South Devon Healthcare NHS
NHS Foundation Trust

Strategic Plan Summary Document for 2014-19

South Devon Healthcare NHS Foundation Trust

Executive summary

1. Background and case for change

South Devon Healthcare Foundation NHS Trust (SDHFT) and Torbay and Southern Devon Health and Care NHS Trust (TSD) are members of a well-performing health and care community that has a background of cooperation and integration between services and organisations.

Increasing demand for services, centrally-driven austerity measures and funding system changes (including creation of the Better Care Fund) have put great pressures on the health and care community, commissioners and providers alike. These manifest themselves as financial challenges in the short and long term.

In the present and near future both organisations are dealing with more activity than ever before with no more resources to meet the need that is arriving at our doors. In the longer term it is difficult to see how the rising demand for some services can be met within the limited resource envelopes available to our commissioners without disruptive cuts being made to other services that could potentially reduce quality or availability of services, neither of which would be acceptable to our commissioners.

These pressures are straining the long term economic viability of both organisations as stand-alone entities. In order to develop plans to break even or make a small surplus for future service investment, both trusts would have to deliver unrealistically ambitious cost improvement programmes.

Thus when TSD developed a case to become a foundation trust and determined that it could not do so from a sustainable financial perspective. It agreed with the TDA to start a divestment process to find a partner to acquire the services.
The TDA ran a robust procurement process that was open to competition and that resulted in SDHFT becoming the preferred bidder in Sep 2013.

An Outline Business Case (OBC) for SDHFT to acquire TSD was developed in 2013 that set out a range of service and quality improvements that could be delivered more effectively within an integrated organisation. It also described a set of financial benefits that could be delivered through merging back-office functions and changing the model of care to provide better value for money.

The development of the OBC into this Full Business Case (FBC) has provided an opportunity for both organisations to work more closely in the development of integration plans from both patient-facing and back-office perspectives. It has also allowed the organisations to jointly work with other partners in the local community (through membership of the “Pioneer” collaboration) to ensure that the vision for the Integrated Care Organisation’s (ICO) future is aligned with the wider community.

It has become clear that this acquisition will put SDHFT and the local community in the best position to face the unavoidable challenges arising from the populations' increasing demands in the context of austere financial settlements. It will bring new opportunities to improve the quality of care with a set of initiatives that are aligned with the core business of SDHFT. In addition, this option presents the best health and care solution for the community as a whole, and we have gone to great lengths to ensure that all of the key partner organisations are supportive.

2. Our community's needs

Like many other health and care providers internationally, we have used the "life course model" to help us analyse and plan service changes around the needs of individuals in our catchment area(s). Priorities for our local community include the following:

Life course stage	Local issues and priorities
Starting and developing well	Significant childhood poverty, smoking in pregnancy, "Troubled families", substance abuse, mental health issues, childhood obesity.
Living and working well	Obesity, smoking, long term condition management, substance abuse, unemployment, self- help.
Aging well	Prevent ill-health, early recognition and treatment, dementia, complex needs and multiple long term conditions, risk management, patient-managed technology (e.g. telehealth) and patient managed budgets for "care packages".
Dying well	Appropriate planning and delivery of end-of-life care, supporting patients' wishes to die at their preferred locations, community and voluntary support.

TSD has also utilised a model built around a fictional "Mrs Smith" to help illustrate the complexities around providing care for elderly people, and to demonstrate the benefits from integrating health and care services. Within the ICO we have broadened this model to include other members of the "Smith family" to highlight the tangible impact that the proposed integration of services will have for people at different stages in the course of their lives.

This approach also demonstrates a planned shift away from a culture of "paternal" care where the provider knows best, to one that is more focussed on the wishes of the patient. We will make the question of "what matters *to* a person" as important as "what is the matter *with* a person".

