Lancashire Teaching Hospitals
NHS Foundation Trust

SPEND WELL
SPEND LESS
SPEND WISELY

Knowing the Business

Finance Strategy 2021–2024

Always Safety First

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Introduction

Lancashire Teaching Hospitals (LTH) has an underlying deficit which is in excess of £80m . This deficit has grown steadily in recent years resulting in a breach of the Foundation Trust provider Licence and a series of financial undertakings were imposed upon the Trust by its Regulator in 2018. All of these undertakings have been addressed with the exception of tackling the underlying financial deficit.

Following a period of evolution toward system based healthcare, the future of the NHS in England is being rapidly reshaped following the NHS response to Covid-19 and cemented by planned legislative changes setting out structures and processes for the future integration of healthcare.

With this backdrop it is timely to take stock of the issues that have and will continue to impact on the Trust's financial sustainability, and plan to take actions to address those issues in our control and seek to influence the Lancashire and South Cumbria system and wider NHS to provide appropriate support to solve wider problems.

This strategy sets out to:

- Review the **national and local factors** that have and will continue to influence our financial sustainability, together with steps we believe can be taken to alleviate their impact and address the underlying causal factors.
- Recognise the roles from Ward to Board for everyone in the Trust to ensure that we use the financial resources available to us as effectively as possible delivering value for money for the taxpayer; spending wisely, spending well and spending less.
- Recognise that to provide patients "Excellent care, with compassion", we also have to **understand the services we provide as an organisation** to ensure they are financially sustainable. This applies equally in our core purpose of patient care, our provision of education and training and also the commercial activities that support our core services both financially and operationally.
- Identify a number of **enabling programmes** that will support all wards, divisions and senior management to implement the financial strategy and improve our services, reduce waste and unwarranted variation. Importantly this includes engaging our front line clinical staff in service improvement as well as a top down review of opportunities by senior clinicians and managers. It also includes a number of Trust wide programmes aimed at standardising our approach to optimising processes and purchasing decisions and improving the use of business information.
- Identify the importance of **capital investment** both to sustain existing activities and transform for the future, particularly investments in digital solutions that optimise work flow and self-service but also investment in our estate optimise the patient pathway and use of our own resources.

Each section identifies the key actions required to implement our financial strategy, which are collated together in Appendix A, into a coherent set of work programmes. The strategy concludes by setting out the **governance arrangements for overseeing and monitoring its implementation**.

Context

Building on work initiated by finance directors in the Lancashire and Cumbria system, summarised in the paper "LSC Drivers of Deficit and Operational Performance". This work aimed to understand and separate out those factors that are systemic at a national or system level from those in the control of the Trust i.e. what is a structural issue and what isn't. This is not to dismiss such factors as out of the Trusts control, but to provide additional clarity on what should and can be proactively improved directly by the Trust and where the drivers relate to external factors that the Trust will need to influence and gain support from external stakeholders to develop workable solutions.

National Drivers

Exit from Covid

Whilst many uncertainties still surround the pandemic, it is clear that hospital based services will face the combined challenge of maintaining social distancing and Protective Personal Equipment (PPE) in higher risk settings, together with restarting normal levels of elective and non-elective service provision. This presents risks where services do not adequately plan to achieve this balance, and ultimately a financial pressure. As such the financial strategy aims take an agile approach to responding to the pandemic but stepping down measures when safe and practicable to do so.

Conversely, large numbers of patients waiting for elective care will require a proactive approach both nationally, regionally and locally. Resources are likely to be targeted toward providers who can make significant improvements within their systems. As such the financial strategy will support the development of systems and tools to support operational teams to optimise elective and non-elective pathways and identify areas where the Trust can use capacity to support the wider system.

Allied to capacity planning is the opportunity to take stock of the role played by the independent sector in our system. Whilst this has provided important additional capacity, it runs the risk of leaving the NHS with more complex cases and cost burden. There is no doubt that the independent sector has a role to play in service provision, and our financial strategy will seek to identify where this is best targeted through capacity planning but also working with system partners to establish a strategic collaboration with the local independent providers.

Changing Structure of the NHS

The Department of Health and Social Care's White Paper "Integration and innovation: working together to improve health and social care for all," sets out the legislative proposals that will shape the NHS for the next decade. Alongside this we are also seeing changes in the way we do business. CCGs are combining under the ICS, financially rules based contracts are likely to change and plans exist to transfer the responsibility for commissioning specialised service to ICS.

Internally this means we will need use the financial strategy to think differently about the commissioning of healthcare and reappraise that our commissioners are and how we engage with them. GPs will still be key players as members of Primary Care Networks and understand what comes after CCGs and at what pace will changes be made to the way Specialised Commissioning works.

As part of understanding the commissioning landscape the Trust will also need to consider the options for formalising its working relationships with commissioners. These could include elective contracts periodically informed or refreshed by Payment By Results (PBR) information and non-elective contracts that provide aligned incentive for a range of providers working with commissioners. This will form part of a prospective work stream which will be led by the Integrated Care System (ICS).

Financial outlook for NHS resource allocation

During Covid the majority of NHS patient care has been funded on a block contract or actual cost basis, which has allowed redeployment of staff to deal with the pandemic and ensured service capabilities remain for the future. As we start to recover from the earlier waves of the pandemic, the focus has been on restoring all NHS services to at least pre-pandemic levels and where possible tackling the backlog of waits and referrals that has built up, including extending the use of the independent sector.

Recognising the challenges facing health and care HM Government has supported an overall recurrent increase to resources funded by increases to taxation. At the time of drafting it is anticipated that the associated additional cash will initially be directed to the downward management of waiting times with a future shift of this funding into care and social services . Over time this will return the NHS towards previously anticipated levels of funding.

Nationally a return to a productivity or efficiency target has already been put forward, with an initial focus on reducing inefficiency or waste. Annual targets of 3% have been mooted, which reinforces the need for the Trust to ensure it can evidence all its services perform well compared to peers and that we have in place a process of continuous improvement and waste reduction as part of the financial strategy.

Balancing the quadruple aim

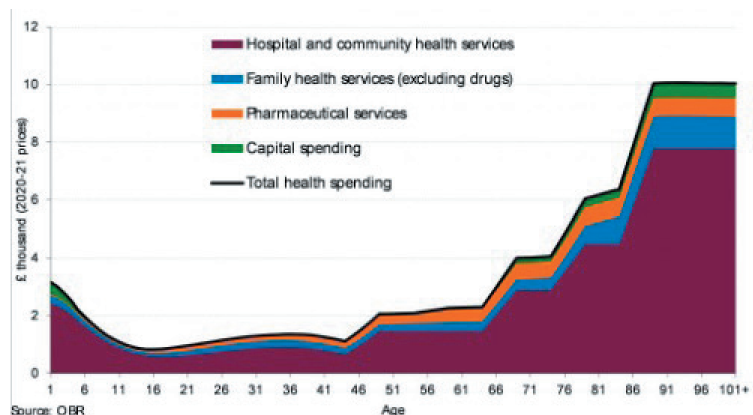
NHS organisations are well used to the competing requirements of quality standards, workforce, performance standards and financial constraints. In line with well governed organisations the Trust uses Quality Impact Assessments (QIA) and business case processes to ensure all factors are considered before reaching a conclusion and balancing priorities and understanding of any adverse impacts and how they can mitigated. As part of the financial strategy we will reinforce the need to balance these factors at all levels of within the Trust.

Local Drivers

Demographics.

The population of Lancashire and specifically the catchment area of the Trust is diverse on many levels. Whilst the main hospitals are based in large conurbations, the catchment has large areas of rural population. The ethnicity of Central Lancashire is equally diverse often with specific healthcare needs, and there are significant areas of deprivation particularly in Preston. Equally there is a growing population of over 65s and Preston and Chorley are popular locations for an increasing number of new families. Both these groups are significant consumers of healthcare services with growing needs, which will lead to growing demand for the most costly interventions to support the needs of the population. Figure 1 highlights the cost profile associated with age with a population aged between 11 and 45 consuming the lowest level of resources.

