City Hospitals Sunderland NHS
NHS Foundation Trust

OPERATIONAL PLAN
APRIL 2016

1.0 INTRODUCTION

The annual plan for 2016/17 builds on the Trust's 1-2year Financial Recovery Plan shared with Monitor in December 2015 and supports the Trust's long term strategy, which has been outlined in previous submissions.

The Trust confirms acceptance of the Sustainability and Transformational Fund and therefore agrees to the conditions attached, however, there are significant risks to the delivery of this and these are detailed in the body of the paper.

2.0 ACTIVITY PLANNING

The Trust's demand planning is based on:

- A statistical model based on two years of data overlaid with trend lines for the 24 monthly data points.

- Base demand (actual activity adjusted for movement in waiting lists) calculated via opening and closing waiting lists. Data derived from 18 Week RTT incompletes, referral data and waiting list data with the definitive position being recommended by the performance team as an adjustment to ensure delivery of national standards.

- A table of demand (by specialty by point of delivery) plus the underlying model shared with directorate managers to add soft intelligence in terms of
    - Capacity changes at local providers (gain or loss)
    - Service delivery changes (clinical treatment or format)
    - NICE and other relevant clinical guidance
    - Deliverability of national standards.
    - Impact of changes at other providers or commissioner led demand management

This will provide the Trust's best view of demand for 2016/17.

Work is underway to understand demand and capacity for cancer pathways as part of the cancer 62 day improvement plan linked to plans to improve pathways. This work has already informed discussions with commissioners around the additional activity required to consistently deliver the 62 day standard from Q3 in 2016/17.

The Trust activity assumptions for 2016/17 are in the main based on 2015/16 out turn plus/minus adjustments for specific service changes, growth or retraction. For example 5% increase in

Urology based on recent service growth and national incentives such as ‘blood in pee’ campaigns, 3% growth in A&E activity based on recent years trends, and 4% decrease in orthopaedics as 2015/16 was especially high to clear 18week backlogs.

At the point of writing the Trust activity assumptions show a reasonable comparison to our main commissioner Sunderland CCG with the main exception of Vanguard non-elective reductions proposed by the CCG as the Trust has yet to see firm evidence to support these reductions. Activity demand plans have been received from other CCGs, however these plans contain a number of activity adjustments for CCG QIPP targets with minimal supporting documentation, hence it is difficult for the Trust to make comparisons at this stage.

In terms of the alliance agreed between City Hospitals Sunderland and South Tyneside NHS Foundation Trust, the only predicted 2016/17 activity change is likely to be for the acute stroke service and this will be captured by an in year contract variation. It is anticipated that the clinical teams will reach agreement on other service changes during 2016/17, but the impact in terms of activity will not be seen until 2017/18.

2.1 Capacity

The Trust uses models at a specialty/sub specialty level to calculate forwards capacity on a week by week basis to:

- Predict for the year forward
- Update with actual delivery in order that services can react to any reduction in capacity which may impact on service delivery/delivery of access targets

The models are updated to include holidays, changes in staffing or delivery methods if they materially affect capacity. Where appropriate, the models reflect substantive capacity, stretch capacity or indicate where other NHS or private providers are being used to deliver the required levels of activity.

2.2 Demand and capacity reconciliation

Both capacity and demand model outputs are annotated to reflect any significant variation from 2015/16 values.

The outputs are shared with the main CCGs as part of the contract negotiations and discussed in light of the CCGs own demand models. This process allows the Trust and the CCGs to agree anticipated activity levels for the forthcoming financial year.

Once predicted demand has been agreed between the Trust and its CCGs, the Trust highlights where demand is:

- Within substantive capacity to deliver
- Within stretch capacity to deliver (though may require additional funding)
- Above stretch capacity and would require the use of subcontractors or alternative providers

2.3 Access standards

The Trust has submitted improvement trajectories against the required indicators outlined in the Sustainability and Transformation Plan guidance. The improvement trajectories submitted as part of this annual plan submission are consistent with submissions to NHSE as part of the Sustainability and Transformation Fund submissions. The risks identified for 2016/17 are cancer 62 days (Q2) and A&E (Q3 and Q4).

In relation to cancer 62 days we have an agreed internal plan to reduce the backlog of patients requiring treatment in Urology and this is reflected in the improvement trajectory for 2016/17.

The Trust's improvement trajectory for the delivery of the A&E 4 hour standard is based on assumptions around attendances and growth. This will achieve an improvement in performance year on year however the enablers required to deliver this are both internal and external/system-wide including:

- Continued focus on improving flow from ED to admission including bed modelling, forecasting and discharge
- Extending ambulatory care pathways further
- Continuous progress on improving process within the ED
- Development of a primary care strategy and out of hospital services, led by the Urgent Care Board, as alternatives to ED
- Involvement in the regional Urgent Care Vanguard to improve the co-ordination of services and reduce pressure on A&E departments

It should be noted that any significant increase in demand (over and above planned assumptions) may affect the Trust's ability to deliver on key access targets.

3 QUALITY PLANNING

3.1 Quality of care and patient safety

The Trust's overall vision, strategy and philosophy reflect the pivotal dimensions of quality; patient safety, clinical effectiveness and patient experience.

The strategic business planning process provides a framework for delivering against key national, local and internal quality and performance objectives. Overall performance is aligned and tracked against these Trust-wide priorities for quality improvement. This ensures that quality underpins any major service change.

Our quality priorities reflect local and national priorities, as well as discussions with key stakeholders. We also consider key 'hard' and 'soft' intelligence and outcomes from a broad range of internal monitoring and assurance mechanisms.

The Clinical Governance Steering Group and Governance Committee, on behalf of the Board of Directors, reviews progress against clinical quality benchmarks and outstanding risks are escalated to the Board of Directors via a monthly Quality and Risk Assurance Report. The Trust routinely analyses organisational performance on key quality indicators, benchmarked against national comparators, leading to the identification of priorities for quality improvement.

