Strategic Plan Document 2014-19

City Hospitals Sunderland NHS Foundation Trust
1.1 Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

Name: Peter Sutton

Job Title: Executive Director of Strategy & Business Development

e-mail address: peter.sutton@chsft.nhs.uk

Tel. no. for contact: 0191 5699651

Date: 20 June 2014

The attached Strategic Plan is intended to reflect the Trust’s business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust’s other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust’s internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust’s financial template submission; and
- The ‘declaration of sustainability’ is true to the best of its knowledge.

Approved on behalf of the Board of Directors by:

Name (Chair): John Anderson

Signature:

Approved on behalf of the Board of Directors by:

Name (Chief Executive): Ken Bremner

Signature:

Approved on behalf of the Board of Directors by:

Name (Finance Director): Julia Pattison

Signature:
**MARKET ANALYSIS AND CONTEXT**

**Introduction**

The Trust’s strategy has been developed by understanding and adapting to the environment in which it operates, this includes taking into account national and local strategies, whilst ensuring that we continue to develop and provide the high quality services that our patients deserve.

Nationally there are a number of strategic documents that complement, further define and reinforce the Trust’s own strategic direction. NHS England, through the ‘Everyone Counts’ document highlights the national direction of travel, which includes the requirement to redesign urgent and emergency care services and the move toward centres of excellence with specialised services being delivered by a limited number of providers. The Trust’s ambition to be the 3rd centre in the North East and a ‘Major Emergency Centre’ as outlined in the Trust’s operational plan submission is aligned to national strategies developed by NHS England and the key areas are highlighted below:

**A modern model of integrated care**

The Trust is actively involved in the wider health economy strategies in relation to integrated care, the use of the Better Care Fund and the requirement for appropriate patients to be managed outside of hospital. The Trust is engaged with the Sunderland Health and Wellbeing Board and supports the local health economy plans to move to locality working across the city, aimed at reducing admissions. The Trust will contribute to the work being led by Sunderland CCG which is focused on developing multi agency teams, which are based around GP localities and the Trust will offer appropriate clinical and nursing input into these local teams to help manage patients, where appropriate, in their local area.

**Access to the highest quality urgent and emergency care**

The Phase 1 report from Sir Bruce Keogh - ‘Transforming Urgent and Emergency Care Services’ highlights the need for significant change across all sectors, primary, community and secondary care. Within secondary care, the report describes the requirement for two types of A&E departments, Emergency Centres and Major Emergency Centres. The latter are not Trauma Centres, of which there are 25 across England and 2 in the North East, but centres that can assess and initiate treatment for all patients and provide a range of specialist services. There would be 40-70 of these centres across England which would offer a range of services for heart attacks, stroke, vascular, critically ill children, etc. This national description is exactly aligned to the Trust’s strategy of the ‘3rd centre’ which has full support from local commissioners. For a number of years, through the ‘Accelerating Bigger Picture’ programme, the Trust has worked closely with other local providers and commissioners and has started service transformation in a number of areas. A key example is that the Trust is now the only the acute inpatient unit for children in South of Tyne and Wear (SOTW) and also provides a 7 day TIA service for patients, which covers all of SOTW over a weekend. The Trust has support for this direction of travel (3rd centre) from neighbouring FTs - South Tyneside and Gateshead, as they recognise the need for wider service changes.

**Step change in the productivity of elective care**

The Trust has commenced a Surgery & Theatres Efficiency Programme (STEP) which aims to deliver a step change in the productivity of elective care. The programme will concentrate on efficient and effective scheduling and reduce waste at all stages of the patient pathway. This should maximise and make most effective use of the existing capacity and should reduce patient waits for surgery. The use of standardised procedures and processes plus the elimination of bottlenecks and consecutive processes will improve utilisation of theatres and improve the outputs and outcomes for patients.

In addition to this the Trust is planning to spend circa £7m to design and build a new state-of-the-art endoscopy unit which will be the first of its type in the UK and will be built on the concepts employed by the Virginia Mason Production System to provide high quality efficient and effective care with an
outstanding patient experience.

The development will provide the physical capacity to deal with the increasing demand for endoscopies which are currently growing at around 15% per annum in the north-east region and also provide a centralised decontamination facility. The unique unit is expected to open in summer 2015.

The Trust has also embarked on a Scheduling Corporate Programme which will incorporate the ambition to move to real-time capacity and demand planning to ensure the best service for patients by maximising the use of available resources. The scheduling project will cover the patient pathway from outpatients to treatment and final discharge.

**Specialised services concentrated in centres of excellence (as relevant to the locality)**

The Trust’s drive to be the 3rd centre and its investments in areas such as a state of the art endovascular theatre, an additional new catheter lab and the new Emergency Department rebuild demonstrate its commitment to develop as a local centre of excellence. The Trust already operates services on a sub-regional basis in a number of areas such as Bariatric surgery, Urology, ENT, OMFS, Nephrology, Neonatology and Ophthalmology and is looking to develop those further by becoming an endovascular centre.

The Trust is confident it has the ability to further develop services in areas such as Interventional Radiology, Cardiology (PPCI) and Vascular Surgery over the next two years and there are robust plans in place for each area covering workforce, population, infrastructure requirements, critical mass for procedure numbers and each development has local commissioner support.

