HEALTHY LIVES HEALTHY FUTURES - 2015 TO 2020

FORMING A FIVE YEAR FORWARD VIEW FOR HEALTH AND CARE ACROSS NORTH LINCOLNSHIRE AND NORTH EAST LINCOLNSHIRE

JULY 2015

Contents

1. Introduction

'Healthy Lives Healthy Futures' (HLHF) puts the person at the heart of everything we do. It is established as the framework for all health and adult social care organisations (commissioners and providers; primary, community and secondary) across the combined areas of North Lincolnshire and North East Lincolnshire: referred to within this document as Northern Lincolnshire to recognise the areas where we are working together to improve quality and outcomes for people.

Our work under HLHF is population based, using the 'local place' concept as the building blocks and combining our collective efforts where it is necessary to consolidate services for greatest effect. It is also designed by health and care professionals working together through using multi-professional groups to co-produce transformations and deliver them.

There is much hard work being done in North Lincolnshire and North East Lincolnshire at local level to ensure services meet our populations' needs in the local place. This report outlines the collaborative work undertaken so far and highlights the areas where planning and delivery is best done across Northern Lincolnshire. It is led by several groups of professionals and overseen by the Accountable Officers representing the local Health and Care organisations.

Sections two and three, set the context and drivers for change. Sections four to six describe the vision, guiding principles and emerging models for the future, specifically around enhanced out of hospital health and care provision and options for acute hospital care provision. Sections seven and eight outline the governance arrangements and summary of the next steps. Section nine describes the key business and organisational structures, systems and processes that run hand in glove with the health and care professionals work. Finally, section ten describes wider geographical implications in assuring sustainable, acute, tertiary and specialist health care services.

This document concludes that securing vibrant integrated care across health and social services, along with full patient and public engagement in local places, are the critical building blocks to deliver our overall vision across Northern Lincolnshire. In years one and two we will, therefore, concentrate primarily on securing the agreed 'Out of Hospital' efficiencies and transformations – seeing more people being supported closer to their home and a greater share of services delivered out of hospital.

Also during 2015-17 we will build and begin to deliver a pipeline of 'In Hospital' schemes in the expectation that capacity and capability will need to be adjusted and transformed to reflect a very different pattern of need and demand for medical and surgical services at acute, specialist and tertiary levels. This

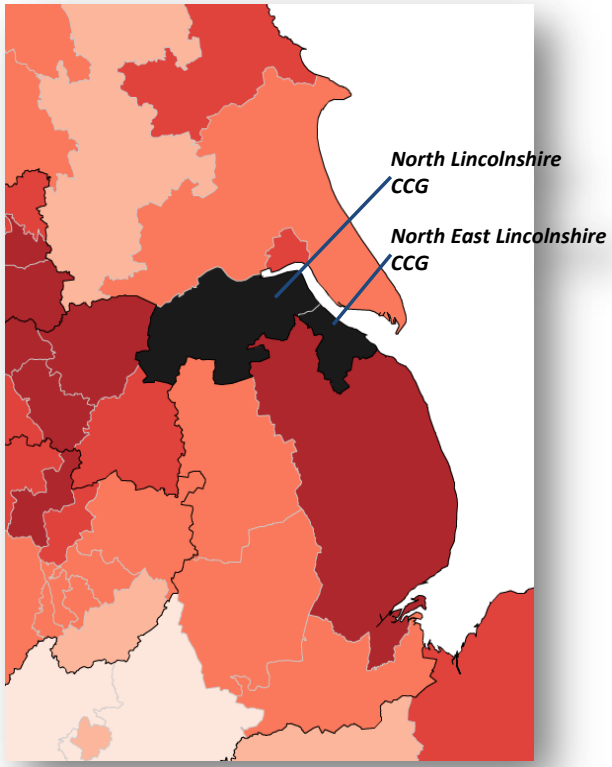
will require significant collaboration at hospital level across a wider area than Northern Lincolnshire. We will consider a range of options that could influence commissioning plans and provision in other parts of Lincolnshire, Humber and beyond where necessary.

This document is a collation of the views and materials produced by a significant number of local clinicians and professionals and draws on models of emerging best practice from elsewhere, both nationally and internationally

2. Health and Care Community Context

2.1 The Strategic Role of Local Government in "Place Shaping"

It is of vital importance to the prosperity of a local area to create a culture and environment that stimulates the development of a strong and sustainable economy, a place that meets local people's aspirations and potential and a place where people want to live and work. This is the primary role of the local authority and this agenda is pursued through a variety of geographies of interest, nationally, at regional and sub-regional as well as within communities in the local authority area. The local authority areas of North Lincolnshire and North East Lincolnshire may share some areas of common concern but they are distinct areas with different drivers and challenges. The future shape of the health and social care economy is an integral part of this agenda, led by local government working with the NHS.



2.1.1 Geography and Health and Care Provision within Northern Lincolnshire

For the purposes of this strategy and delivery plan Northern Lincolnshire comprises the populations of North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups and Local Authorities. These localities span the area south of the Humber River, bordering the East Riding area, South and Central Lincolnshire and South Yorkshire. There is a mix of very rural and urban areas with some heavy industrial areas.

The health and care system is covered through the following network of organisations (commissioners and providers):

- 2 Clinical Commissioning Groups – North East Lincolnshire CCG and North Lincolnshire CCG
- 2 Local Authorities – North East Lincolnshire Council and North Lincolnshire Council
- 1 NHS Acute Hospital – Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)
- 1 NHS Mental Health Trust – Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
- 1 Mental Health Social Enterprise Organisation – NAViGO
- 1 Community Benefit Health and Social Care Provider – Care Plus Group
- 1 Adult Health and Social Care Social Enterprise Organisation – FOCUS
- 1 Independent Hospital provider (planned care) – HMT St Hugh's
- 1 NHS Ambulance Trust – East Midlands Ambulance Service NHS Trust (EMAS)

North East Lincolnshire

In comparison to the national average:

- ✓ General health is worse
- ✓ Deprivation is higher
- ✓ Lower life expectancy
- ✓ Higher under 18 alcohol specific hospital stays
- ✓ Higher rates of teenage pregnancy
- ✓ Lower GSCE attainment
- ✓ Lower rate of breastfeeding
- ✓ Higher rate of smoking at time of delivery
- ✓ Higher rate of obesity in adults
- ✓ Higher rate of alcohol related stays (adults)
- ✓ Higher rate of smoking related deaths
- ✓ Higher rate of adults who smoke
- ✓ More people are killed and seriously injured on roads
- ✓ The rate of TB is better

2.2 Population and Demographics

2.2.1 North East Lincolnshire[1]

The health of people in North East Lincolnshire is generally worse than the England average. Deprivation is higher than average and about 28.6% (8,600) children live in poverty. Life expectancy for both men and women is lower than the England average.

Life expectancy is 12.9 years lower for men and 7.9 years lower for women in the most deprived areas of North East Lincolnshire than in the least deprived areas.

[1] Source: Public Health England: Health Profiles – August 2014

North Lincolnshire

In comparison to the national average:

- ✓ Deprivation is lower
- ✓ Life expectancy for men is lower
- ✓ Rate of under 18 alcohol specific hospital stays is better
- ✓ Higher rates of teenage pregnancy
- ✓ Lower GSCE attainment
- ✓ Lower rate of breastfeeding
- ✓ Higher rate of smoking at time of delivery
- ✓ Higher rate of obesity in adults
- ✓ Lower number of self-harm related stays
- ✓ Higher rate of smoking related deaths
- ✓ Higher rate of adults who smoke
- ✓ More people are killed and seriously injured on roads
- ✓ Lower rates of TB
- ✓ Lower rates of Sexually transmitted infections

In Year 6, 19.1% (311) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 71.8, worse than the average for England. This represents 25 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

In 2012, 27.4% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 683*, worse than the average for England. This represents 1,061 stays per year. The rate of self-harm hospital stays was 201.4*. This represents 323 stays per year. The rate of smoking related deaths was 371*, worse than the average for England. This represents 334 deaths per year. Estimated levels of adult smoking are worse than the England average.

Priorities in North East Lincolnshire include early intervention by investing in children's and family services, tackling health inequalities in the most deprived wards by creating new economic opportunities and building community capacity and resilience, creating new opportunities in communities to help older people maintain their health and independence as long as possible.

2.2.2 North Lincolnshire[2]

The health of people in North Lincolnshire is varied compared with the England average. Deprivation is lower than average, however about 20.4% (6,100) children live in poverty. Life expectancy for men is lower than the England average.

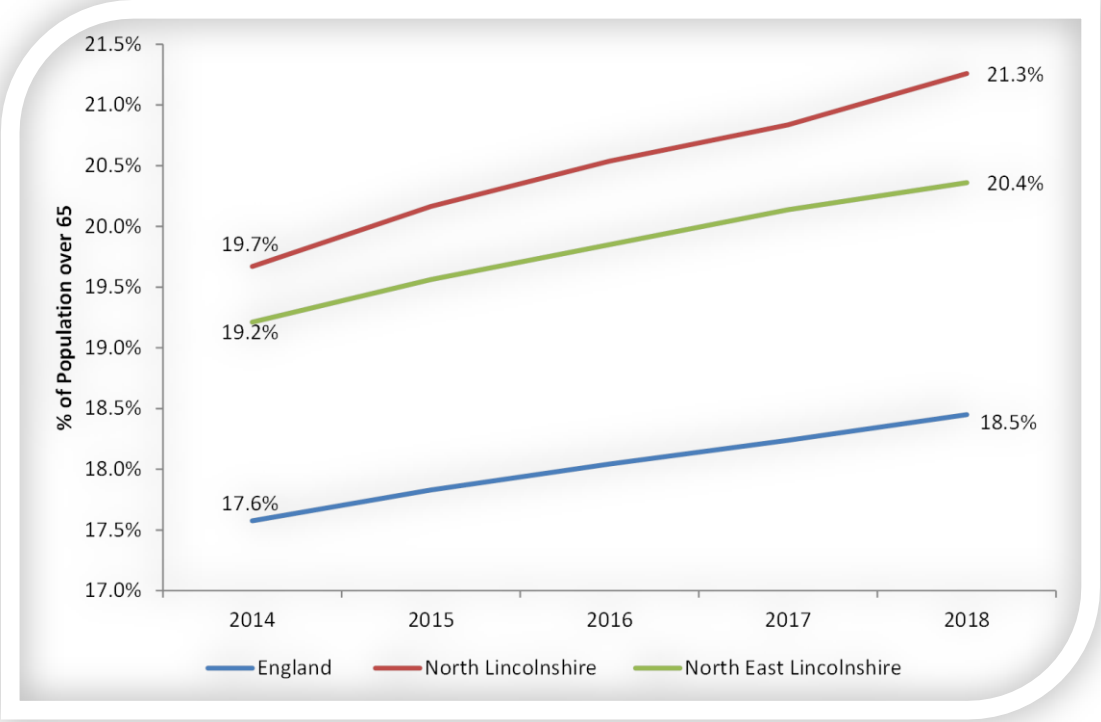
Life expectancy is 6.6 years lower for men and 10.5 years lower for women in the most deprived areas of

[2] Source: Public Health England: Health Profiles – August 2014
*Rate per 100,000 population

North Lincolnshire than in the least deprived areas.

In Year 6, 19.9% (312) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 25.4*, better than the average for England. This represents 9 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

In 2012, 32.0% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 632*. This represents 1,049 stays per year. The rate of self-harm hospital stays was 143.5*, better than the average for England. This represents 237 stays per year. The rate of smoking related deaths was 335*, worse than the average for England. This represents 321 deaths per year. Estimated levels of adult excess weight and smoking are worse than the England average. The rate of people killed and seriously injured on roads is worse than average.



Priorities in North Lincolnshire include improving health and reducing inequality through: Best Start, Healthy Lifestyles and Healthy Ageing.

2.2.3 Northern Lincolnshire

The 'Northern Lincolnshire' system builds on the populations in North Lincolnshire and in North East

Lincolnshire totalling 327,000 residents. Although both places have unique profiles, there are a number of common themes, which make it sensible to plan across the wider footprint.

Health profiles of residents within Northern Lincolnshire are poor with huge variation in deprivation across the region. On average, men living in one of the most deprived areas of Northern Lincolnshire will die 13.6 years earlier than those living in the least deprived area; for women, the figure is 11.5 years. Residents of Northern Lincolnshire have poorer health than most other areas in the country with higher levels of obesity, smoking, mortality from heart disease and drug and alcohol misuse.

Northern Lincolnshire's population is getting older, and ageing faster than the national average. Older patients typically require more health and social care, particularly for conditions such as dementia, and they are also more likely to suffer from complex co-morbidities (several health problems simultaneously), which makes treatment more difficult and costly. The elderly population represents 20% of total population, yet they account for 60% of bed days.

As a result of lifestyle changes and increased obesity, related medical conditions such as diabetes are increasing as well. Diabetes is expected to rise by 2030:

- By 26% in North Lincolnshire
- By 13% in North East Lincolnshire

With a deprived, dispersed and elderly population, all significantly higher than the national average, the pressure is building on the healthcare providers to provide more care, without increased funding. Dispersed sites further compound the problem, providing minimal economies of scale and high reference costs highlighting areas of operating inefficiency.