3. A new model of care

In Torbay and South Devon, there is a commitment to an ambitious and all-inclusive vision for improvement in health and well-being for the population from all local stakeholders in health and social care, and that vision has been awarded Pioneer status by NHS England. The development of an Integrated Care Organisation (ICO) through the acquisition of Torbay and South Devon Health and Care NHS Trust by South Devon Healthcare Foundation Trust will be one of the major enablers in the transformation of services, and developing a new approach to health and social care. We will develop or redesign services that meet the needs of our local population and that are co-ordinated and integrated in ways that benefit service users. We will develop services that are responsive and flexible and which link, without break, with services of our partner organisations such as primary care and mental health services. All services will be included in this redesign, from acute specialist services and inpatient activity, to continuing health and social care at home.

A major feature of the services we develop with be the promotion of self-care. This will cover the promotion of healthy lifestyles and include support and training of service users and carers in self-management of even the most complex chronic health conditions. Many of the services will be about supporting people in their lives rather than focussing on ill-health. We will base service development on the 'Life-course model' to cover all phases of peoples' lives, with a particular focus on 'family-centred care'. We will support the development of services planned within local commissioning groups and services centred in health and social care zones.

We will develop services that are seamless and provide continuity. Our services will not be constrained by the traditional physical and professional barriers of health and social care. Staff involved in the care of individuals within a community setting, will continue to be involved in the care of that person if they need to be admitted to hospital. Staff who have traditionally worked in the hospital will support or deliver care in the community when needed.

Services will be redesigned to provide the most accessible and best quality evidence-based care possible. This will result in a change in focus from the hospital to the community, and may result in a change in the member of the team providing care. The hospital will become smaller and there will be a shift towards specialist teams providing support to colleagues in the community and in primary care, allowing them to care for people closer to home. We will develop new means of contracting to support this new care model and to remove obstacles to the provision of patient-centred care.

The development of the ICO will facilitate a chain of service developments across almost everything we do. Many of the change in services will take 3-5 years to complete. Priorities for early service redesign are:

- Services for the frail and elderly linking with the Pioneer Frailty Hub.
- Transition services for young people moving between paediatric services and to adult services.
- Alcohol services.
- Long Term Condition (LTC) services including people with Multiple LTCs.

The model of care for the ICO has to recognise the broader care model developments across the community, and through the Pioneer collaboration (locally branded as "JoinedUp") it has found the perfect forum for developing a model of care that is aligned across all health and care providers in the area. The priorities for this work include:

Community care model priorities	
Accessibility of services	Opening hours, public transport and buildings that are fit for purpose. Also, access to information.
Communication & Coordination	Joined Up IT systems and information for patients, so people know who to contact.
Education, prevention and self-care	People want to know more about their condition – what it is and how to manage it themselves
Reliability, consistency & continuity of services	People want to know who will come to see them and when they will come. Building relationships with carers is important in making people feel safe.
Support to stay at home	There is a great range of statutory and voluntary services that people consider important to help them stay in their own homes
Wellbeing and community support	Making more use of voluntary services to help people live at home, using support already in communities – 'neighbourliness'

Source: Community services engagement report (2014)

In practice a large part of this is about removing unnecessary interfaces across which services are delivered to patients, while also ensure that the patient and primary care services (provided by GPs) are at the centre of the system.

Figure 1: Un-integrated pathways with many transactional relationships between providers