This strategy is closely aligned to the national review of urgent and emergency care and the Trust plans to be a ‘Major Emergency Centre’ offering a range of services to patients across Sunderland, South Tyneside and County Durham.

**LOCAL HEALTHCARE NEEDS ASSESSMENT**

**Introduction**

The majority of the Trust’s activity comes from Sunderland CCG who also act as lead commissioner for both South Tyneside and Gateshead CCGs. The Durham CCGs use NECS (North East Commissioning Support) to lead their commissioning and NECS work closely with Sunderland CCG. This collaborative approach between the CCGs allows the Trust to have a good relationship with its key commissioners and an excellent understanding of their current and future plans. The following section is based on information/plans provided by Sunderland CCG.

**Key challenges**

The Local Health Economy (LHE) sees its key challenges as:

- Mental Wellness as demonstrated by poor outcomes in relation to depression and self-harm;
- Excess deaths, particularly from cancer, respiratory and circulatory disease;
- Health which is generally worse than the rest of England;
- A growing population of elderly people with increased care needs and increasing prevalence of disease who need to be supported to live independently;
- An over-reliance on hospital care;
- Services which are fragmented and lack integration.
- High levels of deprivation, obesity and substance misuse
Population overview

As a provider the Trust serves different catchment populations depending on the service line in question. However, for planning acute services the Trust uses the Sunderland demographics and trends as a proxy for its overall market demographics for its strategic planning purposes. The healthcare needs and demographics of the Easington area of County Durham (the Trust’s main catchment area within County Durham) and of South Tyneside are almost identical to those of Sunderland.

There are approximately 275,700 people in Sunderland, with an increase of 8,300 (3%) forecast over the next 10 years. The age structure of this population is forecast to change significantly (table 1), as follows:

Table 1

![Forecast percentage change in population in Sunderland 2011 to 2021](image)

The large increase forecast in the elderly, and particularly the very elderly, has significant implications for healthcare providers over the next five, ten and future years. Even if the general levels of health in these age groups continue to improve, the shape and structure of health services will need to change to meet the needs of this growing population, particularly as older people use services more often, have more complex needs and currently stay longer in hospital.

Table 1 above shows a growth rate of 2 to 4% for elderly patients who will tend to be frail and be high consumers of both health and social care.

Health Overview

Sunderland has some of the highest overall levels of deprivation compared to the England average (in the 20% of local authority areas with the highest deprivation). Levels of health and underlying risk factors in the area are amongst some of the worst in the country.

The 2013 Community Health Profiles prepared by Public Health England compare health in Sunderland to England averages, highlighting in red those measures which are significantly worse and in green those which are significantly better. The Community Health Profile for Sunderland can be seen in table 2 (p 6). It is clear that on most health measures, Sunderland is significantly worse than the rest of England.
Expected disease prevalence

Projections of expected disease prevalence have been used to understand what our key disease areas of CHD, COPD, Stroke and hypertension might look like in five, ten and twenty years, if effective change is not implemented. In all four disease areas, Sunderland’s prevalence is higher than the England average, and is forecast to increase if no effective action is taken. These disease areas are the major causes of premature death and emergency hospital admissions in Sunderland, so the health and service implications of an ageing population will be further exacerbated by this increasing burden of chronic disease.

The key long-term conditions and their prevalence are illustrated by table 3 (p 6)
Life expectancy challenge

One of the starkest inequalities highlighted by the Joint Strategic Needs Assessment (JSNA) is life expectancy. The local life expectancy gap against England is:

<table>
<thead>
<tr>
<th></th>
<th>England Average Life Expectancy</th>
<th>Sunderland Life Expectancy</th>
<th>Gap (%) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>79.2</td>
<td>77.0</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Females</td>
<td>83.0</td>
<td>80.7</td>
<td>-2.8%</td>
</tr>
</tbody>
</table>

*Life expectancy gap expressed as a percentage of the England life expectancy.

Over 60% of the gap is caused by cancer, respiratory diseases and CVD and to address this Sunderland CCG have built on previously identified “High Impact Interventions” to deliver an effective approach to improving health and transforming care including:

- Systematic cardiac rehabilitation;
- Systematic COPD treatment;
- Developing & extending diabetes best practice with appropriate local targets;
- Campaigns to improve cancer early awareness and detection;
- Developing best practice in relation to dementia and falls to support people to live independently;

Challenges identified in the Joint Strategic Needs Assessment (JSNA)

The JSNA is a continuous process by which the Sunderland Director of Public Health works with partners including the third sector and patient/public groups to identify the health and well-being needs of local people. It sets out key priorities for commissioners and provides a health baseline for the development of this plan.

The Sunderland JSNA has undergone a major refresh to broaden the coverage of wider determinants of health; takes account of Marmot priorities; updates the analysis of health and wellbeing information; gives greater insight into expressed needs of local people; identifies where effective interventions to address needs are available but not taking place; and includes equality impact assessments as they are developed. The JSNA refresh has used a structured process with clear criteria, which continues to involve partners and the public.

