

Integrated Business Plan

2018-19







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**Purpose**

The purpose of this Integrated Business Plan (IBP) is to set out the Trust’s business plan for the 2018-19:

* Demonstrating a clear understanding of our business
* Providing a clear vision and direction of travel
* Detailing plans for key services – triangulating activity, resource and finance plans

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1. **Who we are**

This section provides a summary of the Trust’s current range of services and a profile of the population we care for.

* 1. **Trust overview**

United Lincolnshire Hospitals NHS Trust (ULHT) is situated in the county of Lincolnshire and is one of the biggest acute hospital trusts in England, serving a population of over 736,700 people. The Trust provides a broad range of clinical services including community services, population-screening services, and a comprehensive range of planned and unscheduled secondary care services including specialised services for stroke, vascular and cardiac services.

We provide acute and specialist services to people in Lincolnshire and neighbouring counties in the following hospitals:

* Lincoln County Hospital
* Pilgrim Hospital, Boston
* Grantham and District Hospital

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health and Care Services or local GPs. These include:

* Louth County Hospital
* John Coupland Hospital, Gainsborough
* Johnson Community Hospital, Spalding
* Skegness and District General Hospital

In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients and over 140,000 inpatients, and deliver over 5,000 babies.

**Our services**

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| --- | --- | --- | --- |
| Audiology | Diagnostic services | Medical physics | Palliative care |
| Breast services | Dietetics | Medical oncology | Radiotherapy |
| Cardiology | Ear, nose and throat | Neonatology | Rehab Medicine |
| Chemotherapy | Endocrinology | Nephrology | Respiratory medicine |
| Children’s services & paediatrics | Gastroenterology | Neurology | Respiratory physiology |
| Clinical immunology | General medicine | Neurophysiology | Rheumatology |
| Clinical oncology | General surgery | Nuclear medicine | Specialist rehabilitation medicine |
| Colorectal surgery | Gynaecology | Ophthalmology | Vascular surgery |
| Critical care | Haematology | Oral and maxillofacial surgery | Therapies |
| Dermatology | Hepatobiliary & pancreatic surgery | Orthodontics | Trauma and orthopaedics |
| Diabetic medicine | Maternity and obstetrics | Pain management | Urology |

**Our clinical directorates**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pan Trust** | **Lincoln** | **Boston** | **Grantham** |
| Cardiology  | A&E | Acute Medicine | Grantham |
| Clinical Support Services | Acute Medicine | Orthopaedics |  |
| Head and Neck | Orthopaedics | General Surgery |  |
| Oncology & Haematology | General Surgery & Urology | Theatres, Anaesthetics and Critical Care |  |
| Women & Children’s Services  | Theatres, Anaesthetics and Critical Care |  |  |

* 1. **Our mission statement**

**1 vision:** Excellence in Rural Healthcare

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**3 ambitions:** Our Patients Providing consistently safe, responsive, high quality care

 Our Services Providing efficient, effective and financially sustainable services

 Our People Providing services by staff who demonstrate our values and behaviours

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**5 values:** Met through our Staff Charter

**Patient-centred** Putting patients at the heart of everything we do, listening and responding to their needs and wishes.

**Safety** Following ULHT and your own professional guidelines. Speaking up to make sure patients and staff are safe from harm

**Excellence** Striving to be the best that we can be. Innovating and learning from others.

**Compassion** Caring for patients and their loved ones in ways we would want for our friends and family.

**Respect** Behaving and using language that demonstrates respect and courtesy of others. Zero tolerance to bullying, inequality, prejudice or discrimination.

* 1. **Profile of the Lincolnshire population we care for**

Lincolnshire is the second largest county in the UK. It is characterised by a dispersed population in towns and in the city of Lincoln and largely rural communities.

|  |  |
| --- | --- |
| **Population estimates** | * Population of Lincolnshire is currently estimated to be 736,700 (ONS, 2015) a rise of 0.7% (5,200 persons) on the previous year.
* Over the past ten years Lincolnshire’s population increased by 8.8%, which is higher than both the East Midlands (8%) and England (8.3%)
 |
| **Age Profile** | * There is a declining younger population and a growing older population.
* The proportion of young people in Lincolnshire (aged 0-19) has fallen from approximately 23% of the total population in 2005 to 22% in 2015.
* In contrast, over the same period the number of people aged 65+ has increased by 3% to 22% in 2015 (compared to a 2% increase nationally to 18%).
* 9.9% are aged 75 years and over compared with 7.8% in England overall.
 |
| **Population Projections** | * Projections indicate that by 2039 the population growth in Lincolnshire will be 14% which is below the projected national growth rate of 17%; the population in Lincolnshire is projected to increase by approximately 103,000.
* This rate of change is not uniform across the county. Between 2014 and 2039 South Kesteven's population is projected to see the largest growth at 18%, followed closely by South Holland (17%). East Lindsey, however, has a much lower predicted growth rate of 10%.
* The trend towards an ageing population profile will continue, with the proportion of people aged 65 and over projected to increase from 22% in 2014 to 30% in 2039 and those over the age of 75 is predicted to increase by 101% between 2012 and 2037, which will result in increasing demand for hospital care from this age group.
 |
| **Deprivation** | * Lincolnshire has areas that are ranked amongst the most deprived in the country, but also has areas that are ranked amongst the least deprived in the country
 |
| **Life Expectancy** | * Life expectancy at birth has continued to increase. Between 2012 and 2014 life expectancy for both males and females were comparable with the England averages of 79.6 years and 83.2 years respectively. However, the gap in life expectancy between males and females is narrowing.
 |
| **Mortality rates** | * The infant mortality rate in Lincolnshire is 3.2 deaths/1,000 live births. This is lower than both East Midlands & England averages
* Since 2011 there has been a slight fall in the number of people in Lincolnshire dying from causes considered preventable, the current rate is 179.2 deaths per 100,000.
 |
| **Ethnicity and language** | * Lincolnshire is predominately white-British. However, 15.1% of the population of Boston were born outside the UK, which is higher than the UK average. The use of hospital services is lower for the migrant population compared to the Lincolnshire population as a whole, with the exception of maternity services.
* Proficiency in English among those who don't speak it as their first language is poorer in Lincolnshire than in England (69.3% compared to 79.3%). Polish, Latvian and Lithuanian are the most common non-English languages spoken in the county.
 |

* 1. **Health & Wellbeing in Lincolnshire**

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| --- | --- |
| **Lincs West:** Coronary Heart Disease (CHD), lung cancer, COPD and mental health affect life expectancy most. Excess weight/obesity is higher than average | **Lincs East:** Prevalence of cancer, diabetes, CHD, stroke, obesity and respiratory disease is high. Emergency admissions of CHD and stroke are significantly worse |
| **South West Lincs:** The prevalence of diabetes, CHD, Stroke and Cancer is higher. Under-75 mortality rates from respiratory disease is slightly higher | **South Lincs:** The prevalence of diabetes, Chronic Heart Disease, Stroke and Cancer is higher in SLCCG than England as a whole. Obesity is higher. |

1. **Where we are now**

This section provides a high level portfolio analysis as well as a summary of the local health economy and market environment upon which the strategy and plans outlined in Sections 3 and 4 have been developed.