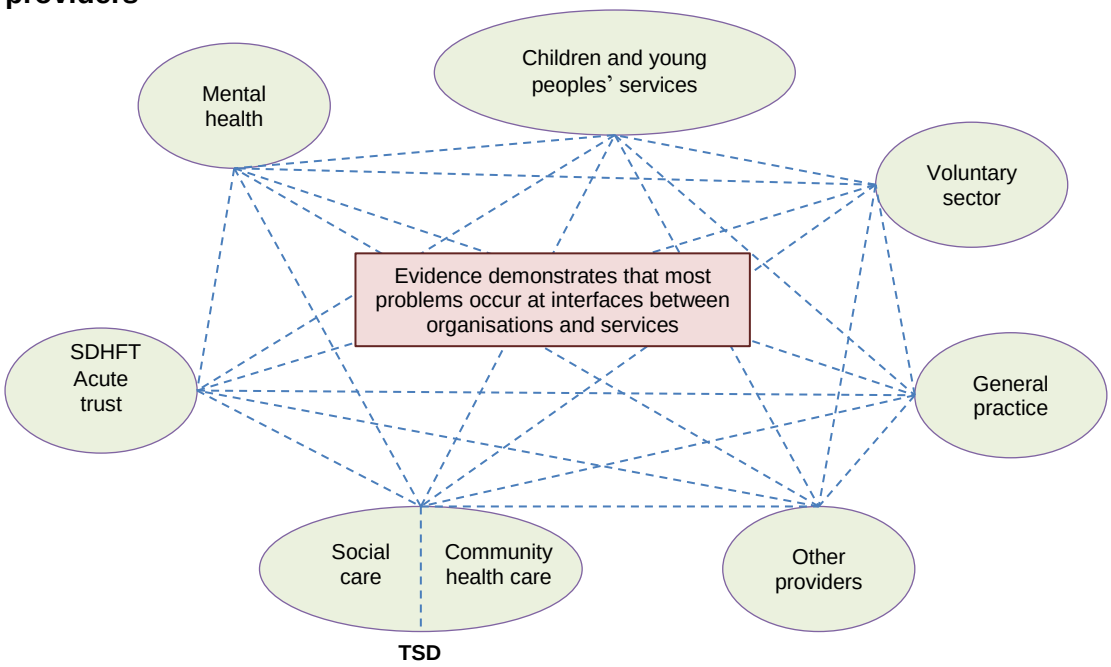
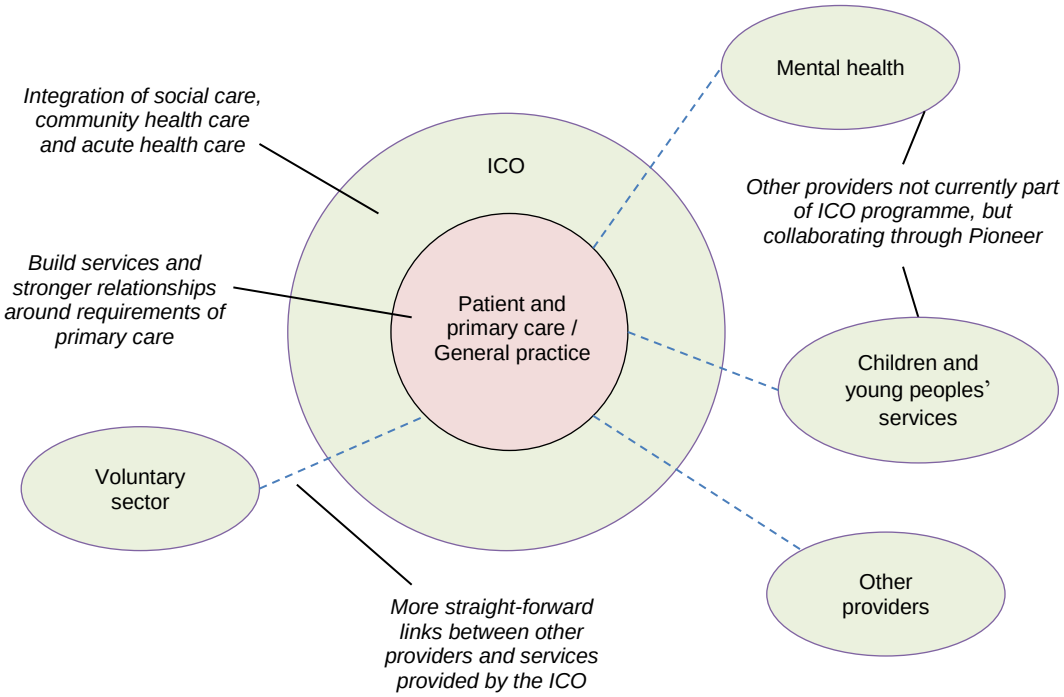


