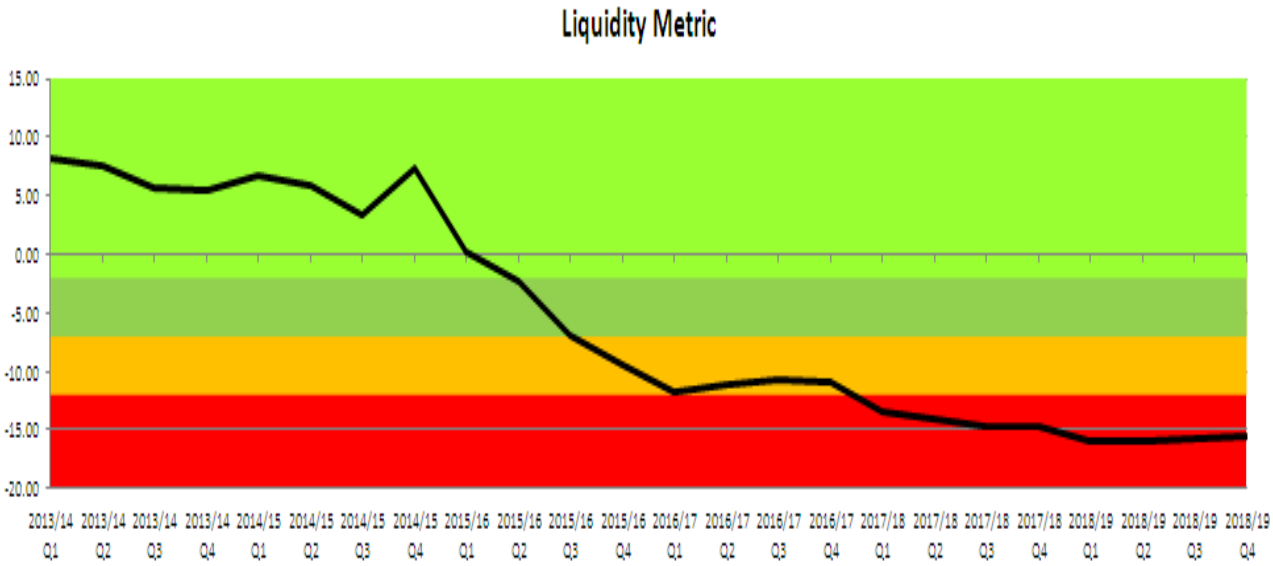
3.21 Initial modelling for this period suggests that NLAG can maintain a stable position if operating within the low demand growth environment envisaged as a consequence of the provider model integration plans, currently developing as part of the Trust strategy. The Trust finance model is based upon a prudent view of the potential for integrated working to control activity demand growth.

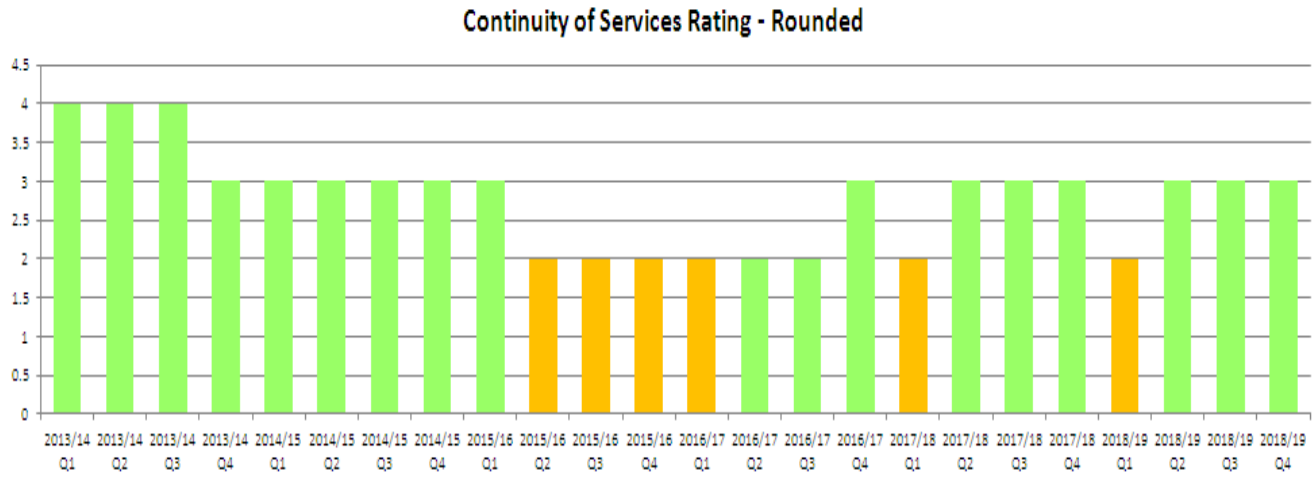
3.22 Given the risks to income in 14/15 and 15/16, the sustainable position above comes into being after the Trust's liquidity levels have been significantly degraded.

