Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	24 November 2016
	Agenda Item:	9.1
	Enclosure Number:	7

Meeting:	**Trust Board**		
Title:	**Organisational Sustainability Review**		
Author:	**Julie Thornby, Director of Corporate Affairs** **For Appendix A (full organisational review report) also Ros Preen, Director of Finance & Mel Duffy, Director of Strategy.**		
Accountable Director:	**Mike Ridley, Chairman**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Resources and Performance Committee (financial aspects) Informal Board	August 2016 August 2016	

Purpose of the report		
To enable the Board to give final consideration and confirmation on whether the Trust is sustainable (clinically and financially) into the future, taking into account the views of our regulator, NHS Improvement, which the Board previously agreed to seek.	**Consider for Action**	✓
	Approval	
	Assurance	
	Information	

Strategic goals this report relates to:			
To deliver high quality care	**To support people to live independently at home**	**To deliver integrated care**	**To develop sustainable community services**
✓	✓	✓	✓

Summary of key points in report

The Board has been considering for some time now whether we are sustainable – clinically and financially - in our current organisational form, based on guiding principles.

Those principles include our ability to deliver high quality services, and our capacity and ability to deliver the transformed out-of-hospital community services that are vital to our own vision, and to the Sustainability and Transformation Plan (STP) with our partners.

These considerations have not come about because the Trust is failing in its performance or finances. From a position of relative strength, the Board has been thinking carefully about what organisational option will best help community services to thrive and develop strongly for the future.

The Board considered the attached detailed report headed "Organisational Sustainability Review" informally in August. The executive summary describes the key limitations and issues we face because of our small organisational size, including the challenge of finding efficiencies and making investment in our services, and limited infrastructure in a range of areas from transformation change management, to quality governance, to support for workforce change, to IM&T and estates.

In August the Board reached the view that the Trust and its services therefore need to become part of a larger organisational model offering the investment and infrastructure for community services to thrive and develop strongly.

Our regulator NHS Improvement (NHSI) supports that view.

If the Board confirms the decision today that the Trust is not sustainable into the future, NHSI will form a Sustainability Board, of which the Trust will be a member. Its role is to lead the review of options for the future organisational form of the Trust's services.

Communications with staff and partners/stakeholders will be a vital part of the process and the communications plan for the first stage is attached.

Key Recommendations

The Board is asked to:

- Confirm its decision on whether the Trust is sustainable (clinically and financially) into the future in its current organisational form.
- If the Board decides it is not sustainable, note that the next step will be for NHS Improvement to form a Sustainability Board, of which the Trust will be a member. The role of the Sustainability Board is to lead the review of options for the future organisational form of the Trust's services.

Is this report relevant to compliance with any key standards? YES OR NO		State specific standard or BAF risk
CQC	No	
IG Governance Toolkit	No	
Board Assurance Framework	Yes	1996 Trust sustainability

Impacts and Implications?	YES or NO	If yes, what impact or implication
Patient safety & experience	Yes	Seeks to maintain and enhance current levels of patient care through strategic change
Financial (revenue & capital)	Yes	Seeks a solution for long term financial sustainability
OD/Workforce	Yes	Potential to address certain workforce risks. Requires substantial staff engagement and communications.
Legal	Yes	Impacts on future legal status of the Trust

1. INTRODUCTION

1.1. The Board has been considering for some time now whether we are sustainable for the future – clinically and financially – in our current organisational form, based on a number of guiding principles.

1.2. Those guiding principles include above all our ability to deliver high quality community services and our capacity and capability to deliver transformed services in line with the Five Year Forward View and the local Sustainability and Transformation Plan (STP). Strong community services are vital to those plans. The Board's key consideration throughout has been whether the Trust's current form as a small standalone organisation is the best option to deliver those services into the future.

1.3. This has not come about because the Trust is failing from a quality, performance or financial perspective, and the Board is proud of all the positive progress which our staff have made since the organisation was formed in 2011. From a position of relative strength, the Board has been thinking carefully about what organisational option will help most to strengthen and develop community health services.

2. BACKGROUND

2.1. The Board has considered the organisation's sustainability a number of times, most recently in August 2016, when it discussed the 'Organisational Sustainability Review' attached as Appendix A. The report assesses in detail the sustainability of the organisation across a range of areas including quality and clinical services, infrastructure, finance, workforce and Information Management and Technology.

2.2 The report sets out the strategic case for change. The Shropshire-wide Sustainability and Transformation Plan is dependent on delivering a substantial transformation programme to make alternative, consistently high quality models of care out of hospital a reality, including workforce redesign and investment in technology and estate. That sets the context for considering our sustainability.