Fig 1 - Office of Budget Responsibility – Health spend per person



Statistically, Central Lancashire may look near the average for demographics in England, but in reality it is dealing with above average numbers at each end of the normal distribution with a consequent impact on a growing demand for healthcare. The Trust cannot control the population dynamics, but it can control how it responds to them and the financial strategy anticipates that this will form a key part of our response as part of the clinical strategy for each service.

The demographic diversity of our system is not reflected in the current national allocation methodologies. To promote an understanding of these issues regionally and nationally, we plan to collaborate with system partners (including Public health) to use population health data to understand and model the impact of health needs and trends, ultimately enabling us to build a case for new resources as they become available or changes in national allocation methodologies.

Workforce

Many factors are driving the national and regional shortage of workforce. First is the increase in demand due to national initiatives such as nurse to bed ratios and midwifery continuity of care. Second is the constraint in supply, partly due to an ageing workforce profile, changes in the funding arrangements for nurse training and staff exhaustion follow the Covid pandemic. On top of this Lancashire's proximity to Manchester and Liverpool makes recruitment and retention a key issue with many staff attracted to working in the larger conurbations. This is further exacerbated by the fact that the majority of clinical education takes place at institutions in those conurbations, which is also reflected in the distribution of Health Education England (HEE) resources for clinical training.

These factors combined with the above demographic factors have led to a growth demand for workforce in the face of constrained or reducing supply. This manifests with Lancashire being an outlier in terms of staff shortages but also in the number of temporary staffing arrangements and associated premium rates of pay which often vary from organisation to organisation.

Internally managing a tight workforce situation calls for good management information and innovative solutions, in order to alleviate pressures and bear down on the costs associated with premium cost workforce arrangements. The financial strategy includes a work stream aimed at tackling these issues.

Longer term, improving the supply of trained workforce into LSC is the right solution. The Trust will need to collaborate with partners within the system, Health Education England (HEE) and the wider NHS to influence an improvement in the current position, and this work is included as part of the financial strategy work on influencing external partners.

The NHS continues to evolve its workforce and the way that it is used. The programme associated with workforce needs to promote continued evolution of organisational and system thinking in a way that allows our clinical staff to work at the top of their licence. Increasingly skills availability become more important that profession, particularly as the supply of medical staff falls further behind demand.

System Financial Position

Locally the LSC ICS is one of the few nationally forecasting a deficit in 2021/22 and an underlying financial gap of c£350m. As such attention is focussed on ensuring services are provided as economically as possible, including consideration of where and how services are provided across the whole county in collaboration with our ICS partners. This could result in reconfiguration of existing services, but also maximising the opportunity to provide support for anticipatory care services and self-management of chronic conditions in a community setting.

The Trust will need to be ready to respond to the challenges this poses in terms of understanding where its strengths can support other parts of the system, but also those services that would benefit from collaboration on a wider footprint or from a complete pathway redesign.

From a clinical service view point, the finance strategy includes a plan to review our portfolio of services using clinical and economic sustainability criteria in readiness for the wider system debate, and inform our own decision making for investment and support going forward.

Clinical support services and other collaborative services face a similar challenge, and to date collaboration between providers on these services has been limited, however there are a small number of positive examples including the Lancashire Procurement Cluster. As such the financial strategy will include a work stream that will evaluate our strengths and weakness in these services, with a view to developing a plan for collaboration with other providers in the system and what this collaboration may look like.

Optimising use of hospital capacity

Earlier we identified the importance of optimising our capacity to meet demand, however with two acute sites operated by the Trust there are opportunities to consider how our physical capacity can be adapted to best serve out population's needs. There will be a spectrum of changes with those that need formal consultation at one end through to those that don't at the other.

With two ageing main hospital sites, the Trust has been challenged to keep up with the standards expected in the provision of modern healthcare, particularly given significant constraints on capital availability during the recent period of austerity. This should mean that we incur more costs in maintaining and working in older facilities than we would in a modern hospital enjoyed by many other Trusts. Paradoxically benchmarking data (ERIC) however indicates that the Trust's costs for estates management are in the lowest quartile and this will require further review to influence future investment decisions.

Royal Preston Hospital has been identified as one the new hospitals in the Government's New Hospital Programme (Hospital Investment Programme) in tandem with its neighbouring hospital Royal Lancaster Hospital (University Hospitals Morecambe Bay). Whilst the new hospital programme is a great opportunity to modernise and transform clinical services, the scheme is currently at business case stage and a number of years away from opening.

In the meantime as part of the financial strategy the Trust needs to determine how it can optimise the use of its sites to support both elective and non-elective pathways, and also consider how to deploy capital investment in the sites to support this and contain the current high cost of maintenance.

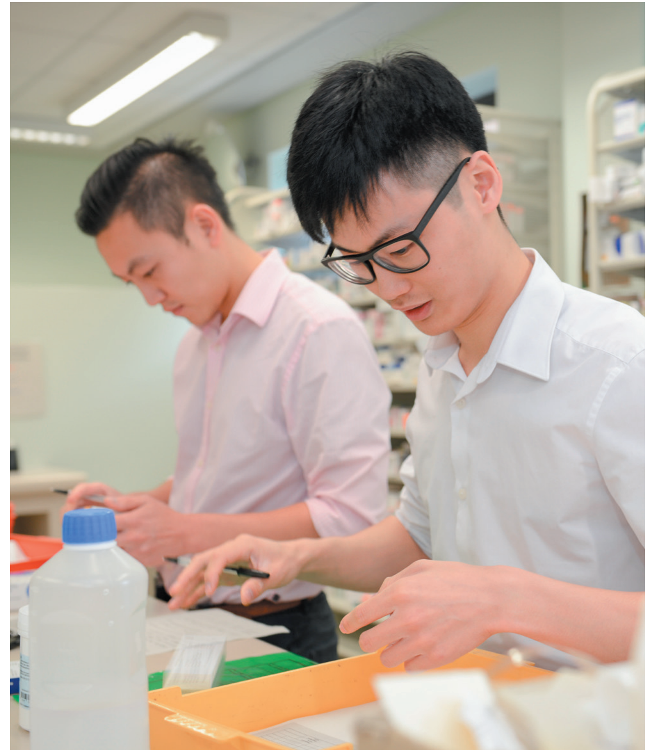
Modelling from NHP indicated that the introduction of new models of care can help to assuage growing demand for hospitalisation, supporting better care closer to home. The Trusts clinical strategy seeks to address these opportunities and as such the is a significant dependency between the Trusts clinical strategy and its financial strategy.

Wider public sector impact

On top of the pressures faced by the NHS in Lancashire, the financial position of Lancashire County Council (LCC) is challenging. For a number of years LCC has carried out a budget review of public health and social care spending, which has impacted on the way other health services are operated.

However, LCC has taken significant steps to engage NHS partners in its difficult decision making process and this has helped the system plan for the changes and in some cases mitigate the impact. The formal health and care partnership that is being established as part of the ICS, will strengthen the approach to joint working and the this will need to from part of the Trust's work in engaging partners across the system.

LCC also takes a proactive role around in the Central Lancashire Partnership which is helping to improve our pathways of care, improving outcomes and user experience.



Financial strategy – Board to Ward

The Board to Ward concept has been used to promote the importance of the connection from front line patient care, support functions and strategic decision makers in understanding and improving healthcare. This concept is equally important in financial management, including recognising:

- The Trust has to balance the quadruple aim of quality, workforce needs, performance targets and finance across the organisation, and everyone has a roles in this.
- Improvement and waste reduction ideas are often best observed by those who work in or use healthcare first hand.
- Divisional and Trust management are well place to make connections across Trust services, engage system partners and set appropriate priorities.

This section is intended to outline the key activities and accountabilities for senior managers through to the ward and department managers in supporting the delivery of the financial strategy, in the context of the quadruple aim. For the purpose of this document the organisational level will be referred to as the macro level, the divisional and specialty tier as the meso level and the sub specialty/departmental level as the micro level.