The Board of Directors and the Executive Committee reviews the Performance Report, the Quality, Risk and Assurance Report and other relevant reports on a monthly basis. Further assurance from external sources such as the Care Quality Commission's Quality and Risk Profile, nationally reported mortality and outcome data, information from our quality provider (CHKS), the results of national audits and external inspections are also considered by relevant committees and the Board. The Governance Committee also provides assurance upon the adequacy and effectiveness of risk management and integrated governance within the organisation.

The executive lead for quality is the Executive Director of Nursing and Quality.

3.2 2016/17 Quality priorities

Priorities for 2016/17 have been drawn from consideration of the national quality and improvement agenda, review of local strategic planning and service transformation as well reflection on Trust internal and external intelligence across all elements of quality. Some of the information sources have included:

- Trust strategic objectives and service development plans, i.e. Monitor Annual Plan, OGSM framework, CQUIN scheme etc.,
- Work streams from the Project Management Office where quality forms part of financial recovery plans,
- Feedback from external reviews of Trust services, i.e. CQC inspections, CCG intelligence, Internal Audit reviews, Clinical Accreditation Schemes and other external audits,
- Patient safety issues from the Trust incident reporting system,
- Patient, carer, governor and public feedback on Trust services, including Friends Family Test, national patient surveys and real time feedback,
- Learning from complaints, PALS, incidents and quality reviews,

- Feedback from patient safety initiatives and staff listening events,
- Progress and feedback from last year's quality priorities

In determining quality priorities it is entirely appropriate and acceptable to continue to focus on areas identified from previous years where the Trust believes further work still needs to be done. New priorities may be selected in response to local issues that have emerged during the year or are part of existing quality plans.

A draft list of quality priorities was presented to Clinical Governance Steering Group in January 2016. These were further discussed and refinements made at a joint Board of Directors / Council of Governors meeting in February 2016. The Trust has also consulted with some key stakeholders, including senior managers and clinicians.

The Trust has identified the following quality priorities to take forward in 2016/17:

Patient Safety

Priorities for improvement

- Reduce the number of hospital acquired pressure ulcers

The Trust will also focus on the following improvement indicators:

- Improve the completion, documentation and visibility of 'Do Not Attempt Cardio Pulmonary Resuscitation' orders across the organisation (NEW)
- Improve the reporting and investigation of hospital associated VTE events (NEW)
- Reduce the number of patient falls that result in serious harm

Patient Experience

Priorities for improvement

- Improve the in-hospital management of patients with dementia and collaborate on integrated pathways

The Trust will also focus on the following improvement indicators:

- Minimise short notice cancellation of patient appointments and operations (NEW)
- Improve the timeliness of responses to patient complaints (NEW)
- Increase the percentage of inpatients who rated their care at City Hospitals as excellent, very good or good (Inpatient Survey) (NEW)

Clinical Effectiveness

Priorities for improvement

- Minimise avoidable deaths

The Trust will also focus on the following improvement indicators:

- Improve the process of fluid management and documentation
- Improve the assessment and management of patients with sepsis
- Reduction in the number of avoidable (predictable) cardiac arrests (NEW)

Staff Experience

Priorities for improvement

- Increase the number of staff participating in the Staff Friends & Family Test

3.3 Top three risks to quality

3.3.1 Trust finances and expenditure

Our current financial position and forecasting will place significant challenges for the Trust and its ability to maintain and improve the quality of care. The priority will be to deliver contracted levels of activity and maintain strong expenditure controls across all departments without compromising patient safety, clinical outcomes and patient experience. The work of the Programme Management Office in undertaking full quality impact assessments will be key as they oversee delivery of Trust cost improvement and transformational plans.

3.3.2 Registered nursing staff recruitment & retention

The Trust has not been immune to the problems of recruiting high calibre, registered nurses following the Francis Inquiry. The nursing resource plays a significant part in helping the Trust maintain patient safety and achieve its operational objectives but despite numerous initiatives to recruit staff, our current vacancy profile does present potential risks to quality in some key clinical areas, i.e. care of the elderly.

Plans are in place to mitigate this in the short and medium term including:

- International recruitment with successful candidates coming into the nursing pool in the summer
- Partnership working with the University of Sunderland to establish non-commissioned preregistered nursing programs recruiting from May 2016
- Ongoing staffing reviews to align the nursing workforce to patient and service needs.

Revalidation plans are progressing well however the behavioural impacts such as early retirement are not at this stage visible but are noted as a risk.

The International recruitment process is expected to provide approximately 42 additional registered nurses (net).

3.3.3 Learning lessons from avoidable harm

One of the Trust's key priorities for improving the quality of care is to reduce the number of patients who experience avoidable harm whilst in our care. Our internal and external information sources still show areas offering potential to improve aspects of safety and quality and these include the incidence of pressures ulcers and falls leading to moderate or severe harm.

The Trust has a defined process to improve its performance including:

- An MDT focusing solely on reducing avoidable harm through continuous improvement
- Defined clinical action plans at individual ward level

- Enhanced education and training to drive improvement
- Monitoring effectiveness through rigorous incident analysis.

3.4 Well-led framework

The Well-led framework for NHS Trust's provides a consistent view as to what constitutes a well-led NHS organisation in terms of its leadership, management and governance. We acknowledge that the framework builds on, and replaces, the existing tools of the Board Governance Assurance Framework and the Quality Governance Framework.

The Trust will undertake a thorough self-assessment against the domains in order to gain assurance that it is being well-led. The Trust Secretary/Director of Corporate Affairs and Assurance team will gather the information and evidence against each question and present their findings and initial conclusions to a Board Development Workshop for discussion and challenge before signing off the assessment and agreeing any actions required. This will be followed by the commissioning of a formal external review to be undertaken later in 2016/17.

3.5 Safety initiatives

The Trust has centred efforts on reducing rates of avoidable harm from events such as failure to identify patient deterioration, pressure sores, and medication errors. The national Sign Up to Safety initiative commenced in June 2014 and the Trust formally joined the campaign shortly afterwards, focussing on the same areas.

During 2015, our bid for Maternity and Emergency Department risk mitigation funding was successful as part of our Sign up to Safety pledges. This included funds to help purchase a centralised system for foetal monitoring in labour and to improve antenatal scanning functionality. Within Emergency Care we were able to work towards additional reporting radiographer support for the Emergency Department at evenings and weekends. These form part of our Safety Improvement Plan which contributes towards the Trust's strategic objectives since it links to the Level 1 Objectives, Goals, Strategies and Measures (OGSM) document (the Trust's planning tool). During 2016/17 we will continue to implement and review the success of these developments and their impact on patient safety.