2.3 The executive summary at the start of the Review report summarises the key consequences for us as a small Trust:

- Our infrastructure (e.g. clinical leadership and management to support transformation, IMT, quality governance and audit) is small and stretched, which affects our capacity to develop services and carry out certain other roles
- As a small trust it is hard for us to offer the range of roles and opportunities that enhance patient services, and attract staff to larger Trusts
- Our small size and critical mass make it especially challenging to continue finding year on year efficiencies
- Although we can deliver reasonably consistent financial performance, our small size hampers our ability to invest

2.4 To recap, when the Board considered the Review report in August it agreed the substantial scale and nature of the transformation needed to support the shift of patient activity from acute to community settings in the STP, and the significant limitations to the Trust's ability capacity to achieve this within the current STP configuration.

2.5 The Board discussed the conclusions from the Long Term Financial Model, and the inability of the Trust to build up reserves and support change.

2.6 The Board's conclusion was that the Trust and its services need to become part of a larger organisation in order to make sure that community services have access in future to vital investment and support to thrive, grow and deliver an ambitious STP.

2.7 The Board was very aware of the uncertainty and concerns that staff would have about the future, and discussed how best to engage with staff and keep them informed.

2.8 The Board agreed to submit the Review report to our regulator, NHS Improvement, and seek their feedback on the Board's view. Their support is required to take the next steps in exploring other options.

3. LATEST POSITION

3.1 View From NHSI

NHSI has considered the Review and the Board's conclusions, and supports the view that the Trust is not sustainable into the future.

In a letter of 13 October, (attached as Appendix B) Dale Bywater, Regional Managing Director, wrote:

"It is clear that the Trust's guiding principle in this work has been to deliver an improved community offering for your local population which is aligned with the emerging STP priorities and plans. I would like to personally thank the Board for taking such an objective, balanced and pragmatic stance in its deliberations.

I can confirm that NHSI is in agreement with your assessment that the Trust in its current form lacks the critical mass and infrastructure to deliver the ambitious programme of change in Shropshire's community services in the coming years.

I would like to thank you once again for the forward thinking stance the Board has taken in this matter, and I look forward to working with you to arrive at an organisational form which is best placed to deliver new and sustainable community models of care."

3.2 Next Steps

3.2.1 If the Board makes its final decision today that the Trust is not sustainable having received NHSI's feedback, then NHSI has agreed to work with us in a timely way to find a solution that will increase and accelerate our ability to deliver stronger, transformed community services in future. Given our position of relative strength, we expect and have been assured by NHSI that we will be central to the decision

which they, in partnership with NHS England, will make about our future organisational form.

3.2.2 The Board has previously discussed the criteria for selecting a new formal partner for our organisation and services, and is committed to using its influence through the process to promote organisational attributes that will specifically strengthen community ways of working. Those include:

- Financial stability
- Track record of delivering transformation at scale
- Sound quality governance that can safely support complex health and care, and practitioners
- Achievement of good quality standards
- Delivery of effective community services
- Partnership working with health, social care and third sector
- Commitment to Shropshire

In line with previous Board discussions, we would not advocate that all our services are widely fragmented between different providers or "cherry picked" as this would fundamentally damage any ability to achieve the capacity, capability and scale which is needed to deliver the future model.

3.2.3 In terms of process, NHSI will establish a Sustainability Board, chaired by NHSI and comprising representatives from NHS England, both local CCGs, and the Trust. The role of the Sustainability Board is to lead the review of options for the future organisational form of the Trust's services. This process will include engagement with our staff and local stakeholders. We will communicate widely with staff and stakeholders as those details become clear.

3.2.4 If the conclusion from that stage of work is that the best solution is for the Trust to become part of an existing NHS Trust, (a "transaction"), then the Sustainability Board will stand down and a Transactions Board, also chaired by NHSI, will be formed.

3.2.5 Communications with staff and partners will be a vital part of the process. We anticipate regular rounds of meetings with partners and staff. A detailed communications plan for the current phase is already in place (Appendix C), and will be developed into more detail for subsequent phases.

4. RECOMMENDATIONS

The Board is asked to:

- Consider Appendix A, Organisational Sustainability Review and Appendix B, letter from Dale Bywater of NHSI dated 13 October 2016.
- Confirm its decision on whether the Trust is sustainable (clinically and financially) in its current organisational form into the future.
- If the Board decides it is not sustainable, note that the next step will be for NHS Improvement to form a Sustainability Board, of which the Trust will be a member.

Appendix A

Appendix A

Gateway 1 Report

Transforming Services –
Organisation Sustainability Review

August 2016

Contents

Purpose

The purpose of this report is to enable the Board to decide whether the Trust is organisationally sustainable, based on the further analysis provided here since the Board considered the issue in February.

Executive Summary

Introduction

The Trust is relatively small with an income of £78 million and employs 1250 whole time equivalents

Background

In February 2016 the Board agreed that on the basis of ability to deliver the Trust's Clinical Strategy, the Trust was not sustainable in its current form and further discussion was needed with NHS Improvement (NHSI) on next steps.