It is apparent that the Northern Lincolnshire health and care system faces a significant challenge to sustain the delivery of high quality care within its financial envelope. The forecast annual uplift of 1.7% will not allow the Northern Lincolnshire system to keep up with the financial consequences of the growth in demand for health and care service because of the unrecognised pressure derived from the size of the growing ageing population and the additional costs associated with providing a multi-site provider.

3. Drivers for Change

The drivers for change are common in the main for North Lincolnshire and North East Lincolnshire with increasing demand, and new technologies expected to be met within an ever-tighter NHS budget

- Locally, we have particularly demanding health needs, due to several factors: high levels of deprivation, public-health issues such as smoking, increased levels of long-term illness requiring support, and a rapidly aging population.
- The NHS overall is setting ever-higher standards of healthcare in order to improve patient experience and meet rising expectations.
- Specifically, our current services need to be transformed to take advantage of new technologies and to build on new and improved ways of working. We have some areas of excellence – such as patient outcomes for hernia operations and hip replacements, and patient satisfaction with GP services – which we must be sure to build upon. On the other hand, given current levels of demand many of our services are under pressure. In our current multi organisational, multi-site configuration services are struggling to attract sufficient workforce to deliver core services across 7 days.

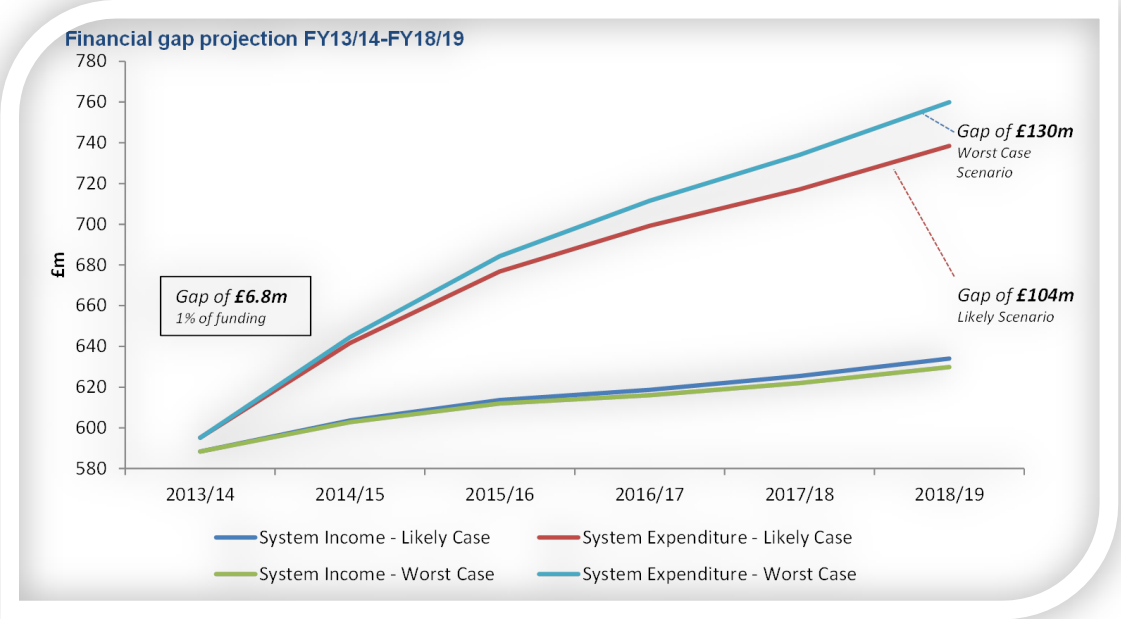
3.1 Quality and Patient Experience Improvement

Under pressure to meet the growing health and care needs of the population more efficiently without compromising the quality of care, it is important to consider the Northern Lincolnshire quality metrics in comparison to peers and national averages, across both health and social care.

Generally both North Lincolnshire CCG and North East Lincolnshire CCG perform very well on 'Adult Social Care Outcomes'.

In North Lincolnshire 10 of the 19 outcome indicators are in the top 25% of England. An additional 4 are above the English average. Admissions of older adults within residential and nursing care are higher than the England average although our age of admission is going up and the length of stay is decreasing, suggesting that people are enabled to remain at home for longer.

However in North Lincolnshire the number of people receiving self-directed support is considerably lower than the average in England, Yorkshire and similar local authorities. This figure is better in North East Lincolnshire where the vast majority of people are receiving self-directed support, however in North East Lincolnshire there are delays in supporting people to leave hospital bringing that above the national average.



The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures. The overall SHMI has improved from 2011 to 2014, however, out of hospital SHMI has remained high.

For the 2014/15 period, out of hospital SHMI has increased, and in hospital continues with the downward trend. This suggests further interventions are required in the community, and the potential need for greater integrated care.

3.2 Financial Challenges

Commissioners and providers within Northern Lincolnshire have been working together to review the financial planning data and form a joint view of the size of the current and forecast financial deficit position for the health and care economy, between funding and cost of service

provision. The graph below shows the base 'likely scenario' along with medium and worst case scenarios based on risk.

In line with other health and social care economies there is uncertainty at CCG level around future funding and the impact of factors such as demographic change, disease prevalence and increased cost of provision. Although the projected gap is estimated at £104m, there are potential risks that could cause this gap to increase to £130m should 'worst-case' criteria be met:

- Allocations may be less than expected
- Demand grows at a faster rate or higher than the 2% expected rate
- Inflation assumptions vary significantly from what is expected
- Pay restraints fail, and pay awards are applied
- Further increase in regulatory quality investment

There will also be implications for Local Authorities from the Care Act 2014, a summary of the reforms can be found below:

- Adults' well-being, and outcomes, is at the centre of every decision;
- Focus on preventing and delaying needs, and integration and partnership working is reinforced;
- Carers placed on same footing as those they care for;
- Embedding the right to choice through care plans and personal budgets;
- New national eligibility criteria;
- From April 2016, a ceiling on care costs incurred by adults;
- Deferred payments scheme with wider range of opportunities;
- Self-funders entitled to ask the local authority (LA) to procure services to meet their needs;
- Places adult safeguarding on a statutory footing
- Extends the opportunity for independent advocacy

From this analysis it is clear that "do nothing" is not a viable option to deliver a sustainable health and care service for people within Northern Lincolnshire.

3.3 National Drivers

As part of the Care Design process, the Northern Lincolnshire system has considered the national and regional direction of travel. The national Five Year Forward View, which was published in October 2014, sets out a clear direction for the NHS – showing why change is needed and what it needs to look like. This plan outlines 7 models of care, and these all have implications for Northern Lincolnshire:

- Multi-specialty Community Providers – proposing expansion of GP group practices bringing in nurses and community health services, hospital specialists and others to work together to provide integrated out-of-hospital care
- Primary and Acute Care Systems (PACS) – with potential to develop list-based health and care services in single NHS organisations that are accountable for the whole health needs of a registered list of patients, changing the accountability of care across a population or patient cohort
- Urgent and Emergency Care Networks – the simplification of urgent and emergency care systems to provide better integration, utilisation of pharmacists, out-of-hours GP services and offering further freedoms for nurses, midwives and ambulance team, strengthening l triage and advice services to help patients navigate the whole system more successfully
- Viable Small Hospitals – proposing a new care model for smaller acute hospitals, which could include new approaches to medical staffing, satellite services, and support for smaller hospitals to achieve sustainable cost structures
- Specialised Care – a drive for consolidation of specialised services for rare diseases. As part of this new care model, specialised providers will be encouraged to develop networks of services over a wider area, integrating different organisations and services around patient need
- Modern Maternity Services – reviewing current maternity services, to make sustainability recommendations, making it easier for groups of midwives to set up NHS-funded maternity services, and to ensure that tariff-based funding supports patient choice
- Enhanced Health in Care Homes – to build on work being done locally with the Better Care Fund, the NHS and local authority social services departments will work in partnership with Care Homes to develop new service models and support mechanisms to improve quality of life, to reduce hospital bed use and yield significant cost savings.

Where it is helpful the HLHF partnership may wish to become part of the national pilot sites and would want to be involved in the learning from them.

4. The Story so Far

The Healthy Lives Healthy Futures (HLHF) programme was established as the framework for all health and care organisations across Northern Lincolnshire to work together to improve quality and outcomes, and to establish affordable and sustainable arrangements that will meet the needs of the complex population within the locality.

The case for change has been developed through a 'Single Version of the Truth' (SVT), which has been agreed by all commissioner and provider organisations within Northern Lincolnshire. This sets out in more detail the inherent challenges we face regarding rising quality requirements and increasing cost restraints.

Although there have been noticeable improvements over the last 10 years or so, the long standing challenges have culminated in significant risks to the sustainability of local services in their current form, for example: workforce gaps through a local and sometimes national shortage of key professionals and other staff, along with an increasingly transient and aging workforce; inconsistent quality and outcomes for people; suitability of some health and care facilities (from hospital through to primary care); and a rapidly expanding gap between expectation/demand for services and the pressures on public funding (the 5 year gap projection has grown by almost 50% in the last year to around £110m).

The NHS Five Year Forward View reinforces the emerging local developments for integration of provision health and care. For example: proactive approaches to prevention and management of care and the 'working together' arrangements e.g. integrated health care provision across community and hospital in NLs and joint venture ideas in NEL, and creating Urgent Care networks across wider Lincolnshire and parts of Yorkshire and Humber. Along with the challenges associated with structural change where we have recognised that we will need high level support.

There are three planning dimensions to the health and care system in Northern Lincolnshire:

1. Local level - defined by each CCG geography
2. Central across Northern Lincolnshire – defined by the NLAG hospital footprint
3. Regional across Lincolnshire, South Yorkshire and Humber – to reflect largely health related networks and specialised services

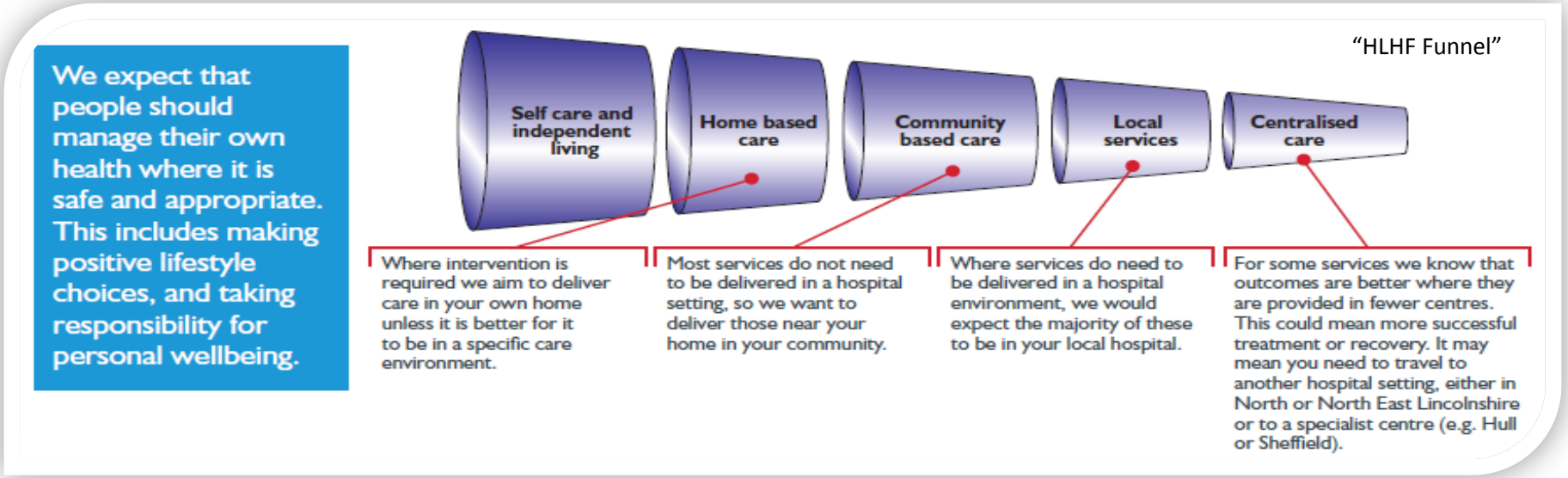
Over the past two years the HLHF programme has been engaging with local clinicians and the public to identify areas of priority in terms of safety and quality and has delivered a full public engagement and consultation process around the centralisation of two specific services:

- Hyper Acute Stroke services
- Ear Nose and Throat Inpatient Surgery services

The consultation process was successfully managed and the CCG's made final, unchallenged decisions on the permanent location of Hyper Acute Stroke services (Scunthorpe General Hospital) and ENT Inpatient Surgery services (Diana Princess of Wales Hospital in Grimsby). The implementation of these changes is part of the next phase of the HLHF programme.

4.1 The Vision

Commissioners and providers of health and care services in Northern Lincolnshire have chosen to work collaboratively to maximise health outcomes for patients through the vision of integrated health and care described locally as the "HLHF Funnel."



To deliver this vision the organisations have agreed to work flexibly and collaboratively across Northern Lincolnshire, working together where appropriate and locally where necessary to ensure that the services that are commissioned for each CCG's population are tailored to the particular local circumstances and the needs of the different areas.

CCGs, Local Authorities (LA) and local providers are working locally to bring together all services at community, home and independent living levels.