3.6 Accountable professionals

The Trust has taken account of the Academy of Medical Royal College guidance and supports the concept of patients having a named accountable consultant and nurse coordinating and providing information about their care whilst in hospital. A review of implementation and progress will be incorporated into the Trust Assurance Programme and feedback to clinical teams will be via local clinical governance arrangements. The Trust will also seek to maximise promotion of the initiative through its patient involvement mechanisms, communicating through the Intranet and by inclusion in it's "Your Stay in Hospital" guide.

3.7 Seven Day Services

Implementation of the 7DS standards is one of the Trust's core objectives for 2016/17 and beyond. The Trust has already made strong progress against a number of the standards, which is demonstrated by the 7DS baseline assessment and the Trust has plans to further improve on this position.

Areas that the Trust will take forward in 2016/17 include:

- Continued refinement to already implemented new ways of working, in relation to consultant presence, ward and board rounds, following the 'perfect week' initiative
- A review of the 'back of house' medical model to ensure patients receive consistent on-going review 7 days a week
- Collaboration with other local hospitals to introduce a 24/7 Interventional Radiology service
- A review of capacity requirements in relation to diagnostics with a specific focus on routine inpatients

In relation to patient pathways and flow across the wider system, governance arrangements are in place which ensures that where relevant, partners across the local health economy are engaged and services outside of hospital operate consistently across the entire week.

The Trust has worked cooperatively with the local CCGs and other providers to redesign and improve the integration of walk-in and urgent care services.

3.8 Quality impact assessment process

Within the Programme Management Office, all projects within the cost recovery plan have rigorous Quality Impact Assessments (QIA) undertaken.

The Quality Impact Assessment form outlines the potential risks that a cost saving or service improvement project might have on the quality of services. The QIA forms are completed with input from the Clinical Director and clinical leads where appropriate. Risks are assessed using a standard 5 x 5 matrix, measuring impact (Patient safety, Clinical outcomes, and Patient experience) against likelihood. All schemes that are worked up in outline undergo quality impact assessments which are then signed off via the Programme Confirm and Challenge group and approved by the Programme Management group (an executive membership group that includes the Medical and Nursing Directors).

The QIA's are then monitored on an ongoing basis and any material changes to the risks or likelihood are updated through the same process.

3.9 Triangulation of indicators

The Trust's objectives are detailed in the level 1 OGSM (Planning Framework) which includes objectives around quality, safety, lead time, staff morale and cost leadership. The associated measures to track delivery of our corporate objectives are presented to Board and its sub-committees monthly in order to triangulate. This approach includes:

- Triangulation of nurse staffing levels with incidents and complaints. We are in the process of developing this further with ward level dashboards which include hospital acquired infections, pressure ulcers, falls, staffing levels, sickness absence and incidents.
- Triangulation of performance against key access targets with activity, workforce pressures/demand and capacity
- Triangulation of Finance reports with activity/income/performance re: penalties/operational pressures causing either reduction in income, reduction in expenditure etc.

As part of the Trust's approach to performance improvement, quarterly performance and operational reviews are held with each specialty. This provides an opportunity to holistically review specialties across a number of areas i.e. key performance indicators, patient experience, patient safety, workforce and contracting. The outcomes of these reviews are reported quarterly to the Operations Committee which is a sub-committee of the Board.

4.0 WORKFORCE PLANNING

4.1 Approach to workforce planning

The Trust produces and submits its 5 year workforce plan to Health Education England (North East). This is produced with input from the Directorate Managers and Clinical Directors in each area, before sign off by relevant Directors. National and local workforce pressures and internal succession planning are reviewed and discussed as part of the quarterly review processes for each specialty.

The key issues for City Hospitals from a workforce perspective were summarised in the annual plan to Health Education England (North East) for commissioning purposes and can now be updated in the light of the Monitor plan.

The plan shows minimal workforce changes in terms of workforce numbers, with an increase of around 42 registered nurses to reflect efforts to fill nurse vacancies, funded by a reduction in NHS Professionals and overtime use. We expect a small reduction in the numbers of Healthcare Assistants as these were over recruited to compensate for registered nursing vacancies which the Trust could not fill in the short term. There is a small increase expected in the numbers of medical and dental staff employed to reflect plans to recruit substantively to some posts rather than use locum staff. A small increase is expected in the numbers of scientific, therapeutic and technical staff

From a medical workforce perspective recruitment difficulties have been experienced in several specialties with national shortages, such as Gastroenterology.

Services are reviewing their workforce and service delivery plans around ongoing difficulties in procuring medical trainees and staff. Roles such as Physicians Associates are being considered in some services, and the use of Pharmacists and Nurses to cover service needs currently carried out by medical staff is being considered. The use of career grade doctors to plug gaps created by a lack of trainees has largely been used to date. A Hospital at Night Model using practitioners to supplement medical staffing is also proposed.

From a nursing perspective the gap in the Trust's nursing workforce has been addressed through international recruitment as a short term measure, but strategic work has been done to address a longer term supply by establishing a non commissioned Adult Nursing degree in partnership with South Tyneside Foundation Trust, Sunderland CCG and Sunderland University. This will provide additional registered nurses from 2019 onwards, all trained in a University within walking distance of the main hospital site.

The Trust has also established pathways for support staff to progress towards registered nursing roles including the use of 3 separate Pre Nursing Experience programmes (a general one, one for Access to Nursing students at Sunderland College and one for non-nursing graduates from the university of Sunderland). The Trust has a plan to test Nursing Associate roles in 2017 in certain areas, and a bespoke Certificate programme to provide HCAs with entry level qualification requirements for a nursing or other degree, to enable them to move into registered nursing roles.

In terms of quality assurance the Trust via the Sunderland CARE Academy, has established a multi-agency Care Certificate programme to ensure that staff who enter roles providing direct clinical support to patients complete a robust programme including competence assessment and portfolio development. This is attended by staff from GP surgeries and nursing homes, as well as the hospital based support staff employed by the Trust.