Against that context, the Board has in recent months been considering the nationally emerging alternative organisational forms for NHS providers. The Multispecialty Community Provider (MCP) is of particular interest currently and is described more in the report. This is a place-based partnership of GPs, community health services and others providing a broad range of joined up services to a particular neighbourhood. It is especially interesting to us because of the work we are doing within the Sustainability and Transformation Plan (STP) with partners to develop a neighbourhood model for out of hospital care.

We have a sound track record of delivery to date, but the key issue now is what organisational form will best deliver much needed transformation in the future.

Strategic Case for Change

We have an ambitious Clinical Strategy (see 'plan on a page' in Appendix A) and supporting plans that centre especially on new models of care supporting a shift from acute to community settings.

Our plans are closely aligned to and vital to the delivery of the system wide Sustainability and Transformation Plan (STP). Succeeding in those plans is dependent on delivering a substantial transformation programme to make alternative, consistently high quality models of care out of hospital a reality, including workforce redesign and investment in technology and estate. System requirements for a saving of £6m from community services, £1m from organisational consolidation, and a drive to share more back office functions have also been identified associated with STP work, although the figures are headline only only at this stage. The prospect in principle of the Community Trust not continuing in its current form, and therefore helping to deliver the consolidation aspect of the STP, is known and supported by Chief Officers in our STP partners.

Achieving our plans requires us to deliver a significant scale of change, at pace. For example, the faster that enhanced community services (as per the STP) can be in place, the more chance we have to start to manage system capabilities in the new way, develop the culture, and test the benefits realisation. The changes will impact on the majority of our adult services, and involve partnership working with a much wider range of organisations, in different neighbourhoods.

An important question is therefore whether the Trust's current organisational form can offer the capacity and sustainability (beyond financial sustainability alone) to deliver what is needed. We could try to achieve that via local collaboration with others while staying in our current form, but there are likely to be limitations to that, given the challenges facing other health organisations in the small Shropshire STP footprint. The local system has been financially challenged for many years, and has struggled against that background to develop a culture of, and capacity for, innovation.

Assessment of Sustainability

Our small critical mass hampers continuing achievement of efficiencies, and the shortfall in business development infrastructure has made more difficult the move to 'business as usual' after winning tenders.

Trust infrastructure is very stretched, and is difficult to expand in the light of efficiency requirements and the need to keep the level of overheads keen. Certain functions have to be provided whether a Trust has income of £50 or £500 million. Our limited infrastructure affects capacity and sustainability in a range of areas from transformation change management, to clinical audit, to support for workforce change, to IMT and estates. Investment in these areas is also challenged.

Challenges to workforce and service sustainability include the absence of more senior specialist nursing roles in our inpatient and minor injury services in the interests of financial sustainability, and difficulties as a small organisation in offering attractive working patterns comparable to those of larger Trusts in order to recruit eg CAMHS.

Shared service arrangements are a potential option for greater efficiency, but the usual delivery via service level agreements consumes still more management time to monitor and manage, whereas a single management structure would provide true economies of scale.

Financial Strategy and Evaluation

This section describes the outputs from applying the Long Term Financial model, including upside and downside scenarios for the future.

Points it tells us include:

- The organisation can continue to deliver a reasonably consistent financial performance over five years.
- However, if any or all of our downside risks occur, the Trust will continue to struggle to maintain a sustainable financial position and any mitigation will impair corporate infrastructure further.

- Upside models do not materially impact on the Trust's overall turnover, nor the I&E position, although cash balances continue to grow.
- The scale of additional income in the upside models will not provide the opportunity to upscale governance much more than that currently in place.
- The Trust would not have the ability to support the requirement to pump prime any upside change.

Conclusion

The Trust is not clinically or financially sustainable to deliver what is vitally needed for the future. A prompt decision on sustainability will optimise the opportunity to make the changes needed to support the STP.

Section 1. Introduction

Shropshire Community Health NHS Trust (SCHT) was established in 2011 from the former 'provider arms' of Shropshire County and Telford and Wrekin Primary Care Trusts. We provide a range of community-based services for adults and children across Shropshire, Telford and Wrekin, and some services in surrounding areas, such as the school nursing service in Dudley. We specialise in supporting people to live independently at home, and through outpatient and inpatient care. Our focus is on prevention and keeping people out of crisis, receiving care at home, or close to home. We have an income of approximately £78m, employ 1250 whole time equivalent staff and serve a population of about 475,000. Services are organised into two Service Delivery Groups and corporate services as shown below.