Where services are best delivered at large scale (e.g. surgical procedures, emergency care, critical care, cancers, cardiology etc.) health and LA commissioners and providers are working together across Northern Lincolnshire to create the arrangements that will maximise health outcomes for patients: creating more effective and sustainable models of hospital and related services at local and central levels ('right side' tiers).

Each of the commissioning and providing organisations are statutory bodies in their own right and have their own Governing Body (or Board), sub committees and wider governance structure. The Governing Bodies are the ultimate decision making bodies within the terms of their defined accountabilities. To support the approach there are a number of staff who work in individual organisations and across the HLHF Collaborative.

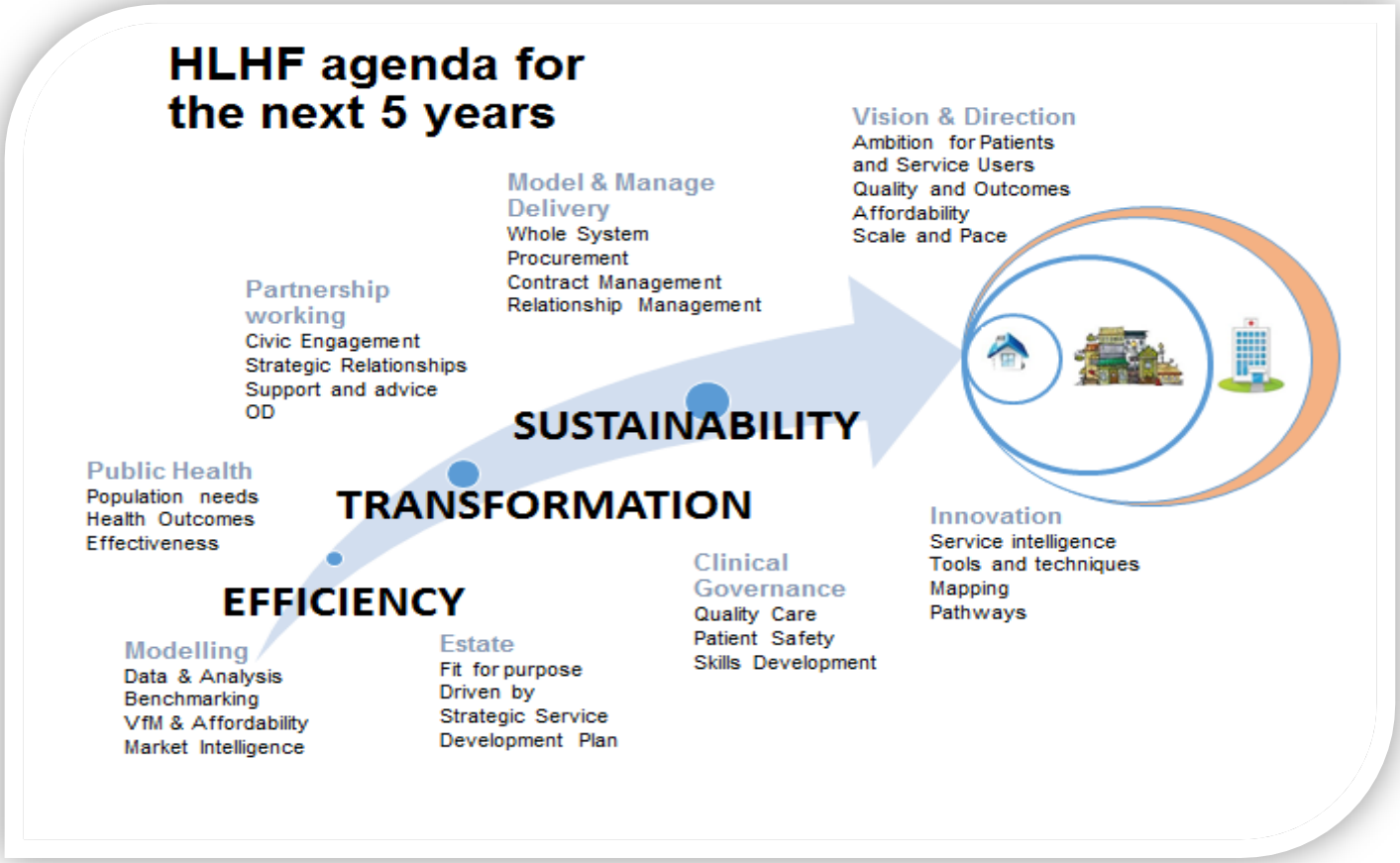
4.2 Guiding Principles

As part of this work we have agreed a set of guiding principles demonstrated on the diagram to the right:

5. Vision for Health and Care Services in Northern Lincolnshire

The HLHF programme is committed to being driven and led by health and care professionals, with a focus on improved quality of care and outcomes for patients. We need to balance this key aim with providing services that are sustainable in both terms of quality and affordability into the future. Our local health and social care professionals have been working together over the past few months to develop a vision for services that will address some of our immediate challenges but also sets out a clear direction of travel that will enable us to be more innovative and dynamic in the way the we plan and deliver health and care services moving forward.

We recognise that we have some immediate issues that we need to address across Northern Lincolnshire (North Lincolnshire and North East Lincolnshire). We have been engaging



with local clinicians across the spectrum over the last few months to agree what our priorities should be for health and care and work with them on some possible options for delivery. These options will need to be supported by a number of activities and functions and an outline of the HLHF agenda over the next 5 years is described in this diagram.

The health and social care community have agreed that there should be a greater focus on enabling people to take more responsibility for their own care (with support where required) and ensuring that we provide as many services as close to people's homes and communities as possible. The aim is to create a "shift to the left" that would see more people being supported closer to home and a greater share of services delivered out of hospital – see section 4.1 'The Vision': the HLHF Funnel.

Throughout the early stages of engaging health and care professionals a common view has emerged that the key to making local services sustainable is to make sure that we get the out of hospital and community care model right. In order to deliver joined up services and improve outcomes for patients, we are clear that we need to enable local health and care professionals to work more closely together and reduce the barriers that they face on a day to day basis.

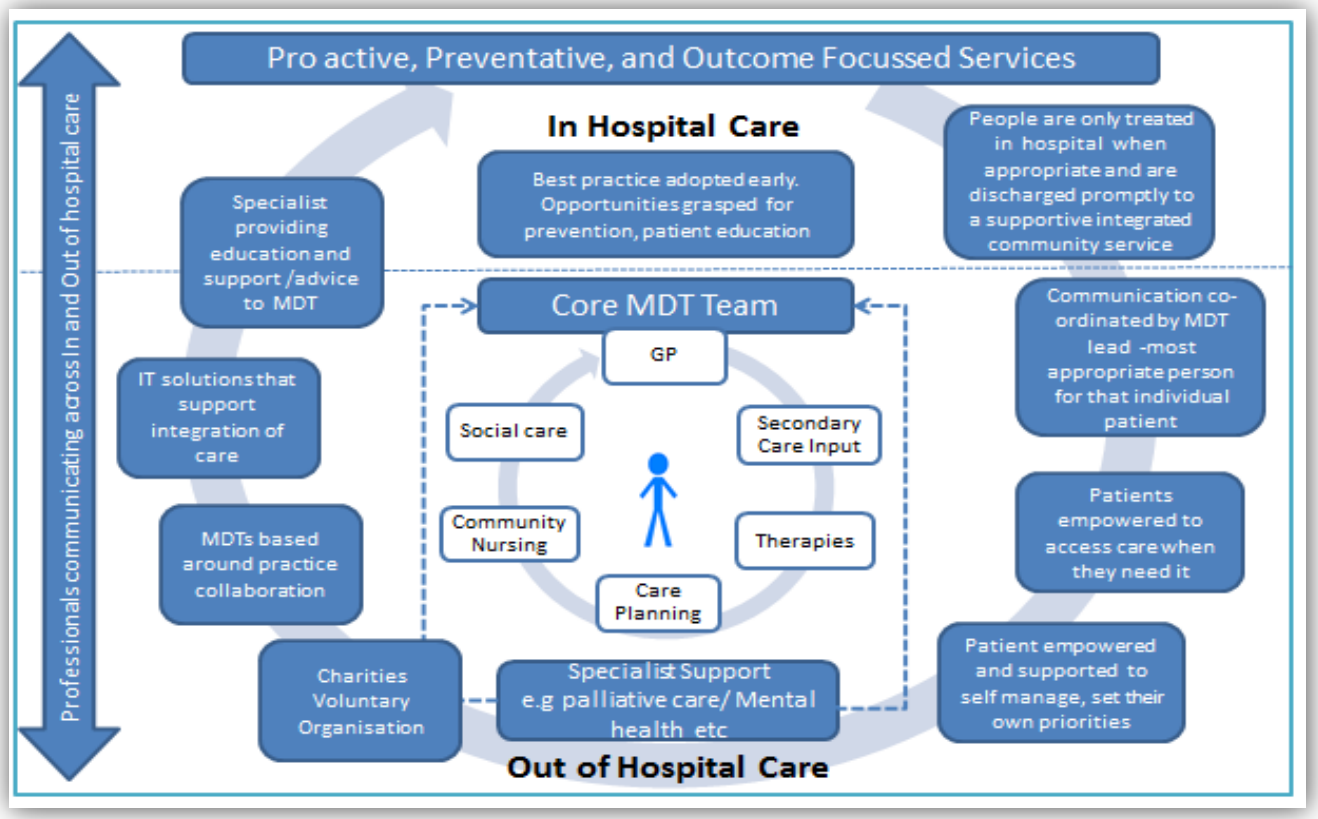
In order to support this process we have developed a framework (page 18) which: identifies 5 health and care workstreams (at the centre of the honeycomb) across in hospital and out of hospital; recognises the key enabling work that will be required to achieve comprehensive, system wide, service redesign; recognises a sliding scale of general and specialist inputs; the importance of a fully involved public in all aspects; and shows how it relates to delivering the vision.

Working groups drawn from a wide range of health and care professionals have been established to strengthen the visions and work up the detailed plans to deliver it. This is described in the framework on the next page:


HLHF Key Work Streams – Clinical Focus
In Hospital
Specialist
Generalist
Workforce Planning & Organisational Development
Clinical and Public Health Engagement
Quality and Outcomes
OUT OF HOSPITAL
PLANNED CARE
UNPLANNED CARE
CHILDREN & FAMILIES
LONG TERM CONDITIONS
END OF LIFE CARE
IN HOSPITAL
Finance and Contracting
Information Technology
Estates, facilities, transport
Out of Hospital
Fully engaged public and patients

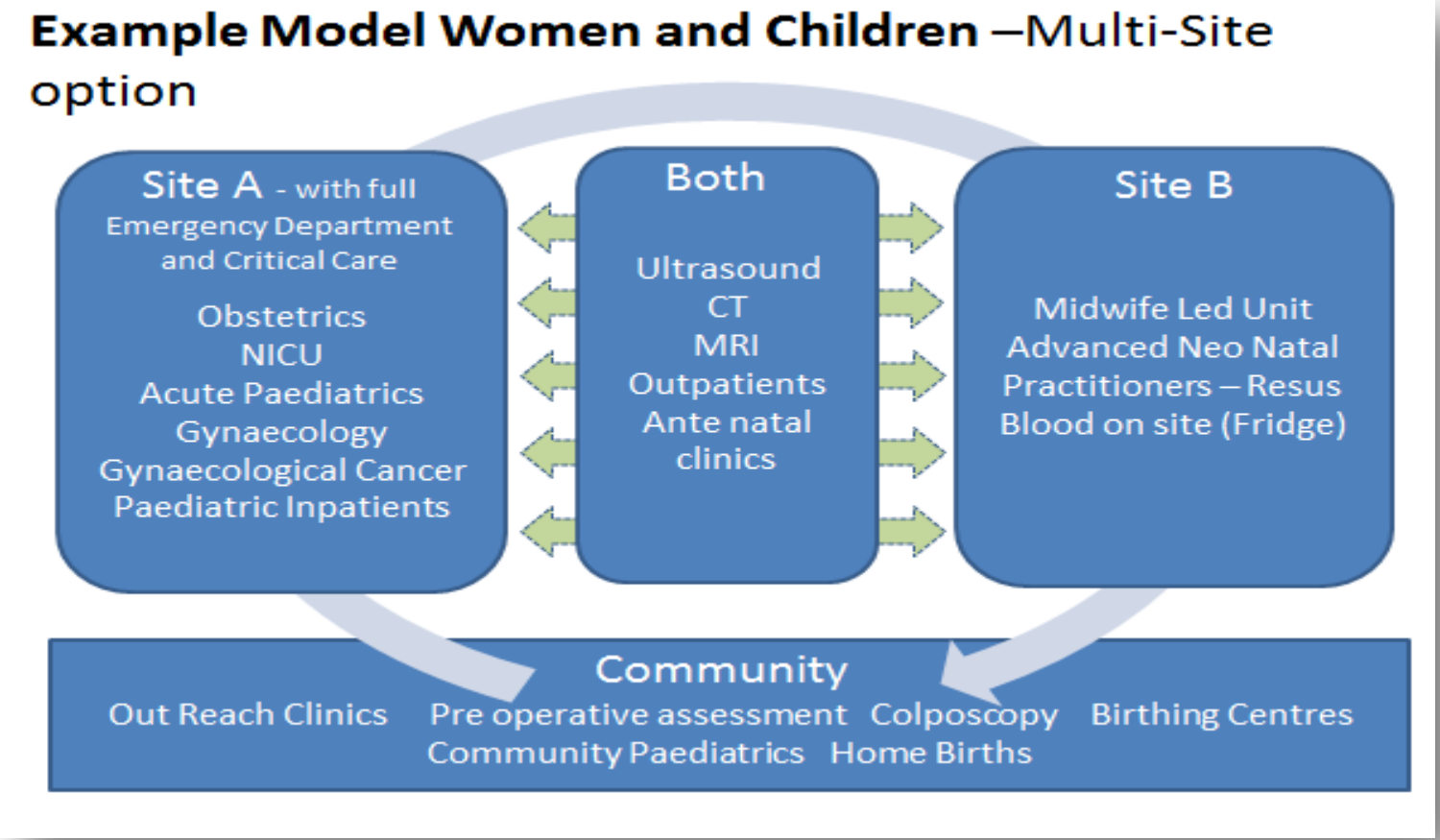
The work of the groups is being overseen by the HLHF Health and Care Professionals Leadership Group. Throughout February and March 2015, the working groups met to describe a high level vision of their respective service areas. On this page is an **example** vision which outlines emerging local thinking around **Long Term Conditions management.**

The diagram opposite describes a multi-disciplinary out of hospital approach that centres care planning around the person receiving services and makes best use of the resources that we have available in local communities. There is a strong link to secondary care, as input can be provided by consultants as part of the MDT team. This model defines what services for particular specialities should be provided in the community and then therefore what else can only be provided safely in a hospital environment, a concept that is being implemented in some areas already such as diabetes, with the "Super 6" model.