* 1. **Current performance**

**Financial, quality and operational performance**

|  |  |
| --- | --- |
| **Finance** | * The Trust ended the 2016/17 financial year with a deficit of £56.9m. This was supported through the delivery of £17.1m savings achieved through the Trust’s Financial Efficiency Programme.
* Deficit for the 2017/18 financial year is £84.8m (subject to audit). This is supported through the delivery of £16.2m savings achieved through the Trust’s Financial Efficiency Programme.
* In September 2017 the Trust was placed into Financial Special Measures and has appointed both a Turnaround Director and external advisors to assist the Trust in developing and delivering plans to return to financial sustainability.
* The Trust’s reference cost index for 2016/17 was 109, compared with 107 for 2015/16.
* Capital funding of £22.1m has been investment to improve the estate, IT infrastructure, medical equipment and deliver the requirements of the fire enforcement notice over the course of 2017/18. (£9.5m has come through a capital loan from the DHSC)
 |
| **Quality & Operational Performance** | * Overall ‘Inadequate’ CQC rating; Single Oversight Framework rating of 4
* Performance highlights for 2016/17: A large number of KPIs reported through Trust Board have started to show an improvement throughout the year, including key national targets such as: Diagnostic 6 week standard; consistently achieving standard in 2015/16 and 2016/17 however in 2017/18 the Trust have been unable to consistently achieve this standard due to an increase in demand for Endoscopy and Echo, Mixed Sex Accommodation – 98 in 2015/16 has reduced to 54 in 2016/17, in 2017/18 this reduced even further and only 12 breaches were reported; Friends and Family Test continues to improve . There has also been a marked improvement in the number of patients being treated within 62 days of referral for cancer in 2016/17 and this is continuing into 2017/18.
* Adverse performance in 2016/17: A&E 4 hour wait remains a challenging indicator for the Trust with unprecedented levels of patients being admitted (4% increase) 2016/17 41,194 and 2017/18 42,750 18 week referral to treatment has shown a deterioration of 1.91% in 2017/18 compared to 2016/17.
* Year on Year Performance Issues - indicators which are non-compliant in 2016/17 and which were also non-compliant in 2017/18: MRSA; Sickness rates; Staff Appraisals, Cancelled Operations and DTOCs, however work in ongoing to improve the position of these indicators in 2018/19.
 |

**Portfolio analysis**

|  |  |  |
| --- | --- | --- |
| **Clinical Directorate** | **Expenditure** | **WTE actual** |
| A&E - Lincoln | 11,227,700 | 184.32 |
| Acute Medicine - Boston | 39,933,700 | 632.31 |
| Acute Medicine – Lincoln | 35,388,300 | 598.08 |
| Cardiology – pan Trust | 15,963,300 | 239.63 |
| Clinical Support Services - pan Trust | 81,094,700 | 1,434.66 |
| General Surgery – Boston | 18,612,900 | 319.22 |
| General Surgery - Lincoln & Urology - Pan Trust | 18,473,000 | 278.52 |
| Grantham | 27,171,400 | 446.34 |
| Head and Neck - pan Trust | 29,193,200 | 214.74 |
| Oncology & Haematology - pan Trust | 16,562,500 | 150.50 |
| Orthopaedics - Boston | 8,906,300 | 123.23 |
| Orthopaedics - Lincoln | 11,357,200 | 145.42 |
| Theatres, Anaesthetics & Critical Care - Boston | 17,634,100 | 298.29 |
| Theatres, Anaesthetics & Critical Care - Lincoln | 26,065,100 | 402.96 |
| Women & Children’s - pan Trust | 49,576,900 | 777.38 |

**The Trust’s biggest challenges**

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| --- | --- |
| **Staffing** | * A shortage of permanent staff, stretched across three hospitals.
* Big shortage of A&E doctors, paediatricians and radiologists -139 doctor vacancies (12%)
* 312 registered nurses and midwives vacancies (12%)
* Morale – only 45% of respondents to last staff survey would recommend ULHT as a place to work
 |
| **Quality** | * Struggle to meet national quality standards
* Reliance on locum and agency staff, which affects the quality of our services
* “Inadequate” CQC inspection rating – put into special measures in April
* Old estate which isn't fit for purpose - £205m backlog of repairs and maintenance
 |
| **Performance** | * Cancer, A&E and 18 week wait for referrals not being achieved
* More patients referred than can be seen and treated within national timeframes
* Delays in discharging patients who are medically fit to be discharged
 |
| **Finance** | * The unaudited deficit for the 2017/18 financial year is £84.8m
* Reliance on expensive locum and agency staff
* The national sustainability transformation fund will not be secured
 |
| **Delays to system wide changes** | * Delays in implementing Lincolnshire health and care (LHAC), now STP, plans
* Uncertainty is causing recruitment problems
 |

* 1. **External Environment**

|  |  |
| --- | --- |
| **Political** | * Urgent Care – government prioritisation of delivery of urgent care targets
* NHSE – focus in 5 year forward view on improving A&E performance, maternity services, 7 day delivery, delivery of cancer targets and increased cancer diagnosis.
* Brexit – exit from European Union in 2019 with 2 year transition period – potential impact on workforce and future recruitment
 |
| **Financial** | * NHS funding agreed to increase by £2.5bn in 18/19 – a further £1.6bn was then announced in the autumn budget, followed by £540m made available since then by the DHSC.
* £1bn of the additional £2.14bn above has been allocated to sustainability funds for CCGs and to support hospitals struggling with deficits.
* Non-government review panel suggests the NHS requires a further £4bn in 18/19 year to meet national standards plus a further £2.5bn in each of following 2 years.
* Most forecasters predict that BREXIT options will lead to decline in GDP and reduce funding available for NHS
 |
| **Regulatory & Legal** | * NHS Improvement’s Single Oversight Framework focuses on five areas: quality; finances/use of resources; operational performance; leadership; strategic change
* The CQC is focussing on four key themes: encouraging improvement, innovation and sustainability in care; delivering an intelligence-driven approach to regulation; promoting a single shared view of quality; improving its efficiency and effectiveness
* New guidance on tendering rules: The “Integrated support and assurance process” describes the integrated NHS England and NHS Improvement process for supporting commissioners and providers looking to procure and bid for complex contracts
 |
| **Technological** | Opportunities in new technology to improve efficiency and patient care:* Using digital technology to enhance self-care in management of long-term conditions eg diabetes
* Optimising use of clinical information decision support tools to standardise care and ensure care quality
* Increasing use of benchmarking tools to support financial and operational decision-making and support quality improvement
* Optimising use of virtual contacts e.g. Advice and Guidance, Non-face-to-face appointments to improve primary care decision-making and make best use of outpatient capacity
* Developing resource management tools to support real-time workforce planning and patient flow and to match capacity to demand
* National initiatives: Personalised Health & Care 2020; Digital Maturity programme; Making IT work; Digital Academy
 |

**National priorities**

The NHS has two-year contracts and improvement priorities set for 2017-19. These were based on the NHS Operational Planning and Contracting Guidance 2017-2019 (September 2016) and reflected in *Next Steps on the NHS Five Year Forward View* (March 2017). The specific deliverables for 2018/19, that relate to ULHT services and that must be addressed in this plan, are:

| **Priority** | **Deliverables** | **Current rating** |
| --- | --- | --- |
|  | Ensuring performance against 4-hour A&E standard is ≥ 90% in Sep 2018 (performance needed for STF payments) | Red |
| Implementing of the NHS 111 Online service to 100% of the population by December 2018 | Green |
| 100% of the population covered by an integrated urgent care Clinical Assessment Service (IUC CAS), bringing together 111 & GP OOH provision. This will include direct booking from NHS 111 to other urgent care services. CCGs should ensure technology is enabled, then ensure direct booking from IUC CAS into local GP systems is delivered wherever technology allows, by March 2019  | Green |
| Designating remaining UTCs in 2018/19 to meet the new standards and operate as part of an integrated approach to urgent and primary care | Green |
| Working with EMAS to ensure that the new ambulance response time standards that were introduced in 2017/18 are met by September 2018. Handovers between ambulances and hospital A&Es should not exceed 30 minutes. Deliver a safe reduction in ambulance conveyance to EDs | Red |
| Reducing DTOCs, with the reduction to be split equally between health and social care | Amber |
| Implementing “Improving Patient Flow” guidance - specifically reducing inappropriate length of stay for admissions, including specific attention on ‘stranded’ & ‘super stranded’ patients who have been in hospital for >7 days and >21 days respectively | Amber |
| Ensuring that fewer than 15% of NHS continuing healthcare full assessments take place in an acute setting | Green |
| Progressing implementation of the Emergency Care Data Set in all A&Es (Type 1 and Type 2 by June 2018; and Type 3 by the end of 2018/19) | Amber |
| Continuing to rollout the 7-day services four priority clinical standards to five specialist services (major trauma, heart attack, paediatric intensive care, vascular & stroke); 7-day services four priority clinical standards in hospitals to 50% of the population | Amber |
| Agree trajectories to improve the safety, choice and personalisation of maternity by June 2018 | Amber |

| **Priority** | **Deliverables** | **Current rating** |
| --- | --- | --- |
| **Cancer** | Ensure all eight waiting time standards are met, including 62 day referral-to-treatment standard via the 10 high impact actions | Red |
| Support the implementation of the new radiotherapy service specification | Amber |
| Ensure implementation of nationally agreed rapid assessment & diagnostic pathways for lung, prostate & colorectal cancers | Amber |
| Progress on 2020/21 targets: 62% of patients diagnosed at stage 1/2; reduce proportion of cancers diagnosed at emergency admission | Red |
| Support the rollout of FIT in the bowel cancer screening programme during 2018/19 in line with the agreed national timescales  | Amber |
| Participate in low dose CT scanning pilot programmes based on an assessment of lung cancer risk in CCGs with lowest survival rates  | Amber |
| Progress towards the 2020/21 ambition for all breast cancer patients to move to a stratified follow-up pathway after treatment | Red |
| Implement of the new cancer waiting times system; begin data collection in preparation for the new 28 day Faster Diagnosis standard | Green |
| **Maternity** | Delivering improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019.  | Green |
| Increasing the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally, so that by March 2019, 20% of women booking receive continuity.  | Amber |
| **Mental health** | Continue to work towards the 2020/21 ambition of all acute hospitals having mental health crisis and liaison services  | Green |