The Trust has addressed leadership development needs in its workforce through significant participation in national leadership programmes at various levels, and hosts national graduate management scheme trainees in different fields.

Directorates are tasked with completing a workforce planning template alongside their key objectives to ensure succession planning, and workforce supply and demand issues are considered.

The strategic partnership outlined in section 7 may also assist some of the Trust's workforce shortages both by combining resources and by providing a more attractive combined service to potential recruits.

4.2 The Governance Process for Board approval of workforce plans.

Relevant Directors comment on the work force plan before its sign off by the Director of HR. The annual planning process includes formal approval of all the plans (including the impact of workforce plans) by the Board of Directors. A summary of key staffing changes for 2016/17 can be seen below:

Staffing Summary	2015/16 WTE	2016/17 WTE	Change	Reason
Medical and Dental	554.10	559.10	5.00	Substantive recruitment rather than agency
Registered nurses, midwives	1,523.60	1,565.65	42.05	Overseas nurse recruitment programme. 60WTE substantive recruitment less 20WTE reduction in NHSP usage
Qualified scientific, therapeutic and technical staff	441.92	447.42	5.50	Ongoing recruitment supporting 7 day support services
Health care assistants and other support staff	1,245.25	1,226.25	-19.00	Substantive registered nurses number so lower unqualified demand
Managers and Infrastructure Support	1,005.71	992.21	-13.50	Back office reviews
Total	**4,770.58**	**4,790.63**	**20.05**	

4.3 Linkage between clinical strategy and local health and care system commissioning strategies.

Directorates/specialties/Departments produce their plans based on their agreed clinical service plans, which are determined and agreed following Trust objective setting. Workforce changes and developments which will arise from agreed commissioning changes and changes to services within the Local health economy are factored in along with succession planning and internal changes/developments.

4.4 Workforce transformation programmes and productivity schemes.

Working with South Tyneside NHS FT, the Trust proposes to transform its administration function through the development of a back office efficiency programme.

The Back Office Function Programme will utilise activity based costing principles of;

1. Establishing service function/purpose
2. Identifying service outcomes
3. Eliminating low value transactions – based around risk analysis and reference to mandatory/ statutory functions v discretionary
4. Applying lean methodology i.e. removing non-value added waste
5. Exploiting technology

The programme will also incorporate consideration of other models of service delivery to;

- Leverage cost reduction through scale
- Match resource to process
- Explore wider aggregation of the service.

The intention is that this will inform the reallocation of resource to highest value activities, changing the way services are delivered and centralising where appropriate. This will ensure all activities are aligned towards efficiently delivering the priorities and needs of their department and the Trust as a whole.

The review will take place during 2016/17, with the majority of changes expected in 2017/18.

4.5 Use of e-rostering.

The Trust's use of agency staff is already at low levels, with the majority related to procuring essential medical staff. Strong emphasis is placed on job planning within directorate teams to avoid staffing issues.

The Trust's use of nursing agency staff is almost zero, and it implemented a successful project to source additional staffing cover from NHS Professionals, rather than via a nursing bank.

A project to introduce e-rostering across the nursing workforce is to commence in April 2016. The project team is being led by the Deputy Director of HR and includes the Head of Nursing and Patient Experience. The system is expected to go live in June 2016 with the first wards using e–rostering in July and the overall roll out process is expected to take 9 months.

4.6 Alignment with Health Education England plans to ensure workforce supply needs are met.

The Trust is part of the Health Education England Workforce Planners Network, which discusses workforce planning processes and issues between trusts in the region.

We are therefore aware of the expected supply and quality issues relating to NHS services in drawing up our workforce plan.

Once our workforce plan is submitted to Health Education England, they review it to ensure it is line with NHS service and workforce plans and priorities, and query areas where further clarification is required.

4.7 Triangulation of quality and safety metrics with workforce indicators to identify areas of risk.

The Trust has a Workforce Assurance Group which considers activity, complaints, alerts and incidents against staffing levels and regular 6 monthly reviews are conducted of staffing for each area with corrective action where appropriate.

4.8 The application and monitoring of quality impact assessments for all workforce CIPs

Within the Programme Management Office, all projects (including workforce CIPs), within the cost recovery plan have rigorous Quality Impact Assessments undertaken.

All schemes that are worked up in outline undergo quality impact assessments which are then signed off via the Programme Confirm and Challenge group and approved by the Programme Management group (an executive membership group that includes the Medical and Nursing Directors).

The QIA's are then monitored on an ongoing basis and any material changes to the risks or likelihood are updated through the same process. More detail on the QIA process can be found in section 2.8.

4.9 Plans for any new workforce initiatives agreed with partners and funded specifically for 2016/17 as part of the Five Year Forward View.

The collaboration with South Tyneside NHS FT is outlined in the Sustainability and Transformation section (7.0) but these have yet to be translated into a level of detail that would be suitable for inclusion in this plan in relation to workforce initiatives for 2016/17.

4.10 Balancing of agency rules with the achievement of appropriate staffing levels.

The Trust uses NHS Professionals to provide additional staffing within Nursing and its use of nursing agency staff was nil within the previous year. It has recruited additional Healthcare Assistant staff to provide some cover whilst it makes efforts to recruit to registered nursing vacancies.

With regard to medical staff, it has done work on job planning with its Consultant workforce to minimise use of agency staff. Where agency staff must be utilised to maintain services, these are procured via the agency framework agreement.

The Trust welcomes the national cap rates for agency staff, the introduction of cap rates will allow the Trust to realise significant financial benefits against the price of agency staffing. For 2016/17 c£500k CIP has been identified as cost reduction. In addition the Trust continues to increase substantive recruitment in key areas to reduce the volume of, and reliance on, agency staffing.

4.11 Systems in place to regularly review and address workforce risk areas.

The Executive Committee regularly reviews risk and incident performance versus staffing information.

At a specialty level, workforce pressures are reviewed and triangulated against key performance measures such as 18week RTT, cancer targets, mandatory training, appraisals as part of the quarterly review process in order to explore and implement solutions to short and long term problems.