3.23 Ratings Trends:

The trend for the key rating measures over the full period in the base case scenario is shown below:







Political Environment

3.24 There is a risk that the Trust and wider local health community embark upon a strategic direction which generates adverse political interest given the forthcoming election. The Trust has already experienced concern from local MPs with recent service changes and given the potential for sensitive issues to be consulted upon with key stakeholders there is the potential risk of delays if they are not sufficiently engaged in the process.

Strategic Options

3.34 The January submission provided a detailed report on the strategic options available to the Trust. The options were as follows;-

a) A hot/cold configuration

b) A clinical network model across other district general hospitals or tertiary centres.

c) A new organisational construct with a tertiary centre

d) Integration with local providers across primary, secondary and community care

3.35 The option to progress to a hot/cold configuration significantly worsened the challenge the health community faces and was removed as an option.

3.36 Expanding the services the Trust delivers alongside its current tertiary provider within a network model would provide the tools needed for clinical stability going forward for the population of Northern Lincolnshire. The greatest financial gains can then be sought from the integration of local providers.

3.37 The January submission concluded the option to maintain comprehensive provision at each of the two local DGHs in the short to medium term, with some service consolidation and development of joint recruitment and workforce models with other providers in order to

eliminate cross-organisational boundaries. This submission was reliant upon the contractual negotiation process and as detailed above this hasn't been successful across all commissioners.

Concluding comments

The Monitor report looking into smaller hospitals identified that one of the more robust findings related to that of higher tariff share of clinical revenue is related to worse financial performance. One reason for this could be that the tariff adopted is not wholly cost effective for some services. This reflects the pace of transformation seen across Northern Lincolnshire and the current contractual position.

To ensure a robust financial platform to sustain the quality improvements seen and enable the pace needed to progress the transformation agenda, the Trust will seek more formal avenues available to conclude the contracting position with North Lincolnshire CCG.

The Trust plan, despite the adverse adjustment to income, can deliver a sustainable position in terms of liquidity, if the necessary changes in resource allocation system can be made locally. This lives within the local resource envelope, and is hence affordable, but without effective joint planning locally the risk remains of poor decision making and a less favourable financial outcome – for the Trust and also for other players in the health economy.

The position set out in the plan, because of the extended period of material deficit and the resultant additional erosion to liquidity, no longer delivers a Continuity of Services rating of 3 or more through the full period, with a rating of 2 through 2015/16 and in the first quarter of following years. However, the plan does demonstrate the possibility of eventual sustainability emerging from the particular pressures of 2015/16.

Section 4 Strategic Plan

4.1 The NHS is facing challenges of unprecedented scale needing to balance the needs of the population, ensuring high quality care and financial balance is delivered. Provider organisations need to be responsive to the findings of recent publications and develop a culture of engagement, transparency and accountability.

4.2 The Trust has made significant quality improvements to enable a shift in both culture and quality of care which is evidenced by the improvement in SHMI. This is a continuous journey and as services transform the quality of provision must be at the fore. It is therefore imperative that the strategic plan adopted by the Trust maintains and enhances the quality improvements seen.

4.3 The five year strategy adopted by the Trust Board in January is built upon three key steps

a) Delivery of internal efficiencies at the following percentages;

2014-15	2015-16	2016-17	2017-18	2018-19
4%	4%	2%	2%	2%

b) Continue the programme of integration across the wider Health and Care economy.

c) Progress larger scale transformation where clear benefits can be evidenced.

Internal Efficiencies

4.4 The Trust has cost improvement plans quantified for the period 2014-2016. The plans are being delivered as we progress into 2014-15. A robust governance framework is in place to oversee continued delivery with members of the executive team taking responsibility for individual CIP groups.

4.5 PWC have been Commissioned by the Trust to provide an independent review of the cost improvement plans and their deliverability. They have also been requested to identify any areas of potential savings that haven't yet been incorporated into the programme. Early indications from PWC have identified further areas the Trust can explore within 2014-15. This will afford sufficient time for providers to embed the integration work streams, enabling the savings from these to then emerge in their entirety from 2016/17 onwards.

Integration Agenda

4.6 The January submission provided a high level summary concluding that the integration agenda is the most appropriate strategic direction for Northern Lincolnshire and Goole Trust. A detailed review of all services, at specialty level, commenced to begin to identify where there is a clinical and financial benefit arising from;

a. Developing pathways straight into a tertiary centre

b. Integrating with other health and care organisations

c. Wider scale change

4.7 By triangulating the demand for the service with key quality performance measures and the service line reporting position, the programme of both provider integration and Trust service reconfiguration has commenced.