* 1. **Market Mapping**

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| --- | --- |
| **Patients’ expectations** | * Increase in life expectancies reversed for first time this year but number of people over 75 still set to double in Lincolnshire over next 20 years
* People are living longer, with more individuals living with multiple and complex health conditions. People are experiencing a longer but less healthy old age.
* Increase in working population leads to need for access to services outside of conventional working hours.
* Technology use increasing for social as well as business uses. Patients expect that technology interfaces are provided e.g. online booking, text reminders, and email communication. Patients’ ability to interact in this way increasing.
* Patient expectations of solutions to health problems increasing, widespread expectation that ‘perfect health’ is obtainable.
 |
| **Workforce Priorities** | * Increasingly mobile workforces leading to brain drain from rural areas and consequent recruitment difficulties
* BREXIT risks to EU recruitment going forward - willingness of EU citizens to settle here even if given protected status
* Proposed legislation on gig economies may reduce workforce flexibility
* The age profile of the workforce is changing with an increasing number of potential retirees in next 10 years
* The current employment market for medical and nursing staff is challenging and this has resulted in shortages in key clinical staff groups further exacerbated by the challenge of recruiting into Lincolnshire
* A medical school in Lincoln will open in September 2019. In the medium-term this should improve the supply of medical staff in the county.
 |
| **Local commissioning**  | STP priorities: * spend more money on keeping people well and support patients in self-care and increase use of personal health budgets,
* reduce numbers of admitted patients and provide care closer to home through a network of small community hospitals and urgent care centres working with neighbourhood teams
* Have a smaller acute hospital sector providing emergency and planned care with specialist services, improving links between consultants and primary care.
* Improve consistency through evidence-based approach to available treatments and improve the care experience of patients with long-term and life-threatening diseases.

Commissioner priorities:* All 4 Lincolnshire CCGs in financial deficit with significant QIPP values to achieve in 2018/19.
* Movement towards a single CCG management structure likely with 3 or 4 localities
* Contract Management for CCGs in Lincolnshire to be managed collaboratively across the 4 CCGs and 2 CSUs.
* Commissioners continue to support repatriation of elective work to ULH from out of county providers.
 |
| **Competition** | * New independent sector providers entering market e.g. Spire Nottingham
* Continued stagnancy in private healthcare market increases competition from independent sector for NHS work
* New models of care, e.g. consultant-led services, increase competition for work and for clinical resource.
* Continuing merger solutions to poor Trust performance put autonomy at risk
* NHSE stated aim that all care will be commissioned at top quartile performance.
 |

* 1. **The Lincolnshire Health & Care Economy**

**Lincolnshire’s health and social care challenge**

Lincolnshire’s Sustainability and Transformation Partnership (STP) plan clearly outlines the residents’ views and the financial and performance imperatives for why health and care services need to change:

* Key NHS standards are not being met
* 2,000 planned operations are cancelled every year
* In 2017/18, it is forecast that the system will spend £110m more than it has in funding.
* Too much money is spent on treating people in hospital, rather than on prevention and early intervention to support people in the community and prevent acute care needs. The current ‘do nothing’ scenario for Lincolnshire health and social care organisations generates a £182m deficit by 2021 (providers and commissioners); within the acute sector, there is a predicted 13% growth requirement.

**Achieving clinical and financial sustainability**

System thinking at a national and local level is rapidly developing. There is recognition that if whole system change does not happen, it will be detrimental to patient care and the health of the population. Sustainability is only achievable at scale, across the system, not at service level. In the last 12 months, local senior leadership forums such as the Lincolnshire Co-ordinating Board (LCB), the Joint (shadow) Commissioning Committee, and the System Executive Team (SET) have all agreed to a system-wide approach to the problem.

Consequently, the Lincolnshire STP plan has been developed, which sets out five system themes that are planned to support £136m savings across the county, spanning across: clinical redesign; capacity optimisation; operational efficiency; workforce productivity and redesign; and Right Care/commissioning priorities. Overall, there is a critical focus on a ‘shift left’, to support patient pathways that are more preventative and community based. These changes and governance surrounding shared decision-making and accountability will be managed through the LCB, Joint Commissioning Committee, and SET.

**Acute services**

Acute care spend is the largest component of all commissioner expenditure (£528m of £1.3bn in 16/17 for Lincolnshire county).The majority of acute activity within Lincolnshire is delivered by United Lincolnshire Hospitals NHS Trust (ULHT), which serves the over 760,000 population of the county. The viability and long term sustainability of services within ULHT is therefore critical to the county’s wider long term sustainability.

In the last 12 months, ULHT has returned to special measures for finance and quality; their financial position is deteriorating, following the trend of the wider health economy. Previously proposed improvements at ULHT have not necessarily taken hold at the pace anticipated, but there is now a renewed commitment by system leaders to deliver safe and effective hospital services across Lincolnshire county; and to therefore review acute services across the patch.

* 1. **Acute Services Review**

**Overview**

The configuration of acute services within Lincolnshire must be clinically, operationally and financially sustainable and underpin the safe, efficient and effective delivery of quality services to the local population. A review of acute services across the county has been undertaken within the context of the wider STP plan which aims to improve population health management, improve prevention and redesign community and primary care services.

It is acknowledged that the current STP plan is not ambitious enough to address quality, staffing and financial challenges across the system, the acute services review (ASR) has focused on ensuring acute provision across Lincolnshire is adequate to address both the growing demand across the county and the need to achieve the plan, and financial savings, set out in the STP plan. The review has considered current and projected future needs for hospital services, taking into account planned developments in prevention, supported self-care and out of hospital care in line with the STP. Its aim has been to make a set of recommendations on the optimal configuration of acute services across Lincolnshire county to maximise clinical, operational and financial sustainability in the next 5 years, to 2022.

Between December 2017 and February 2018, commissioners and providers across the county came together to answer the question posed by the Lincolnshire Co-ordinating Board:

*What is the optimum configuration of ULHT services (and the role of neighbouring acute trusts), in order to achieve a thriving acute hospital service in Lincolnshire (and for the population as a whole) achieving clinical and financial sustainability across the Lincolnshire NHS health economy?*

This work, which is referred to locally as the Acute Services Review (ASR), gathered specialty specific information from across ULHT to establish the case for change and evaluate potential alternatives. In parallel KPMG developed a whole system model to assess the impact of different options on activity, finance and patient access.

There are a number of challenges across the local health and care economy that have been addressed and considered as part of this review:

* Patient pathways across Lincolnshire are very hospital dependent, putting pressure on all acute provision across the county
* There is clinical variation across providers, including across sites within providers, impacting on patient care and outcomes
* There are significant workforce challenges both current and future e.g. low staff morale, low productivity, staff shortages, and impending future skills shortages
* Inefficiencies exist as there is duplication in services even across sites within providers -some services are sub-optimally sized and/or distributed over a large geographical footprint

**ASR Phase 1 outputs**

*Approach*

* Service review for each specialty within Lincolnshire using key drivers for change: quality, workforce, performance, accessibility and affordability
* Understanding of the future needs of the Lincolnshire population
* A proposed future state configuration for each specialty across the county
* Recommendations on the optimum configuration of services and the respective role of acute trusts serving Lincolnshire.