Adult SDG

- Community Hospitals
- Minor Injury Units
- Integrated Community Services
- Inter-Disciplinary Teams
- Long-Term Conditions & Frail Elderly
- Diabetes
- Tissue Viability
- Continence Services
- Shropshire Wheelchair Service
- Rheumatology
- Physiotherapy
- Podiatry
- Advanced Primary Care Services
- Prison Healthcare
- Diagnostics, Assessment and Access to Rehabilitation and Treatment (DAART)

Children and Families SDG

- Health Visitors
- Child and Adolescent Mental Health Services (CAMHS)
- Children's Therapy Services
- Community Children's Nurses
- School Nurses
- Family Nurse Partnership
- Child Development Centres
- Safeguarding
- New Born Hearing Screening
- Child Health and Audiology
- Community Paediatrics
- Immunisation and Vaccination
- Dental Services

Corporate/Support Services

- Finance
- Workforce/HR
- Organisational Development
- IT and Informatics
- Hotel Services
- Administration Support
- Business Development
- Performance
- Complaints and PALS
- Emergency Planning
- Patient Experience and Involvement
- Assurance (non-clinical)
- Quality
- Communications and Marketing

Section 2. Background

This section:

- takes stock of the Board's discussions to date about the Trust's organisational form
- describes new options for organisational form that are emerging nationally
- sets out how far the Trust has come in strengthening community services

2.1 Local background – Trust considerations of organisational form so far

2.1.1 This paper develops further the report about the Trust's future sustainability which the Board considered in February 2016. At that meeting, the Board agreed that if the future envisaged in the Trust's clinical strategy was to be realised, the Trust was not sustainable in its current form. A different organisational form was needed, and more work to develop the next steps and discuss this with the Trust Development Authority (now NHS Improvement, NHSI).

2.1.2 Subsequently NHSI have clarified the Gateway process that applies in these circumstances. The first step is for the Trust Board to make a decision on the Trust's sustainability based on a report assessing financial and clinical sustainability, including long term financial modelling. This report provides that fuller detail. If the Board decides the Trust is not sustainable, this report then passes to the regional NHSI for their consideration.

2.1.3 This section recaps briefly on the background to the Trust's establishment, and Board discussions since then about organisational form and sustainability. After being formed in July 2011, the Trust initially worked to achieve stand-alone Foundation Trust status as quickly as possible, which was a clear national requirement for all Trusts at the time. However, we 'paused' (in discussion with the Trust Development Authority) in summer 2013 in the Foundation Trust pipeline, on the basis that we needed a period to focus solely on developing more stability and sustainability, including establishing a new executive team after a period of management turnover.

2.1.4 In December 2014 and again in January 2015 the Board considered papers which assessed the best organisational option for the Trust at that time. This took into account the NHS Five Year Forward View and the associated Dalton Review which suggested a wider range of organisational options for providers than before.

2.1.5 Alongside this, in late 2014 the TDA was looking to segment trusts into one of a number of categories ie those with credible plans to reach Foundation Trust (FT) status in either a shorter or longer timescale, or with no timescale or assessed as not able to reach FT status. Like all Trusts, we were asked to advise the TDA which category applied to us.

2.1.6 Against that background, in late 2014/early 2015 the Board agreed a set of criteria for assessing the Trust's future options including clinical sustainability and 'fit', financial

stability and local focus. It used those to consider a range of options, from continuing to pursue a stand- alone FT application, to merger with specific other trusts, to a collaboration with other trust(s), to a social enterprise.

2.1.7 The Board's conclusion at that time was that the preferred option for the Trust was to continue to work with aspirant NHS Foundation Trusts, using FT frameworks to strengthen the Trust's clinical and financial sustainability, rather than focussing on achieving FT status in our own right. The Board recognised that we needed an option flexible enough to allow us to develop our thinking with the rest of the health economy about ways of working differently with other providers, while maintaining sustainable services. The TDA accepted our assessment of being capable of reaching FT status over a longer timescale.

2.1.8 Since that time, national policy has moved away from a targeted drive solely for Foundation Trust status for providers and the previous focus on creating individual 'sovereign' institutions. At the same time, our Sustainability and Transformation Plan (STP) discussions have supported the consolidation of organisations locally, and increased sharing of back office functions.

2.2 National background - Emerging new models and consolidation of back office

2.2.1 A range of new organisational options and ways for previously separate Trusts to work together are currently emerging - to improve Trusts' ability to offer robust outcomes in a system under pressure. This is important context for the Board in considering the sustainability of the Trust, ie available alternatives and their potential for delivering future care models needed locally.

2.2.2 The health and social care system in England is under huge pressure to deliver better outcomes for patients in the face of increasing demand, limited resources and tightening budgets. These huge challenges cannot be tackled by individual organisations working inside their own traditional boundaries. The challenges require local organisations to become much more collaborative in their approach to healthcare. This is reflected both in system planning (Shropshire's STP) and organisational form.