The HLHF programme recognises that whilst women and children's services are not the priority driver for change, the services have some fundamental interdependencies with other services. The working group have defined alternative models that would apply in scenarios where the acute trust is providing services across multiple sites (see diagram), or from a single site:

Emerging models will be further refined throughout the year with a view to public engagement and consultation towards the end of 2015/early 2016.



6. Options for Delivery of the HLHF Vision

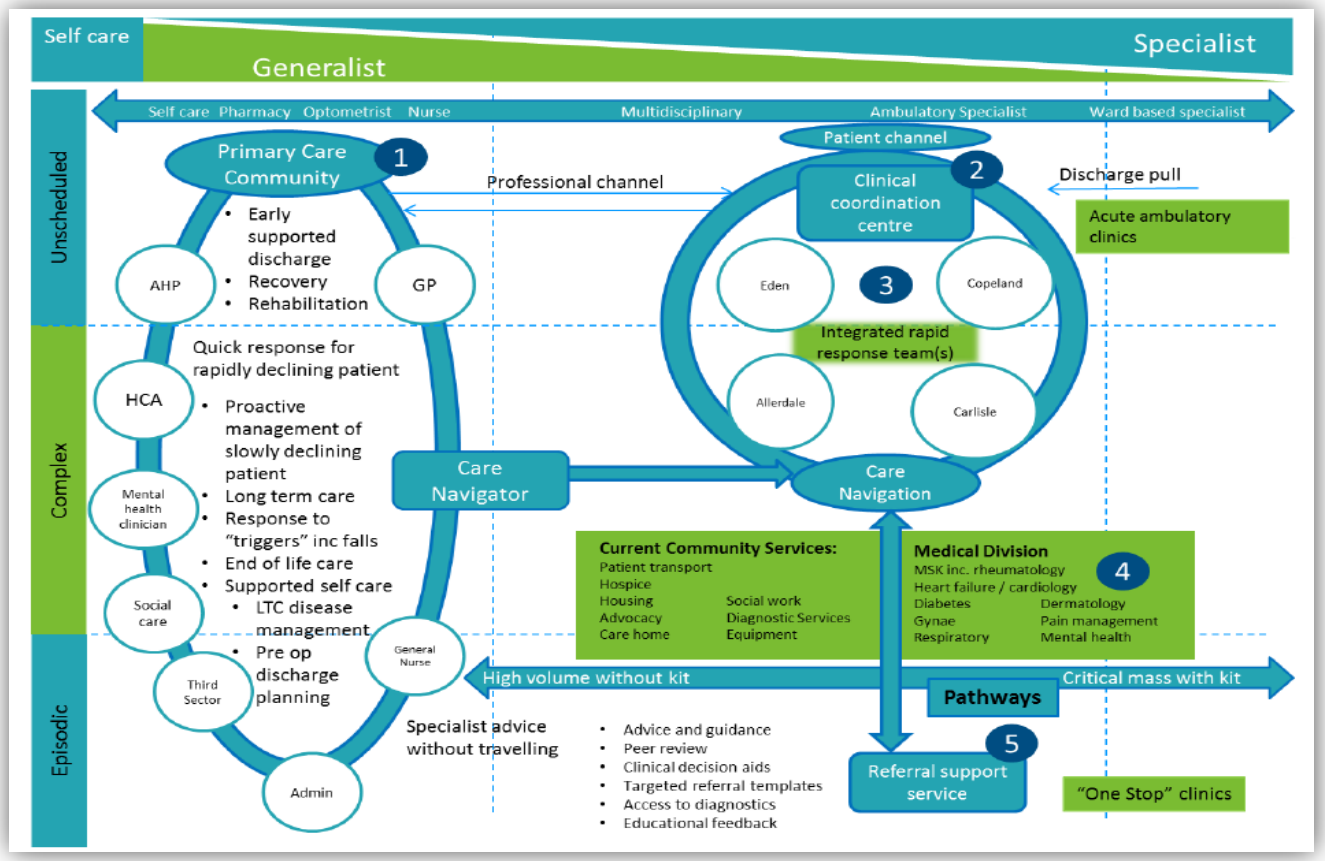
Example A – North Cumbria

6.1 The Enhanced Out of Hospital Model

We are clear that an enhanced out of hospital model which enables health and social care professionals to provide more joined up services closer to people's homes and communities should form the basis of any system wide model of care and so the variation in the options outlined below centres largely around the acute element of the system wide model, using the enhanced out of hospital model as a basis.

We have considered many existing models for out of hospital care, nationally and globally, and we believe that this is the key to building a sustainable future for health and care services across Northern Lincolnshire.

Example models that we have considered from



North Cumbria (A), York (B) and Valencia (Alzira Model) can be seen on pages 21 to 24 – both North Cumbria and York are in early stages of delivery and recognised as NHS Vanguard and Pioneer for Integrated Health and Care, respectively:

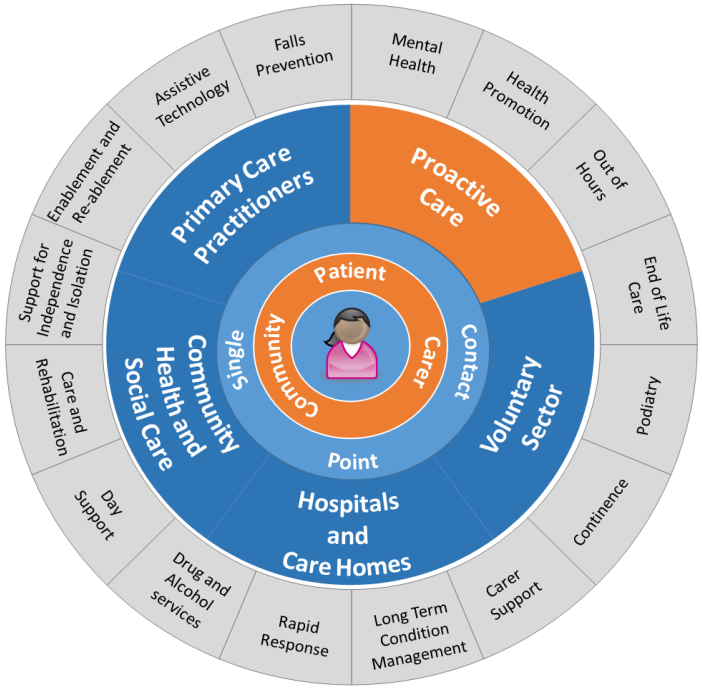
Source – Price Waterhouse Coopers

The York model is built on the CareMore model from California.

Example B –York

WHAT

- A range of health and care professionals working together to meet all of the health and care needs of their residents
- Actively liaising with professionals where onward referral for specialist support is needed



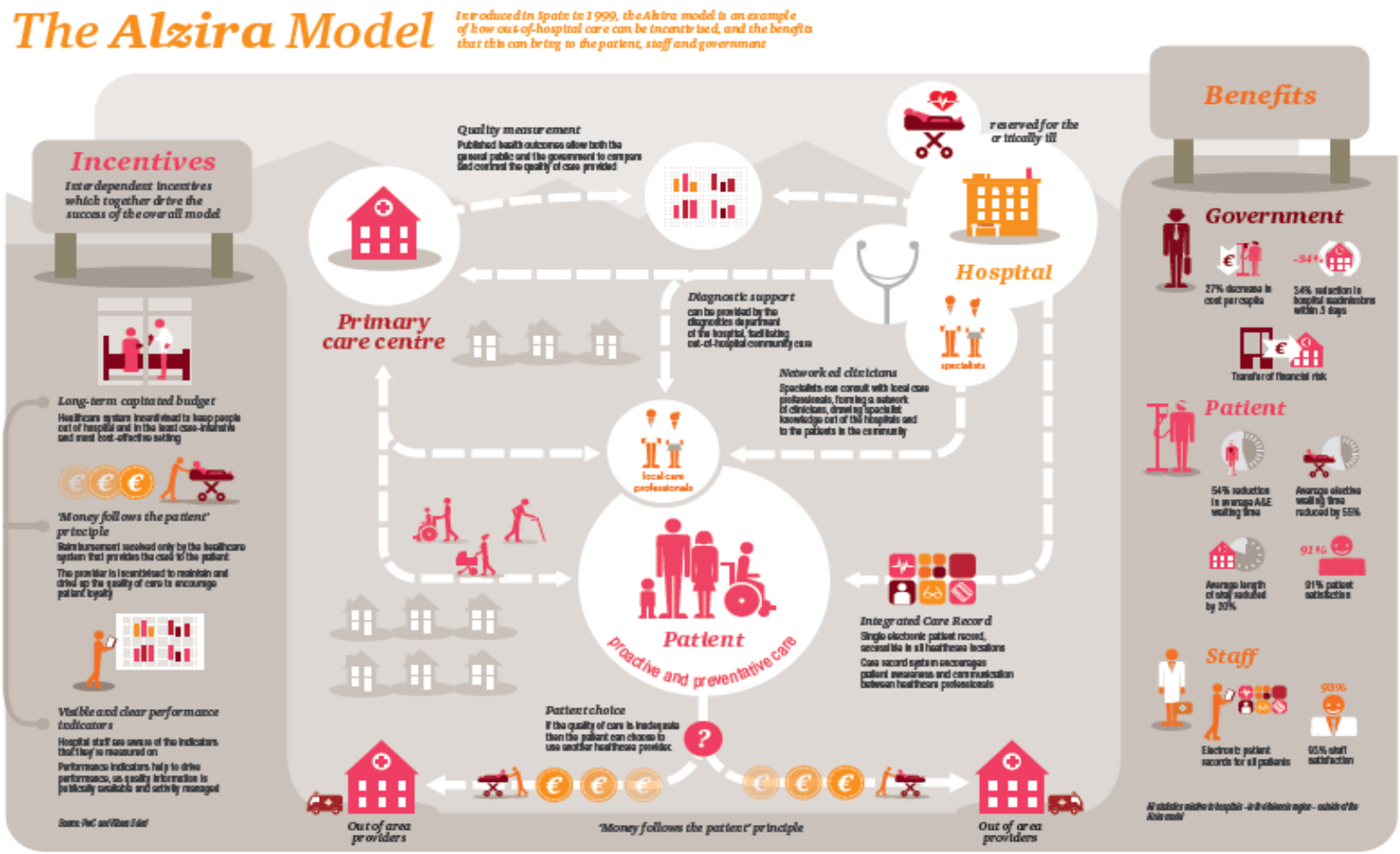
HOW

- Doctors (family health and medical), Nurses, Social Care, AHPs and Pharmacists
- Working from health and care facilities integral to the Hub
- Accountable for outcomes and funding across all settings in an outside the 'Hub'