Figure 2: Integration of social care, community and acute health care



4. Map illustrating integrated care changes in practice

Key:

ICO provided service

Wider community provided service

INTERMEDIATE CARE

Review and refine service specification and available capacity to meet community needs. Continue to manage the market for IC services accordingly.

FRAILTY SERVICE PIONEER

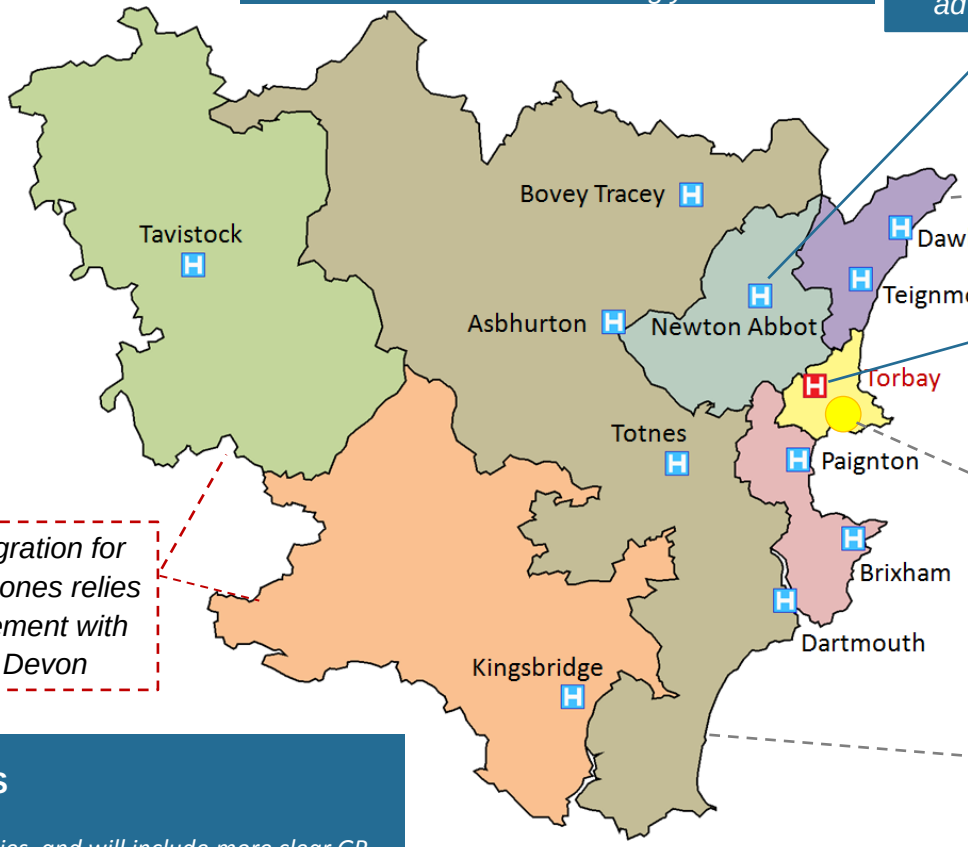
Initial site for implementation of new frailty service model that will subsequently be rolled out across South Devon. Takes advantage of diagnostic and specialist

H OMMUNITY HOSPITALS

More generalist, multi-disciplinary services to include some bed-based care, tailored to meet the needs of local communities.

Improve efficiency and utilisation to increase capacity

Commissioning locality focus on falls



ACUTE HOSPITAL

Will have less bed-based care, and more focus on provision of specialist advice and services to the wider community.