2.2.3 The Five Year Forward View in 2014 called for collaboration across boundaries between primary care, community services and hospitals while expanding out-of-hospital care. It pointed to a small number of different and more flexible *care models* for providers working across local health systems and boundaries. It did not specify any particular new legal/governance forms, and assumed that existing bodies would work together in new ways. These included **'multispeciality community providers'** (MCPs), centred around primary care, and hospital-led integration of acute and community services (so called **"vertical integration").** Thinking on this has now developed further – see below.

2.2.4 The Dalton Review (December 2014) completed the analysis by setting out a range of organisational forms for NHS providers, all based on providers working much more closely together, on a spectrum ranging from informal collaborations, to contractual alliances between organisations, to legal mergers or acquisitions. Foundation Trusts were still seen as a building block, but not 'an end in themselves'.

2.2.5 The Board report from February 2016 set out a range of options:

a) Continue with a stand alone FT application – the key issue remains the sustainability required.

b) Legal structure change – acquisition by an existing Foundation Trust or merger with another NHS Trust
Recent examples elsewhere in the country include Manchester, Liverpool, Cornwall, Derbyshire and Birmingham. An NHS Trust can be acquired by an existing Foundation Trust, or can merge with another NHS Trust with a view to becoming a Foundation Trust.

c) Alliance contracting models – eg multi-specialty community provider.
An agreement between legally separate providers about how they will work together and share risks and rewards. Can be created in response to tenders that require integrated services; multi-specialty community providers can take this form.

d) Dissolution and transfer of services to different providers
Most likely as a consequence of commissioners deciding to contract for all or most services from a range of other providers. For the NHS Trust, approval for a Trust to dissolve effectively rests with NHSI.

e) 'Assistance' models where a trust is deemed to be failing and in need of external support – ranges from buddying with another Trust, to 'extreme buddying' involving a shared management team from another trust, franchising.

f) Mutuals – eg social enterprise or community interest company
Raised in national policy some years ago as independent, "staff-led" organisations. A small number were established with mixed success; no longer strongly promoted and lack a clear pathway to establishment.

New Emerging Models

2.2.6 Since the ideas in the Five Year Review and Dalton Review, a number of 'vanguards' have been developed across the country which are testing and progressing those ideas. As a result, more detail is emerging about how the new organisational models might look.

Multi-Specialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS)

2.2.7 One such is the **'multispeciality community provider' - MCP**. Locally this is of particular interest because of work we are undertaking with partners especially GPs – aligned with STP priorities – to develop a neighbourhood model for out-of-hospital care delivery, and what organisational form may emerge. There are 14 MCP vanguards across the country which have been developing this approach. NHS England has very recently published a new framework for them ("The multispecialty community provider (MCP) emerging care model and contract framework, July 2016"), to provide learning from the vanguards and set the scene for a forthcoming standard contract for them

2.2.8 MCPs are **placed- based partnerships** of GPs, community health services, social care, some acute services (eg outpatients, diagnostics), and mental health services, providing a broad range of joined-up services. They support people with long term care, urgent care and prevention in community settings via integrated teams. The neighbourhood teams approach in our STP and our own community "offer" very much reflects this. The building blocks of the MCP are local hubs of 30,000 to 50,000 people – but an MCP will consist of a number of such hubs and may be much larger in total. They serve the whole population in that neighbourhood based on GP registered lists, and GPs are the cornerstone of the care model.

2.2.9 The Framework stresses 10 "essential jobs" needed in creating an MCP, including a dedicated and skilled engine room with the capacity to drive and manage local transformation ie capacity and experience will be key. Six local systems are working with NHSE to shape a national contract for MCPs due to be issued in September.

2.2.10 The NHSE Framework envisages that the organisational form for MCPs will be the alliance contracting model – see (c) above, but that the providers involved will want to agree a new organisational form. The Framework states: "In developing a bid to deliver an MCP, prospective providers will need to agree an organisational form… In all cases, an MCP will need to be a formal legal entity, or group of entities acting together to form the MCP, that is capable of bearing financial risk, and which has clear governance and accountability arrangements in place for both clinical quality and finance. The robustness of this organisational form will be assessed as part of the contract-awarding process……It is quite likely that many existing organisations that deliver parts of the proposed MCP service scope will be unable in isolation to be credible holders of a fully integrated MCP contract, and they will need instead to forge new partnerships."

"The precise form of legal entity will be for local determination. With the vanguards, we will develop examples of organisational forms in local systems, to avoid other local systems needing to initiate duplicative work. Options include:

- a limited company or limited liability partnership (LLP). These could be a GP super-practice or a federation bringing a much broader range of services into the general practice model. They could also be newly formed as a (joint venture) vehicle for the purposes of delivering the MCP contract.
- a community interest company (CIC) – a particular type of company, bringing parties together as a social enterprise, using its assets and profits to improve the care of the population;
- an NHS trust or foundation trust (FT) , building on its existing assets and workforce."