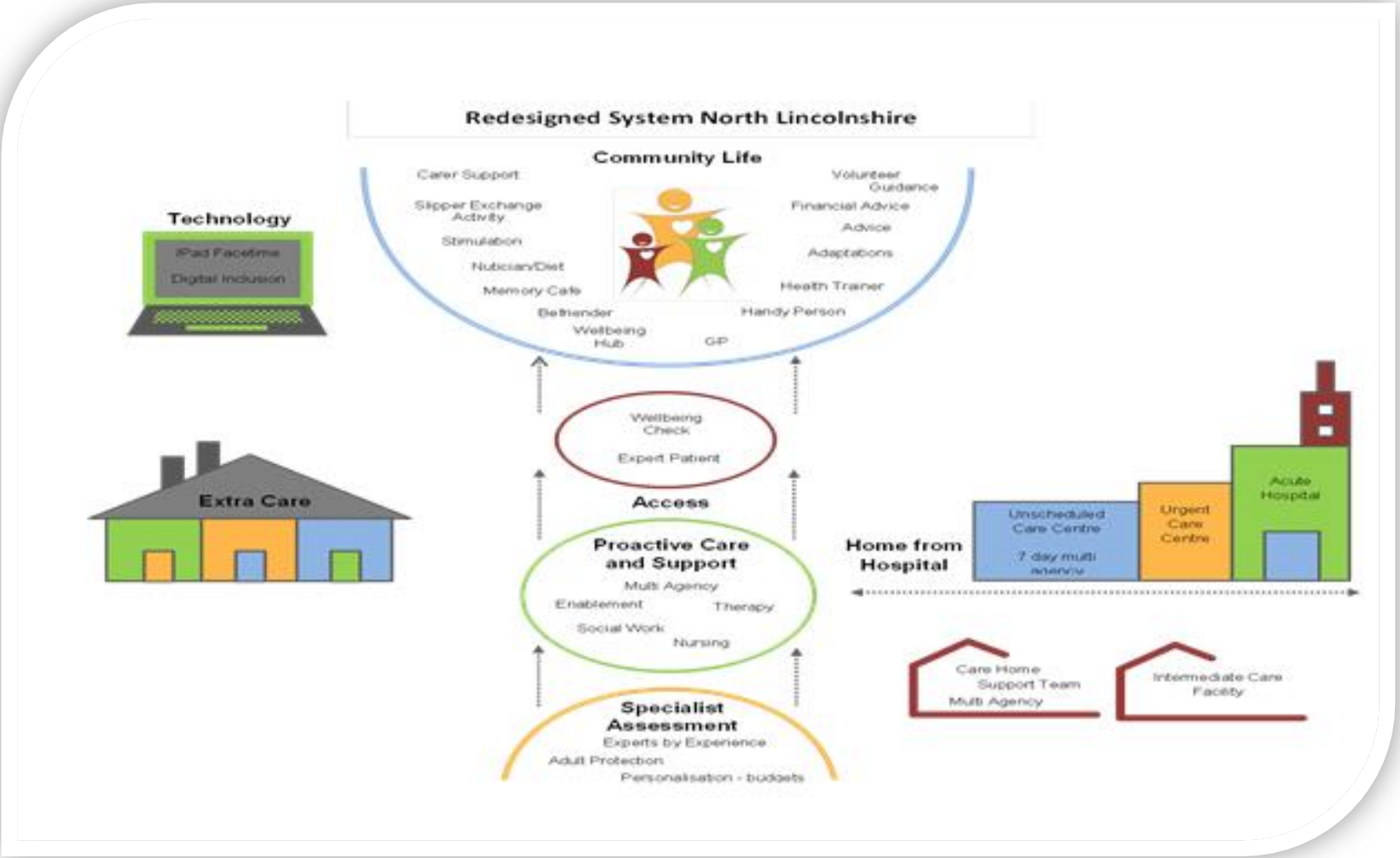
Example C – The Alzira Model

From a delivery perspective we can draw on learning from the "Alzira model" from Valencia (see next page), which is a strong example of the 'art of the possible' and a powerful indicator of the time required to realise system wide benefits (5-10 years).

Source – Price Waterhouse Coopers



There is also a lot of work already happening in North and North East Lincolnshire that will support the delivery of the HLHF vision, such as the model developed as part of the Better Care fund (BCF) Work in North Lincolnshire.



Each of these models place a strong emphasis on health and social care working together with robust communication and being enabled by the organisational and functional support provided by a truly integrated working environment. Core teams assess people's needs jointly and are able to quickly work with colleagues to decide on the appropriate course of action or support required. The core teams are able to refer directly for specialist input (palliative care, drug and alcohol services etc.) where appropriate and the person receiving support is included in all decisions and care planning, in line with the "national voices" narrative for person centred coordinated care.

Across Northern Lincolnshire, we are committed to developing an out of hospital care model that is built on these principles and adapted to suit the particular demographic, geographic and demand profiles for North Lincolnshire and North East Lincolnshire.

We will need to adapt to what we see as our priorities, for example in some models that we have considered, mental health services sit "outside" or separate to core working, however we see mental health as an integral part of our model that will need to be considered on par with all services for local people.

We know that the biggest challenge will be engaging with our staff across the health and social care system, supporting people to recognise the benefit of our future model and then describing in detail how we are going to help them change the way that they work, to be part of a pro-active, preventative service that will deliver better outcomes for local people. Nowhere will this change be more acute than in primary and community services where much of the new care model we describe will have to be delivered.

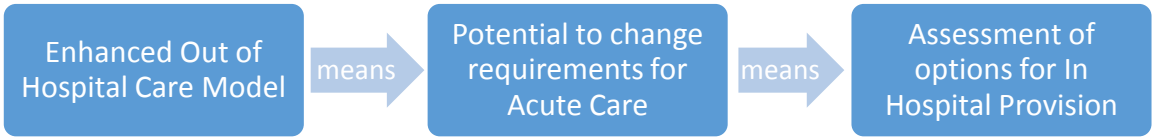
We will need to transform our workforce – sometimes with different and new skills, and better co-ordinated to provide effective and sustainable out of hospital care, which is fully integrated with secondary care specialists where people's needs indicate.

We will need to transform our health and local authority estate portfolio: integrate planning, be more efficient in how we collectively use our assets. This may mean revising current arrangements and agreeing new ways of sharing costs and risk across the system.

We will need to harness the most up to date technologies, enabling our staff to work more effectively from different locations and bases. Integrated IT and communication solutions will be one of the key enablers to developing this model of care.

6.2 The Options for Delivery of "In hospital care"

As stated above, we believe the enhanced out of hospital model will be the foundation upon which all other elements are built.



In considering the potential long term impact of transformed out of hospital care, along with the current challenges to modernising our acute hospital services, we believe the options should be tested in depth for feasibility.

North Lincolnshire CCG and North East Lincolnshire CCG have also outlined their respective plans for "Strategic commissioning Intentions". These plans describe what services the CCG consider, as an absolute minimum, should be delivered within their respective local areas, what services they believe can be safely and effectively delivered within an hour and what services are better delivered beyond an hour's travel time due to their specialist nature or the expertise that is available in other geographical locations. Therefore, these "Commissioning Intentions" must form the basis of the "local core offer" of services and so must also be taken into account when considering options for acute care delivery as part of this process.

Work that has been undertaken previously across Northern Lincolnshire has concluded that local health services as currently configured are not sustainable in the medium to long term, in terms of quality and cost. This was further supported in the document titled "Single Version of the Truth", which conducted detailed analysis of our expected population growth, activity and financial projections. If there is no significant change to the way that we provide services, we will not be able to sustain them into the future. Therefore we have concluded that "do nothing" is not an option we can put forward for further consideration.

Through the engagement process, other acute providers have confirmed their inability to support a transfer of activity from Northern Lincolnshire without significant investment in their infrastructures. Whilst investment could be possible, given current climate and the level of investment needed it would be unlikely. Therefore this document assumes a strengthening of flows to and from tertiary centres to ensure appropriate lengths of stay and timely repatriation of patients locally, it does not see a case for a health economy without acute provision within it.

Defining the configuration of in hospital care will take shape by following these steps;-

1. Delivering Efficiently Supports Delivering Quality –A robust, independently assessed, savings programme is in place, a programme which will drive efficiencies and eliminate wastage. Improved systems of working can deliver savings, through better focus of resources, and also support the consistent delivery of quality services to patients. This equates to £53m of £104m financial challenge set out in 3.2 above, £40m planned delivery from acute provision.

2. **We Must Work Together as a Health and Care Community:** 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 local economy. Integrated care 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.

3. **Consolidate where needed:** Given the continual difficulties faced with recruitment and activity volumes experienced in specific services there are areas of care currently provided which need to transform to ensure continued quality of care in the future.

The assessment of options available for acute provision is being driven by the following key factors;-

- ✓ Ability to access emergency care
- ✓ Critical mass of patient flow across the health and care pathways
- ✓ Ability to recruit and retain a 7 day workforce across core health and care services.
- ✓ The population base, referring to 5.1 above.

There are services which given the nature of provision are interdependent upon each other and therefore must continue to be provided in the one place. The clinical engagement discussions identify these services as those shown on the diagram to the right:

There are services which would benefit from the ability to consolidate, in particular services that are quite specialist/independent in the type of care they provide. These services would require co-location/access to acute infrastructure and are more planned care type services. Consolidation of services will only be possible when sufficient critical mass of activity volume is delivered through the enhanced out of hospital model. An enhanced out of hospital model when fully embedded needs to deliver sufficient transfer of activity to enable acute provision to be transformed to provide elective, day case and attendance based care within the NHS quality standards on a consistent basis and flex resources appropriately to meet variation in emergency care needs throughout the year.

Dependent upon the quantification of activity transferred through the out of hospital model and the population base served, the options that the clinical team feel merit further exploration are;

Option 1 - An in hospital configuration based across multiple sites, the portfolio of services dependent upon case mix, volume and ability to recruit.
Option 2 - One site option sufficient in size and capability to care for the level of demand.

a) New build
b) Expansion of an existing site

To further define the options over the coming weeks, the table below identifies key questions raised through the clinical teams which need to be addressed

Define the change in patient flows	In addition to the question regarding distance between the Grimsby, Scunthorpe and Goole sites, Northern Lincolnshire & Goole FT provides care to approx. 22,600 (25%) inpatients and 89,000 (26%) outpatients not resident to North and North East Lincolnshire.
Dependent upon a) and b) above, how could we minimise the number of patient transfers between the sites?	Given patients already travel from tertiary centres back into Northern Lincolnshire, how can we ensure minimal additional transfers?
Define a high level timeframe for transformation	A new build would take at least 10 years from idea to completion, the clinical team would need to identify what would action be needed in the short/medium term.
Quantification of inter-dependencies	Acute services are inter-dependent upon each other in many ways, a full service map is needed to ensure reconfiguration does not worsen quality of care provided.
Quantify the financial implications of each option	Compare the levels of investment needed and potential efficiencies in comparison to the current financial gap identified in the Single Version of the Truth.

7. Governance and Leadership

HLHF has been created as a collaborative that builds on the strengths of local and individual organisations and applies them across the geography of Northern Lincolnshire. As health and social care system leaders, this challenge is one that we are responding to collectively, unanimously and with the full energy of our organisations.

7.1 Health and Well-being Boards Leading Integration Strategy and Delivering Integrated Care

The role of Health and Wellbeing Boards is to cultivate an integrated approach across health, public health and social care outcomes for the whole population. In doing so H&WB Boards can play a strong leadership role in the place shaping agenda for each area. This leadership role in each local authority area benefits from co-terminosity between the commissioning organisations and whilst this is at an early stage of evolution, integration of these three areas of responsibility is a key driver. There is a need to also strengthen the role of the Health & Wellbeing Boards in their oversight and leadership roles. It is important as HLHF develops to ensure the programme is responding to the strategic fit and outcomes identified by this mechanism. This is separate from but complimented by the local authority scrutiny role and the ability to challenge commissioning plans to ensure they contribute to overarching outcomes for a local area.

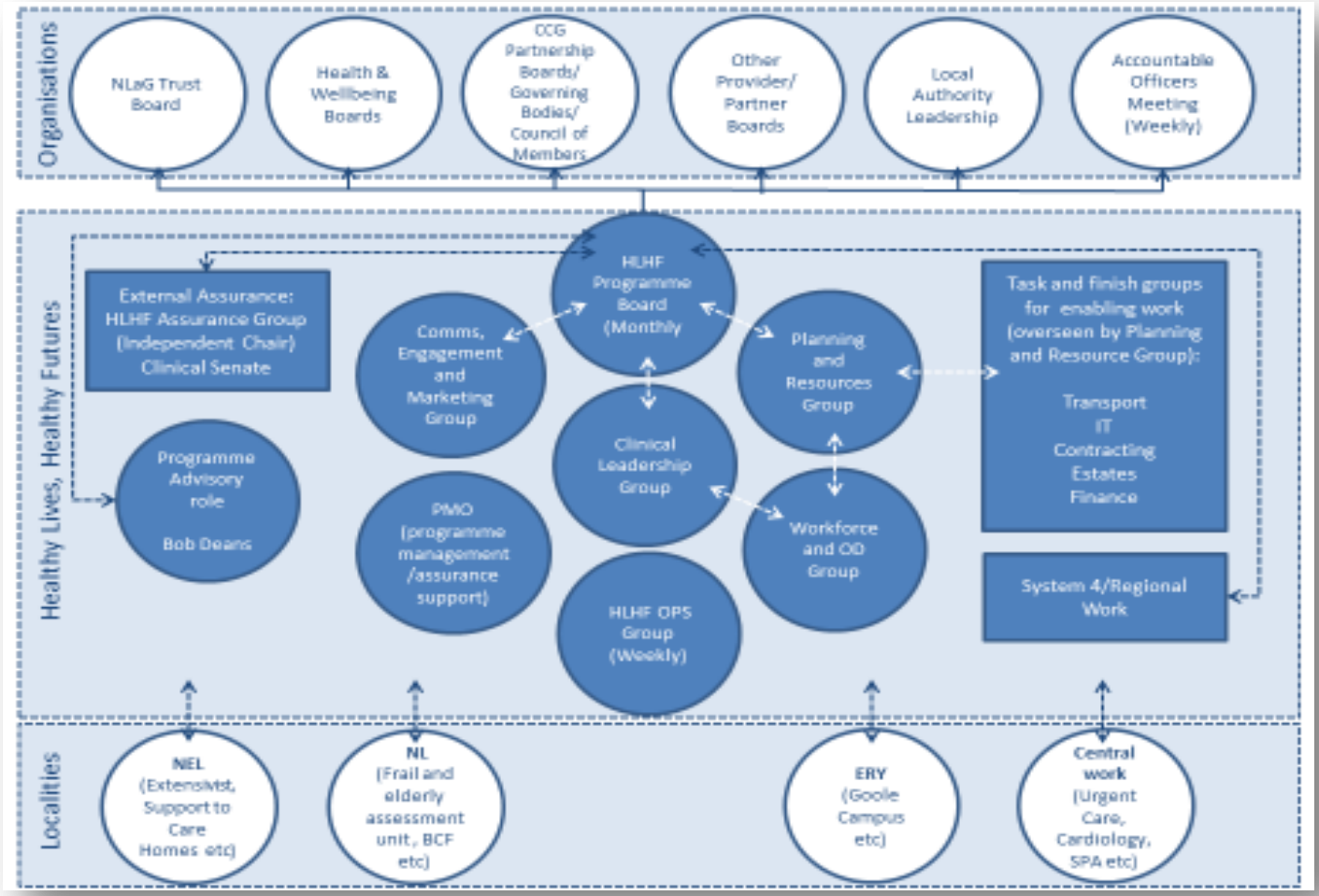
7.2 Providers and Commissioners Working Together Through a Programme Board and Sub Groups.