Community Zones

- Coastal
- Moor to Sea
- Newton Abbot
- Paignton and Brixham
- Torquay
- Tavistock
- Ivybridge and Kingsbridge

Full integration for western zones relies on agreement with West Devon

YOUNG PEOPLES' SERVICES PIONEER

Initial site for implementation of new young peoples' service model that will subsequently be rolled out across

Commissioning locality focus on healthy lifestyles

ZONE TEAMS

Zones are co-terminus with GP commissioning localities, and will include more clear GP leadership and care coordination. Standardisation across the region and efficiencies will deliver more capacity within the same cost base. Zone team skills will include:

- *Primary Care*
- *Secondary care specialists*
- *Community Nursing*
- *Social care*
- *Mental Health Services*
- *Care coordinators*
- *Greater involvement of voluntary sector*

New systems for long term conditions: These will include a generic "wellbeing service" for individuals who need support for symptom control and services for multiple long term condition management that will be integrated at the patient level.

SINGLE POINT OF CONTACT

New remotely-accessible information service that provides:

- *Call centre for patients to access the health and social care system with emphasis on signposting to support with self-care whenever appropriate; Gateway to complex MDT services.*
- *Referral Advice service for clinicians seeking to match patients with specific needs to available services in real time.*
- *Home Monitoring, Location (tracking) Services, Tele-health-care centre, etc.*

5. Infrastructure and enabling developments

The broad impact of creating the ICO can be divided into two parts:

- The integration of SDHFT and TSD's core services that will be enabled and better facilitated by delivery through a single organisation.
- The merging of legal organisations, with associated back-office functions, systems and governance arrangements.

While the majority of benefits in the medium and longer term will be realised through the improved pace and scale and efficacy through which an integrated organisation can deliver integrated services, the merger of the two trusts will also bring significant benefits from integrating back office functions. There are also a number of systematic changes which will be required to enable the merger to take place from a practical perspective.

Key infrastructure and enabling changes include:

Project	Description
Clinical governance	Put in place common systems, policies and processes that ensure that throughout the transition and beyond services are safe, that people receive high quality care and that they have a good experience.
Corporate governance	Ensure there is an appropriate corporate governance framework in place for the ICO, including aboard of directors that reflects the wide remit of the new organisation. To oversee the recruitment of new members to the ICO and new governors to the Council of Governors.
Financial support services	Put in place a single finance function and set of supporting systems that improves understanding of costs across the services. This will help to ensure that resources are employed in the most effective manner to deliver value for money for the organisation as a whole.
Business and performance information	Ensure that accurate information is available to appropriate people, and to support good decision making in the delivery of care to service users. This will include standardisation of reporting mechanisms and reports across the community to improve confidence in the use of information.
Procurement and logistics	Provide a single procurement and logistics function that through delivery of best practice approaches will contribute to the overall objectives and operational effectiveness of the ICO. This will include management and development of supply markets, ensuring that goods and services are of an appropriate quality, that they are available when needed and that they meet the users' needs.
Information technology	Extend the existing shared services to incorporate remaining stand-alone elements, to provide a single, shared IT and health records function to the ICO. This will include provision of a central data warehouse and supporting team to achieve "one version of the truth" for all users.
Estates and facilities management	Complete the integration of teams that has already started in order to ensure that assets are appropriate for their users' needs and maintained appropriately. Estates will be developed to meet the changing needs of the ICO and a range of easily accessed services will be harmonised to support the organisation and provide best value for money.

Contractual arrangements and risk share agreement	Ensure that existing contracts are passed across to the ICO appropriately, and put in place a new risk-share agreement between the ICO, South Devon and Torbay CCG and Torbay Council. This will help to ensure that financial incentives are aligned between the organisations as service developments are agreed and as public finances come under increasing pressure in the future.