This work involved:

* Extensive engagement across ULHT and the wider system
* Analysis of current performance data
* Population/activity modelling and impact analysis

*Outcomes*

* A base case in which configuration is not changed revealed that across Lincolnshire, bed requirements, activity, travel times and the financial deficit would all increase over the next five years.
* Eight specialty areas were identified as having a strong case for change and became the areas upon which reconfiguration scenarios were concentrated:
* Breast
* Trauma & Orthopaedics
* General Surgery
* Stroke
* Acute Medicine
* Women’s and Children’s
* Urgent and emergency care pathways
* Haematology & Oncology
* Using a set of agreed design principles, key leaders across Lincolnshire’s health and care economy came to a professional opinion consensus regarding a preferred reconfiguration option for the future. This option aims to produce:
* Improved financial position
* Minimal impact on activity
* Decreased bed requirements
* Enhanced access, quality, sustainability and deliverability
* Promotion of a ‘one trust’ team approach
* Successful recruitment and retention of talent.

*Specialities’ case for change*

|  |  |  |
| --- | --- | --- |
| **1. Strong case for change**  | **2. No case for change or will respond to changes in specialties activity** | **3. Some case for change but not currently prioritised** |
| **Breast**: Lack of consistent model of care across sites and compliance with clinical guidelines, lack of breast radiologists and wider workforce issues. | **Clinical Support Services (Radiology, Nuclear Medicine, Audiology & Endoscopy, Therapies, Pharmacy)**:responds to changes in other specialities | **Care of the elderly**: operational sustainability challenges, not enough consultants. Strong co-dependency with Acute Medicine. |
| **Trauma & Orthopaedics**: currently unsustainable service with significant workforce and financial challenges.  | **TACC: Anaesthetics & Pain Management, ICU & Critical Care**: responds to changes in other specialities | **OMF & Orthodontics**: heavily reliant on locum workforce |
| **General Surgery**: workforce challenges limiting ability to provide adequate cover across the geography; not meeting performance targets. | **Gastroenterology**: no case for change | **ENT**:high use of agency |
| **Stroke**:Clinical standards and performance standards not being met, and significant workforce gaps against clinical guidelines staffing levels. | **Palliative care**:no case for change | **Ophthalmology**: shortage of staff nationally  |
| **Acute Medicine including Respiratory, Cardiac Services**:significant workforce challenges impacting on ability to deliver safe, quality service. Operationally unsustainable in current form. | **Diabetes and endocrinology**: no significant case for change | **Vascular**: recently consolidated services at Pilgrim, independent clinical review is expected to recommend that arterial work ceases to be provided in Lincolnshire with a transfer to specialist centre |
| **Women’s & Children’s including Obstetrics, Gynaecology, Neonataology and Paediatrics**:Significant staff shortages impacting capacity and ability to meet national standards on staffing. Quality challenges in Obs& Gynae and viability of current birthing units configuration in question. |  | **Interventional radiology**:a case for consolidation of vascular interventional radiology |
| **Urgent & Emergency Care pathways**: significant workforce issues impacting coverage. 4 hour target and financial challenges. |  | **Nephrology**: doubts about appropriate level of inpatient services provided |
| **Haematology& Oncology**: heavy reliance on agency staff and lack of compliance with standards. |  | **Urology**: currently ongoing detailed piece of work to review Trust provision. |
|  |  | **Neurology**: mainly outpatient activity, not a driving factor in reconfiguration |

**ASR Phase 2**

The East Midlands Clinical Senate and NHS England agreed that there is a strong case for change in relation to some services and determined a best solution in terms of future option for configuration of services. The system has reached a broad consensus there are further questions to consider and points for clarification in order to conclude this work.

Phase 2 ASR work will aim to:

* Answer the specific questions posed by NHS England and refine the configuration option that gained professional opinion of consensus;
* Establish the Programme Management Office (PMO) and Governance necessary to drive forward the work, assess the impact on neighbouring providers and expedite work on capital planning and workforce implications; and
* Complete the supporting analytics and modelling.

The work will consider current and projected future needs for hospital services, taking into account planned developments in prevention, supported self-care and out of hospital care in line with the STP.  The Acute Service Review (ASR) is be focused on the next 5 years to 2022.

**Impact on this Integrated Business Plan**

* The ASR is a key strategic driver and the outputs will heavily inform the evolution of the Trust’s 2021 Improvement Programme
1. **Where we want to be**

This section articulates our vision in terms of ensuring high quality, sustainable services that best support the Lincolnshire health & care system

* 1. **Excellence in Rural Healthcare – our 2021 Strategy**

We have been continuing to work on our 2021 Strategy since our launch in November 2017, where we outlined our vision and our ambitions together, with the changes we need to make to achieve them. We are clear that we are striving for excellence in everything we do in caring for our patients.

2021 is a marker in time, where our ambitions are for our services to be consistently safe, responsive and give great care to our patients. Our 2021 programme outlines the affordability and sustainability of transformational changes. It sets out how we will put our people (our staff and volunteers) at the heart of how change is managed and how we will equip and empower them to make improvements.

**Striving for Excellence**

Our ambitions for Our Patients, Our Services, Our People are described below:

|  |  |  |
| --- | --- | --- |
| **Ambitions** | **Objectives** | **Outcomes** |
| **Our patients** | * Will receive consistently compassionate, safe high quality care
* Will be listened to and be involved in shaping their care around their needs to achieve successful health outcomes
* Will be involved in shaping our services around lessons learned from their care
* Will want to choose us for their care and be champions in our communities
 | Providing consistently safe, responsive, high quality care |
| **Our services** | * Will work in partnership to develop integrated models of care
* Will value our patients time and get things right first time
* Will develop centres of excellence across all of our hospitals
* Will deliver financially sustainable services
 | Providing efficient, effective and financially sustainable services |
| **Our People** | * Will be proud to work at ULHT
* Will feel valued, motivated and adaptive to change
* Will challenge convention and improve the way we do things
* Will strive for continuous learning and development being supported to be innovative
 | Providing services by staff who demonstrate our values and behaviours |

**Delivering Excellence**

The Trust has developed an improvement programme that will deliver the 2021 ambitions, outcomes and objectives. This is summarised below:

|  |  |  |
| --- | --- | --- |
| **Improvement Programmme** | **Key Activities** | **Outcomes** |
| **Improving quality and safety** | * Quality Strategy
* Improving CQC rating
* Delivering the Quality & Safety Improvement Plan
 | We will focus on having the right numbers of staff, preventing infections and developing a culture of safety |
| **Saving money and improving our environment** | * Long Term Financial Plan
* Financial Turnaround/Grip & Control
* Efficiency savings
* Estates
 | We will be smarter, saving money and modernising our buildings |
| **Redesigning our clinical services** | * Clinical Strategy
* Clinical redesign
* Service Review Programme
 | We will make sure patients get the right care first time |
| **Delivering productive services** | * Outpatients
* Theatres
* 7 day services
 | We will deliver great patient experiences by improving our systems and processes |
| **Developing the workforce to meet future needs** | * People Strategy
* Workforce capability, productivity and performance
* Recruitment and retention
* Talent management
 | We will retain and recruit more staff. Staff will be trained, healthy and supported. |

The Trust’s Operational Plan 2018-19 provides detailed information on specific priorities for the next two years.

Completion of the Acute Services Review and ongoing consultation will further fine-tune these plans

* 1. **Our clinical vision**

Our 2021 Improvement Programme, which will evolve in line with the outcomes of the Acute Services Review, will set out the future of each of our sites, subject then to formal public consultation. The opportunity for developing new and innovative systems of care through integrated partnership pathways will mean:

* Our hospitals will be smaller with fewer beds as more patients are treated and cared for in their communities.
* Improved patient care and patient access to services locally.
* Prevention of admissions to hospitals, whilst ensuring that those patients who need specialist hospital treatment get safe, high quality care at the best hospital, not always at their nearest hospital.
* Our patients will have shorter stays and be discharged home as quickly as possible with local support.
* Improved health, quicker access to tests and treatments, fewer cancellations, and better hospital care for the people of Lincolnshire.
* Developing our potential to become a national, if not international, Centre for Rural Health and Care, through health and care reform working in collaboration with our wider health partners and stakeholders.
* For staff, this will mean that there will be new roles and new opportunities and that they will be part of well-staffed teams, which often work across professions and organisations. Our staff will have access to training and development and have opportunities to retrain and gain new qualifications together with access to the latest technology to help in their role.
* Our patients and staff “voices” will be listened to, and will lead to improving care, and shaping and improving our services.