The roles and responsibilities of providers and commissioners are clearly defined in order to harness the skills, capabilities and the governance structures across health and care. We know that we can be more effective through collaboration, for example: the providers group in NELs, which brings together leaders of all of the providers across the public sector, independent sector and third sector. Further examples are the formal arrangements for commissioning adult health and care in NEL and commissioning through the Better Care Fund in NL.

7.3 The HLHF Governance Arrangements

In order to achieve the large scale transformation that will be required in Northern Lincolnshire over the next 5 years and beyond, the HLHF programme has established a robust governance structure that enables system wide engagement and ownership of the process. We have ensured that all organisations have a voice and are engaged at accountable officer level, with support from relevant organisational managers and clinicians.

HLHF is built on the foundation structures of all partner organisations, which assure their independent governance and accountability arrangements. It aims to bring together the collective contributions of the organisations in meeting challenges that are common to all. It does not substitute the sovereign decision making processes of individual organisations but does create a consistent, rigorous and efficient support structure for delivery of collaborative transformations at scale and pace.



The diagram outlines the HLHF Governance Structure. It is primarily built around ensuring that the HLHF programme has the capability

to deliver the transformational work required and ensure that the HLHF programme board and the relevant organisational boards can be assured of programme progress.

The programme structure links the service redesign being done by the local health and care team leaders with that of the planning and resource leads, who are redefining the supporting structures (Contracting, Finance, Estates, Workforce, IT) that will be required to deliver the HLHF vision. This is underpinned by the work of the Marketing, Communications and Engagement group who are developing the most effective ways to engage with our key stakeholders (Public, staff and politicians).

This work is co-ordinated by a central Programme Management Office and led by a group of local organisational accountable officers, with the Lead Accountable officer being Karen Jackson, CEO of NLaG.

7.4 Sub Groups

7.4.1 Health and Care Professional Leadership and Engagement

Commissioners are accountable for the effective use of the local NHS budget in meeting the needs of their registered populations and it is acknowledged that it is providers, when working together, who can draw on their collective expertise to design and deliver the best possible care in ways that should transcend historical organisational boundaries.

The HLHF programme is led by health and care professionals (the professionals) and it is intended that plans will be developed and delivered through a fully engaged professional workforce. In order to reinforce this practice the professional leadership community is headed by a CCG Medical Director who, along with professional colleagues has established start and finish (time limited) action groups to create visions and plans for out of hospital and in hospital care across the spectrum of conditions and the dimensions of planned and unplanned care. Action groups are made up largely by multi disciplines and facilitated through management support.

A small cohort of professional leaders has been established with the intention to increasingly engage the wider workforce – doctors, nurses, allied health professionals and social care professionals. As the arrangements are strengthened, an important part of the work plan will be to work alongside marketing, communication and OD colleagues ensuring the widest and deepest possible involvement of staff, patients and citizens across northern Lincolnshire.

7.4.2 Planning and Resourcing

The Planning and Resources group will ensure that programme and organisational planning processes align to the Healthy Lives, Healthy Futures delivery strategy. The group will:

- ✓ Agree a memorandum of understanding between all parties in order to:
  - Co-ordinate strategic approaches
  - Adopt a joint approach to planning and contract management
  - Work collaboratively to interact with other CCGs/providers as part of HLHF.
  - Share experiences and adopt common solutions
- ✓ Oversee the development and maintenance of the HLHF community finance and activity modelling/planning
- ✓ Establish sub groups and ensure appropriate implementation plans are in place for key enabling work such as:
  - Financial and activity planning
  - Workforce Planning and OD
  - Information Technology
  - Transport
  - Estates

7.4.3 Workforce Planning and Organisational Development

A workforce planning and OD group has been established as a sub group of the HLHF Programme Board to ensure that workforce issues are considered as a key part of the strategic planning process at both organisational and programme levels. The group will:

- ✓ Oversee the development and maintenance of the HLHF workforce implementation plans.
- ✓ Establish a baseline of current workforce indicators and perform a gap analysis against the HLHF delivery strategy.
- ✓ Link closely to the professional leadership group to ensure that the workforce implications of emerging health and care models are understood and integrated with service designs.
- ✓ Be pro-active in identifying any gaps in workforce planning support, which may support the programme as a whole.
- ✓ Ensure that the need to maintain and, where appropriate, enhance the quality of service provision is at the heart of all workforce plans and initiatives.
- ✓ Ensure that terms and conditions of the workforce link to national Policy and the local Government agenda.
- ✓ Work with the communications workstream to ensure all plans are communicated to staff involved.
- ✓ Oversee the complex Organisational and Development needs of the Health Community to support staff through the change process

7.4.4 Marketing, Communications and Engagement

The success of the HLHF transformational change programme is heavily dependent on the effective communication of its purpose and development as well as active engagement and consultation with all relevant stakeholders and the general public.

With this in mind the Marketing, Communications and Engagement function of the programme needs to be fully integrated into the machinery of the programme in order to ensure both proactive and reactive approaches to informing stakeholders, eliciting their input and delivering the appropriate assurance to the programme board and external observers.

For significant service change, the constituent CCGs are required to consult the public on proposed options for transformation and to demonstrate compliance with the statutory requirements for the service change assurance process. Failure to consult appropriately would expose the programme and the CCGs to a successful judicial challenge to service changes which could impede implementation significantly.

Therefore there are two key elements of Marketing, Communications and Engagement function of the programme

- Stakeholders/professionals/public engagement, consultation and marketing
- Compliance with statutory regulations

Marketing, Communications and Engagement is resourced to ensure that these key elements are delivered effectively, the programme is supported and transformational change is not held up.

7.5 Assurance

An assurance group has been established with leadership from an Independent Chair. The group will ensure that the Healthy Lives, Healthy Futures programme can fulfil its statutory responsibilities with regard to the four key tests for service change, as outlined in the NHS mandate, including specific requirements relating to engagement and communications with regard to large scale service change.

The group will establish a baseline of statutory requirements against which any service change proposals and supporting evidence will be assessed and will align with the NHS England assurance process.

The group will also act in the role of “critical friend” and be pro-active in identifying any gaps in assurance, across the programme as a whole.

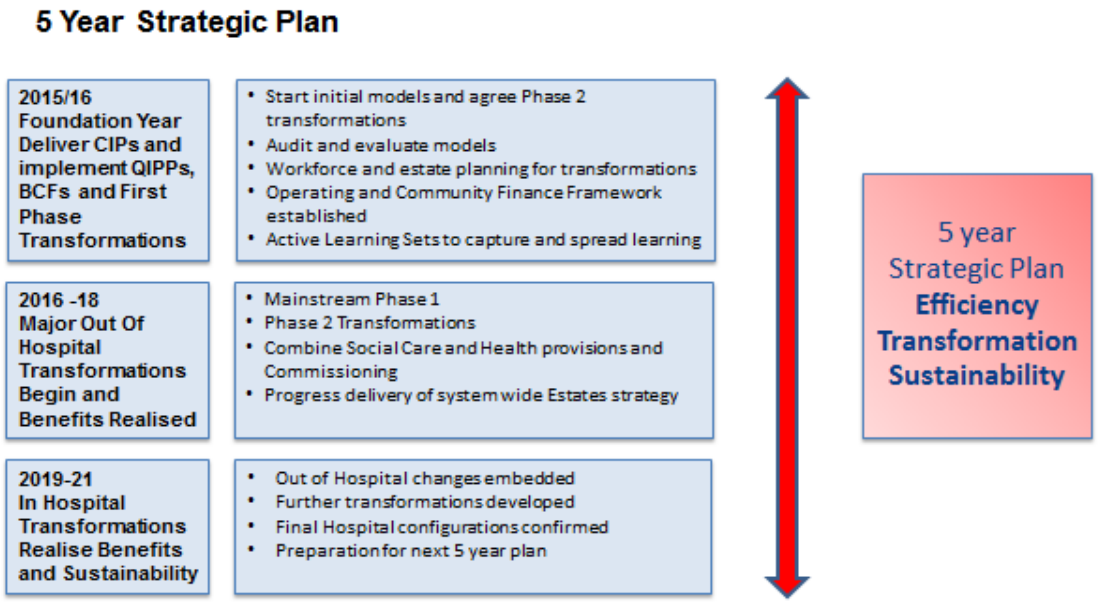
8. Next Steps

8.1 Five Year Strategic Plan

There is a fundamental need for a change in the relationship between individuals and services. An integrated approach to deliver outcomes and quality, requires a greater emphasis on prevention not only expressed in terms of healthy lifestyles and health inequalities but at all levels of care and ability:

- Preventing occurrence
- Delaying deterioration
- Restoring to health
- Maintaining independence

Maintaining good health, preventing ill health, stemming the flow of people into secondary care, and actively participating in the local economy/community, seeing much of unscheduled care as a failure of the system is likely to significantly impact increasing demand and expectation. Although our early plans concentrate our collective efforts on improving the efficiency and effectiveness of health and care services, our forward plan recognises the challenge and opportunity of the changing forms of engagement and accessibility by people to services and the need to shift the channels used to access services. In due course we will be developing plans that resources the service user and neighbourhoods towards greater independence by utilising technology to enable control and responsiveness for a people centred solution.



The diagram describes a high level delivery plan which is fleshed out in further detail year by year later in this section.

The table describes how this plan will be delivered over 5 years. Year 1 is in greater detail

High Level	2014-15	Year 1 2015-16 Qtr 1	Qtr 2	Qtr 3	Qtr 4	Year 2 2016/17	Year 3 2017/18	Year 4 2018/19	Year 5 2019/20
Assessment of QIPP Schemes									
Assessment of current workstreams									
HLHF Options Paper (the narrative)									
HLHF Options Paper to be Developed into Milestone Chart									
Appoint into HLHF agreed structure									
Assessment and Challenge of Locality Variances									
Confirm Population Footprint for Planning Purposes									
Confirm Tertiary Centre for Population Footprint									
Confirm Out of Hospital Model									
Develop Out of Hospital Model									
Implement Out of Hospital Model									
Confirm in Hospital Model									
Develop in Hospital Model									
Implement in Hospital Model									
Complete Service Review - Phase 2									
Identify Service Review - Phase 3									
Complete Service Review - Phase 3									
Identify if need for further service reviews / review process									
Update the timetable to reflect the outcomes of the above									
Strategic Enablers									
Partnership Agreement - Together Case									
Embed Clinic Working Group revised structure (in hospital/out of hospital)									
HLHF Resource Strategy (MOU) including implementation									
HLHF Activity and Finance Model including Principles document									
HLHF Communications Strategy									
Assessment of Trust Productivity and Efficiency									
Establish governance structure co-ordinating Estate									
Assessment of Northern Lincolnshire Estate									
Northern Lincolnshire (or wider) Estate strategy									
Establish governance structure co-ordinating IM&T									
Review IM&T Proof of Concepts and propose future options									
Northern Lincolnshire (or wider) IM&T strategy									
Establish a data flow across organisations with the aim to monitor across boundaries									
Strengthen Stakeholder Management Strategy									
Develop Performance Management Strategy including monitoring mechanisms									
Assessment of Workforce position									
Identify content to be engaged / consulted upon									
Proposed Engagement / Consultation Period									

KEY:
Planning Stage
Implemention Stage
Benefits Realised

8.2 Draft Year One Implementation Plan 2015 -16

Workstream Level	2014-15	Year 1 2015-16 Qtr. 1	Qtr 2	Qtr 3	Qtr 4	Year 2 2016-17	Year 3 2017-18	Year 4 2018-19	Year 5 2019-20
7 Day Hospital Social Work Team (NL)									
Advanced Community Care (NEL)	Proof of Concept								
Ambulatory Care Service (NL)									
Assisted Living Centre (NEL)									
Breast Service Review									
Cardiology CDCU (DPoW)									
Cardiology Review									
Care Home Liaison Service (NL)									
Carers Support (NL)									
Children's Surgery									
Chronic Wound (NL)									
Critical Care Strategy									
Dermatology (NEL & NL)									
Diabetes (Super 6) (NL)									
Discharge to Assess (NL)									
End of Life Services									
Endoscopy									
ENT Centralisation									
Extra Care Housing									
Frail and Elderly Assessment Unit - with Integrated Discharge (NL)									
Frequent Service Users	Proof of Concept								
Goole HLHF - Campus									
Goole HLHF - Elective									
Goole HLHF - Medicine Inpt beds									
Goole HLHF - MIU									
GP Front Ending									
Haematology/Oncology Review									
Home from Home (Grimsby)	Proof of Concept								
Independent Living Service (NL)									
Integrated Locality Teams (NL)									
LTC Model (NL)									
Max Fax Service Review									
Older People's Mental Health Liaison (NL)									
Ophthalmology									
Out of Hospital Model				Proof of Concept					
Outpatients Model									
RATL (Rapid Assessment Time Limited)									
Respiratory									
Single Point of Access (H&SC)									
Stroke									
Support into Nursing and Residential Care Homes									
Well Being Hubs (NL)									
In Hospital Model									

The table below describes the work that is happening in 2015-16 by CCG locality and also what is being done on a Northern Lincolnshire footprint. For some schemes that are currently only listed by locality, it indicates if there may be potential for a Northern Lincolnshire solution.