4.8 Following a fairly static level of GP referrals between 2011/12 and 2012/13, 2013/14 has seen a material increase. This is material when the services also have to ensure sufficient capacity for the follow on care is available.

4.9 The Trust is seeing differing non elective demand between its two main sites. The introduction of the Better Care Fund is intended to rebalance demand across Health and Care providing earlier access to out of hospital and social care services. Whilst the risk regarding the pace of changes has been escalated, the principles of integration and improved care are aligned to the Trust strategy.

4.10 Both of the Trusts main A&E departments have seen a period of change transforming into Emergency/Unplanned Care Centres. The most significant changes include the introduction of multi-disciplinary teams and a single point of access. Due to variations in commissioner approaches, the service models have progressed at differing paces however the integration agenda detailed below should begin to see activity volumes stabilise initially and then reduce as the out of hospital services embed.

4.11 Based upon the above, the integration agenda was developing around the following principles;

- Explore service developments which provide the person with the confidence and support to remain within their place of residence where appropriate.
- Clear ownership of the person / patient throughout their pathway.
- Where acute care is needed there is a clear 'decision to admit'.
- Discharge planning commences as soon as the decision is made to enter inpatient care.
- Services are available 7 days where there is a clinical need.
- Proposed changes take into account the whole patient journey thus delivering true transformation and avoiding a shift of the difficulties between providers.
- The reconfigured services are both clinically and financially sustainable.
- Common systems are developed across provision aiding a seamless care journey eg development of registers for specific groups of patients where care plans can be access where needed.

4.12 The Trust has previously shared the programme of initiatives in its entirety as an addendum to the original January submission. The prioritisation of those initiatives forms the integration programme and expansion to Trust community services agenda across Northern Lincolnshire detailed below;

- Investment in community services to enable people to receive their care within their place of residence where clinically appropriate. An example includes investment in rapid responder teams will support people whose condition is changing / deteriorating.

- Ensure access to the right healthcare professional first time through the continual development of the Single Point of Access. Increasing awareness of the alternatives to acute care where clinically appropriate will alleviate the pressure on front line emergency services.

- Development of an extensivist model delivering care tailored to the local population. This will be a multifunctional team who will wrap around cohorts of people in most need. The team will be responsible for the patient across all care settings enabling prompt access and discharge.

- Expand provision of community equipment across 7 days through the development of an Assisted Living Centre within North East Lincolnshire. Supporting people to live independently in their place of residence and enabling discharge from acute care over the weekends.

- Continued programme of investment in both clinical and non clinical system infrastructure to support integration of care across the healthcare pathway.

4.13 A recent publication by The King's Fund titled 'Community Services, How they can transform care' describes the alternative services to acute care needed. Alternative services referenced included intermediate care, nursing homes, rehabilitation and home with services. The report adds a level of external assurance that the work the providers have started to deliver has been successful in other areas.

4.14 All of the above aim to develop services which provide an alternative to acute care therefore acting as enablers to the reconfiguration of acute services.

4.15 The enablers will generate an element of dual running as the above services need to be embedded prior to any significant reduction in acute cost base. It is critical that alternatives to acute care are proven to deliver both quality care and the intended outcomes prior to the removal of the acute infrastructure.

4.16 The Trust is working alongside East Riding CCG to develop Goole Hospital with proposals including a Health Campus model. Given its close proximity to Hull Royal, Doncaster and Scunthorpe Hospitals, a health campus model will build upon specific services already delivered from the Goole site whilst widening the service portfolio closing current gaps identified in healthcare provision.

4.17 Through the integration and expansion to Trust services agenda above the aim is to control demand and provide an ability to care for the forecast growth in elderly population in the most appropriate setting. The above agenda reduces the reliance on an acute inpatient setting and provides care closer to the patient.

Wider scale change

4.18 Given the continual difficulties faced with recruitment and small activity volumes experienced in specific services within a district general setting, there are areas of acute care currently provided by the Trust where wider scale change may be required. These predominantly fall into two categories;

- Provision of elements of care from a single location within Northern Lincolnshire delivering safe and sustainable services through compliant rotas and an increase in volume for smaller specialties to enable skills to be maintained.

- In line with National Specialist Commissioning, provision of elements of care from a Tertiary Centre where necessary to ensure optimal outcomes for patients.

Strategic Enablers and Risks to Delivery

4.19 The Trust has commenced a period of significant transformation both internal to the Trust and external across a number of organisations. The magnitude of transformation will inevitably face many challenges and risks. Delivery of the strategy is only possible if a stable and effective implementation framework exists.

4.20 For both Trust services and the wider integration agenda, the following framework identifies the key strategic components **within provider's control** that are needed to be able to deliver the ultimate strategic goal of clinical and financial sustainability.