The core themes in our transformation and efficiency programmes include:

* Consolidating services where necessary to promote safety, clinical and financial sustainability
* Protecting bed and theatre capacity for elective activity, to reduce the number of procedures currently being cancelled due to pressures of non-elective medical admissions; Maximising the use of Grantham and Louth hospital sites for elective work, thereby improving our performance against the NHS Standards and ensuring their future viability
* Creating “hub and spoke” models to deliver care close to home where possible and safe to do so
* Optimising productivity and efficiency through the implementation of the national GIRFT (Getting it Right First Time) programme for all clinical specialities
* Localising more routine care to ensure easy access for most outpatient, diagnostic and therapy services,
* Shorter hospital stays requiring fewer hospital beds, with sufficient protected elective beds to meet patients’ expectations for waiting times and timely access.
* Increased focus on Pilgrim and Lincoln Hospitals for a broad range of emergency services where it is safe and viable to do so, but with a concentration of very specialised urgent care on a single site
* Single site services for areas where there is evidence it will improve outcomes e.g. acute cardiology, hyper-acute stroke services and vascular surgery
* Emergency and Urgent Care services being delivered as part of a network of care ensuring rapid access to urgent care in the right place when needed with a tiered A+E service that is staffed on a sustainable basis, with the development of urgent care models which are less dependent upon scarce skills
* Developing and expanding our workforce skills to enable specialist care to be delivered in an integrated way in the community
* Developing new and different roles, where historically it has been difficult to recruit
	1. **System impact: supporting delivery of the Lincolnshire STP**

|  |  |
| --- | --- |
| **Facilitating integration** | * Working with established partners: across acute health care, community health, primary care, mental health and palliative care services to support the development of place-based services using integrated service delivery models
 |
| **Moving care from acute hospitals to the community** | * Neighbourhood Teams
* Supporting the neighbourhood team model of care by providing in reach services for frailty, long term conditions management for diabetes, respiratory, heart failure, neurological conditions and stroke alongside the development of cross-organisational working to support the health and care needs of populations
* Urgent Care
* Developing a network of Urgent Care Treatment Centres as an accessible and more appropriate alternative to A&E that are staffed with an integrated staffing model drawing on skills from both primary and secondary care
* Planned Care
* Leading the 100 day NHSE transformation programme for Ophthalmology: Our ambition is that no patient goes outside of Lincolnshire to have their cataract operation.  We will do this by ensuring referrals into secondary care are appropriate and as a result we will reduce the new referrals in to secondary care by 10% and improve our conversion rate from 60% to 90%.
* In Dermatology**,** also through the NHS 100 day transformation programme and working in partnership with community primary care services for patients from a specific neighbourhood (East Lindsey tbc), the aim is to decrease median wait times between referral and treatment from 8 weeks to 6 weeks.
* For Diabetes, and the final element of the NHSE 100 day transformation programme, again working with primary and community services colleagues, by the end of the 100 days the referral rate into specialist care will reduce by 50% for patients in 3 GP practices South West Lincolnshire CCG.
 |
| **System Efficiency** | * Introducing technology into acute care services across the Trust, including; telehealth, telemedicine and self-care apps to transform the way people engage in and control their own healthcare.
* Using telemedicine to facilitate the introduction of one medical rota for stroke medicine across the Trust’s hospital sites
* Taking forward and implementing the recommendations from the national GIRFT (Getting it Right First Time) programme. Services currently in the programme for the Trust include; Trauma & Orthopaedics, Ophthalmology, General Surgery, Gynaecology, Vascular services and Urology.
* Right-Care: positioning Trust services to be better placed to realise Right-Care – Commissioning for Value opportunities to improve outcomes & efficiencies, specifically with regards to reducing non-elective admissions.
 |
| **Making it happen** | * Supporting the development and implementation of:
* Innovative contractual solutions (e.g. alliance, lead provider) which focus on system value, outcomes & accountability for STP delivery
* The Single System Plan, which includes single system efficiency and investment plans and aligned incentives across providers
 |

1. **How we will get there**

This section provides a summary of the Trust’s service plans, highlighting key developments and priorities.

* 1. **Summary of the key deliverables for 2018-19**

| **Ambitions** | **Objectives** | **Key deliverables for 2018-19** |
| --- | --- | --- |
| **Our patients** | * Will receive consistently compassionate, safe high quality care
* Will be listened to and be involved in shaping their care around their needs to achieve successful health outcomes
* Will be involved in shaping our services around lessons learned from their care
* Will want to choose us for their care and be champions in our communities
 | * Delivering harm-free care: reduction in pressure ulcers, falls and infection rates
* Improve our safety culture by delivering the Quality & Safety Action Plan
* Initiate the implementation of E-prescribing
* Strengthening our clinical governance and risk identification: developing a positive and open reporting culture as a learning organisation
* Ensuring that the experience our patients receive reflects our ambitions as a Trust to put patients and safety first
 |
| **Our services** | * Will work in partnership to develop integrated models of care
* Will value our patients time and get things right first time
* Will develop centres of excellence across all of our hospitals
* Will deliver financially sustainable services
 | * Design and implement a revised leadership and performance management framework.
* Preparing for a comprehensive Electronic Patient Record
* Delivering the trajectories to achieve operational performance targets identified in the 2018/19 planning guidance
* Deliver the financial targets agreed by the Board
* Ensuring compliance with the fire enforcement notices
* Delivering the ULHT-related elements of the Lincolnshire Single System plan
* Acute Services Review, design & consultation and implementation
* Deliver inpatient ward reconfiguration at Pilgrim Hospital, Boston
 |
| **Our People** | * Will be proud to work at ULHT
* Will feel valued, motivated and adaptive to change
* Will challenge convention and improve the way we do things
* Will strive for continuous learning and development being supported to be innovative
 | * Redefine the workforce we need & seek to reduce overall workforce cost, whilst delivering high quality services to patients
* Increase workforce supply, working on new supply pathways we need to fill our new establishment
* Improve retention rates, by focusing on the development opportunities we provide
* Improve training and development to ensure that staff have the requisite skills and competencies
* Maximise productivity and performance, by getting back to basics in the way we manage our workforce.
* Developing and defining an offer for our staff that ensures they feel valued and believe that we are concerned about their well-being
* Engaging our staff around a positive future vision, giving them a greater sense of “hope” and belief the Trust can move forward positively
* Giving confidence to our staff that their voice will be heard and their concerns listened to
* Involving our staff in improving what we do, encouraging innovation and continuous improvement (as a learning organisation) and empowering people to deliver change
* Ensuring that people at all levels are held account for behaviours that reflect the ULHT values
 |

* 1. **2021 Improvement Programme**

**Improving quality and safety**

* **Baselining quality and embedding improvements in a sustainable manner: delivering the Quality & Safety Improvement Programme:**

The purpose of this plan is to define, at a high level, the Quality and Safety Programme and the continuing quality and safety improvement journey ULHT is making, including improvement goals that ULHT will work towards over the next 12 months and through the 2021 Milestones. The Improvement Programme will be supported going forward by the delivery of the Quality Strategy setting out our priorities for improvement. The plan includes all of the Compliance Notice requirements and MUST DO recommendations in the CQC Quality Reports. The plan is broader than the specific CQC requirements/recommendations and includes longer-term pieces of work that the trust is pursuing to improve overall quality and safety across the organisation. The key projects are:

* Safety Culture
* Governance
* Eliminating avoidable hospital harm
* Learning lessons from SIs
* Sepsis
* GI Bleed Service
* Airways Management (NIV Pathway)
* Mental Health and Learning Disabilities
* Safeguarding
* Medicines Management
* Training and Competencies
* Appraisal and Supervision
* Out-Patients
* Infection Control Governance
* Infection Control Governance
* Gram Negative Bacteraemia
* Cleanliness of Environment
* Safe Environment of Care
* Competent, Knowledgeable Practitioners
* Patient, Public, Staff Information
* Reducing Variation in Clinical Practice
* Clinical Staffing - Nursing
* Clinical Staffing - Medical
* Medical Engagement
* Strengthening Support for Pilgrim Hospital
* Estates Environment
* Fire Action Plan
* **Quality aspirations for the future: ensuring a harm-free care environment**
* Reduction of pressure ulcers
* Reduction of falls

The Operational Plans will be the local management of the delivery of improvements to Quality and Safety.