This may include areas such as resolution of short term staffing pressures or exploring options to mitigate longer terms issues such as national/ international staff shortages or the reducing service delivery due to the new junior doctor training initiatives.

These staffing pressures may cover a number of specialties and the proposed solution may be implemented on a corporate rather than specialty basis.

To address the level of vacancies for registered nurses the Trust has conducted an overseas recruitment drive in February 2016, with the aim of filling some vacant posts from the summer of 2016. This recruitment has been reflected in the Trust financial submission showing a net increase in 42WTE registered nurses during 2016/17 partly offset by savings elsewhere.

5 FINANCIAL PLANNING

The financial planning within this annual plan is heavily based on the 1-2 year financial recovery plan shared with Monitor in December 2015 although adaptions have been made for revised national inflationary assumptions and key operational changes in the interim period.

5.1 High level forecast for 2016/17

The Trust has submitted a draft plan to deliver the required STP control total for the organisation of £2.1m deficit for 2016/17. The 1-2 year recovery plan in December 2015 stated a plan for 2016/17 of £16.4m deficit, however improvements through STP funding of £10.6m, and a better 2015/16 outturn, plus a 'stretch' target of £2.5m means the Trust is now forecasting a planned deficit of £2.2m.

This target is heavily dependent on the delivery of CIPs at £15.0m, pragmatic clinical contract agreements with commissioners for the year ahead, and the ability of the Trust to identify a £2.5m stretch target through either additional clinical activity delivered at 'profit' or greater cost efficiencies. Delivery of the 'stretch' is a significant risk to the Trust ability to achieve the required control total for 2016/17.

5.2 Contract income assumptions for 2016/17

The following basis has been used to forecast the level of clinical income for 2016/17:

1. Out turn 2015/16 at month 11. £312.3m
   This includes a level of assurance through a year-end agreement with the Trust's main commissioner Sunderland CCG plus reasonable estimates for other commissioners where year-end discussions are on-going
2. Removal of £2.5m of genuine one off income that will not be refunded
3. Removal of one off non-recurrent funding gained in 2015/16, of which some is expected to be refunded in 2016/17. (£6.7m)
   Note income streams classified in contracts as 'non recurrent' that have been funded/agreed for more than 1 year have not been removed.
4. Net Tariff efficiency applied of 1.1%. £3.0m
5. Clinical activity growth above 2015/16 levels. £2.3m
6. High Cost Drugs pass through growth, both inflation and volume. £2.3m
7. Regain of 50% of 2015/16 non recurrent funding levels. £3.35m
8. Addition of penalties applied in 2015/16. £0.1m
9. Movement of 'other' income into contract for 2016/17. £0.2m
10. Addition of stretch income target. £1.0.
11. Value based commissioning impact £nil.
12. STP Funding. £10.6m
13. 2016/17 plan £325.8m

The Trust Board has approved the organisations acceptance of the conditions attached to the Sustainability and Transformational Fund and therefore £10.6m allocation to City Hospitals Sunderland has been included in the annual planning.

At the point of writing the Trust has agreed a contract in principle with our main commissioner Sunderland CCG, the agreement has been a block contract to ensure stability for both organisations during this year of transition. Despite this arrangement discussions are on-going to finalise the details in this contract offer as the principles agreed with Sunderland CCG will have a knock on impact for other commissioner contracts. Due to these discussions a formal contract for 2016/17 has not yet been signed although both the Trust and the CCG do not see the requirement for arbitration at this point.

The value of this contract is £179.5m which is c£1m lowered than the Trust assumed however it is expected by both parties that this gap could be closed if Sunderland CCG are permitted to 'release' their 1% non-recurrent funding held back at the request of NHS England.

A block contract contains numerous risks for the Trust and therefore it is essential that we work closely with Sunderland CCG to ensure patient demand is managed appropriately throughout the year. Currently the Trust is working with Sunderland CCG on their Vanguard scheme to improve patient access to emergency care outside of hospital, however information to date does not provide the Trust with assurance that activity volumes at City Hospitals will reduce hence it is essential to work in year to manage this risk and the ensure that 'risk share' agreements for this are in any block contract arrangement.

Contract offers have now been received by the Trust from all other commissioners; however these offers have been of variable quality with limited backup data. Contracts from CCGs supported by NECS (North East Commissioning Support) namely North Durham CCG, Durham, Darlington, Easington and Sedgefield CCG, Newcastle/Gateshead CCG, South Tyneside CCG, Hartlepool and Stockton CCG and South Tees CCG are all financially lower than Trust assumptions. The key concern with NECS commissioner offers is their requirement to offer a contract no more than they are 'mandated' to do so, this has meant a 'balancing' negative figure on each CCG offer for QIPP. In essence any changes to base contract for activity/PbR has been offset with an increase in the QIPP value to ensure that their mandated maximum contract offer is not exceeded.

As yet the Trust has not received the requested level of detail/assurance on what or how these CCGs will deliver QIPP efficiencies and reduce patient volumes coming to City Hospitals. A number of local commissioner plans in 2015/16 included reductions in non-elective hospital admissions that were never realised and resulted in over performance against base contract in year. Therefore for the purpose of this annual plan the Trust has assumed that the total QIPP value removed across these CCGs c£2.8m will flow through patient activity and be paid for under PbR guidance. Both Durham CCGs have recognised the likelihood of over performance against their current contract offers and negotiations on financial payment for this are ongoing.

At this point no contracts have been signed with NECS supported commissioners for 2016/17.

A contract offer from Specialised Commissioner has been received, however the offer is currently too far away from Trust requirements to agree a formal contract. The contract offer as it stands contains a number of items the Trust fundamentally disagrees with; in addition this commissioner has decreased CQUIN from 2.4% to 2.0% which is still under challenge at a national level. In contrast the Dental contracts with NHS England are in the final stages of agreement; crucially activity and finance have both been agreed and are realistic. No contracts have been signed for NHS England for 2016/17.