6. Organisational development and workforce plans

Over 70 per cent of the ICO's resources will be spent on staff, and the success of the new organisation and the delivery of its objectives will be dependent on the capability, expertise, flexibility and motivation that these staff can bring. This will in turn be linked to the opportunities that can be offered by the ICO in respect of career pathways and education and development. The broad model of the workforce should be one of joined up professional practice, integrated team working and the flexible delivery of care in the most appropriate settings.

Linked to the above themes a number of significant implications for the ICO workforce follow. There will be:

- A reduction in the numbers of acute hospital staff.
- An increase in the numbers of staff in community settings.
- Changes to the ratios between registered and non-registered staff in community settings with a move away from a very profession centric workforce to one of skilled care workers
- Introduction of new generic roles in community settings at both a professional and care worker level.
- Introduction of new professional roles such as "Physicians Associates" and "Surgical Care Practitioners".
- Holistic approaches to care for staff in all settings.
- Greater provision of specialist medical support in community settings.

These changes will take place alongside organisational developments looking at culture, behaviours and values as well as education and the new skills required to make the ICO a success.

The workforce will need to develop to meet the changing needs of the population and shape of service provision, and preliminary plans have been developed to illustrate what this is likely to mean for the overall staffing levels in the ICO by comparison to the sum of the two existing provider organisations.

Table 1: Combined establishment of SDHFT and TSD as at 1st April 2014

Staff Group	B1	B2	B3	B4	B5	B6	B7	B8	B9	Medical	Other	Total
Add Prof Scientific and Technic			5.14		86.17	112.66	25.84	27.06	2.00		11.52	270.39
Additional Clinical Services	-0.26	507.11	310.07	160.32	29.14	2.55					0.29	1,009.22
Administrative and Clerical	0.56	348.29	311.26	209.01	207.15	109.49	79.65	120.79	2.00	8.18	15.80	1,412.17
Allied Health Professionals				0.19	81.02	217.82	101.58	43.18				443.79
Estates and Ancillary	143.94	247.28	103.33	15.80	14.61							524.96
Healthcare Scientists			1.00		14.30	39.43	20.89	21.87				97.49
Medical and Dental					10.57					443.75		454.32
Nursing and Midwifery Registered					666.08	449.61	172.90	46.28		0.61	0.25	1,335.73
Others											12.97	12.97
Grand Total	144.24	1,102.67	730.80	385.32	1,109.03	931.56	400.86	259.18	4.00	452.54	40.83	5,561.04

Table 2: Preliminary view of ICO establishment following integration of organisations and services

Staff Group	B1	B2	B3	B4	B5	B6	B7	B8	B9	Medical	Other	Total
Add Prof Scientific and Technic			5.14		82.54	123.41	21.84	27.06	2.00		11.52	273.51
Additional Clinical Services	-0.26	465.00	232.21	137.45	19.45	0.28					0.29	854.42
Administrative and Clerical		350.76	283.36	167.35	162.38	86.60	51.21	87.83	2.00	8.18	13.36	1,213.02
Allied Health Professionals				0.19	94.23	167.03	96.58	41.18				399.21
Estates and Ancillary	117.22	222.42	91.25	13.80	14.61		-1.00					458.30
Healthcare Scientists			1.00		12.79	37.43	18.89	21.87				91.98
Medical and Dental					10.57					419.30	8.61	438.48
Nursing and Midwifery Registered					584.33	423.85	174.65	37.28		0.61	0.25	1,220.97
Others												0.00
Grand Total	116.96	1,038.17	612.96	318.79	980.89	838.60	362.17	215.22	4.00	428.09	34.03	4,949.89

7. Financial plans

The financial case for the acquisition of TSD by SDHFT is based on a jointly developed set of plans with support from commissioners and other stakeholders in the local community.

The historic financial positions reported from both organisations have been generally positive, with small surpluses delivered every year. In the most recent full year (2013/14) SDHFT made a normalised net surplus of £200k, while TSD made a normalised net surplus of £800k.