**Saving money and improving our environment**

* **The key financial priorities are:**
* Delivery of the Financial Turnaround Plan
* Delivery of the Long Term Financial Plan
* **Financial milestones/targets**
* 2018/19: Deliver as a minimum a deficit of £79.4m or better.

Utilise SLR/PLICS benchmarking and reference costs to support the creation of the plan to achieve breakeven.

* 2019/20: Deliver circa £20m FEP to continue the move to breakeven, enable delivery of the Quality CQC rating and the STP strategic framework
* 2020/21: All services deliver a break even position by the end of the financial year, expect those affected by the wider structural deficit.
* **Trust approach to identifying potential productivity and efficiency gains**



**Redesigning our clinical services**

* **Urgent and Emergency Care**
* One A&E Team across the Trust delivering emergency care at 3 sites.
* One combined rota for emergency stroke admissions made possible through the introduction of telemedicine.
* **Haematology & Oncology**
* Inpatient activity (elective and non-elective) service improvements.
* **Orthopaedic Transformation**
* In line with the GIRFT recommendations, orthopaedic services will be transformed with better quality, fewer cancellations and greater efficiencies.
* **Clinical Service reviews to optimise productivity and efficiency**
* By 2020 reviews will be completed and actions implemented for: Trauma & Orthopaedics, General Surgery, Urology, Respiratory Medicine, Gastroenterology, Gynaecology, Cardiology, Ophthalmology and ENT.
* Bringing these services back into a clinically sustainable position with financial balance
* **Delivering ‘left shift’**
* Stroke: developing a new service model to support the rationalisation of acute stroke service facilitating discharge on average at day 7 in the pathway
* Planned care: based on the diabetes 100 day programme: designing and implementing the blueprint for how the care for long term conditions can be moved from acute hospital into the community; working with system partners to develop more effective MSK and community Pain Management services

**Delivering productive services**

* **Productive hospital strategy**

The Delivering Productive Services programme envisages that ‘More patients access their care in Lincolnshire and we have the operational capacity and capability to effectively respond’. This programme is critical to the delivery of the Trust’s ambition to be a thriving, competitive partner in the healthcare economy and ensure all individuals have access to high quality, accessible, safe and sustainable services for the future. The programme will provide the direction and support for building ownership and the embedding of change necessary to sustain and deliver an acute care portfolio of services, in a changing healthcare market. The programme is closely associated with the day-to-day operational governance and delivery to ensure alignment, appropriate prioritisation of initiatives and achievement of delivery milestones. Key deliverables are:

* Outpatients Optimisation: eBooking system implemented (including patient self-booking); consultant eReferrals; maximising clinic utilisation; wait times are equivalent to or lower than the national average
* Theatres and Endoscopy Optimisation: re-design of pre-operative assessment pathway; rotas and job plans aligned with theatre/bed capacity and provision for prospective cover; scheduling/start times/turnaround times are equivalent to or better than benchmark peers; efficiency of theatre lists –increase number of mean cases per lists; optimise endoscopy service to reduce ‘uncovered/lost sessions’ and long waits increase utilisation of endoscopy slots
* Outpatient Parenteral Antimicrobial Therapy (OPAT): implementation of local OPAT infusion centres; implement additional service models to meet demand
* Emergency and Urgent Care: recruit into right sized emergency care; reconfiguration of hospital floors to enhance access and flow; develop and implement a single medical Emergency Department workforce

**Developing the workforce to meet future needs**

* **Developing a sustainable workforce, with the right capability and capacity in place**
* Reduce the cost of the temporary workforce we do employ, but ensure they are engaged with what the Trust is striving to achieve
* Improve recruitment success rates, so that we alter the workforce mix between permanent and temporary
* Redefine the workforce we need & seek to reduce overall workforce cost, whilst delivering high quality services to patients (linking to changes in clinical pathways)
* Increase workforce supply, working on new supply pathways we need to fill our new establishment
* Improve retention rates, by focusing on the development opportunities we provide
* Maximise productivity and performance, by getting back to basics in the way we manage our workforce.
* Create a “brand” in ULHT of which our staff can feel proud
* Developing and defining an offer for our staff that ensures they feel valued and believe that we are concerned about their well-being
* **Engaging staff in the design and management of change**
* Engaging our staff around a positive future vision, giving them a greater sense of “hope” and belief the Trust can move forward positively
* Ensuring that the experience our patients receive reflects our ambitions as a Trust to put patients and safety first
* Demonstrating compassionate, inclusive leadership at all levels and consistently across ULHT, so that we can build higher levels of trust in our leaders
* Giving confidence to our staff that their voice will be heard and their concerns listened to
* Strengthening the “golden thread” through sound governance (including structure), holding people more effectively to account
* Involving our staff in improving what we do, encouraging innovation and continuous improvement (as a learning organisation) and empowering people to deliver change
* Ensuring that people at all levels are held account for behaviours that reflect the ULHT values
* Being seen to be equitable and fair in the way that we treat all our people, promoting the value of diversity
	1. **Enabling Strategies**

**People strategy priorities**

The purpose of the People Strategy is fundamentally to ensure we have the “Right number of people, in the right places, with the right skill mix, attitude and behaviours, motivated and manage to perform at their best (at a price we can afford) and engaged on high value care”. This addresses the two core strategic risks of:

* Failure to sustain adequate workforce
* Failure to sustain engaged workforce

The ULHT People Strategy fits within the overall framework of the STP and the ULHT 2021 programme. The People Strategy delivers the “Developing the workforce to meet future needs” strand 2021. It must align and integrate with the other four 2021 programmes.

Based on the analysis of “where we are”, in workforce terms (using all the data available, such as national staff survey), against “where we want to be”, expressed in terms of the 2021 ambitions, a number of priorities have been set in the people strategy. They reflect the two key areas around workforce in the 2021 programme (skills and numbers and engagement around change) and also fit closely with the priorities for 2018/19.

The key priorities are detailed in Section 4.2 as part of the 2021 improvement programme **‘***Developing the workforce to meet future needs***’**

**Engagement strategy priorities**

The broad aims of the communication and engagement strategy are

* Developing a good reputation so people will want to be treated at one of our hospitals and people choose to work at the Trust.
* Our staff and patients will be well informed about our vision and values, become advocates of the Trust and will talk positively about our care and about the Trust an employer, and people will want to get involved and share their views
* Meeting the Trust’s statutory duties.
* Most importantly, we will become a listening and responding organisation.

Key priorities are:

* Building the ULHT brand and raising the profile of ULHT as trusted credible organisation.
* Embracing social media and digital technology to engage our diverse audiences.
* Ensuring all communications and engagement is aligned to organisational priorities
* Ensuring staff have an excellent understanding of our brand and feel valued as an employee.
* Evaluating the impact of all communications and engagement activity

**IM&T strategy priorities**

* **Information Services**
* Information Services will continue to expand on real-time patient monitoring to ensure clinical and managerial decisions are supported more pro-actively. This includes further development of dashboards for urgent and planned care activities, consolidation of existing data warehouses, review of existing data visualisation tools.
* We will also be reviewing our manual processes and automate as much as possible to ensure more capacity is given to analyses and enhanced decision making capability.
* **ICT Operations and Programmes**
* Following the recent successful implementation of a significant upgrade to our Medway Patient Administration System along with the introduction of our new Maternity, Theatres and Electronic Observations and Charting systems, we will continue to invest in the technologies that will deliver our vision of a fully integrated digital patient record across all care settings. This will help deliver the quality and safety improvements that our clinical services are fully committed to as well as drive greater efficiencies to help provide more time to care for our patients. It will transform the quality of our information and the way it moves freely and securely around our organisation and the wider NHS.
* Our Digital Hospital Strategy objectives
* Improve health outcomes and safety.
* Empower service users and support shared decision-making.
* Facilitate and drive integration, within and between organisations and care settings.
* Inform local health and wellbeing strategies.
* Drive greater efficiency and productivity.
* Our Digital Hospital Strategy priorities
* e-Health Record
* E-Prescribing
* Digital Dictation/Speech Recognition
* Telemedicine
* Robotic Pharmacy
* Video Conferencing Technology
* Virtual Desktop Infrastructure (Clinical)
* Cyber Security