In summary (excluding STP Funding) the Trust has internally calculated what we believe should be the realistic value of clinical contracts for 2016/17 as £315.2m; this is based on prior year activity

levels with adjustments made for tariff efficiency/inflation plus expected activity growth/retraction. Current offers from commissioners total £308.0m, representing a gap against Trust assumptions of £7.2m. It is the Trust view that although the current gap in contract offers versus Trust assumptions is £7.2m the realistic clinical income gap accounting for the above items such as QIPP, non-recurrent funding and other fundamental contract items to be finalised is far lower but remains at least £1.5m.

The Trust is keen to avoid the need for arbitration however a number of key contract issues are still to be agreed with all commissioners to avoid this process.

5.3 Non clinical income assumptions for 2016/17

The Trust has assumed growth on non-clinical income of 1.1% in line with tariff inflationary levels, plus an income level for Training and Education in line with Health Education England's draft Trust schedule for 2016/17 which benefits City Hospitals. In addition one off non recurrent funding streams of approximately £1.8m have been removed.

Further to this £1.0m of additional income has been included for revenue generation CIPs for 2016/17.

5.4 Expenditure assumptions for 2016/17

Delays in commissioning intentions for 2016/17 have had a knock on impact on expenditure modelling therefore a number of assumptions have been made on the best information available. The following basis has been used to forecast the level of expenditure for 2016/17:

1. Out turn 2015/16.
2. Removal of one off costs
3. Addition/Removal for the full year effect of CIPs and/or non-recurrent 2015/16 CIPs
4. Inflationary uplifts in line with national guidance
5. CNST above inflationary increase in line with 2016/17 NHSLA guidance
6. Full year impact costs of Trust investments in improving patient care e.g. new/rebuilt Emergency Care Department staffing and non-pay
7. Increased recruitment of registered nurses to approved safe staffing levels
8. Increased costs to offset assumptions made for clinical activity increases especially high cost drugs
9. Capital charge increase in line with ITFF loans interest payment schedules and depreciation for recent new builds
10. CIPs to the level of £14.0m for expenditure have been removed (note £1.0m under revenue generation)
11. Additional stretch target of £1.5m of costs have been removed.

Financial and WTE nursing workforce budgets for 2016/17 have been shared and approved by both the Director of Nursing and the Human Resources Director. These plans include the increase of approximately 42WTE registered nurses across the financial year to achieve established safe ward staffing levels. These increases represent 62wte through overseas recruitment and will be partly offset by a reduction in non-substantive backfill provided through NHS Professionals (20wte) and lower costs on unqualified nursing staff.

The above assumptions contain a number of risks due to a lack of clarity on commissioning intentions for 2016/17 which will have an impact on Trust expenditure planning. In addition a challenging CIP target of £15m has been set. This needs to be delivered in full plus identification of the stretch target to achieve the planned control total of £2.2m deficit for the year.

In addition no financial impact has been assumed for potential costs due to changes in junior doctor's contracts pending agreements at national level.

5.5 Cost improvement plans for 2016/17

The Trust originally set a CIP target for 2015/16 of £13m, however due to increased focus on efficiency and external support the forecast delivery in year is now £13.8m, of which £10.0m is recurrent. The successful delivery in excess of target during 2015/16 combined with the necessity to achieve a challenging financial control total for 2016/17 has led the Trust to setting a CIP target of £15m for the upcoming period.

The establishment of the Trust PMO plus external support from Deloitte and opportunities from the Lord Carter review allows the Trust to have confidence (though significant risks remain) that despite a CIP target higher than the prior year, this level of savings is achievable.

At this stage savings plans are in place for £10.0m CIP in year against the target of £15m.

5.6 Examples of CIPs in place

Savings schemes	Full Year Effect savings		In Year savings	
	Potential saving	Risk adjusted saving	Potential saving	Risk adjusted saving
	£000s	£000s	£000s	£000s
PMO/Divisional CIP schemes	£6,546	£5,388	£6,140	£5,139
Deloitte	£2,038	£1,491	£1,705	£1,250
Additional Initiatives	£2,460	£1,659	£2,110	£1,484
Allocation of remaining CIP	£5,046	£2,523	£5,046	£2,523
Total	**£16,090**	**£11,061**	**£15,000**	**£10,396**

5.6.1 Outpatient Capacity and Demand

The Trust will seek to more closely align the outpatient capacity to outpatient demand. By focussing upon capacity delivered compared to capacity commissioned through consultant job plans the Trust will ensure that all contracted clinics are run and that premium clinics are only run once contracted clinic capacity has been delivered. This focus upon filling clinics to capacity means staff down time can be reduced and surplus clinics cancelled.

The Trust anticipates the cost of additional sessions in 2015/16 to be c£3.2m, some of which is essential to cover vacant posts however an element relates to providing additional clinics due to unutilised capacity issues. Savings of £695k have been identified based upon the assumption that 50% of unutilised capacity can be removed from outpatient clinics. It is anticipated that the savings will commence from quarter 4 in 2015/16 and will be fully implemented (with savings being realised recurrently) throughout 2016/17.

The proposal does not envisage changes to clinical practice or delivery of service, merely more efficient booking and clinic administration to minimise underutilisation of capacity.

5.6.2 Procurement

The Trust currently has firm plans in place to deliver procurement savings of £1.9m in year, this is through a number of work streams focused on areas such as best prices for medical and surgical equipment, contract maintenance renewal efficiency and a review of materials management in the organisation.

The Trust welcomes further details from the Lord Carter review in early 2016 and would expect this information to support the on-going strategic service review work to improve procurement efficiency within the organisation. In addition the Trust fully supports the opportunity to share information on the 100 most common non pay items to gain the best price available for the NHS.

5.6.3 Agency Cap Rates

The Trust has significantly reduced its agency spend (predominantly in relation to medical staff) in the last 12 months from £7.7m in 2014/15 to a forecast level of £6.1m in 2015/16. Despite this agency staffing is required in a number of key service areas to maintain service delivery e.g. A&E and Gastroenterology. Whilst the Trust continues to focus on substantive recruitment, the introduction of cap rates from November 2015 will allow for significant savings against current agency spend levels.

To note the Trust uses minimal agency usage for nursing posts with less than £10k spent to date in 2015/16.

Initial calculations have identified approximately £500k of savings from current agency spend levels in 2016/17. This saving is heavily dependent on the wide uptake both locally and nationally of capped rates to reduce the ‘bargaining’ power of locums and agencies. To note this saving is net of new costs for substantive staffing.