2.2.11 The Framework also mentions (but gives less coverage to) the alternative option of **primary and acute care system (PACS)**, which is also place-based and includes primary care and other services as per the MCP, but also provides most or all local acute hospital services. The Framework suggests that PACS may not be appropriate either where "there is insufficient desire from local GPs to integrate with the local hospital" or where the local acute hospital "is happy to 'dock' with the local MCP but does not want to run it".

2.2.12 The Board is also asked to consider as context the letters received from NHS Improvement in June and July 2016, which required us to identify a summary of the opportunities for consolidation of back office functions across the STP footprint, as one of

the key actions needed to tackle the total provider deficit. This is described further in section 4.9.

2.3 Positive track record: strengthening community services

2.3.1 Part of the local context is the work we have done internally to strengthen community services and their potential. We have used the opportunity since the 'pause' in the original FT pipeline to continue to strengthen our relationships with commissioners and partners, actively support strategic change across the local health economy, win additional business, continue the track record of delivery against almost all the national targets relevant to us, refine our clinical and quality strategies, and work proactively to develop organisational culture, including year on year improvement in the overall measure of staff engagement. We have for example:

- delivered our financial plan resulting in a surplus position at year end
- extended our joint Integrated Community Service (with Shropshire Council) to provide access over 7 days extended until 8pm.
- gained approval for the business case for our new Electronic Patient Record system (EPR) which will drive significant efficiencies in the future and support the development of new models of care.
- Introduced new ways of working in childrens' services and won the tender to provide school nursing in Dudley
- Substantially strengthened our patient and carer involvement

2.3.2 We recognise that our future clinical and financial sustainability is intrinsically linked with the development of new models of care and our ability to deliver these models with our system partners. This has underpinned the development of our 2016/17 plans. While we do not want to lose momentum, there is a fundamental decision to be made about the organisational form which can realistically deliver that in future.

Section 3 Strategic Case for Change

This section describes:

- the ambitions of the Trust for developing community services, and the close alignment of that to the STP
- the challenging scale of the work which our organisation needs to be capable of
- how this is critical to the success of the system-wide plan.
- how a change in our organisational form would fit with STP priorities
- limitations to effective delivery through local collaboration

3.1 Our Clinical Vision and Strategy

3.1.1 Our ambitions for community services are important context for assessing the capacity and sustainability required from the organisation. Our ambition in summary is to develop with partners sustainable models of care, designed around the patient, that meet the changing needs of our local communities and provide high quality care in a community setting. How we will deliver our ambition is described in our vision, goals and objectives, and in our Clinical Strategy, all summarised in our 'Plan on a Page' format (see Appendix A).

3.1.2 Suceeding in our ambitions and those of the local health economy is dependent on delivering a substantial transformation programme to make alternative, consistently high quality models of care a reality, including workforce redesign and investment in technology and estate.

3.1.3 Vision

"We will work closely with our health and social care partners to give patients more control over their own care and make necessary treatments more readily available. We will support people with multiple health conditions, not just single diseases, and deliver care as locally and conveniently as possible for our patients. We will develop our current and future workforce and introduce innovative ways to use technology."

We recognise the increasing need to work across historical boundaries in partnership with colleagues from across the health and care economy to develop integrated new models of care. This supports the ambitions of the Five Year Forward View and the delivery of the local System Transformation Plan.

3.1.4 Strategic Goals and Corporate Objectives

Our goals and objectives describe the outcomes we are trying to achieve:

- *To deliver high quality care*
- *To support people to live independently at home*
- *To deliver integrated care*
- *To develop sustainable community services*

3.1.5 Strategic Initiatives and Priorities

Future services must be clinically sustainable and financially sustainable. Our priorities are to:

- Further develop the Trust patient and carer feedback systems.
- Develop and deliver a solution for sustainable Local Enhanced Community Services focusing on: Frailty, Children and Young People, Long Term Conditions and Urgent Care pathways.
- Develop and implement a new 0-25 years Emotional Health and Well-being service.
- Develop and implement robust systems to ensure the delivery of key programmes and targets.
- Continue to pursue growth opportunities.
- Implement the new Electronic Patient Record (EPR) and deliver benefits realisation.

- Develop a sustainable strategy for the future of our estate, including our community hospitals, to support new ways of working.
- Implement innovative workforce solutions to deliver transformation and support new models of care.
- Improve productivity in key areas, reduce expenditure on agency staff and transform services to provide more efficient care.