Summary of JSNA messages

The refresh of the JSNA recommends that those commissioning services in Sunderland continue to take the following approach:

- Increasing life expectancy and reducing health inequalities through focusing on addressing the causes of premature morbidity and mortality;
- A tiered approach to prevention, risk management and early intervention;
- Enhancing choice, control and personalisation of services for individuals, families and communities whilst maximising beneficial outcomes;
- Identifying those who would benefit from wraparound health and social care services;
- Integration of services, whether NHS, social care or other services which affect health (e.g. spatial planning, housing, transport, libraries, wellness services, addressing fuel poverty, mitigating the impacts of welfare reform etc.);
- Reducing health inequalities by focussing on giving children the best start in life and strengthening ill health prevention as well as addressing the wider determinants of health, including deprivation, employment, education, housing, social isolation, environment and by identifying neighbourhoods to target;
Commissioners and providers engaging with individuals, families, neighbourhoods, and communities in order to deliver on all the above to build resilience at all levels to enable greater levels of self-care.

The top ten priorities from the JSNA to improve health in Sunderland are:

1. Improve mental health and mental wellness;
2. Raise the expectation of being healthy for all individuals, families and communities and promote health seeking behaviours;
3. Reduce worklessness;
4. Address the impact of tobacco leading to reduced overall smoking prevalence (all ages) and numbers of young people starting to smoke;
5. Reduce overall alcohol consumption and increase treatment services for those with problem drinking;
6. Increase active living
7. Commission excellent services for cancer;
8. Commission excellent services for COPD;
9. Commission excellent services for cardiovascular disease including diabetes;
10. Support people to live independently and increase levels of self-care.

COMMISSIONING PLANS

Using the information outlined previously, Sunderland CCG has developed its 5 year plan and the key headlines and initiatives that will impact on CHS are outlined below.

Sunderland CCG Demand Management

The CCG’s initial “Plan on a Page” (Diagram 1) demonstrated an ambition to reduce emergency admissions by 15% and emergency readmissions by 14%.

Of the total £12m cost reduction goal outlined in the CCG’s plan, £10m is directly related to this reduction in admissions. Starting in 2016/17, this ambition would potentially reduce the Trust’s income over 3 years by £9-10m (as a small number of Sunderland residents attend Queen Elizabeth Hospital in Gateshead).

The PCTs have previously, over a number of years, tried to introduce demand management schemes such as the musculo-skeletal triage process but chart 1 (page 10) demonstrates the lack of success in terms of reducing demand. That is not to say that these initiatives have not reduced the rate of increase of demand but the Trust is yet to see a process that has reduced the overall demand against the increasing baseline of need. The health needs analysis and health demographics clearly indicate an increasing demand for healthcare and it remains to be seen whether this increasing demand can be met within the community with new services or if a portion of this increasing demand will still fall upon acute trusts to deliver.

The CCG has used a number of models (Any Town, Oliver Wyman, LGA) to identify their approach to reduce demand and Diagram 1 (p 9) shows the work that has been done to identify the areas that are likely to deliver the biggest financial gains and improvements in health care for the CCGs.
Diagram 1 also highlights that 3% of patients account for 50% of the CCGs spend across secondary, community and mental health. 3% equates to just under 10,000 patients and the CCG has these patients identified and split by factors such as locality, GP practice etc.

The CCG, local authority and other partners are working cooperatively to use the Better Care Fund to deliver integrated care in the community and although the detail of the model is still to be worked through, the focus is on developing integrated teams working in localities across the city. These teams will have a specific focus on the frail elderly sector of the population (currently 2800 residents) to support individuals with their health and care needs and avoid unnecessary admissions.

As these models are in the early stages of development there is as yet little detail available to the Trust to enable it to accurately assess the impact of the CCG’s proposals and on this basis scenario planning will be used as a means of deciding the likely impact for the future thus enabling the Trust to plan effectively going forward. The Trust’s likely case scenario is based on the success of previous schemes offset against the increasing demand of the elderly population and it predicts that the CCGs assumptions will be around 50% successful. This scenario has been used as the most likely case in relation to income predictions, workforce planning and other areas of infrastructure such as bed capacity.

However, it is important to note that the Trust will not reduce capacity (physical or workforce) until robust evidence is available that demand is genuinely reducing.

**COMMISSIONING OVERVIEW**

Sunderland CCG commissions 77% of its acute healthcare from the Trust, spending circa £180 million. The CCG is potentially overfunded vs. the allocation formula by approximately 11%. The CCG’s intention is to invest significant non-recurrent funds until 2015-16 to facilitate service redesign to improve efficiencies prior to an expected reduction in allocation funding.

The Trust also provides care across its full range of services to the North Easington and other areas of the Durham CCGs and their £50m spend, whilst significant for the Trust, is at less risk given that their potential reduction in funding is less severe than for Sunderland CCG. North Easington has similar health
needs and levels of deprivation as Sunderland therefore Durham follow the commissioning lead of Sunderland, in terms of direction and commissioning intent.

A key area of focus for Sunderland CCG is urgent and emergency care including the Urgent Care Centre (UCC) procurement and integration of A&E and UCCs. Further development of ambulatory care pathways across the Trust’s services will also contribute to an expected reduction in avoidable non-elective and A&E attendances CCGs assume. The cooperative manner of these developments will allow them to reduce their spend whilst the Trust is able to improve its efficiency and free up capacity to deliver more complex or specialised pathways of care currently delivered at other Foundation Trusts.