Board/Executive

At the macro level the Trust Board are ultimately accountable for all aspects of Trust performance, including striking the right balance between competing priorities. From the point of view of financial management the Board and the Executive are best placed to:

- Balance the quadruple aim, balancing the quality, performance, workforce and finance objectives at an organisational level, including ensuring effective procedures are in place via an financial operating framework are place to help the rest of the organisation do the same.
- Create the conditions for success, which will include setting out and communicating the financial management framework, that includes the annual approach to budget setting and guidance on financial decision making (Spend Wisely, Well and Less), and provides including priorities and the framework for financial management which will guide decision making on finances. This will continue to promote the use of benchmarking, e.g. Getting it Right First Time (GIRFT) and Model Hospital.
- Put in place enabling programmes, to support the delivery of key strategic aims which will include a range of waste reduction programmes in line with the Trust's Continuous Improvement (CI) strategy.

- Provide leadership, to communicate the financial strategy objectives in the context of the Trust's overall strategy and the associated values and behaviours.
- Portfolio service review, by taking the strategic overview of the challenges and opportunities faced by individual services and where necessary prioritising where the Trust invests its scare time and resources (e.g. management time and capital investment).
- Influence external stakeholders, including ensuring the Trust's priorities are recognised and supported by its partners locally, regionally and nationally.
- Govern, by putting in place systems to monitor progress with delivery of the financial strategy and take action when required.
- Macro level change programmes will be led by Executive leads through the Executive Transformation Group. It can be anticipated that these programme also feature across the Provider Collaborative Board and the local placed based partnerships. These group will have the opportunity to outline the new models of care for frail elderly, diabetes, respiratory medicine; pathways which will result in a better use of resources with fewer patients coming to hospital and consuming scarce resources.
- The Trust will also need to outline a programme of achieving better clinical decision making earlier in a patients journey, resulting in appropriately sized Medical Assessment Units in our response to same day emergency care. Better decision making results in improved outcomes for patients. It results in clearer treatment plans and speedier discharge, reducing the poor demand placed upon G&A beds.
- A more systematic approach is required for changes to patient administration and the associated change management processes. Many systems have evolved over time resulting in duplication and poor processes. The harness in of digital enablers at scale with sound change management processes will help to improve communication and remove waste.
- The 'collaboration at scale' agenda needs to consider the future target operating model for the provision of corporate and 'indirect' clinical services, removing organisational bureaucracies and duplication.

Divisional/Service line

Structurally the Trust is organised into Divisions with groups of service lines. At this meso level accountability is for divisional and service line performance and delivery, alongside a responsibility to co-operate with other parts of the Trust and externally. Divisions and service lines sit at the centre of our structure, and are key to interpreting the finance strategy and ensuring their teams; wards and departments understand what is expected of them. In particular divisions and service lines:

- Develop clinical service strategies, reflecting the needs of our system's population, taking account of latest best practice including clinical and operational performance benchmarking and opportunities to collaborate with partners in the health system.
- Provide clarity on service pressures, ensuring a risk based approach is taken to prioritise and mitigate pressures and where necessary inform internal and external discussions to develop plans for resolution.

Focus on making sure services and departments are being run as effectively and efficiency as possible, ensuring value for money (spend wisely, well, less).

Service review process, develop a programme to consistently review service performance and opportunities for improvement and waste reduction using data from for example PLICS, GIRFT, model hospital and HES.

Access and Implement Trust wide programmes for efficiency and waste reduction, including procurement plan, medicines management, reduction in premium rate pay, and paperless workflow.

Ensure the Continuous Improvement methodology is embraced by wards and departments, including seeking input from staff, patients and relatives.

Ward/Department

Wards and departments are the engine room of the Trust where decisions get made that influence how the Trust deploys its resources on a day to day basis. At this 'micro level', budget holders are directly accountable for spending with the resources allocated to them as a budget, together with agreed objectives on changes that reduce waste and improve service quality.

To fulfil this role it is crucial that budget holder understand what is expected of them through the financial framework, but also that they are empowered and equipped to discharge their responsibility. Specifically this includes engaging budget holders in financial management, which the finance strategy plans to achieve by a programme of training and communication.

Finance Strategy – Starts with 'knowing the business'

Whilst the Trust's core business is providing patient care to the local and wider LSC population, it also has important activities that support its core business. This includes education and training of doctors, nurses and other professions allied to medicine and all also a number of trading activities. These three business segments total in excess of £560m, with their main components are shown in the following table.

Fig 2 – Business Segments

Segment	Activities	Turnover (£m)
Patient care	Local population – planned and urgent care hospital services	300
	Specialist/tertiary services	185
	Community facing services	26
		Total 516
Education and training	Doctors, nurses and PAMs	Total 22
Trading activities	Research and development	3
	NHS trading income	7
	Non-NHS income	18
		Total 28

Patient Care

During the Covid period the majority of NHS patient care has been funded on a block contract or actual cost basis, which has allowed redeployment of staff to deal with the pandemic and ensured service capabilities remain for the future. As we start to recover from the earlier waves of the pandemic, the focus has been on restoring all NHS services to at least pre-pandemic levels and where possible tackle the backlog of waits and referrals that has built up, including extending the use of the independent sector.

In addition the 2021 NHS white paper "Integration and Innovation: working together to improve health and social care for all" will significantly change how patient care services are commissioned. In particular services previously commissioned by CCGs and NHS England will move the ICS, and alongside this contracting and commissioning processes are likely to undergo significant change.

The White paper will also establish ICS's on a statutory footing which is aimed at accelerating the move to pathways and systems of integrated care, which is likely to lead to opportunities to review, redesign and optimise how and where services are provided across the ICS.

Given the significant changes and pressures identified above, as part of the financial strategy the Trust will need to prepare itself by:

- Determine how it responds to the opportunities presented by the move to integrated care, by evaluating the clinical and economic sustainability of its portfolio of services.
- Developing and Implementing supporting clinical strategies, including opportunities to provide care outside of our hospitals.
- Anticipate and influence the development of commissioning in the LSC system, including the use of the independent sector.

Evaluation of clinical and economic sustainability of services

Periodically reviewing the position of each of the Trust's key patient care services provides an opportunity to take stock and anticipate both externally driven changes and those the Trust might want to pursue.

There are many ways of carrying out such a review, but the basic SWOT (Strengths, Weaknesses, Opportunity and Threats) is easy to understand and provides a basis for consideration of internal and external factors. Ultimately the process should try to identify the actions required to support each service becoming more sustainable. This might include:

- Investment of time and resources to grow sustain and improve.
- Collaboration with partners with the ICS to strengthen service provision e.g. where it is difficult to fill roles.
- Redesigning how we provide strategically important services so they are more sustainable.
- Where changing the pathway across the ICS makes sense including becoming more community focussed.

The financial strategy envisages an approach to evaluating services by the planning department using clinical and economic sustainability criteria, an example is provided in Appendix B. The objective of this process should conclude with a set of actions to inform the development of an appropriate clinical strategy for each service that supports future sustainability.

Development of Clinical Strategy

Alongside the strategic evaluation of service provision, the financial strategy also plans to support a evolution of the clinical strategy and development plan for individual services. With the approval of the Trust clinical strategy each service will be required to develop an annualised business plan to inform the Trusts Big plan. These plans will be assessed and subject to an approvals process which will consider each of the quadruple aims and the alignment to the Trusts aims and objectives.

The development of these strategies will start with a review of the data available on external factors, performance and benchmarking. Externally this will include information relating population/demographic factors affecting demand, plans already in place for services at a system level. Internally this will be about understanding our current performance using a variety of data sources (see graphic) and associated constraints. Together these should help identify priorities for performance improvement, efficiency and waste reduction, but also inform the options for pathway redesign for further consideration as part of an integrated care system

We will also be using data from sources such as Model Hospital, GIRFT and performance information and benchmarking to identify areas of unwarranted variation and improvement, together with ways of tracking the benefits of changes

Fig 3 - Benchmarking/Performance data sources

- Getting it Right First Time (GIRFT).
- Model hospital & model system.
- Dr Foster.
- Right care.
- Demand and referral patterns.
- HES performance data.
- PLICS/SLR.