5.6.4 E- Rostering

The Trust plans to implement E Rostering to efficiently and objectively manage its workforce from the bottom up, based around the alignment of staffing levels to patient demand.

Financial Savings are made through more efficient deployment of staff, including better use of contracted hours and improved management of leave requests and shift swaps, thereby reducing the number of unfilled shifts and spend on temporary staffing. It is anticipated that this will also provide a number of additional benefits around quality of care, workforce productivity, clinical governance, risk management and the administration burden. The proposed full year net savings is estimated at £300k this is based upon roster savings of at least 0.25 WTE per ward per month. This saving is viewed as prudent at this stage and further operational benefits will be gained in due course.

A detailed project plan with a project manager, designated action owners and time scales for delivery (which includes the recruitment of administrators) has been drawn up for full implementation on 34 wards in 2016.

5.6.5 Lord Carter Review

Whilst further detailed guidance on Lord Carter opportunities will enable the Trust to be able to pin point savings, the Trust welcomes the essence of the review and has already carried out a number of investigations based on initial findings.

The Trust is currently validating the information; this will be enhanced upon the sharing of further guidance nationally at a more granular level. To date the Trust has been reviewing opportunities provided in the national Radiology benchmarking report, and is also comparing length of stay data against peer organisations. In addition the Trust has reviewed the Lord Carter recommendations and has assigned leads where we feel opportunities are available for cost reductions.

The Trust already has challenging procurement savings plans in place. These savings values may be further increased through opportunities raised by aspects of Lord Carter's reports.

The PMO is co-ordinating an estates rationalisation project but as the Trust operates predominantly from a single the site the limited potential gains make it a lower priority.

5.6.6 Further opportunities yet to be quantified

The Trust has worked closely in the past with other local acute providers under the banner 'Accelerated Bigger Picture'. This approach of greater collaboration with South Tyneside FT will develop further in 2016/17 with the aim of providing a range of benefits (including financial) to both organisations and the populations they serve.

Planned commissioner reductions in hospital contacts through Vanguard programmes may provide the Trust with opportunities to remove costs in service areas we know are unprofitable. This is a long term local health economy programme and benefits are likely to be in years beyond 2016/17.

The Trust has commenced service reviews in a number of areas during Q3 and Q4 of 2015/16 and this will continue into 2016/17. These reviews will provide the organisation with a clearer understanding of strengths and weaknesses of all the services provided. This will allow the Trust to be in a position to make informed decisions on service delivery going forward in order to maximise financial opportunities.

5.7 Capital Planning

The Trust has made significant investments in buildings over the past 2 years, for example the new/refurbished Emergency Care Department and the new Endoscopy suite. The final element of the ED build continues into 2016/17.

The Trust capital commitment in 2016/17 is £8.2m, of which £6.7m is for the new/refurbished Emergency Department and £0.8m is to cover investment into IT infrastructure, the balance is to

cover capital costs in key areas. This commitment for £8.2m is after a review to the cost effectiveness of leasing equipment in key areas rather than outright capital purchase.

This capital spend is linked to supporting a key element of the Trust's strategic direction as well as improving the flow of patients through the Trust thereby improving performance target delivery and increasing back of house efficiency.

The current Trust capital programme for 2016/17 has been reviewed and all costs are deemed as committed and essential therefore there is no scope to reduce further.

The Trust has fully drawn down all ITFF loan agreements and has no further bid applications planned. The completion of the Emergency Department build will also include a retention fee of 1.5% which will due 6 months post completion (into 2017/18).

The Trust is carrying out an estates rationalisation project but as the Trust operates predominantly from a single the site the limited potential gains make it a lower priority.

To further improve efficiency in estates management CHS has in principle agreed to set up a separate legal entity to own and operate the Trust's estate and provide an operated healthcare facility to the Trust, namely Property Facilities Management Company (PFMC). The provision of a fully managed healthcare facility will allow the Trust to focus on healthcare delivery.

Subject to approval of a full business case it is anticipated that the model will be fully established late in quarter 3 or early quarter 4 of 2016/17. Initial calculations have identified £250k of savings could be made during 2016/17 through greater efficiencies in a fully managed healthcare model, with additional benefits relating to cash. The cash benefits have not yet been factored into the 2016/17 position as they are likely to be delivered in 2017/18.

Implementation of the PFMC is highly complex and will involve the TUPE transfer of a significant number of staff. The Trust will be heavily engaged with union representatives throughout the process. Subject to approval significant HR implications will need to be managed. In addition external legal and tax advice will be sought.

5.8 Cash

The Trust end of year cash position for 2015/16 was £14.2m. Based on the financial calculations within this plan it is forecast that the closing cash position for 2016/17 will be £9.9m.

This cash position assumes the Trust gains full STP payment in year, full delivery of £15m CIPs, plus identification of £2.5m 'stretch' to provide an income and expenditure position per our required control total position of £2.2m deficit.

On this basis the Trust has answered 'DH Support NOT Required' to the declaration of interim or planned support in 2016/17.

5.9 Sensitivity Analysis

The delivery of a planned deficit of £2.2m for 2016/17 contains a number of risks and therefore the Trust has also considered a number of options in 'downside' planning. The following movement against base case £2.2m deficit has therefore been included:

- 50% closure in the £7.2m gap in clinical contracts as noted in section 5.2 - £3.6m worse
- Delivery of only 50% of the £5.0m CIP gap to date - £2.5m worse
- Achievement of only 50% of the £2.5m 'stretch' target efficiency - £1.25m worse

No financial downside or upside has been assumed for the risks in 2016/17 contract delivery levels as no contracts have been signed to date.

This downside sensitivity will put delivery of the required control total at risk and in turn may restrict the value of some or all of the £10.6m STP funding identified for the Trust. Furthermore none receipt of this funding will have a detrimental effect on the Trust cash position for 2016/17.

5.10 Financial Sustainability Risk Rating

It is expected that the risk rating for the Trust be 2 during the course of 2016/17.