In addition it is assumed utilisation of the Better Care Fund will help to improve integration across local health economy services and the Trust must work closer with partners to ensure that the overall system manages patients in the most appropriate location which may not necessarily be within the acute sector.

For the future, the proposed changes to the funding formula for CCGs/GP funding will place an increasing financial pressure on local CCGs, a portion of which will be transferred to the Trust to deliver in terms of improved efficiencies. This has been factored into the CCG plans and reflected also in the Trust plans.

**CAPACITY ANALYSIS**

**Demand and admission trends**

As highlighted in the previous section, in order to make a judgement on the likely success of the CCGs plans the Trust has analysed historical demand.

Chart 1 shows the increasing demand for services that City Hospitals Sunderland has faced over the last 5 years split into categories of non-elective admissions, elective admissions and new outpatient attendances. It can be seen that new outpatient attendances have been subject to sustained growth of approximately 29% over the period whereas elective admissions have grown by only 15% and non-elective admissions by only 6%.

Chart 1

**CHS admission/attendance trends (all CCGs)**
Non elective

The increasing demand for A&E services over the same period equates to 24% and the lower level of growth in non-elective admissions can be attributed to the increased use of ambulatory care pathways plus the development of readmission avoidance and community support schemes. The increase in new outpatient appointments further demonstrates the shift to treating many A&E patients within ambulatory pathways thus converting potential admissions into new outpatient appointments/outpatient procedures.

The redevelopment of pathways to avoid admissions provides a number of benefits for the Trust which includes a reduction in the number of bed days required, although the Trust’s average length of stay for admitted patients may well appear to increase as these patients would typically have been very short stay patients had they been admitted.

Elective

As highlighted by chart 1, elective activity has increased by 15% over the five year period 2008/09 – 2012/13. However, at a service line there is a large variation with some services seeing significant growth over and above the 15%, such as Bariatric Surgery ~ 99.1%, Gastroenterology ~ 47.2% and ENT ~ 19.8%

The operational plan to ensure capacity meets demand for each area is different depending on the specific requirements.

Operational Pressures

The Trust faces a continual increase in demand for its services with A&E being a prime example and this brings with it the problem of continuing to deliver a high quality patient experience with excellent outcomes from a department that was built in the 1970s when the volumes were significantly smaller and which now has problems with “flow” and ambulance handover from the sheer numbers of patients arriving.

At periods of peak demand bed pressures can cause problems with the flow of patients through the hospital and the delivery of the A&E targets becomes challenging, therefore the Trust has chosen to invest in a significant Emergency Department rebuild as well as two strategic trust wide projects, ‘Safe and Sustainable Emergency Care’ and ‘7 Day Services.’ These projects will reduce admissions by moving patients to ambulatory care pathways and reduce the length of stay/number of beds required in order for the Trust to be able to more easily flex its capacity to meet demand.

Our Endoscopy Department is facing increasing pressure and the current endoscopy facilities will not be able to deliver the anticipated future demand. The Trust is therefore investing in a new endoscopy unit which should future proof capacity for between 7 to 10 years (operational by summer 2015).

With the ever-increasing demand for elective procedures, the Trust’s theatre capacity is coming under increasing pressure and this is compounded by the development of more complex procedures which, whilst delivering better outcomes, often require more theatre time. As a result two corporate projects have been developed – ‘Scheduling’ and the ‘Surgical and Theatre Efficiency Programme’ to improve the efficiency and quality of existing assets rather than building additional physical capacity in the first instance.

Bed Capacity

The Trust currently has approximately 870 core beds available to manage its elective and non-elective inpatients. The Trust has no plans to increase this number and in fact expects to reduce the number of beds required due to the following strategies:

- A shift from routine admission to ambulatory care pathways
- Redevelopment of the A&E footprint to smooth patient flows, avoid admissions wherever possible and reduce length of stay to a minimum where admission is unavoidable.
- Admission and readmission avoidance schemes in conjunction with the local CCGs
Facilitated discharge schemes in conjunction with community nursing, social services and third sector companies.

The CCGs plan for GP led urgent care centres to reduce unnecessary A&E attendances.

A more integrated approach between primary, secondary and social care to manage a greater number of patients closer to home.

The development of CCGs led demand management schemes.

A culture and practice of continuous improvement to deliver improved efficiency, productivity and outcomes.

A set of corporate programmes to deliver transformational change.

Focusing on increasing day case rates through Day Of Surgical Admission (DOSA) and Surgical and Theatres Efficiency Project (STEP).

Analysis of bed configuration by specialty to ensure appropriate allocation of beds to patient groups e.g. frailty unit to deal with increasing numbers of frail elderly patients.

A wide range of initiatives to reduce LOS.

It is difficult to predict the exact impact these schemes will have on bed requirements, however, linked to the assumption that the CCG’s plan will be 50% realised the Trust is planning to reduce its bed capacity by just over 100 beds by the end of 2018/19. The majority of this reduction will be linked to the CCG’s plans, focused on the frail elderly, however there will be some reductions in elective areas linked to the assumed increased daycase rates and reduction in LOS.

In terms of phasing, the Trust is planning these reductions over 4 years and this generally equates to one ward (27 beds) per year, starting in 2015/16.