3.1.6 Clinical Strategy

We have recently refreshed our clinical strategy to reflect the emerging System Transformation Plan. Our priorities in 2016/17 include the development of:

- New models of care supporting a shift of services from acute to community settings.
- New roles and skills to deliver new models of care.
- Expansion of admission avoidance and care coordination services.
- More efficient ways of working optimising effectiveness and efficiency.
- New technologies for health records and mobile working.

3.1.7 Key Deliverables

The key deliverables for the priorities are described below.The potential for growth they represent, and the impact on our financial sustainability, is covered in 3.3 below, in the scenarios in our long term financial modelling described in Section 5, and at Appendix B. These local enhanced community services are vital to support the overall system model reducing the demand on acute services and ensuring patients receive the best possible care in their local community. Taken together they are a challenging volume of work and investment - redesign, delivery of transformation, and work in partnership on a range of fronts. Our key deliverables are as follows, noting that the first three in particular relate closely to the neighbourhood work we are currently doing as part of the STP, described more in 3.2.5 below:

Development of community bases or 'hubs' based on community hospitals/larger community premises offering proactive sub-acute care and both step up and step down reablement, alongside assessment, a wider range of ambulatory care, and voluntary sector support especially for self care and social needs. There is potential to develop the model using opportunities from optimising current bed use and resulting efficiencies.

Development of MIUs and DAART as part of new urgent care provision, with links to ambulatory care and diagnostics at local level.

Development of more productive teams around the practice, and also the roll out and further development of Integrated Community Teams. This is now an integral part of the STP neighbourhood work.

Development of childrens' services including a new model of care for CAMHS; working closely with local Councils to enable jointly planned services for children with disabilities and fully exploring the potential of the community children's nursing service and hospital at home concept.

3.2 Sustainability and Transformation Plan

3.2.1 Our own ambitions for community services, as described above, are directly aligned to the system-wide Sustainability and Transformation Plan (STP) and are critical to its delivery.

3.2.2 The scale of change required in the STP is significant and requires the implementation of radical change at pace in our services , in order to help manage demand and create a sustainable system – see also 3.2.6 below. For example, the neighbourhood model described below will impact on the majority of our adult services (community teams, community hospitals, minor injury units) in terms of their ways of working, roles and pathways, integration with a wider range of partners, and potential relocations.

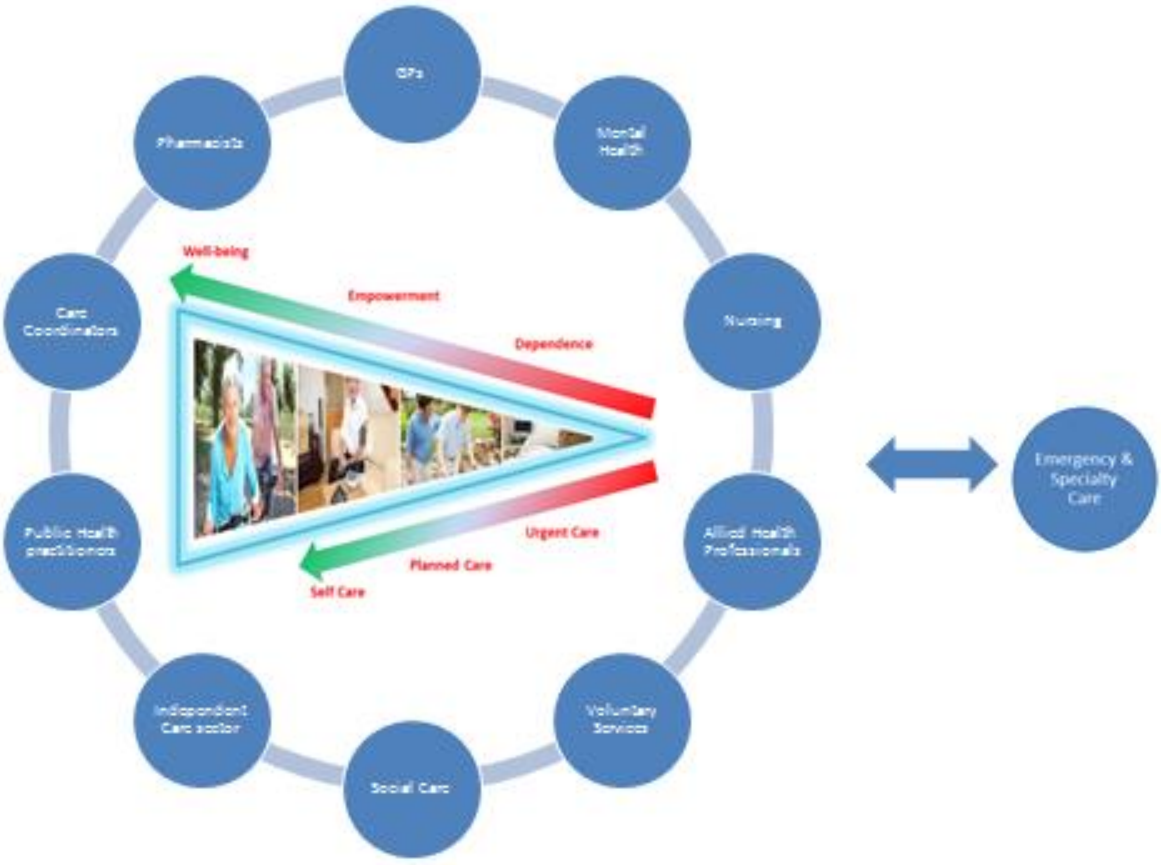
3.2.3 The local health system has described a 'unified vision for our population to be the healthiest on the planet. To achieve this goal we need to have the safest acute provision, independence into older age for the majority of our population and integrated delivery models'. The associated Community Fit Programme describes 'Community or Primary Care Alternatives' as pre-requisites of change.