**Estates strategy priorities**

* **Capital, Land and Estate Utilisation**
* Finalise the ‘Technical Estates Strategy’ as far as practical. Design and propose a process to implement the estates strategy, including;
* STP and 2021
* Land release
* Strategic estates partnership
* Disposal strategy
* Carter Efficiencies Review - delivery of capital scheme and ProCure 21+; Test best value for the Trust and propose any changes.
* Supporting delivery of Trust’s clinical strategy and STP transformational change
* Manage the sale process for the Welland site, subject to the timescales imposed by Lidl and the planning process
* Delivery of the capital programme in respect of development and £3m backlog plans
* Delivery of fire programme for enforcement notice compliance
* **Financial Turnaround including Carter Efficiency** (Meeting Recommendation 6’ of the national efficiency programme)
* Develop short term efficiency plan for FEP
* Develop 2018/19 plan for change by 2020/21 incorporating recommendations for space utilisation and non-clinical space improvements
* Develop land release strategy
* Improve overall data quality of estates and facilities function
* Improve space utilisation and reduce vacant space.
* Target to move to the lower quartile in cost.
* Energy Performance Contract implementation.
* Sustainability Plans – Board Sustainable Development Plan, rolling programme of auditing, prepare for DH Energy Efficiency Fund for viable applications
* **Safety and Compliance**
* Deliver fire safety improvement plan and overall compliance action plan.
* Conclude backlog review and update into strategic plans including Estates Strategy and STP.
* Embed and expand the risk review process.
* Deploy ‘systems thinking’ risk process using MiCAD.
* Increase levels of compliance against statutory requirements and PPM.
* Establish Premises Assurance Model into reporting process FSID/Board.
* Undertake PPM review and rationalisation, introduce SFG 20.
* Review Authorised Engineer/Person/Competent governance and external audit.
* Finalise asbestos management plan.
* Develop strategy for electrical systems investment.
* Governance and Assurance via NHS PAM and EEIC – standardise assurance evidence and reporting using MICAD (SFG20/ Canty Comp/ Auto CAD site) – using Core Risk/ Compliance Programmes
* **Staffing and Engagement**
* Appointment of site Associate Director’s for Business Continuity & Quality
* Development of action plans following estates workforce review
* Development of formalised engagement plans
* Embedding of the plans into business as usual
* **Facilities**
* Housekeeping Review and implementation of the recommendations
* PLACE and interim PLACE Lite - Improve place scores – patient quality, perceptions
* Security review conclusions and proposals.
* Retail tender conclusions and proposals.
* **Health & Safety**
* Audit of function and review of resources

**Procurement framework priorities**

The Trust currently spends over £140m a year on non-pay goods and services. Procurement covers the whole process of buying appropriate goods and services from planning and the definition of requirements through to the purchase and payment. The scope includes the procurement of a wide range of clinical and non-clinical goods and services ranging from consumables and equipment through to outsourced services.

The 2018/19 Procurement deliverables are:

* Develop and deliver a financial efficiency plan (FEP) that delivers £1m per annum recurrent savings
* Clinical engagement to be developed and fostered as part of all procurements (as applicable)
* Introduce and facilitate a Clinical Product Evaluation Group (CPEG) that takes responsibility for product review and approval through clinical engagement, buy in and sign off.
* Develop and utilise data analysis (Purchase Price Information Benchmarking) to identify opportunities, improve benchmarking & increase market intelligence
* Support the regional and national strategic procurement agenda, including STP and wider collaborative working, the Future Operating Model, Cater Metrics and National Transformation plan. Working in partnership with the Regional Head of Procurement (NHSI) to support the Procurement function.
* Deliver the Procurement staffing restructure to ensure fit for purpose resources are in place to meet serviced delivery, including training requirement review.

**Performance framework priorities**

* **Performance Review Meetings with Directorates**
* Creation of a single source of data to report against Trust wide
* Development of service level improvement plans
* Sharing of best practice
* Trend Analysis of operational, financial and quality performance
* **Integrated Performance Report**
* Consistent information throughout all performance reporting
* Central production of reports
* Ability to utilise report to assure variety of Trust audiences
* **Early Warning Tool**
* Internal benchmarking tool for wards and directorates
* Communications Trust wide to explore areas of inconsistency and identify poor performers
* Capability to fore-warn of future concerns
* **Benchmarking**
* Better dissemination and utilisation of benchmarking information
* Use benchmarking data to inform performance reporting and to explore opportunities for development/improvement
1. **Key planning assumptions**

This section provides a summary of key planning assumptions, triangulating activity, workforce and finance plans

* 1. **Finance**

**Introduction**

Financial planning is an embedded part of the Trust’s planning cycle thus ensuring an integrated approach between activity, workforce and finance is achieved. Clinical and corporate teams are part of the cycle to deliver a financial plan that represents the priorities, risks and assumptions agreed as part of the overall process.

The key financial metrics for 2017/18 (unaudited) and 2018/19 (planned) are:

|  |  |  |
| --- | --- | --- |
| **Key Financial Metrics** | **2017/18£m** | **2018/19£m**The plan for 2018/19 reflects:* Deliver a deficit of £79.4m exclusive of Sustainability and Transformation Fund (STF) of £20.7m. The Trust has received an increased STF offer from £14.7m in 17/18.
* Aspiration to deliver a £30m Financial Efficiency Programme although recognising that in year delivery is likely to be £19.7m (4.5% of turnover).
* Following approval from NHS Improvement the capital plan includes £26.6m of external funding to continue the works to comply with the Fire Enforcement Notices.
 |
| Net surplus/(deficit) | (84.8) | (79.4) |
| STF funding | 0 | 0 |
| Turnover | 429.6 | 439.8 |
| Expenditure | (514.4) | (519.2) |
| CIP savings | 16 | 19.7 |
| Gross Capital Programme | 23.0 | 37.7 |
| Cash position | 1.5 | 1.6 |
| Contingency | 4.0 | 2.0 |
| SOF Rating | 4 | 4 |

As part of the Trust’s planning process the Board has considered the financial parameters it wishes to operate within with a balanced view between challenge, risk and long terms sustainability. The plan is therefore predicated on the following key assumptions:

* A £3m contingency along with £4m quality investment fund are held representing 1.5% of turnover.
* The Trust’s Single Oversight Framework risk rating remains at a 4.
* Inflation assumptions have been based on national guidance unless the Trust has specific knowledge to the contrary.
* Cash support through DHSC loans continues to be available to the Trust to cover the deficit.
* The key operational priorities set out in the national planning guidance are achieved during 2018/19.

**Financial Forecasts**

The bridge chart below shows the impact of the assumptions form 2017/18 to 2018/19.

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The notional STF funding and income (CHKS) could improve the 2018/19 outturn but are subject to negotiation and agreement before they can be transacted.

The Trust received £3.6m STF and £1.4m CQUIN Risk Reserve income non-recurrently in 2017/18. These amounts are not included in the 17/18 outturn figure above as they do not form part of the Trust’s delivery against target set by NHS Improvement.

**Financial Efficiency Programme**

The financial plan assumes benefits from a range of efficiency schemes derived in the main from the ongoing work with our external Financial Special Measures partner. The current progress of the plan is shown below and has a planning gap of unidentified schemes of £1.3m. Work is ongoing to ensure detailed plans are backed by robust evidence based information from a variety of benchmarking sources both local and national such as Model Hospital, Reference Costs and the NHS Benchmarking Network.

|  |  |  |
| --- | --- | --- |
| **Scheme** | **Target 2018/19 £m** | **Most likely 2018/19£m** |
| Workforce | 6.0 | 2.9 |
| Clinical Transformation | 5.1 | 4.1 |
| Productive Services | 5.6 | 3.4 |
| Corporate Overview, Procurement and Estates | 4.5 | 1.7 |
| Directorates | 4.9 | 5.0 |
| Income | 2.6 | 2.6 |
| Unidentified | 1.3 | 0.0 |
| **Grand Total** | **30.0** | **19.7** |

All schemes will be subject to a Quality Impact Assessment (QIA) signed off by the Medical Director and Director of Nursing. Each is supported by detailed milestone development and implementation plan.