Infrastructure/Estates

The Trust’s investment plans and corporate programmes recognise the need to provide an infrastructure that will deliver the Trust’s activity for the next five years. Investments such as the hybrid vascular theatre, redevelopment of the A & E department and the multi-storey car park will provide the infrastructure for the Trust to be able to deliver its anticipated activity for the next 5 to 10 years.

Similarly the Trust’s investment in a new state-of-the-art endoscopy unit will future proof its physical endoscopy capacity for 5 to 10 years whilst also making it a more attractive centre in which to work in which may help the Trust to recruit scarce endoscopists and gastroenterologists.

In 2016/17 the Trust will invest in improving the physical infrastructure of Sunderland Eye Infirmary (SEI) which has a national reputation for both the high quality services it provides and how efficiently the department operates. It is important that the Trust ensures the Ophthalmology department continues to operate out of first class facilities for the future.

Staffing

The Trust believes that it has, or will be able to recruit the staff required to deliver the anticipated activity. Where the Trust is facing short to mid-term operational pressures it is planning to meet demand by designing different ways of working and using subcontractors (NHS and private) to deliver activity in the short term whilst implementing long term strategies.

The national drive towards seven day working will increase pressure on some areas of the Trust, however, through continuous improvement the Trust is confident that it will deliver seven day working by increasing efficiency and thereby making better use of existing resources supported by focused recruitment where improvement alone is believed insufficient to meet anticipated demand.

The Trust will continue to review staffing levels and skill mix at least twice a year providing uplift as necessary to provide assurance that the quality of care is not compromised.
The Trust plans its workforce on a five-year basis although it is not an exact science as the direction of travel needs to cover areas requiring up lifts due to growing demand, the outcome of the Francis, Keogh and Berwick reports and seven-day working whilst balancing this with the CCG’s plans to reduce both non-elective demand and income which will need to be supported by a reduction in beds and the associated staffing.

Junior doctor staffing projections are an ongoing concern for most Trusts given the change in training whereby junior doctors will have a more supernumerary role rather than providing service cover. The Trust response to this new direction will be to expand our ‘Hospital at Night’ approach.

**FUNDING ANALYSIS**

**Historic Trends**

The Trust has seen significant increase in patient demand over the last 5 years which has resulted in contractual income growth from £286m in 2009/10 to £323m in 2013/14. Access to emergency care at the Trust has seen significant growth over this period and represents the main increase in funding. The Trust has, and will continue to work with the wider local health economy in a collaborative way to reduce hospital attendances and re-attendances through a number of avoidance schemes aimed at delivering more care in the community.

Standard elective care has seen a slight decrease over recent years as part of the drive to provide day-case surgery wherever clinically appropriate. In addition the Trust has worked closely with local commissioners to move many day cases into outpatient procedures in specialties such as ENT, Ophthalmology and Gynaecology. These initiatives provide significant patient benefit as well as improving the efficiency of elective surgery.

Discussions with Sunderland CCG and Durham, Dales, Easington and Sedgefield (DDES) CCG have demonstrated that they are keen to continue this direction of travel over future years.

Financial modelling has been prepared as part of the sensitivity analysis to understand what the outlook would be over the next 5 years if the historic trends of growth continued for the organisation.

The Trust has a clear understanding that historic trends are unsustainable from both an internal capacity perspective and financially for the health economy.

**Future Trends**

The Trust has held regular meetings with our main commissioners Sunderland CCG and other local commissioners to jointly manage population demand for hospital health care over the coming years. High level activity assumptions from both local partners are detailed below:

The Trust has assessed Commissioner assumptions and considered our financial planning accordingly. The Trust has aligned its plans with Sunderland CCG as the main commissioner, with the exception of the anticipated reduction in non-elective activity of 15%. The Board of Directors have agreed that in the absence of detailed plans from commissioners around the means of delivering this ambitious target, that 50% of the CCG assumptions will be factored into the Trust plans, equating to a 7.5% reduction in admissions over the 3 years. The Trust is assuming that none of this funding retraction associated with the Better Care Fund will be reinvested with the Trust, although it is likely that specialist clinical staff employed by the Trust may be utilised in a community setting to support the aim of reducing emergency admissions and readmissions.
Market Share analysis

The table below highlights the Trust’s overall market share in relation to our main commissioners.

<table>
<thead>
<tr>
<th>Area</th>
<th>Non elective inpatients, elective inpatients and new outpatients</th>
<th>Combined market share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunderland CCG</td>
<td>159,228</td>
<td>87.6%</td>
</tr>
<tr>
<td>Durham CCGs (all)</td>
<td>56,643</td>
<td>19.8%</td>
</tr>
<tr>
<td>South Tyneside CCG</td>
<td>24,100</td>
<td>25.6%</td>
</tr>
<tr>
<td>Gateshead CCG</td>
<td>3,924</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

(Source of all information: Dr Foster Hospital Marketing Module)

The Trust’s market share in Sunderland is 87.6% and it would be difficult to grow this significantly as the Trust does not offer either Dermatology or Plastic surgery services and there will always be an element of specialised work that would have to be carried out at a tertiary centre such as the Newcastle Hospitals Trust. Additionally there are GP practices on the western borders of Sunderland CCG which are closer to Gateshead Foundation Trust than Sunderland and so an element of patient choice reduces our market share for these practices. Without expanding our range of services it would be difficult for the Trust to increase its market share with Sunderland CCG.