It is likely that there will be a number of early priorities for this service review process, some from a performance improvement view point and others where considering options for improving the pathway is the priority. However, it will be important to get a balance across the divisions within the Trust. Importantly the Trust needs to balance individual service needs with the whole and as such whilst some decisions need to be expedited on a case by case basis it is expected that the majority of decision making falls into the annualised decision making processes, culminating in the approval of the annual budget plan by the Board of Directors.

Anticipate and Influence changes to Commissioning

Planned Care

In the past most planned or elective care has been funded using the system of Payment by Results (PBR). The system worked well in terms of incentivising increases in capacity and tackling waiting lists, and some elements have re-appeared as part of the recovery plan following Covid i.e. the Elective Recovery Fund.

PBR has been criticised for distorting the allocation of resource toward over-producing treatment at the expense of preventing ill health and the need for treatment. In an integrated care system, there is a lot to be said for having a population based budget for care and local decisions made on where and how this allocated. However, a by-product of PBR have been a clearer understanding of cost and a common measure of production across the acute sector.

Whilst the move to integrated care is likely to move payment mechanism away from PBR, it is likely that PBR will be retained to inform commissioning discussions and capacity planning in providers. One scenario is that initial block contracts are established using baseline activity and PBR prices, and then variances against the block are reviewed and periodically realigned.

The detail of this will emerge over the next year, but the broad approach is likely to favour Trust's that can optimise the use of their funded capacity across theatres, beds, clinics and consultants. The new system is also likely to provide the flexibility to move resource without penalty (e.g. in the past Trusts would be financially disadvantaged if they reduced outpatients by using alternate follow up methods). As such it is important that as part of the financial strategy that the Trust models the likely scenarios and uses this to influence the ICS approach to commissioning planned care.

Urgent Care

PBR has long been recognised to not serve the funding of urgent care services well. With high fixed costs, few incentives to direct patients to other services and fluctuating demand the PBR arrangements moved to a marginal cost basis some time ago.

Prior to Covid, the use of an aligned incentive contract was being piloted nationally for urgent care. The intention with this arrangement is to ensure that all partners in a system have a common purpose in managing demand. On one level a block contract enables elements of this as resources can be redirected (e.g. to triage services) without fear of losing revenue, but to be really effective this needs to extend across all providers in the patient pathway.

Urgent care is complex territory and lends itself to focussing on a few key priorities that will make a difference for the local population's health. Initially these are likely to include end of life pathway, frailty and respiratory. As part of the financial strategy the Trust will need to agree these priorities within the ICS and also with its local partners i.e. primary and community care providers, and then establish how the pathways can be optimised and how the system of aligned incentives will work across all providers involved to influence demand/referral patterns taking account of funding constraints and population needs. As indicted above with a population that is aging as a faster rate than the average particular attention need to be given to wider health and care reform to better support the increasing demand on public resources.

Independent Sector

During the pandemic independent health care providers have been an intrinsic part of the healthcare provision system, with Ramsey Healthcare being a key provider in Preston, Chorley and west Lancashire. Following the cessation of the national contract arrangements, ICS contracts with Ramsey have been put in place to support the restoration of services and restarting choose and book services for CCGs, with an opportunity to extend these over a longer period.

From a Trust point of view, the independent sector can provide useful additional capacity but it is also "margin dilutive", with admission criteria at private hospitals favouring lower risk cases the NHS case mix can skew to higher cost complex cases.

Collectively the LSC system is a large customer of Ramsey Healthcare, and there is a case for developing a more strategic relationship that addresses the needs of all parties – Trust, Commissioners and Ramsey. Contracting with the independent sector to date has been led by CCGs at an ICS level, however as part of the capacity planning work with the financial strategy the Trust will seek to influence and involve itself in the strategy for the next stage of commissioning independent sector capacity.

Specialised Commissioning

The White paper also reinforces the earlier proposals to transfer the responsibility for commissioning most specialised services to ICS, reversing the previous aggregation to regional Specialised Commissioning teams under NHSE. The details of how and when this transfer will take place have yet to be finalised, but it is likely that this will be carried out as a financial transaction using current funding levels. This creates risk that agreed funding over time is not secured and historic issues get "baked in" to the new arrangements.

A key piece of work within the financial strategy is for the Trust to map all its Spec Comm service funding against costs to inform discussions with external parties and the ICS on the issues that need to be resolved or avoided.

Whilst the historic funding arrangements are likely to be 'baked in', it is understood that a distance from target will be introduced for this funding element (similar to the weighted capitation formula for commissioning resources) which will resolve funding inequities over time. This is subject to clarification from the annual national planning processes.

Education, training and development

The business of educating and training doctors and nurses is an important supporting activity to the provision of hospital services, not least because clinical work has to be partially learnt in practice. Earlier we identified the importance of expanding the supply side of trained workforce to meet local demand, and retain those skills in the system. To support success the Trust and the wider system needs to see an increase in investment with a higher level of training to better meet both current and future demand. This challenge is best tackled at a system level and as such the work in this area calls for engagement and influence of external stakeholders including:

- Working the HEE, to prioritise resource for training placements for the Trust and influence how this is allocated. This should include quantifying and strengthening the decision making process for current and future unfunded posts.
- The HEE engagement also needs to include identifying ways of increasing the proportion of more experienced trainees who spend their time with the Trust.
- Working with higher education institutions in Manchester, Liverpool and locally in Preston and Lancaster to expand clinical training for local people.

Trading activities

The Trust's trading activities are an important part of the business as they support the core business of patient care, either by creating support services that are stronger or by earning a margin to improve the Trust's overall funding position. Trading activities breakdown into three broad areas Research and Development (R&D), trading with other NHS organisations e.g. pathology provision and activities that earn income from outside the NHS e.g. pharmaceuticals and catering.

Most trading activities have been adversely affected by the Covid pandemic, and during 2020/21 and to a lesser extent 2021/22 national funding has been provided to substitute the lost revenue. These arrangements are being progressively withdrawn, with an expectation that most areas fully recovery during this period. Clearly this is a significant assumption, and as part of our planning work we intend to carry out an assessment of the likelihood of full recovery and set out the consequences of a number of scenarios. The Trust will improve its reporting to better understand the net contribution made by each of these service lines and this will form part of the annualise business planning process.

Research and development income at c£3m offers the opportunity for further development. NHIR and NHSEI provide toolkits for developing costed proposals for research on a commercial basis, and the financial strategy proposes to use these tools to take stock of existing research activities and develop proposals for future research in collaboration with the R&D function. Strategically the Trust needs to consider the positioning of R&D across the ICS and how a more collaborative approach in the future could result in improved investment supporting higher levels of contributions to support Trust overheads.

The Trust provides services to other parts of the NHS totalling £7m. As part of the financial strategy/ we intend to ensure we have a full understanding of all of these arrangements and the costs of providing to inform service level agreement discussions going forward. We will also develop a template for costing the provision of future services. In doing this we need to be mindful that we also purchase services from other parts of the LSC system, and any additional income recovery made by the Trust will not improve the system's overall financial position.

Finally the Trust earns a source of income from selling goods or providing other services, for example: special pharmaceutical preparations, car parking, catering and retail concessions. Whilst these arrangements are all in place, we intend to use the financial strategy to take stock of the main sources of commercial income, with a view to establishing our strategic approach to each going forward. For example it is better to keep prices in line with annual inflation rather than a big leap in prices periodically to catch up with inflation.

Trust-wide programmes

The previous sections have referred to a number of Trust-wide programmes that are aimed at supporting the implementation of the financial strategy. Some of these are enabling programmes e.g. Continuous Improvement and others provide specific tools and resources for use across the Trust to directly improve use the use of resources, efficiency and reduce waste.