Like many community health organisations, TSD does not have the same detailed understanding of service cost structures as an acute trust would have. This is to be expected and is in part due to different national reporting requirements and payment systems. However it does present a degree of uncertainty and risk regarding the financial projections, particularly when cost improvement plans are taken into account. Due diligence has indicated that the financial position of TSD has often been supported through non-recurrent funding, and the recurrent position would not break even without the external support that has been regularly received to date. It is this position that led TSD and the Trust Development Authority (TDA) to conclude that TSD could not continue to be financially viable as a stand-alone organisation, and subsequently they sought a partner to acquire TSD.

In order to break even as stand-alone entities the Cost Improvement Programmes (CIP) for SDHFT and TSD would be unrealistic to deliver, and would also require significant cut backs to critical investment in services and infrastructure.

The acquisition is expected to deliver significant recurrent net benefits (in addition to the organisations' stand-alone CIP plans) over the course of the five year transition period. While some of these benefits may be sought as independent organisations (if the acquisition were not to proceed) the risk of delivery as an integrated organisation is significantly reduced, and the pace and scale of benefits realised through the ICO will be much greater. Details of the timing of delivery may be seen in the integration plan (available upon request).

Table 3: Summary of financial benefits of integration

Area	Net benefits (brackets denote net cost)
Organisational merger benefits (inc. back office savings)	£1,790k*
Service integration benefits (inc. demand reduction)	£5,312k
Other benefits and costs	-
Total net recurrent benefit	**£7,102k**
One-off implementation costs	(£2,615k)

The organisational merger benefits are net of any additional costs required as a result of the integration. £200k of additional IT recurrent support costs and infrastructure costs have been included.

With these benefits from integration taken into account, while the overall CIP targets are still extremely challenging, they become realistically deliverable. This is the key financial case for integration through acquisition rather than by other means, which would not offer the same scale of benefits or alignment of purpose.

SDHFT and TSD have negotiated a risk-share agreement with their two most significant commissioning organisations: South Devon and Torbay CCG and Torbay Council. This agreement effectively pools budgets for health and social care and removes the financial incentives in activity-based payment systems to increase activity.

With the new care model and incentives driven through the risk-share agreement, the whole community will be financially incentivised to manage the growth in demand (for health and social care) that is anticipated over the coming years. If demand growth is not managed appropriately, both commissioners and providers risk insolvency which would be catastrophic for the community as a whole.

8. Stakeholders and engagement

The communications needs of the myriad stakeholders affected by this work are complex and constantly evolving. A communications strategy and action matrix has been developed to:

1. Ensure staff are well-briefed, motivated and involved.
2. Ensure stakeholders are well-briefed and engaged appropriately.
3. Manage media interest and proactive media engagement.
4. Establish new brand and organisational identity.
5. Develop unified online resources.

Each stakeholder group has different needs that we are planning to address in a variety of ways, and key groups prioritised at this stage include:

- Service users and the wider public.
- Staff.
- Governors and members.
- Commissioners.
- Regulatory bodies.
- The wider community of health and care providers.

Key communications principles throughout will include:

"We'll come to you" - As much as possible, the strategies use existing meetings and communications methods to convey key messages. For example, clinical workshops on the care model have 'piggy-backed' pre-scheduled meetings to avoid over-burdening those attending. As much as possible information is delivered using existing publications, bulletins and meetings.

"Not everyone wants to know everything" - The ICO is a huge project and few stakeholders will have an interest in every aspect. Communications and involvement requests are carefully tailored to meet specific needs.

"Integrated care also requires integrated communication" - The integration agenda is much wider than just the ICO. Not only is it important to put the ICO in context of this change but also we must avoid our communications being lost in a potential deluge of information going out. The partner organisations in Pioneer have therefore agreed to issue new a joint monthly e-bulletin that will offer a snapshot of progress for integrated health and care in South Devon and Torbay.