Given these factors the Trust believes that it has, and will continue to have, a dominant presence in its home market.

The Trust’s market share for the Durham CCGs is 19.8% and this is predominantly due to the geographic nature of County Durham with the Easington area having a natural flow to Sunderland with shorter travel times for the majority of patients. In addition, our sub regional specialties such as Urology, Nephrology, ENT and Oral and Maxillofacial Surgery offer outpatient clinics and some minor surgical procedures on an outreach basis at sites across Durham.

The Trust has a market share of 25.6% for South Tyneside CCG and this is because:

- We offer a wider range of services compared to South Tyneside Foundation Trust.
- We have some clinical networks with South Tyneside where complex patients are often brought to Sunderland for treatment.
- We provide outpatient clinics at a range of venues in South Tyneside including at the South Tyneside Foundation Trust Hospital.

The Trust has only 3.9% market share in Gateshead which mainly comes from our sub regional specialties as the natural direction of travel for most patients is to The Newcastle Hospitals Foundation Trust if their local Trust cannot provide. For Gateshead residents, the majority of work and shopping journeys are to the Newcastle area so if their home Trust cannot provide the required services it is quicker for patients to travel to the RVI or Freeman hospitals in Newcastle rather than to City Hospitals Sunderland.

The Trust’s OGSM process ensures all of the Trust’s key objectives are aligned and cascaded throughout the organisation. Each service line has an OGSM plan in place which is monitored through the Trust’s robust business and governance frameworks, including a quarterly review process and clear escalation routes where urgent action is required. This information is used as part of the quarterly review process with each service line to ensure robust planning is undertaken so each service line understands their position in the market and plans accordingly.

The outcomes of the quarterly review process are submitted to the Trust’s Operations Committee, which is a sub-committee of the Board, to ensure there is a clear reporting route to the Board on relevant service issues.
ALIGNMENT OF THE TRUST PLANS WITH THE LOCAL HEALTH ECONOMY

The Trust’s plans are fully supported by local commissioners, other local FTs and other key stakeholders. The Trust has highlighted its strategic plans to local commissioners through various forums, including executive to executive sessions and they fully support the Trust’s direction of travel.

The Trust is fully engaged in the wider health economy strategies in relation to integrated care, the use of the Better Care Fund and the requirement for appropriate patients to be managed outside of hospital. This is focussed on developing multi agency teams, which are based around GP localities and the Trust will offer appropriate clinical and nursing input into these local teams to help manage patients, where appropriate, in their local area.

Co-operation within the local health economy is further evidenced by the Trust being represented and fully engaged in key planning forums such as the local Health and Well Being Boards, City of Sunderland partnership Board and local CCG’s main planning groups in relation to unscheduled care, planned care and integrated care.

NHS England, through the ‘Everyone Counts’ document highlights the national direction of travel, which includes the move toward centres of excellence with specialised services being delivered by a limited number of providers. The Trust’s ambition to be the 3rd centre and a ‘Major Emergency Centre’ is aligned to national strategies developed by NHS England.

The Trust also participates in the Health and Well-being boards of both Sunderland and Durham ensuring that its plans are aligned with those of its main providers. In Sunderland a Transformation Board has been created by Sunderland CCG which will oversee the future investment of items such as the better care fund to deliver the priorities of the local CCG’s and local authorities.

In relation to alignment of plans across the North East, there are likely to be specific areas where FT plans are not in alignment in relation to certain service lines. These are predominantly to specialist services where FTs will have different perspectives on how many centres should provide such services. The potential changes to specialist services are difficult to predict and the commissioning of these services are mainly decided by NHS England. Therefore, at this stage the Trust has not included any changes in relation to activity, income or the workforce due to the uncertainty of outcomes and the absence of any published timescales.
1.2 Risk to sustainability and strategic options

ASSESSMENT OF THE LIKELY IMPACT OF THE CHOSEN OPTIONS ON THE BROADER LHE

The Trust’s intention is to further enhance and develop the wide range of services the Trust already provides. The Trust is already in a strong position to become a recognised ‘Major Emergency Centre’ and the developments outlined further strengthen this position.

Over time (and work has commenced in a number of areas) the Trust expects that an increased number of complex patients from areas such as South Tyneside and parts of County Durham, who require specialist input for services such as Cardiology, Stroke, Vascular and emergency surgery will be treated at Sunderland Royal Hospital.

The likely impact on local commissioners, in particular, South Tyneside and Durham is that for certain HRGs or service lines, CHS will increase market share for their respective populations, though the overall numbers would not significantly change. The Trust has been clear on its direction of travel and has active support from local CCGs, in particular South Tyneside and Sunderland.

The Trust is committed to, and supports the CCG and LA plans to manage patients, where appropriate, in their local community. The Trust’s plans in relation to Elderly Medicine are aligned to that of the CCG in terms of developing the service model, although as a Trust we do not agree with the CCG’s assessment of the reduction in activity by the end of 2018/19.

Where relevant, and linked to specific service lines, the Trust’s plans are aligned to that of other partners, such as South Tyneside FT in relation to community services, NEAS in relation to the urgent and emergency care system and Northumberland, Tyne and Wear Mental Health FT on specific service lines.