	North East Lincolnshire	Northern Lincolnshire	North Lincolnshire	East Riding
Year 1 Resilience	Assisted Living Centre Cardiology CDCU (DPoW) End of Life Services ⟷ Advanced Community Care Extra Care Housing Frequent Service Users ⟷ GP Front Ending ⟷ Home from Home (Grimsby) Support to Nursing & Residential Care Homes	Cardiology Review - Phase 2 Children's Surgery Critical Care Strategy - Phase 1 Dermatology ENT Centralisation Stroke - Phase 2 Outpatients Model Max Fax Service Review Ophthalmology Respiratory - Phase 2 Breast Services Review Endoscopy Goole HLHF - Campus Goole HLHF - Elective Goole HLHF - Medicine Inpt Beds Single Point of Access (H&SC) Out of Hospital Model Frail Elderly Assessment Unit - with Integrated Discharge Haematology / Oncology Review - Phase 2 In Hospital Model	Ambulatory Care Service Carer Support Chronic Wound Diabetes (Super 6) ⟷ Discharge to Assess ⟷ 7 Day Hospital Social Work Team ⟷ Integrated Locality Teams LTC Model Older Peoples Mental Health Liaison RATL Well Being Hubs Independent Living Service Care Home Liaison Service	Elective Medical Health Campus

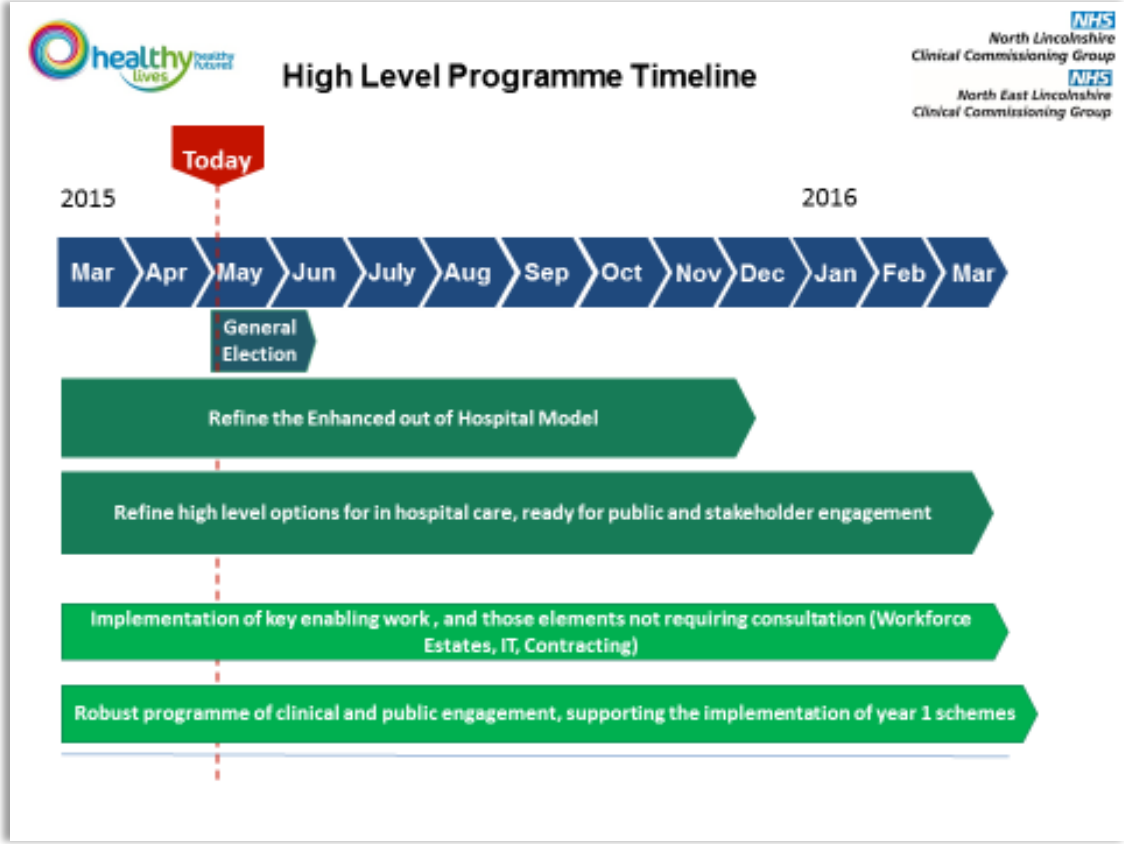
Key;-

⟷ Potential for a Northern Linconshire solution to be explored

8.3 Implementation Timeline and Enabling Activities Through 2015/16

The high level activity is demonstrated on the timeline, there are also some key overarching enabling activities that we need to achieve in the coming months if we are to remain on track to meet the challenges we face, these are:

- ✓ To continue the engagement of professionals and redesign work across the health and care system to further define our vision throughout April – July 2015.
- ✓ To explore the options outlined in this paper in more detail and further understand the impacts on quality and finance in particular
- ✓ To specify the enhanced out of hospital care model and consider implementation of work that does not require consultation
- ✓ To confirm that our current plans are on track to deliver their aims and objectives using the HLHF activity and finance model
- ✓ To continue work to redefine local approaches to financial planning and contract management underpinned by a comprehensive Memorandum of Understanding



- ✓ To work with workforce and organisational development specialist to understand how we plan to support out staff through this transformational change

- ✓ To continue to engage with our key stakeholders regarding significant changes we are planning to make
- ✓ To facilitate conversations around potential for "bigger" Lincolnshire vision

9. Key Enablers

The HLHF programme is driven and led by professionals, with strong engagement across health and social care towards building high quality services for our citizens. In order to make these plans sustainable, we recognise that there are key business and organisational structures, systems and processes that need to be in place and run hand in glove with the health and care professionals' processes – these are implemented through the sub group arrangement described in section 7 above. The following paragraphs describe the key enablers that will underpin and ensure sustainability of the health and care models, designed and tested by and with the multi-professional teams.

9.1 Health and Care Professional Leadership and Involvement

The role of health and care professionals has always evolved in response to population need and demand, the structure of health and social care services and the development of new technologies and expertise. *The term 'HEALTH AND CARE PROFESSIONALS' refers to: doctors; nurses; social workers; allied health professionals; and public health professionals – across primary, community, secondary and specialised care.*

Our collective aims are to create a culture where we:

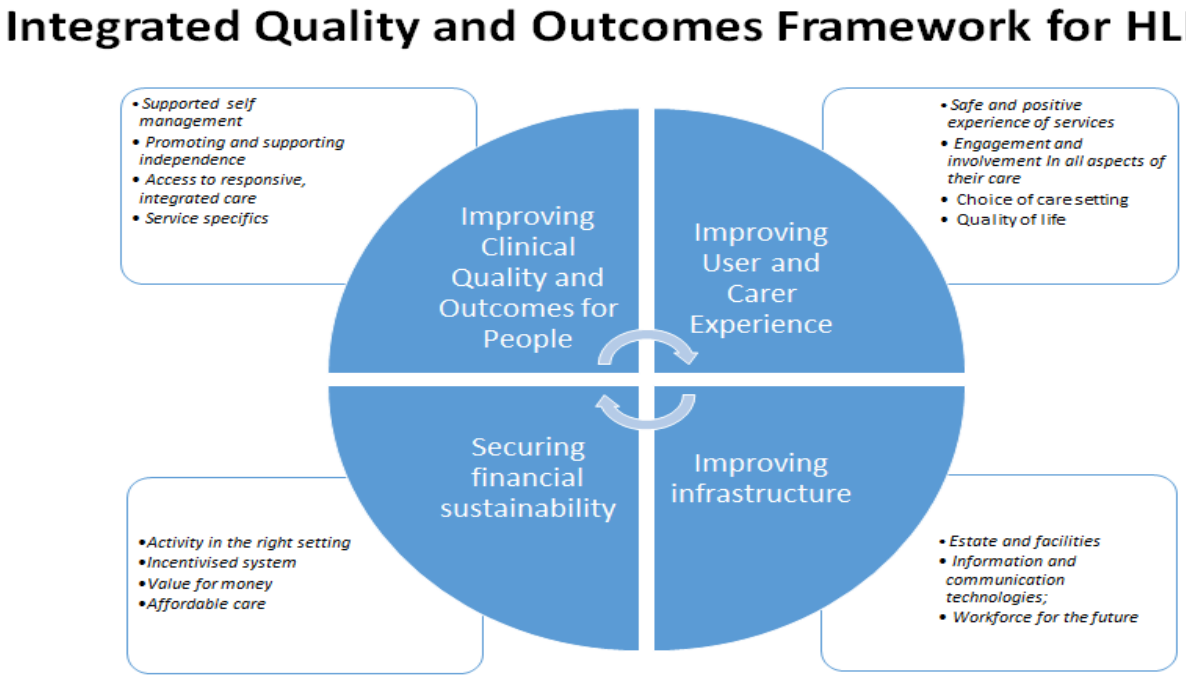
- provide the best quality and outcomes for local people in local places and in centres of excellence
- enable health and care professionals to make the most effective use of their expertise and to play the role they should in shaping the future
- improve and maintain motivation in the wider health and care workforce
- attract and maintain the most talented people
- find most cost effective ways of providing and sustaining affordable health and wellbeing

Members will come from different organisations and should aim to find solutions that are workable within local context.

9.2 An Integrated Quality and Outcomes Framework

The intention is to have an integrated quality and outcomes framework (IQOF), with four dimensions to guide delivery of the vision. The framework draws on the following four key national frameworks: *DH (2014) Adult social care outcomes framework 2015/16; DH (2014) NHS Outcomes Framework 2015; DH (2013) Public Health Outcomes Framework 2013/16; Policy Innovation Research Unit (PIRU) (2014) Integrated care and support Pioneers: Indicators for measuring the quality of integrated care Final report.*

Each dimension will be underpinned by a set of Key Performance Indicators (KPIs) that are informed by the national frameworks and local plans, which will indicate progress on delivery of the vision.



9.3 Public Health

The Health and Social Care Act 2012 set out a vision for Public Health whereby LAs would take on responsibilities to improve the health of their populations[3], led by a Director of Public Health (DPH). DPHs are a statutory member of the Health and well Being Boards and are responsible for championing health across the whole of the LA's business.

As part of HLHF, public health is expected to ensure the promotion of healthier lifestyles and to scrutinise and challenge the NHS and other partners to promote better health in relation to all parts covered by this programme.

Within this scope of HLHF, public health will:

- Provide continuously reviewed joint strategic needs assessments
- develop joint health and well-being strategies within the framework of the national Public Health Outcomes Frameworks
- ensure rigorous focus on local priorities and action across all ages and conditions: ensuring a preventative approach is embedded in the local system

9.4 The Whole Community Finance Plan – 'One Plan, One Community, One Vision'

Joining up planning, financial management and contract management is key to securing delivery of the health and care models. As part of HLHF it was discussed that Payment by Results (PbR) had become part of the problem and was not helping to incentivise/support transformation and the objectives of HLHF. Finances in all organisations in Northern Lincolnshire were getting even more tight which had contributed to strained relationships and was absorbing a lot of staff capacity. In addition, inconsistent messages from regulators made things difficult. Therefore a different approach was needed for 15/16 and beyond.

In terms of HLHF, initial financial modelling had been done in 2013 of the financial gap. Following the gateway feedback, Price Waterhouse Coopers (PWC) had been procured to re assess the economy's financial gap (called Single Version of the Truth) totalling circa £104m as well as the validity of existing

[3] The new public health role of Local Authorities: DH; October 2012.

identified schemes. The Chief Finance Officers (CFOs) had already been meeting monthly during the past year and the Finance Group presented collectively to their fellow Directors 'one plan, one community, one vision'.

In essence this was the rationale for a joint planning approach and a different financial incentives model and having a single voice for the health economy. The group wanted to facilitate working across boundaries and not let finance be a barrier.