Enabling Programmes

Waste Reduction Programme/Continuous Improvement

Whilst the traditional approach to cost reduction still has its place, our Continuous Improvement methodology recognises the significant opportunity for identifying and eliminating waste in its many forms (see graphic). It also recognises that those best place to see how things can be improved are those who work in and use our services – staff, patients and relatives

Fig 4 - Types of Waste

Waste		Examples in Healthcare
Transportation Moving people, items or information		Moving patients between units, moving equipment to and fro from an area, transporting medical records
Inventory Too few or too many items or information		Overstocked supplies, expired supplies or medications, batched admissions or discharges processed at the end of a shift, stockpiles of pre-printed forms
Motion Excessive movement in the workplace		Increased walking due to poor layout and building design, reaching or stooping for frequently used supplies and equipment, non-ergonomic patient transfers between beds, wheelchairs, or operating tables
Waiting Waiting for information, services or items to arrive		Delays in results of tests, patients in waiting rooms, waiting for pharmacy processing, waiting for discharge letters so beds can be freed up, high-tech equipment not being used
Over-processing Doing more work than is necessary		Collecting unnecessary information or more than once (duplication of assessment), extending hospital stay beyond necessary, preparing medications for a discharged patient
Overproduction Doing work before it is needed		Needless tests, filling out multiple forms with same information, data entry in multiple systems, extra approvals/signatures, producing it before it is required
Defects Mistakes or errors that need to be redone		Errors in documentation, repeating tests due to incorrect information, medication errors, surgical errors
Skills Not using our people to fullest of abilities		People with advanced skills doing routine work, failure to utilise peoples talent, ideas for improvement ignored

As part of the financial strategy we will we will be working with each division to identify the most appropriate Continuous Improvement programmes, such as Always Safety First collaboratives, Flow Coaching Academy or Micro Coaching Academy to help identify opportunities to eliminate variation, reduce waste and make processes more reliable". Each division will have a number of improvement activities within year and progress will be regularly reviewed with benefits identified. These benefits will be in line with the organisations quadruple aim: increasing quality provision of care (population health), achieving value based care (cost per capita), improving patient experience and creating joy at work for staff. We will support the CI team to calculate the financial benefits of the improvement programmes delivered. These improvement programmes will be fully aligned with the ICS priorities and the finance team will support the adoption of the system level improvement model.

Some of these benefits will manifest as a financial saving, but often they will also result in reduced waits or more patients been seen and treated. All these benefits are equally valid, and ultimately accrue an economic benefit to the Trust and the System. What will be important is establishing how me measure the benefit and monitor its realisation.

The publication of the Trust's Green plan and Social Value Framework in 2021–22 will support a more environmentally balanced future for the Trust by reducing carbon emissions and minimising waste. The Trust will increasingly focus for example on technologies that consume less, it will seek the wider engagement of staff and service users to reduce wastage and will improve segregation. A focus on necessary consumption will seek to influence the way that resources are utilised.

The Trust will seek to promote better decision making through its idea generation and business case development. Seeking to embrace and adopt innovations which have a strong evidence base or where there is a compelling case for change.

Creating the right environment, leadership skills and behaviours

Creating the conditions for successful implementation of the financial strategy will require clarity of what we are require from divisions, services and budget holders together, alongside empowerment to make decisions quickly and in the right place.

The financial strategy plans to achieve this by publishing a financial framework that sets out the Trust's approach to annual budget setting and decision making that has financial consequences. Alongside this we will develop and deliver training in financial management and improvement methodologies at all levels across the Trust with appropriate training.

Development of patient level information systems

Patient level costing and information systems (PLICS) have been developed across the NHS, in part to support the management of PBR. However, arguably, the real strength of patient level information lies in gaining an understanding of the drivers of treatment costs. The Faculty of Medical Leadership and Management also sees patient level information as providing clinicians and finance professionals to speak a common language of performance improvement.

Developing and embedding our local approach to PLICS is will be enabler on many levels including, providing the data to improve performance, measure improvements such as waste reduction and engage clinicians in performance improvement, provide an evidence based approach to costing new initiatives.

As such as part of the finance strategy we will be building on our current work in this area using the our patient level costing system with an agreed list of priority specialities, reflecting the clinical service review process outlined above. The intention in the first phase is to share the current information with clinical teams, with a view to further improving the capture of information and allocation of costs.

It is not anticipated that the Trust will introduce further interdepartmental financial recharges, as the benefits whilst helpful require significant underpinning processes. The Trusts developing planning processes and budgetary systems will need to adjust for variable and semi variable costs in an appropriate way.

Specific Programmes

Returning to Business as Usual

During the Covid period additional costs associated with living with Covid and its impact have been incurred. Whilst funding for Covid costs continues it will be on a declining fixed allocation basis. As such there is an incentive to re-appraise all continuing Covid costs and establish what can now be curtailed or reduced and what conditions will need to be in place to remove the remaining costs at some future point.

This process will be co-ordinated between finance and operations, and is intended to ensure that we continue to respond appropriately to the needs of managing Covid risks, but only spend what is necessary. It will also provide us with the intelligence to flag continuing risk up to the ICS and the wider NHS.

It will be important to provide some early analysis as to what investment may be required on an ongoing basis and what will require withdrawal. Given the financial constraints it can be anticipated that HM Government will wish to disinvest in many areas that have been temporarily resourced. It can we anticipated that the requirement to disinvest is likely in some areas to be met with a range of concerns from staff and leaders alike.

Capacity Planning

Operating from two acute sites and restoring services after Covid present both challenges and opportunities to optimise the use of constrained capacity, particularly in planned care for inpatients and outpatients. Developing capacity plans taking account of the theatre, bed, clinic and workforce availability, will allow the Trust to maximise the use of available capacity. This should also help reduce the reliance on the independent sector and reduce costs on premium rate staffing. Short term it will also allow maximise access to restoration funding for both the Trust and the wider system.

The finance strategy plans for finance and the operations team to jointly develop a model to allow capacity to be planned ahead and proactive steps taken to deal with any anticipated constraints in the system, and taking account of additional funding that will allow capacity to be enhanced. This plan should be capable of matching a patient stay to all the treatment and bed capacity required, and factor in the benefits of new ways of working e.g. remote consultations.

Managing down the cost of premium rate pay

Earlier we identified the demand and supply factors that lead to the Trust's reliance of workforce models that rely on overtime, bank and agency premium rate pay costs. To truly solve this problem, the underlying factors leading to a workforce shortage need to be tackled as outlined above. However, there are a number of steps the Trust is and can continue to take to proactively reduce the cost of these types of workforce costs.

As part of the financial strategy, this work will require a joined up effort between human resources, operations and finance with a lead Senior Responsibly Officer (SRO). The remit of this group will be to advise and make recommendations to the Executive/Hospital Management Board on the approach to be taken and specifically:

- Develop a standardised approach to the use of Waiting Listing Initiatives (WLIs), including who is eligible and in what circumstances.
- Implement systems to provide budget holders with clarity on the impact of temporary staffing solution on the run rate budget performance now and in the future.
- Identify, recommend and monitor the implementation of innovative models to replace traditional approaches that are likely to improve either fill rates, costs or both e.g. alternative engagement models for groups of clinicians, bonus payments to encourage bank shift take up.
- Identify and make recommendations on the implementation of technology solutions that can be used to manage scheduling, recruitment and retention including rostering and forward look on vacancies.
- Provide a link to each division within the Trust to ensure the agree recommendations are understood and can be implemented.

Linked to the improvements in internal management information, the Trust will also seek collaboration with the LSC provider system to standardise premium pay rates and extremis "break glass" rules to reduce differentials and situations where providers are competing on pay rates with each other

Use of technology to improve efficiency

During Covid the use of technology has been embraced both to allow remote working and consultations with patients. The use of the national Attend Anywhere remote consultation solution went from being a niche product to universal adoption in a matter of weeks. As well as providing solutions to problems, technology solutions can be a useful lever to reduce waste, a good example being the use of text reminder systems for appointments to reduce Did Not Attends (DNAs).