LHE support required and alignment with proposed options

Sunderland CCG has recently released their revised plan on a page (see below) for the next 5 years.
This plan is based on the original plan on page highlighted on page 11 and has been updated with the priorities of the wider health economy. A number of the Trust’s initiatives and importantly our vision to become the 3rd centre in the North East are clearly supported by our main commissioner.

The Trust has worked in collaboration with other local FTs, predominantly South Tyneside FT in a number of areas, such as Stroke, Cardiology, Radiology, OOH Surgery and others and there is general support through the ABP programme for CHS to take the lead role for the provision of more complex services, which again is aligned to the Trust’s strategic direction.

In relation to NHS England and the move to concentrate centres of excellence to provide specialised services, the number of centres required to support the demand in England has not yet been finalised and is likely to vary from specialised service to specialised service. For those services that NHS England commission the Trust is not expecting formal support, as a more transactional approach is likely to be taken in relation to individual service lines and the Trust will update its plans as and when NHS England take forward commissioning decisions.
1.3 Strategic plans

**Strategic Direction**

The Trust’s strategic aim in relation to service provision is captured in the concept of ‘the 3rd Centre’ and the Trust has defined this in the operation plan. The Trust will focus on becoming the 3rd Centre in the North East region which means we will plan to develop more complex/specialised sub-regional services for a larger population with appropriate alignment of investment in the workforce, technology, equipment and capital plans as required.

This direction of travel is aligned with national strategies which include having fewer centres of excellence and the development of 40-70 major emergency centres across England. The Trust currently provides a range of services for heart attacks, stroke, vascular, and critically ill children as outlined in the Keogh report and this national description is exactly aligned to the Trust's vision of the '3rd Centre'. The Trust has full support from local commissioners and for a number of years, through the 'Accelerating Bigger Picture' programme, the Trust has worked closely with other local providers and commissioners and has started service transformation in a number of areas.

The Trust’s investment strategy, covering areas such as a state of the art endovascular theatre, 2nd catheter lab and a new Emergency Department demonstrates its commitment to the delivery of its vision. The Accelerated Bigger Picture, in collaboration with 2 local NHS Foundation Trusts, demonstrates a cooperative health economy that is willing to concentrate services at key locations in order to achieve a high quality, safe service for the population, whilst delivering financial and clinical stability and sustainability for the three NHS Foundation Trusts. As part of this process Pathology, Medical Physics and Acute Paediatrics have already been implemented as hub and spoke models across the Trusts.

**Centre of Excellence**

The Trust already has a number of 3rd Centre services such as Bariatric surgery, ENT, OMFS, Urology, Ophthalmology and Nephrology which operate on a regional/sub regional basis and where part of the services are commissioned by the North of England Specialised Commissioning Group and part by the local CCGs. The Trust’s direction of travel to be the 3rd Centre supports commissioners to demonstrate that they are delivering a key element of their plan to have specialised services concentrated in centres of excellence relevant to the locality.

It is also important to note that such services operate on a hub and spoke model, which ensures local provision of services where possible (outpatients and daycases) and the advantage of Sunderland Royal Hospital as the hub is that, with the exception of Ophthalmology, all the key services are delivered on one site, therefore ensuring that patients have the benefit of immediate input from specialist teams 24/7.

**Key milestones, resourcing requirements, dependencies and risk mitigations**

The Trusts key schemes which are linked to the wider health economy plans and initiatives are outlined below:

- Integrated care – The Trust’s ‘likely case’ in terms of planning is based on the CCGs plans being 50% achieved. In this scenario, the Trust would reduce Elderly Medicine beds by 2-3 wards and reduce the workforce accordingly. From a nursing perspective, the required reductions in the workforce are achievable through natural turnover and this is therefore low risk. This is also true if the CCGs plans are fully realised as the Trust would be able to reduce the nursing workforce accordingly and therefore the majority of associated costs in a planned manner due to the normal turnover of nurses.

- Major emergency centre – the Trust is confident it will have developed its existing services to provide all the requirements of a Major Emergency Centre by the end of 14/15. The Trust does not
require a significant increase in resources, either physical or manpower, as these are already in place. Over the past few years the Trust has put in place the necessary building blocks to secure this future, therefore reducing the risk. However, increasing the population base for certain emergency services is dependent on both local FTs (who support CHS) and commissioners, (CCGs and NHS England) and timescales for key services are yet unclear.

- Accelerating the Bigger Picture – as highlighted throughout this plan, the ABP programme is ongoing across a number of areas. Each area is working to different timescales and will have different resource implications depending on the service model being implemented. The associated risks are different depending on the nature of the proposed changes and these are managed through the ABP operational board, with senior representation from each FT and the ABP strategic board, which includes colleagues from local CCGs.

**Communication plan**

The Trust has robust communication frameworks in place in relation to monitoring service line plans, engaging with clinical directorates, communicating with all staff and the Trust is a member of all the appropriate forums to engage with external partners and stakeholders.

Externally, co-operation within the local health economy is evidenced by the Trust being represented and fully engaged in key planning forums such as the local Health and Well Being Boards and the local CCG’s main planning groups in relation to unscheduled care, planned care and integrated care. The Trust has already used and will continue to use these forums and our relationship with the recently established Healthwatch to highlight the Trust’s strategy and gain support to help deliver the Trust’s objectives.