It was agreed for the footprint of Northern Lincolnshire, 2 Commissioners and 3 Providers initially as other providers/commissioners were not yet in a position to join. However there is every intention to extend for future years. The finance group would take the lead with planning colleagues to develop an Memorandum of understanding (MOU) community finance plan, cash plan, joint investments, Minimum (and maximum) Income Guarantee and risk map/strategy. The finance group meet weekly from Christmas to Easter to ensure full transparency of positions for 14/15 and emerging 15/16 plans and to develop the schedules and work plan going forward.

Plans do not yet include repayment of any Public Dividend Capital (PDC) loans or interest, but will need to for future. However, it was felt this couldn't be done in isolation of delivery, so a delivery plan was also developed and agreed, led by the planning leads before final signature.

At each stage the HLHF groups were kept updated on progress and the MOU and schedules were taken through the HLHF and individual organisation governance structures for wider agreement.

It is important to note that a minimum and maximum income has allowed us to increase certainty and minimise risk and incentivise transformation. However, there is no financial advantage to the Provider(s) of the arrangement as such as it has been reconciled back to PbR less Quality Innovation Productivity and Prevention (QIPP) plus specific investments relating to national initiatives such as BCF and SRG. Key performance indicators (KPIs) have been harmonised to ensure greater focus on key deliverables.

The MOU holds us all to account for behaviours as well as deliverables. The rigour and principles are helping adopt a collective reflection, problem solving and action learning approach. By meeting regularly we are able to identify early any issues or problems and resolve them proactively. It is recognised that the open book approach will continue through the year with clear tracking of year to date and forecast positions as we are now stakeholders in each other's financial position.

Where possible we will also attend each other's meetings with regulators to ensure there is confidence in the system overall and consistency in messages.

This is just the start, the first step in what will be a long term strategy but it is an important one. Quick wins will be needed in terms of the strategy to build momentum and confidence that we can make the changes we need locally and ensure the financial problem does not continue to grow, we start to 'turn the curve'.

9.5 Workforce Modelling and Organisational Development

The workforce and Organisation Development (W&OD) sub group will drive and deliver whole system actions to ensure delivery of HLHF outcomes through fully integrated systems and processes across health and social services:

- Securing a dynamic workforce modelling tool
- Co-ordinating workforce analysis 'as is' and for the future ('to be')
- Identifying skill gaps and securing development resources for individuals and teams
- Steering recruitment and retention
- Organising OD opportunities to help embed new ways of integrated working across HLHF

9.6 Public and Patient Engagement

The marketing, communications and engagement subgroup will lead activities across health and LAs that:

- Encourage ideas and discussion
- Signal potential for change and engage people in debate
- Inform people of and organise engagement opportunities
- Produce communications materials and lead consultations
- Work closely with LA colleagues to ensure that local elected representatives are engaged and well informed.

9.7 Buildings

Transforming the way health and care services are delivered is likely to lead to consideration of how current estate is used and its fitness for purpose for the new models. Currently individual organisations have developed their own estate strategies. Given our ambition for integrated care through enhanced out of hospital care, alongside excellent in hospital services, we will pull our collective efforts together and develop a whole health and social services estates and facilities strategy (akin to Strategic Service Development Plans produced by NHS commissioning organisations.

The estates and facilities strategy will consider primary care estate; community services estate and hospitals, including those buildings currently managed and maintained by 'NHS Property Services[4]'.

9.8 Transport and Travel

Transport has been regularly cited as a key concern throughout the public and stakeholder engagement activities of the Healthy Lives, Healthy Futures programme. Much work has been done with key stakeholders and local transport providers to understand current provision across Northern Lincolnshire and to identify the transport challenges faced by local communities.

We must ensure that transport and access is a key element of service planning and forms part of the wider suite of considerations taken into account when developing business cases for service change. This process will be lead and overseen by the planning and resource group, as part of their remit to ensure that all key enabling work is appropriately monitored, fit for purpose and on track.

[4] NHS Property Services was set up on 1 April 2013 and is wholly owned by the Secretary of State for Health.

9.9 Information Technology

Modern information and communications technology creates significant opportunities for efficiency in the public sector. Capability is patchy across organisations in Northern Lincolnshire, which leads to, for example, inefficiency in management practice and delays in access to care and care co-ordination between professionals. Through 2015/16 we will aim to build systems and processes that:

- Improve our ability to engage patients in self-care, accessing knowledge and support, as well as communicating with professionals and organisations about their care experience and ideas for improvement.
- Improve our ability to plan for services, agree delivery frameworks (activities and budgets) track delivery (quality, outcomes and activities)
- Improve networking capability between professionals

9.10 Developing the Provider Market

Quality and choice of provision will be critical to delivering the integrated care visions for HLHFs. There are established and emerging provider networks across the patch, which are fully involved in shaping the future and delivering the plans. However there is more to be done to create truly integrated person centred care, where the finite resources across the systems can be used with greater effect. For example: bringing together primary care practitioners with public health, social care, health care specialists and third sector providers in meeting the needs of people with long term conditions.

The current models being explored through the national 'Vanguard' sites could indicate solutions that would match the ambitions for Northern Lincolnshire. In the meantime we are exploring the development of 'Community Hubs' which are intended as the vehicle for integrating all health and care provision to populations in local 'places' (to be defined). As part of this work, we would want to explore the benefits of creating Lead Accountable Care Organisations (LACO) where a provider takes responsibility for delivering their own portfolio, co-ordinating other local provider offers (Associates) to enable personalisation and choice, as well as sub-contracting care - such as acute hospital care for their populations.

The aim would be to enable

- Implementation of outcome measures rather than measures of activity

- changes to payment structures to ensure that providers are appropriately incentivised (see section 9.4 ‘Community Finance Plan’)
- providers to have freedom to improve services within the contract envelope

It would be essential to secure the following behaviours as a minimum in delivering this model

- Continued application of the principles and focus on the objectives for person centred care
- Working together in co-operative and innovative ways to deliver efficiency and transform services
- Share all relevant information openly and timely, with Information Governance and Competition in mind
- Be mindful of conflicts of interest in relation to service offers and personal responsibilities
- Share all risks and opportunities associated with the delivery of the initiative

10. A Sustainable Geography for Acute Hospital, Specialised and Tertiary Care

The health and care community leaders in Northern Lincolnshire are clear that in order to deliver sustainable change, we must think on a larger scale than ever before. We need to consider solutions that will make the greatest impact, the best use of resource, increase choice, attract and retain skilled staff and most importantly, deliver the best possible outcomes for local people.

Real progress has been made on the patch in terms of collaborative working and we are seeing progressively more examples of organisations (nationally and globally) realising the benefits of working together to achieve better outcomes for patients and make services more streamlined financially efficient.

We now expect that 'in hospital' capacity and capability will need to be adjusted and transformed on the back of integrated 'out of hospital' care. This will require significantly greater collaboration at hospital level across a wider region than Northern Lincolnshire.

In order to deliver this, we believe that we should allow ourselves to think beyond current organisational and geographical boundaries and consider what would work best for the people we serve, who largely do not recognise our traditional "false" boundaries and divisions. As a result, we have started some early thinking and dialogue to consider a range of options, for the medium and longer term that could influence commissioning plans and provision in other parts of Lincolnshire, Humber and beyond where necessary.

There are three potential options that we plan to explore further:

1. Greater Northern Lincolnshire (GNL)
2. Lincolnshire Countywide (LC: including GNL)
3. Humber and Lincolnshire (H&L: including LC)

10.1 Greater Northern Lincolnshire (GNL)

With this in mind, a group of local professional and managerial leads were tasked with developing a vision for health and care services in Northern Lincolnshire that could address some of the significant challenges we face over the next 5-10 years. A vision has emerged from this work that has been dubbed "Greater Northern Lincolnshire" and would be described as a medium to long term solution.

Greater Northern Lincolnshire (outlined on the map below) is a concept that is based on dealing with need, not boundaries. Essentially, this solution divides Lincolnshire in half and would therefore create "Greater Northern Lincolnshire" and South Lincolnshire planning areas. This would give a planning footprint in "Greater Northern Lincolnshire" that would serve approximately 650,000 people and would offer system wide opportunities as described in the diagram herewith.

The GNL option questions current boundaries by suggesting there is a more natural population flow into health and care services. Clearly, delivery of this vision will require the collective will and engagement from all relevant parties and will face some potentially significant whole system barriers. We have started conversations with our neighbouring commissioners and providers about our vision and will continue to involve them in the process as we move forward. We also recognise the importance of engaging with local authorities and elected members about our vision and plans are in place to begin that dialogue.

This vision has been shared with local clinicians throughout our recent engagement process and the response has been largely very positive.

10.2 Lincolnshire Countywide (LC)

In exploring the idea about GNL with colleagues across Lincolnshire as a whole, feedback suggests that there would be mileage in considering a greater geographical patch in order to deliver affordable services with greater effectiveness and cost efficiencies for acute services and some local specialisms.

This option has not been discussed in any detail, but we feel it deserves analysis and feasibility testing.

10.3 Humber and Lincolnshire (H&L)

Traditionally, there is some patient flow across the Humber to Hull Infirmary for some specialised services. Although cases are relatively small in number, we feel that this will need to continue for the foreseeable future, due to clinical effectiveness, economies of scale and efficient use of resources across the NHS as a whole.

In addition, it is essential that we work closely with commissioners and providers of tertiary services to ensure our patients can be treated and cared for in centres of excellence and return close to home for recovery and appropriate on going treatment as soon as possible.

In discussion with colleagues in East Riding and Hull we are fully aware of the impact that our decisions could have on provision in those areas and this should fully tested.

APPENDIX – HLHF - Health and Care Professional Working Groups, 2015

Health and Care Leadership Group – 17th March 2015	Long Term Conditions – 24th February 2015
Robert Jaggs-Fowler, GP and Medical Director NL CCG	Nicholas Stewart, GP NL
Bob Deans, HLHF Director, YHCS	Sarah Barnes, Community Nursing Sister, NLaG
Caroline Briggs, Director of Commissioning, NL CCG	Dawn Daly, Senior Physiotherapist, NLaG
Helen Buckley, GP NEL	Doug Flockhart, HLHF Programme Manager, YHCS
Margaret Sanderson, GP and Chair, NLCCG	Susan Levison-Keating, Consultant Hematologist , NLaG
Alexandra Dudson, NL Transformation Programme Manager, NL CCG	Mandy Logan, OT Adult Service Manager, NLaG
Doug Flockhart, HLHF Programme Manager, YHCS	Arun Nayyar, GP NEL
Julie Clark, NL Council	Holly O'Connor, Community Matron, NLaG
Helen Kenyon, Deputy Chief Executive, NEL CCG	Pav Tandon, GP NL
Rakesh Pathak, GP NEL	Ruth Thompson, Head of Unplanned Care, Care Plus
Lawrence Roberts, Consultant Obstetrician & Gynaecologist, NLaG	Faisal Riaz – Consultant and Clinical Lead in Rehabilitation Medicine NLAG
Ruth Thompson, Head of Unplanned Care, Care Plus	Shankar Kamath, Consultant Physician and Geriatrician, NLaG
Joe Warner, Chief Executive, FOCUS	Helen Kenyon, Deputy Chief Executive, NEL CCG
Kate Wood - Clinical Director of Anaesthesia and Critical Care, NLAG	
Catherine Wylie, Director of Quality and Risk Assurance, NL CCG	
Oltunde Ashaolu, Associate Medical Director, NLaG	
Arun Nayyar , GP NEL	
Peter Melton, Chief Clinical Officer NEL CCG	
Pav Tandon, GP NL	
Nicholas Stewart, GP NL	
Susan Levison-Keating, Consultant Hematologist , NLaG	

Planned and Unplanned – 5th March 2015	Maternity – 4th March 2015
Fergus Macmillan, GP NL	Lawrence Roberts, Consultant Obstetrician & Gynaecologist, NLaG
Ruth Thompson, Head of Unplanned Care, Care Plus	Pav Tandon, GP NL
Susan Levison-Keating, Consultant Hematologist , NLaG	Heather Gallagher, Operational Matron Obstetrics and Gynaecology, NLaG
Caroline Briggs, Director of Commissioning, NL CCG	Margaret Sanderson, GP and Chair, NLCCG
Jane Ellerton, Assistant Senior Officer, NL CCG	Sandeep Kapoor, Consultant Paediatrician, NLaG
Doug Flockhart, HLHF Programme Manager, YHCS	Marcia Pathak, GP NEL
Bob Deans, HLHF Director, YHCS	Aswathi Shanker – Consultant, NLAG
Helen Kenyon, Deputy Chief Executive, NEL CCG	Jane Warner, Matron, NLaG
Kate Wood - Clinical Director of Anaesthesia and Critical Care, NLAG	Michelle Barnard, Assistant Director - Service Planning & Redesign, NEL CCG
Shankar Kamath, Consultant Physician and Geriatrician, NLaG	Doug Flockhart, HLHF Programme Manager, YHCS
Mr Bhojwani, Consultant Eye Surgeon, NLaG	
Mike Bellini, ENT Consultant & Clinical Leader (ENT & Oral), NLaG	
Pam Clipson, Director of Strategy, NLaG	
Martin Gough – Consultant, NLAG	
Lawrence Coombes, Consultant Urologist, NLaG	
Faisel Baig, GP NL	