**Capital Planning**

The Trust has internally generated capital resource of c£11.1m. This is an extremely limited resource to maintain the estate and infrastructure of the organisation across three main and a number of peripheral sites.

Capital plans are risk based with the majority of resources targeted at medical and IT equipment replacement and estate compliance. The opportunities to invest in service and clinical developments are significantly constrained. Any funding available will be prioritised based on the combined impact on quality, access, performance and finance.

The Trust will be looking to rationalise elements of the Estates throughout the next planning cycle that will generate additional capital resources that will be allocated based on the same risk based and benefits approach highlighted above.

The Trust was served two fire enforcement notices in 2017/18 at Pilgrim and Lincoln sites with a timetable of compliance phased over 3 financial years. The significant capital requirement to deliver this programme was supported in 2017/18 with a loan of £9.5m from the Department of Health (DH) and the Trust has received confirmation of a further £26.5m external loan support for 2018/19.

The Trust is in discussions with NHSI and fellow Lincolnshire STP organisations in respect of opportunities to access additional capital funding to support transformational change and investments in improved and modernised IT and clinical capacity. The Trust is producing a number of business cases during the first quarter of 2018/19 to submit to NHSI to apply for specific capital support for these projects.

The Trust is continuing to develop and finalise detailed schemes as part of the business planning process, and therefore the table below provides a high level indication of the split of capital schemes which are currently in development.

|  |  |
| --- | --- |
| **Scheme** | **2018/19£m** |
| Medical Equipment | 3.4 |
| IM&T | 2.6 |
| Estates | 3.0 |
| Fire Compliance (includes £26.5m external support) | 28.6 |
| Contingency | 0.1 |
| **Grand Total** | **37.7** |

**Financial Risk / Assumptions**

* By not accepting the control the Trust forfeits accessing the CQUIN relating to this metric. For the remaining CQUIN schemes the Trust has applied a realistic assessment of delivery.
* Non-Pay inflation does not exceed the nationally published rates.
* Pay inflation is constrained within the 1% or additional funding is made available if it increases above 1%.
* Whilst the Trust has not accepted the 2018/19 control total the £79.4m deficit plan makes no provision for the impact fines and penalties as it is assumed that agreement with CCGs will be reached to not transact them (as in 2017/18) and / or the Trust delivers the performance metrics to avoid incurring them.
* A&E performance delivers so the Trust qualifies for that element of STF funding linked to A&E performance although income not received (£6m).
* Assumes depreciation is in line with planned capital spend.
* The costs arising as a result of the CQC inspection are contained within the ring fenced contingency.
* Investment in A&E to achieve the 4 hour wait is contained within the previously agreed business case.
* The costs of winter do not exceed the provision made within the plan.
* Interest rate on borrowings reduces from 6% to 3.5% from August 2018.
* All FEP schemes deliver cash savings in full to an in year value of £19.7m.
* The Trust delivers the signed activity contracts and values.
* CCG QIPP does not exceed the provision made within the plan.

**Statement of Comprehensive Income 17/18- 18/19**



**Statement of Financial Position 17/18 – 18/19**



**Statement of Cashflow 18/19 – 18/19**



* 1. **Activity**

Activity planning has been undertaken in conjunction with commissioning colleagues. This coordinate approach allows the plan to represent a community wide view of requirements for acute services and strengthens the level of challenge imposed throughout every stage of the process. Delivery has been modelled at site and specialty level providing a clinically recognised level of granularity.

For all types of activity the plan has been based on 2016/17 actual activity to ensure that the data the full seasonal effect of winter experienced in the acute sector. Adjustments have then been made to ensure that the plan accounts for the following

* Increases in patients registered with Lincolnshire GP’s. 0.7% has been added per year for 2017/18 and 2018/19
* Patients waiting for care; 18 week referral to treatment including Cancer patients, Patients waiting for outpatient follow up appointments, Patients waiting for New Outpatient Appointments
* Reduction in activity for procedures of low clinical value
* STP schemes that have been implemented or are scheduled for implementation in 2017/18

The resultant activity plan has then been triangulated against actual experienced activity levels in 2017. Where current trends differ from 2016/17 and are expected to continue the plan for 2018/19 has been adjusted.

Finally changes and developments to service delivery have been incorporated into the planning numbers. This ensures that the activity plan reflects the most up to date service provision.

* Recent changes in A&E services incorporating the collaboratively managed A&E/GP Streaming initiative which has been successfully operating since October 2017
* Continuing roll-out of advice and guidance services which enable GP’s have direct contact with Consultants
* Ensuring that activity is delivered in the most effective setting

Delivery of the identified activity levels will be challenging requiring a focus of increased productivity and continuation of work already in place to ensure that services are provided efficiently and effectively within available resources.

* 1. **Workforce**

**Challenges around workforce planning**

Our workforce plans for 2018/19 are recognised as not being as well-developed as they need to be. The ULHT Workforce Operational Plan for 2018-19 was produced in September 2017 and it should be the reference point for more detailed information on our workforce plans for the 18/19 financial year. That document recognises that our ability to undertake effective workforce planning is inhibited by:

* A lack of confidence in our current establishment and the validity of it as a sound, cost effective base on which to build
* Lack of clear plans (at both STP and ULHT levels) for services and clinical pathways, around which we can build a workforce plan.

Two important projects are address this:

* The ‘right sizing’ exercise, led by KPMG. This work looks to map current demand for services against current workforce resources and configuration, making recommendations on the optimum staffing numbers and skill mix. It seeks to benchmark ULHT against model hospital comparators to identify areas of focus. This work will be completed by the end of March.
* The internal review of all clinical services programme known as the Clinical Services Review (“CSR”). This work focusses on improving the quality, productivity and performance of each service. Aligned with the STP work and the Acute Service Review, this project will set a future direction for services and changes required in the workforce are being assessed as part of the project.

**Factors impacting on the establishment**

Alongside this fundamental review of the services ULHT provides and the way it provides them, we know of a number of other factors that will impact on the ULHT establishment during 2018/19:

* Contract negotiations – we expect, as we negotiate new contracts with the CCGs, that there will be an expectation of efficiency savings to be delivered by the Trust
* There will be further opportunities during the year to explore different workforce models and to pilot the introduction of new roles
* Other 2021 work programmes, such as “productive hospital” will identify efficiency opportunities that will impact on staff

**Workforce construct**

The current construct of the workforce has been analysed, in terms of age, gender and grade mix and recognise. There are a number of key workforce planning issues arising from this:

* Assuming no change to the existing workforce then in 5 years’ time, 36.81% of Trust employees will be aged 55+ and 20.89% will be aged 60+. There is a risk therefore of a significant loss of numbers, skills and experience as people take the retirement option
* The need to ensure there are equal opportunities for female staff to take senior positions in the Trust and that Clinical Excellence Awards have no gender bias

**Key areas of focus**

The workforce plan focuses on how the Trust establishment is filled, once it is clear what it should be, how it is sustained and how staff productivity can be maximised. Particular priority areas include:

* Reducing agency spend e.g. by maximising the usage of banks and by managing down rates
* Improve recruitment success rates e.g. by being clear about our employment brand and our offer to staff and using agencies to support recruitment to vacant positions
* Increase workforce supply e.g. by extending the work of our successful Talent Academy, maximising our use of apprenticeships, looking at development pathways for staff
* Improve retention rates e.g. by focusing on an offer based around development opportunities, providing more flexibility in contracting arrangements to enable staff to remain in employment with ULHT, approach to talent management
* Maximise productivity and performance – e.g. by job planning and rostering, effective performance management, robust sickness management and structured learning and development
* Consistent safety culture across all sites e.g. by having a clear narrative, based around our vision and values, consistent leadership and targeted learning
* Sustaining engagement through change e.g. by introducing and involving staff in a consistent improvement methodology
* Address equality and diversity issues in the workforce