A Transformation Board has recently been established, where the Trust has highlighted its strategic direction with local partners, including Sunderland CCG, Sunderland City Council, Northumberland, Tyne and Wear Mental Health Trust, NHS England, South Tyneside FT and Healthwatch.

The Trust will use Governors to help further communicate the Trust’s strategic plan with the wider FT membership and also by our existing communication methods with members.

Internally, the Trust has a number of methods and forums to communicate with staff, which include:

- Publication of annual plan summary
- Senior Managers Forum
- Clinical Directors Forum
- Annual Planning Days
- Quarterly review process with each directorate
- Corporate Management Team
- Team Brief
- CE Updates and newsletters

Over and above this, the Trust is preparing a specific communication brief in the form of a small booklet, which looks back at the last ten years of CHS being an FT and this will also include a high level summary of the Trust’s plans for the future. This will be available for all staff and will further strengthen the communication of the Trust’s strategic objectives.

**Monitoring of the strategic plan**

The Trust has a variety of methods that it uses to monitor its strategic plan and achievement of goals that move the trust towards its vision. To deliver these strategies at a service line the Trust has a robust planning framework in place which describes the Objectives of the Trust, the specific Goals that need to be achieved, the Strategies that will be adopted and the Measurements that will be in place to track progress. The OGSM framework is used across the Trust to ensure all plans are aligned to deliver the
The OGSM process ensures all of the Trust’s key objectives are aligned and cascaded throughout the organisation. Each service line has an OGSM plan in place which is monitored through the Trust’s robust business and governance frameworks, including a quarterly review process and clear escalation routes where urgent action is required. The outcomes of the quarterly review process is submitted to the Trust’s Operations Committee, which is a subcommittee of the Board to ensure there is a clear reporting route to the Board on relevant service issues.

The Trust has a number of strategy groups, including IM&T, Capital Development and Human Resources, all of which support delivering the Trust’s strategic plan. These groups ensure the relevant aspects of the Trust’s plans are appropriately resourced and managed accordingly, escalating issues to the Trust’s Executive Committee where relevant and if necessary the Board.

The strategic business planning process provides a framework for delivering against national, local and internal quality and performance key quality objectives. Overall performance is aligned and tracked against these trust-wide priorities for quality improvement. This ensures that quality underpins any major service change. The quality priorities reflect local as well as national priorities and discussions with stakeholders have shaped these.

Regular reports on progress against the Trust’s plans are also presented to:

- Board workshops
- Council of Governors
- Clinical Directors Forum
- Executive Committee
- Senior Manager Forum
- Consultant Briefing

Supporting Financial Information

The Trust has reflected on Monitors feedback to our Operational Plan submission and taken the decision not to revisit year 2 of the financial plans. The Trust feels that year 2 plans were considered and did not include over ambitious growth assumptions; the details therefore reflect our expectations for 2015/16.

Financial Plans for 2016/17 to 2018/19

Income

The Trust financial details reflect discussions held with local Commissioners taking into account our assumption of 7.5% non-elective activity reduction to 2018-19 rather than 15%. Tariff growth/retraction assumptions fully align with our main Commissioner Sunderland CCG.

Overall the Trust has assumed minimal growth in income over the next 5 years, total income in 2013/14 was £322m, and planned income for 2018/19 is £332m. This movement is around 0.5% increase year on year for 5 years and includes funding for 7 day working. The Trust views this as a prudent assessment at this stage and it represents a significant drop in real terms funding against the previous 5 years.

Expenditure

Assumed pay and incremental uplifts have been provided for in line with National guidance, in addition the Trust has also accounted for increases in employer pension contributions in future years.

Costs associated with increased/decreased activity have also been assumed in line with income received. The trust financial details also reflect inflation uplift on non pay items, plus increases in energy and NHS
Litigation costs for the future years. In addition provisions have been made for depreciation costs linked to recent and upcoming capital projects.

Overall CIP assumptions for future years equate to approximately 3.7% of operating expenses for every year of the plan.

The Trust has planned for a £0.5m surplus per year, equating to approximately 0.2% of total income. Given the risks identified, the Trust is assuming a lower level of surplus in comparison with previous years, at a net £500k. The implications as detailed in the main financial submission are summarised in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Forecast</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Income</td>
<td>296,987</td>
<td>296,988</td>
</tr>
<tr>
<td>Other Income</td>
<td>24,874</td>
<td>25,903</td>
</tr>
<tr>
<td>Total Income</td>
<td>321,861</td>
<td>322,891</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>196,460</td>
<td>198,416</td>
</tr>
<tr>
<td>Non Pay Costs</td>
<td>111,176</td>
<td>107,970</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>307,636</td>
<td>306,386</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>14,225</td>
<td>16,505</td>
</tr>
<tr>
<td><strong>Non Trading</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and PDC</td>
<td>13,825</td>
<td>14,543</td>
</tr>
<tr>
<td>Interest</td>
<td>1,274</td>
<td>1,462</td>
</tr>
<tr>
<td>Total Non Trading</td>
<td>15,098</td>
<td>16,005</td>
</tr>
<tr>
<td><strong>NET (DEFICIT)/SURPLUS</strong></td>
<td>-874</td>
<td>500</td>
</tr>
</tbody>
</table>