5.11 Financial Summary

The Trust will face significant pressures in delivering the required control total position for the upcoming period with expected increases in expenditure and patient demand outstripping income growth. The forecast position is £2.2m deficit; the implications as detailed in the main financial submission are summarised in the table below:

	2015/16 Out turn Excluding Revaluation impact	One off income removal/Non Rec CIP impact/ FYE CIP impact	Cost and Income Inflation/ CNST/ tariff efficiency	Activity changes/ pressures/ STP funding	2016/17 CIP	Control Total Stretch Target	Annual Plan 2016/17
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Income							
Clinical Income	-312,255	5,629	-2,985	-4,720	0	-855	-315,186
Other Income	-27,719	1,785	-270	-530	-1,000		-27,734
STP Income		0	0	-10,600	0		-10,600
Total Income	-339,974	7,414	-3,255	-15,850	-1,000	-855	-353,520
Expenditure							
Pay	207,681	2,166	6,851	3,303	-7,500		212,501
Non Pay	130,065	402	2,996	2,524	-6,500	-1,600	127,887
Total Expenditure	337,746	2,568	9,847	5,827	-14,000	-1,600	340,388
EBITDA	**-2,228**	**9,982**	**6,592**	**-10,023**	**-15,000**	**-2,455**	**-13,132**
Non Trading							
Depreciation and PDC	13,006	-43	0	442	0		13,405
Interest Payable/Receivable	1,765	0	0	129	0		1,894
Total Non Trading	14,771	-43	0	571	0	0	15,299
NET Deficit	**12,543**	**9,939**	**6,592**	**-9,452**	**-15,000**	**-2,455**	**2,167**

6.0 THE EMERGING "Sustainability and Transformation Plan"

City Hospitals Sunderland and South Tyneside NHS Foundation Trusts have formed an ambitious strategic alliance to work together to protect the future sustainability of hospital and community health services across Sunderland and South Tyneside. Looking ahead it is clear that delivering sustainable, financially viable high quality health services for our local populations is essential for patients and taxpayers alike.

City Hospitals Sunderland has for some time been pursuing 3rd centre status and has continued to expand and grow a range of specialist services both locally and regionally. Increasingly its focus will be on leading and providing emergency surgical and complex acute services covering South of Tyne, with Sunderland Royal Hospital and Sunderland Eye Infirmary focusing on becoming hubs for more specialist complex, emergency and planned acute care.

In parallel, South Tyneside NHS Foundation Trust has been increasingly moving away from complex acute care and it will in the future lead on out of hospital services (using the Vanguard as the key vehicle), rehabilitation, diagnostics and screening services.
South Tyneside District Hospital will continue to provide a broad range of emergency and planned hospital services. The Trust will also be the lead provider of community services working closely with respective local authorities and primary care.

As a result both City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust now believe that significant transformation leading to greater integration of services across both populations is essential in delivering the above, and this needs to be delivered at speed and scale. The trusts will now formalise this arrangement through the establishment of a group function to ensure the delivery of this significant transformation, using specific input from both organisations, together with some targeted external support.

Starting in 2016/17 and continuing into 2017/18 the trusts will work together to review and where necessary transform the sustainability of clinical services. The first phase of work will cover Stroke, Trauma and Orthopaedics, Maternity, Pharmacy and emergency surgical services. A full programme of reviews has been agreed for all clinical services and the relevant infrastructure has been identified in order to take the reviews forward.

The impact of the Better Care Fund and the emerging 'out of hospitals' models will also be reviewed to ensure where possible there is alignment on both 'in hospital' and 'out of hospital' services across Sunderland and South Tyneside.

Governance of this partnership will be provided through:

- Strategic partnership board (Chairs and Chief Executives including appropriate CCG input to provide strategic leadership for the programme)

- Partnership delivery board (director and clinical lead representation to ensure delivery at pace of the programme)

- Individual transformation work streams to deliver each of the clinical transformations, reporting to the partnership delivery board.

7.0 MEMBERSHIP

The Trust's Membership Community is made up of local residents, patients, carers and staff within the following constituencies.

1. **Public Sunderland Constituency** – Any member of the public living in the electoral wards of the City of Sunderland.
2. **Public North East Constituency** – Any member of the public living in the North East electoral wards.
3. **Patients' Constituency** – Registered patients (or carer of such patient) who have been invited by the Trust to become a member and therefore become a member without an application being made unless he/she chooses to opt out.
4. **Staff Constituency** – All members of staff who have been in post for 12 months or more automatically become members unless they choose to opt out. There are three classes within this constituency, namely Medical and Dental, Clinical and Other.

No elections have taken place since June 2013 however elections will take place on 22 June 2016 to elect governors for all of the above constituencies. The Electoral Services Team at Sunderland City Council has been appointed to undertake these elections on the Trust's behalf. Two information events for members interested in standing for governor election are been arranged for 4 and 5 May 2016.

Examples of governor involvement and engagement, in addition to their Council of Governor meetings attendance, include:

- **Participation in the Trust's real time feedback process** – the Trust has been collecting real time feedback from patients since August 2010 and this process now covers all in-patient wards. Volunteers, including governors, visit wards and collect this important information. During the past year approximately 3000 survey questionnaires have been completed and these provide valuable insight into patients' experience.
- **Participation in the Trust's PLACE process** – the system for assessing care environments.
- **Involvement in a number of Board Committee sub-groups** – including Maternity Services Liaison Committee, Nutrition Steering Group, Corporate Governance Committee, Deteriorating Patient Group, Charitable Funds Committee, Clinical Governance Steering Group, Organ Donation Committee and Revalidation Group.
- **Membership of the Community Panel** – a panel providing the patient's perspective and key insights in the development and implementation of quality improvement initiatives related to improving patient experience.

The Trust will continue to publicise the opportunity to become a Foundation Trust member via its website, within key public areas, via social media and within the "Your Stay in Hospital" bedside booklet. We will continue to ensure our membership represents the demographic picture of the City, using the membership database to identify areas which may be under-represented – either based on geography/location within the City, age, sex, ethnicity etc. In 2016/17 we will be focusing on improving methods of communication and developing new opportunities to communicate with our members and we are currently planning our Medicines for Members programme of activity for 2016/17.