Many more opportunities exist to improve services and reduce waste, and as part of the financial strategy work we aim to establish a programme of initiatives that will allow services and departments across the Trust to improve efficiency. This will be led by a group comprising of technology experts , clinicians along with representation from relevant corporate functions. The aim of the group will be to identify solutions and develop business case for approval that can:

- Automate routine tasks, including the removal of the opportunity for human errors.
- Provide additional solutions to help patients manage their own conditions and serve themselves when they need to interact with the Trust.
- Streamline and remove process steps in patient pathways and workflow in support functions.
- Reduce the use of paper across the Trust, including making information available on-line.

It is anticipated that NHS Digital will re-focus its allocation of transformation resource to both supporting the strengthening of infrastructure and specific system solutions that will improve productivity. As such the above work should help to ensure the Trust is ready to secure NHS Digital resources via appropriate business cases when the time comes

Effective use of medicines

Pharmacists supported by the Trust's prescribing committee are proactive in identifying opportunities to improve the use of medicine, including the use of generic drugs and standardising the formulary. However, medicine management is a continually developing area and the advent of the ICS provides different opportunities for a joined up approach between primary and secondary care prescribing.

As such the financial strategy plans to build on the work already led by the Chief Pharmacist to ensure:

- Clinicians across the Trust are aware of the opportunities available to manage the use of medicines more effectively e.g. formulary, use of 'generic' medicines etc.
- Co-ordination between the Trust and primary care, with a focus on the implementation of best practice opportunities from GIRFT and Right Care, wherever the benefit accrues in the system.
- Advise and recommend approaches to benefit and cost share where these accrue to the wider system.
- Ensure continuing capture of all high cost drugs and devices.

Management of non-pay expenditure

The Trust's procurement department already produces an annual plan to make savings by driving down the cost of goods and services we consume. A national programme has been established to extend this approach to procurement across ICSs. Going forward the Trust's procurement programme will need to take account of the wider opportunities that are likely to be generated at a system level, but these are likely to focus on:

- Reduce the number of transactions and suppliers the system works with.
- Product standardisation across the system.
- Process changes that could reduce or increase the need for consumables.
- Joint tenders for goods and services as these come up for renewal.

The Trust's head of procurement will continue to oversee the programme for the Trust and will work with individual divisional finance and management teams to ensure that the opportunities can be maximised.

Investing in our estate and equipment

The work proposed in this financial strategy is likely to identify a number of strategic investment proposals alongside the priority maintenance and replacement of buildings and equipment. To implement change we are likely to have to prioritise a larger slice of capital to strategic projects over time, however nationally and regionally earmarked capital is likely to continue to be identified for specific risks e.g. specific additional allocation have recently been made for A&E, endoscopy and cladding rectification.

The finance strategy will strengthen the process for identifying capital investments, with a specific risk based business case appraisal process included in the financial framework, ensuring the revenue implications of capital investment are properly understood.

It is planned that each year the Executive will identify capital budget allocations for IT, backlog maintenance, equipment replacement, minor estate works and strategic schemes against which proposals will be prioritised. Inevitably, not all proposals will be affordable. However, a list of reserve priority schemes will be maintained with business cases ready in case additional funding becomes available or approved schemes are delayed for any reason allowing another scheme to substitute.

Implementation and Governance

The role of the Executive Team, Divisional Management and Budget Holders in implementing the financial strategy is set out in section 3 above. The Trust's existing governance structure will be used to oversee and provide assurance on the implementation of the strategy. Specifically:

- Finance and Performance Committee, will oversee the implementation of the work programme and provide assurance to the Board on progress and resolution of any issues that arise.
- The Performance Framework will be used to provide an opportunity for the Executive Directors to progress specific aspects of the work programmes with individual divisions and departments, including service reviews and the waste reduction work programmes.
- The outline timetable set out in Appendix A is aligned to the conclusion of H2 2021/22 planning and the normal annual planning process heading into 2022/23. The annual planning process and documentation for 2022/23 will be updated to include key activities set out in the work programmes.

In addition to the formal governance structure, the following elements of the Trust management structure will be important in delivering the strategy as follows:

- The Executive Team as a group and individually will be crucial in shaping and delivering the work programmes set out in Appendix A.
- The Hospital Management Board will similarly allow a broad range of views to be incorporated into the way the financial strategy is implemented, and a regular discussion on progress with this group will be planned in during the year.

Our system partners will also play a crucial part in helping us deliver the strategy, particularly where our plans extend into areas not totally within our control e.g. HEE resource allocation, commissioning arrangements and provider collaboration. Whilst not exhaustive the following fora will be important to engage in various aspects of the financial strategy:

- ICS Board.
- ICS Partnership Board.
- ICS Provider Group.
- ICS Director groups (e.g. finance and HR).

Appendix A - Programmes of work to support the financial strategy

Governance and Communication

Programme: *Creating the conditions for success*

Objective: *Put in place and communicate the financial strategy internally and externally*

Key Activities	Timescale	Lead
1 Share financial strategy with Executive Team for comment and update as necessary	Q3 21–22	DoF
2 Share financial strategy with ICS for comment and update as necessary	Q3 21–22	DoF
3 Share financial strategy with Finance and Performance Committee for comment and update as necessary	Q3 21–22	DoF
4 Share financial strategy with Executive Management Group for comment and update as necessary	Q3 21–22	DoF
5 Finalise slide pack for wider communication of financial strategy internally and externally, set in the context of LTH "Big plan", values and behaviours	Q3 21–22	DoF
6 Formally sign off financial strategy at Board and agree governance for overseeing the implementation of the financial strategy	Q3 21–22	DoF
7 Review budget setting framework and budget holder guidance and update as necessary in line with financial strategy	Q3 21–22	DDoF
8 Review Trust business case process to align with the financial strategy and reinforce the importance of balancing quality, performance, workforce and financial considerations in key decisions	Q3 21–22	DDoF
9 Programme of communication with Divisions and Support functions	Q3 21–22	DDoF/Director of Comms
10 Review current finance training for budget holders and managers and align/update in line with financial strategy	Q3 21–22	DDoF

Operational Capacity Planning

Programme: *Managing with Covid*

Objective: *Prepare the Trust for the next phase of managing the Covid pandemic alongside restoring for business as usual*

Business cases for funding

Flag continuing risks outside of funding envelope

Key Activities	Timescale	Lead
1 Establish process to review all continuing covid related costs identifying • What's here to stay?. • What can be removed/reduced and when?.	Q3 21–22	DoF/COO
2 Develop restoration plan for Q3/Q4 2021/22 as part of overall capacity planning in conjunction with ICS	Q3 21–22	Director of Service Development/ COO
3 Put in place systems to monitor restoration performance and access to Elective Recovery Fund and Accelerator bid	Q3 21–22	Director of Service Development/ COO
4 Develop plans to respond to the defunding of covid related investments.	Q3 21–22	Director of Service Development/ COO

Programme: *Integrated approach to planning*

Objective: *Develop a set of tools to support operational teams to model and optimise capacity and pathways resulting in a clear annual plan*

Key Activities	Timescale	Lead
1 Develop capacity model to match demand with supply (consultants, theatres and beds) to model backlog wait clearance and increased referrals	Q3 21–22	CIO/COO
2 Use capacity model to identify and agree plans to overcome constraints	Q3 21–22	CIO/COO
3 Use modelling tool to identify where opportunity exists to deploy different service models, including enhanced community provision for inclusion in commissioning discussion	Q3 21–22	COO/Director of Service Development
4 Review of the provision of services across the two hospital sites to identify opportunities to improve capacity utilisation and streamline pathways	Q3 21–22	COO/Director of Service Development
5 Create a clear planning timetable for the 22-23 planning round resulting in the production of a business plan for approval by the Board in April 2022	Q1 22-23	Director of Service Development

Programme: *Establish Strategic Collaboration with Independent Sector Providers (ISPs)*