Workforce: The Trust, and wider NHS, faces continuous workforce difficulties as described in section 3.2 above. Whilst delivering an operational workforce focus, as the Trust progresses the programme of transformation, new structures and workforce models are being introduced across both clinical and non clinical areas. As new / reconfigured posts are developed to meet the clinical pathway identified, the workforce needs to be trained and given time to learn.

Risk: Given historic difficulties the Trust has faced with regards to recruitment, there is a risk that all the recruitment and retention actions being taken by providers don't attract a sufficient workforce people both in terms of numbers to deliver 7 day services and skill set. This will delay service reconfiguration.

Mitigation Actions: The Trust revised its Organisational Development and Workforce strategy in March 2014 detailing how it will address the challenges faced. Continued implementation of this strategy including how organisations will work together to attract and retain a skilled workforce will alleviate the risks faced.

Clinical Leadership: During 2013/14 the Trust implemented a new clinical leadership structure incorporating Associate Medical Directors and Clinical leads providing them with dedicated time to lead their services. Whilst this structure is in its infancy, the leadership team is tackling historic barriers to delivery and driving forward key service changes linked to the Strategic Direction.

Risk: The structure is in its infancy and faces a significant agenda. Developing new pathways across organisations will be challenging and to be able to ensure goal congruence across different disciplines working within differing organisational cultures will provide a huge challenge and carries a significant risk of delay.

Mitigation Actions: Multi organisational engagement from the outset. Key decision makers from each organisation involved in the change process.

Stakeholder Engagement*:* A stakeholder is anybody who can affect / is affected by the organisations strategy or project.

Risk: It is crucial to ensure key stakeholders are engaged from the outset, should this not be managed sufficiently there is significant risk of delay.

Mitigation Actions: Development of a stakeholder management strategy to support timely and robust delivery of the strategic direction.

IM&T: The Trusts IM&T strategy details;

a) the clinical and non clinical IM&T infrastructure needs and

b) the needs for the collation, management, use and sharing of information to deliver both its own service objectives and those needed to deliver the integration agenda.

IM&T is it a critical enabler to integration agenda. The sharing of information throughout the healthcare journey is vital to delivering quality, seamless care.

Risk: There are a significant number of different systems currently in use across the Trust and provider organisations with differing organisations administering and reporting to different standards and formats.

Mitigation Actions: The Trust is entering its second year of investment in its IM&T strategy. This strategy includes cross organisational integration. The recent success in securing additional funding via the Safer Hospitals IM&T bid has enabled pace into the Trusts strategy.

4.21 To deliver the elements of the strategic direction, a robust programme management infrastructure is required. Recently concluded Trust consultation developed a structure enabling clinical leadership, strategy and performance to work alongside one another. This infrastructure will develop processes to provide an early indication of potential implementation risks. There is a risk that the new processes and pathways don't deliver the planned outcomes. It is vital to plan and monitor the developments from the outset through to successful operation and delivery.

4.22 The Trust and other Providers have **no control** over one of the most fundamental changes needed to enable the Strategy to be delivered successfully, systems management. Whilst all organisations can and will contribute via the avenues of engagement available, no direct control is held.

Systems Management: Without the wider systems management, described throughout this document and previous Trust submissions, changing to reflect the reconfiguration agenda,

sustainability will continue to be undermined across all provider organisations. This will inevitably cause friction between Commissioners who would be bound by a traditional payment system and providers who would be striving for integration in the absence of an enabling environment.

Risk: Non delivery of the Strategy Direction delaying and potentially destabilising clinical and financial sustainability.

Concluding comments

The Strategic Direction concluded in the January submission remains the Trusts primary direction of travel.

Whilst service configuration across the sites will change, a three site healthcare provider will be maintained in the medium term.

Integration across health and care providers within Northern Lincolnshire and the wider Tertiary footprint is critical to control demand and build relationships across clinical teams, removing historic organisational boundaries. This is within the control of providers and is deliverable within the next five years.

For the Integration agenda to be successful in delivering sustainability, it is crucial that the NHS recognises the need for wider systems change and establishes a transformational funding flows system which supports the change needed. Without this the Strategic Direction delivering clinical and financial sustainability will not be delivered.

Section 5 Conclusion

5.1 The Healthy Lives, Healthy Futures (HLHF) Programme established to deliver sustainable services across Northern Lincolnshire has not yet proposed or delivered any material change to service provision. The process of engagement with the general public has been well structured and has delivered the message that change is required.

5.2 The provider model of integration can begin to control demand and unify clinical teams by removing historic organisational boundaries delivering sustainability within the next 5 years. The Healthy Lives, Healthy Futures programme will support providers and enable the providers to drive the change forward.

5.3 The strategic plan described in this document and previous submissions, details structures which are working in other localities. Coupled with a revised resource allocation framework which meets the needs of the transformed services, a sustainable health and care structure can be developed across Northern Lincolnshire and Tertiary providers.