Objective: *Negotiate a new partnership arrangement with the main ISP*

Key Activities	Timescale	Lead
1 Engage with ICS lead to understand current ISP contractual position	Q3 21–22	Director of Service Development
2 Review LTH current utilisation in conjunction with capacity model to identify opportunities for strategic collaboration with ISPs	Q3 21–22	Director of Service Development
3 Engage local ISPs to establish opportunity for strategic collaboration	Q3 21–22	Director of Service Development
3 Share LTH thinking with provider group to establish opportunities for a wider system approach	Q3 21–22	Director of Service Development
4 Negotiate revised arrangement under the national framework or a separate local arrangement	Q3 21–22	Director of Service Development

Knowing the Business

Programme: *Portfolio service review*

Objective: *Use clinical and economic criteria to assess the sustainability of key services and develop forward plans*

Identify opportunities for integrated care

Key Activities	Timescale	Lead
1 Agree outline of approach with Exec Team	Q3 21–22	Director of Service Development
2 Develop programme of reviews to cover all services within a 12 month period (4 cohorts, one per quarter)	Q3 21–22	Director of Service Development
3 Identify services in the first cohort – Q4 2021/22	Q3 21–22	Director of Service Development
4 Agree clinical and economic criteria aimed at evaluating sustainability	Q3 21–22	Director of Service Development
5 Carry out desk top SWOT for first cohort and present pack to Exec Team	Q3 21–22	Director of Service Development
6 Clarify any areas of uncertainty with service lines	Q3 21–22	Director of Service Development
7 Complete evaluation using criteria	Q3 21–22	Director of Service Development
8 Present outcome of evaluation with suggested next steps to Exec Team for agreement	Q3 21–22	Director of Service Development
9 Formally report summary of actions to be taken to Finance committee/ Board and add to implementation plan	Q3 21–22	Director of Service Development

Programme: *Understanding population health dynamics*

Objective: *Identify and use data to model health needs and trends to support allocation of resources*

Key Activities	Timescale	Lead
1 Engage director of public health to understand ICS approach to population health analytics	Q3 21–22	CIO/MD
2 Review approach to population health being taken by providers locally, regionally and nationally	Q3 21–22	CIO/MD
3 Develop plan for LTH to use existing data, or support the development of additional information sets to model health and prevention needs	Q3 21–22	CIO/MD
4 Use the above data to benchmark resource need versus allocation and share findings	Q3 21–22	CIO/DoF

Programme: *Service Reviews*

Objective: *Use available data to identify opportunities for performance improvement, efficiency and waste reduction, including options for pathway redesign*

Key Activities	Timescale	Lead
1 Engage with each division to agree a programme of service line reviews to be conducted over next 12 months	Q3 21–22	Director of Service Development
2 Prepare data packs for each division's first cohort (Q4 2021/22) spanning clinical, operational, workforce and financial metrics and benchmarks to inform initial discussions	Q3 21–22	CIO/Director of Service Development
3 Use data packs to carry out service line review and identify areas for service improvement and waste reduction	Q3 21–22	Divisional Directors
4 Divisions to finalise outcome from individual service lines reviews , together with recommendations on next steps	Q3 21–22	Divisional Directors
5 Divisions to report findings to Executive team and incorporate action plans into divisional objectives as part of performance and planning process	Q3 21–22	Divisional Directors

Programme: *Patient level information*

Objective: *Use existing internal and external data sources to understand service and patient level costs and performance metrics, to inform service line review and commissioner discussions*

Key Activities	Timescale	Lead
1 Take stock of progress with PLICS internally and re-clarify objectives to complement financial strategy (post PBR)	Q3 21–22	DoF
2 Develop a plan to roll out PLICS to service lines in support of the service line review process (above)	Q3 21–22	DDoF

System Engagement

Programme: *Commissioning Approach*

Objective: *Prepare the Trust for the anticipated changes in the commissioning landscape, so we are ready to act and influence the ICS approach*

Key Activities	Timescale	Lead
1 Map existing commissioning relationships to anticipated new arrangements and identify key relationship issues that will need to managed	Q3 21–22	Director of Service Development
2 Identify and develop relationships with Primary Care Network representatives, focussing on how care models can be revised and resourced	Q3 21–22	Director of Service Development
3 Engage with local authority, community and third sector providers to identify areas of common ground that provide a basis for engagement with commissioners	Q3 21–22	Director of Service Development
4 Explore and appraise the different contract mechanisms that will be available, and establish preferred approach including the use of PBR going forward	Q3 21–22	Director of Service Development/ DoF/COO
5 Review the current specialised commissioning arrangements, and work with ICS to plan the pace of transfer to local arrangements whilst flagging any historic funding issues	Q3 21–22	Director of Service Development/ DoF/COO

Programme: *Provider collaboration*

Objective: *Prepare for taking a lead role in shaping and delivering provider collaboration*

Key Activities	Timescale	Lead
1 Carry out a systematic appraisal of all support functions and establish strengths and weaknesses, opportunities and threats	Q3 21–22	Director of Service Development
2 Use the outcome from the above review to inform Exec Team in formulating obvious "make vs buy" preferences for all or parts of support functions	Q3 21–22	Director of Service Development
3 Use the Exec Team discussion to help determine LTH approach to provider collaboration and a set of objective criteria that can be used to evaluate each collaboration opportunity on its merits as they are developed	Q3 21–22	Director of Service Development
4 Engage with and influence the emerging ICS strategy for provider collaboration to ensure those areas with the greatest potential for improvement are progressed	Ongoing	DoF

Workforce

Programme: *Develop Workforce Information*

Objective: *Standardise the approach to workforce information to support managers and budget holders in taking cost effective decisions*

Key Activities	Timescale	Lead
1 Identify and make recommendations on the implementation of technology solutions that can be used to manage scheduling, recruitment and retention including rostering and forward look on potential vacancies	Q3 21–22	Director of Workforce

Programme: *Reducing the cost of premium rate pay*

Objective: *Proactively reduce the use and associated cost of workforce models that rely on overtime, bank, agency and waiting list arrangements*

Key Activities	Timescale	Lead
1 Review run rate dashboards of premium rate costs, that show the impact of decision on budgets as they are made	Q3 21–22	HRD
2 Review standardised approach to premium rate pay (including WLIs)	Q3 21–22	HRD
3 Re-evaluate opportunities for innovative approaches to filling shift and sessions by Trust employees that are cost effective	Q3 21–22	DHRD
4 Work with LSC provider collaborative to standardise approach to premium rate pay including conditions that allow "break glass" arrangement	Q3 21–22	HRD

Programme: *Influence allocation of HEE resources*

Objective: *Provide quantified analysis to support and inform strategic discussion with HEE and HE providers*

Key Activities	Timescale	Lead
1 Develop 2/3 case studies of examples that quantify the impact of current training arrangements with alternate proposals and share with HEE and ICS	Q3 21–22	DoW/MD
2 Use the above case studies to engage HEE with a view to influencing change to the way training programmes are structured for the Trust	Q3 21–22	DoW/MD
3 Engage with HE providers to understand how local collaboration can be used to alleviate training shortages and expand opportunities for local people	Q3 21–22	DoW/MD/DNS

Enabling Waste Reduction and Efficiency

Programme: *Continuous Improvement*

Objective: *Establish a programme that rolls out the Trust's continuous improvement methodology in a systematic way*

Key Activities	Timescale	Lead
Each division will be encouraged to undertake a variety of Continuous Improvement activities, which will be in line with the organisational strategy. These include: 1. Enrolling divisional teams in the Always Safety First programme (participation in BTS Collaboratives) 2. Identify priority clinical pathways and undertaking the Flow Coaching Academy programme 3. Identification of local-level improvement initiatives and utilise the Microsystem Coaching Academy as a way to deliver change on the frontline These will be actively reviewed using measurement for improvement which will be vital to the demonstration and success of working towards the quadruple aim and the impact of Continuous Improvement activities. Q3 21–22 Director of Continuous improvement	Q3 21–22	Director of Continuous Improvement
Through the publication of the Trusts Green Plan and Social Value Framework provide a focus on Environmental sustainability and the reduction of waste	Q4 21–22	DoF

Programme: *Develop commercial approach to trading activities and R&D*

Objective: *Maximise the potential for contribution from trading activities*

Key Activities	Timescale	Lead
1 Carry out a review of each line of income comparing pre/post covid position and identify what can be done to restore remaining income or replace with new trading activities	Q3 21–22	DoF/ Divisional Directors
2 For trading activities above a pre agreed threshold, task service manager/ division to reviewing current position using benchmarks and identifying areas for improvement (could be incorporated as part of service reviews)	Q3 21–22	Divisional Directors
3 Update contract register for all trading activities including NHS SLAs, and identify any gaps/opportunities and action plan to address	Q3 21–22	DDoF
4 Implement a system of contribution reporting for trading activities, with all activities with a turnover above an agree threshold reported annually in summary to Finance committee and quarterly to relevant divisions	Q3 21–22	DDoF
5 Include standard costing templates for trading activities in guidance to managers on financial management	Q3 21–22	DDoF

Programme: *Technology led productivity and waste reduction*

Objective: *Identify and ready for implementation opportunities to deploy technology to improve productivity or reduce waste.*

Key Activities	Timescale	Lead
1 Identify, evaluate and prioritise opportunities to: • Automate routine tasks, including the removal of the opportunity for human errors. • Provide additional solutions to help patients manage their own conditions and serve themselves when they need to interact with the Trust. • Streamline and remove process steps in patient pathways and workflow in support functions. • Reduce the use of paper across the Trust, including making information available on-line. • Develop business case ready for NHS digital.	Q3 21–22	CIO
2 Support divisions and departments in implementing the prioritised improvements	Ongoing	CIO

Programme: *Effective use of medicines*

Objective: *Collaborate with partners across the ICS to identify opportunities to improve the use of medicines and reduce costs*

Key Activities	Timescale	Lead
1 Ensure Clinicians across the Trust are aware of the opportunities available to manage the use of medicines more effectively e.g. formulary, use of generics etc…	Q3 21–22	Chief Pharmacist
2 Ensure Co-ordination between the Trust and primary care, with a focus on the implementation of best practice opportunities from GIRFT and Right Care	Ongoing	Chief Pharmacist
3 Advise and recommend approaches to benefit and cost share where these accrue to the wider system	Q3 21–22	DoF/Chief Pharmacist
4 Ensure continuing capture of all high cost drugs and devices	Ongoing	Chief Pharmacist

Programme: *Effective management of non-pay expenditure*

Objective: *Build on Trust procurement strategy to ensure the benefits of collaboration with partners across the ICS is maximised*

Key Activities	Timescale	Lead
1 Refresh the Trust's procurement strategy to take account of the Procurement Target Operating Model (PTOM) requirement and opportunities presented from working at a system level.	Q3 21–22	Head of Procurement
2 Support divisions and departments in implementing the prioritised improvements	Ongoing	Head of Procurement

Capital Investment

Programme: *Investment strategy*

Objective: *Develop strategic prioritisation plan for capital investment*

Key Activities	Timescale	Lead
1 Agree approach to capital 2022-23 allocation with the Executive team, including: • Indicative budgets for each type of investment (Strategic, backlog, IT, med equipment). • Priority and reserve schemes (for when additional funds get announced). • 3 year rolling programme.	Q4 21–22	DoF
2 Implement a risk based approach to capital investment prioritisation within the above allocations that: • Prioritises critical equipment most at risk from breakdown. • Backlog maintenance that could adversely affect service provision.	Q3 21–22	Head of Estates/CIO

Appendix B - Service line portfolio analysis

The contents of this appendix are reproduced (with some tailoring) from the following article: Service Line Portfolio Analysis: Identify Leaders and Laggards **https://www.healthleadersmedia.com/finance/service-line-portfolio-analysis-identify-leaders-and-laggards**

Conducting a service line portfolio analysis includes four major steps:

1. Defining the service lines
2. Identifying and weighting service line evaluation criteria
3. Scoring the service lines against the evaluation criteria
4. Discussing the results and, ultimately, making service line decisions

The entire process should be supported with ample process facilitation and discussion.

Defining the service lines

Defining the service lines, sets the foundation for the portfolio analysis. The following recommendations will help ensure a smooth first step in service line portfolio analysis:

- Use service line definitions that are easy to understand and facilitate data collection. Complex definitions hinder data collection and may inhibit future use of the evaluation tool.
- Ensure clinical buy in to the service line definitions to maximise engagement in the process and ownership of the results.
- Avoid double-counting, which may occur when the same services are included within multiple definitions. This can be a tricky proposition as it is common for many services to make contributions to multiple service lines. Nonetheless, a sound allocation of services to individual services lines is necessary to ensure both accuracy and buy-in of the portfolio analysis process.

Identifying and weighting service line evaluation criteria

The second step, identifying and weighting service line evaluation criteria, focuses on determining which service line characteristics are most important.

It is envisage that these will focus on two domains – clinical and economic sustainability. However, this can be tailored as necessary. Clinical sustainability criteria might include workforce availability, ability to provide the full range of specialty services and clinical performance metrics. Economic sustainability is likely to include financial performance, growth potential and commissioning intentions.

Good evaluation criteria have the following characteristics:

- They are clear, straightforward, and easily understood (i.e., not subject to creative interpretation).
- They reflect all major organisational objectives without "double counting" or overlapping.
- They focus on the "critical few" criteria that reveal what is truly important to the organization (i.e., developing 20 different criteria will hinder, not help, the process).
- They are measurable and objective (to the extent possible).
- They help to differentiate alternatives (i.e., do not result in the same score for all projects).

After service line criteria have been developed, the next step is to assign each criterion a weight. It can be helpful to start with a pool of potential points (e.g. 100) and allocate to each of the criterion based on organisational priority.

Scoring

The third step--creating the service line information set and scoring the services lines based on the criteria and weights--are a relatively simple process. Each service line is scored against the criteria in each domain each of the criterion based on the information collected in the information set.

Based on the results of the scoring, each service line can be ranked. Since simple scoring can be misleading, it is often helpful to plot that the score for each service against the two domains on a 2x2 matrix. The relative size (budget, patients or staff) and be reflected by the size of the dot representing the service line.

Discussing the Results

The fifth and final step, discussing the results and making planning decisions, is where it all comes together. Decisions about service lines often fall into four distinct categories: invest or grow, divest or shrink, reposition, or maintain. Open discussion of the portfolio analysis is critical to ensure that stakeholders buy into the decisions that are made. If stakeholders are not allowed to view and discuss the results, it is likely they will feel decisions have been made behind closed doors.

Service line options

Option	Description
Invest or Grow	These services should be top priorities for resource allocation and program development (in other words, areas for extraordinary attention).
Divest or Shrink	In selected cases, an organisation might decide to downsize or divest services in order to free up resources that would be better used in support of other strategic initiatives or services. In the NHS system world this could also include collaborating with partners to sustain, otherwise fragile, services
Reposition	Services in this category need to be fundamentally changed in order to improve their performance. Could include moving to a community based offer
Maintain	Focus should be on maintaining, but not necessarily growing, these services.

Steps to ensure success

Like any potentially controversial course of action, there are steps that can be taken to smooth the process. These steps include the following:

- Develop a core (no more than 10) set of evaluation criteria that truly focus on what is important to the organization.
- Obtain agreement up-front on the service line definitions, criteria, and criteria weighting to limit the amount of post-analysis gaming that occurs.
- Keep the process open with continual communication throughout the steps.
- Get clinicians involved early in the decision-making steps.
- Use common sense. Portfolio analysis should not trump prudence and experience.

Service line planning has never been more necessary than in today's turbulent healthcare environment. Following a logical and largely data-driven process such as the one outlined in this article can help ensure that timely and appropriate planning decisions are made substantially free of the emotions and politicking that are often associated with decisions to expand, divest, reposition, or maintain service lines.