3.2.4 Strong community services are a requirement of the STP, key elements of which include:

- Support by an enhanced community offer (Neighbourhood working) to reduce pressure on both primary care and acute services
- A recognition of the scale of the challenge faced by the NHS in Shropshire and Telford and Wrekin
- Development of a single shared view of the place-based needs of the population, and a model of coordinated and integrated care across the NHS, Social Care and the Voluntary Sector
- A commitment to preventative work
- Supporting strategies for workforce, estates and IM&T
- A sustainable workforce that is fit for purpose, supported by modern technology
- Plans to deliver financial sustainability across the health economy
- Acknowledgement of the future provider landscape for community services emerging from work taking place

3.2.5 The Neighbourhoods Workstreams of the STP are developing the wider place-based approach for community and primary care service delivery. We are central to this work and our development of community hubs and teams around the practice is fully aligned to deliver it, bringing together multiple organisations to work as one to meet the place based needs of their local neighbourhoods. This work will also strategically steer the future of community hospitals. In partnership with others on the STP neighbourhood workstreams, our ambitions are for locality based Multispecialty Community Providers (MCPs, described earlier in section 2.2) potentially with a new umbrella legal form eg an out of hospital Accountable Care Organisation. The diagram below shows the neighbourhood model, with providers working in partnership to keep communities well and out of acute services. It would strongly support the development of such a model if our services were to become part of a larger entity delivering services that are co-terminous with our Teams and Hubs (rather than centralised).

Neighbourhood Care Model



3.2.6 Managing demand and creating a sustainable system are key priorities for the Shropshire health economy. The faster that enhanced community services (as per the STP) can be in place, the more chance we have to start to manage system capabilities in the new way, develop the culture, test the benefits realisation and quantify in more detail what the acute sector needs to deliver. It would therefore be our view that the new neighbourhood models should be up and running by December 2017.

3.2.7 Our other strategies also reflect the requirements of the STP e.g. developing a sustainable strategy for the future of community estate, including our community hospitals, to support new ways of working and implementing innovative workforce solutions to deliver transformation and support new models of care.

3.2.8 Shropshire system leaders have acknowledged that the transformational journey needed over the next 5 years will require significant leadership, resilience and joint working. Delivery is dependent on large scale change at pace. A key consideration for the Board in the context of *this* report is our organisational capacity and sustainability to deliver all these essential ambitions on a range of fronts with a number of partners.

3.2.9 The STP economy

The Shropshire STP footprint is small and faces significant system challenges. The commissioner and acute provider are financially challenged. Two providers (Sath and RJAH) received a 'requires improvement' grading from CQC and we anticipate we will have the same rating when CQC's inspection report is finalised. The STP relies on the

delivery of a robust community offer. Collaboration with other(s) in the STP could help bolster our own small capacity to do so. However, the weakness of the system and the financial and quality challenges facing our immediate partners make this unlikely to be effective. We have been a financially challenged economy for years and this has impacted on the system's capacity and culture to innovate, especially in community services. This points to very real benefits from bringing capacity, capability and investment, both in finance and quality, into the STP.

3.2.10 How a change in our organisational form fits with STP priorities/views of Chief Officers

The STP sets out plans for closing the financial gap across the footprint of £140.5million before solutions. Of this, £6 million has been identified as coming from community services and £1 million from consolidation of organisations. It should be stressed that these figures are currently headlines only, not yet backed up by detailed plans. Discussions about the prospect of the Community Trust not continuing in its current form, and therefore helping to deliver consolidation, has so far been kept to Chief Officer level including with the Local Authorities. This is to allow the Board to make its decision and NHS Improvement to formally consider it first. All the Chief Officers are broadly supportive in principle. The STP anticipates that a new organisational form for community services will emerge, taking account of neighbourhood models.

On the efficiencies requirement for community services, the Trust is raising with commissioners the need to take a planned approach, and balance short term needs with a longer term approach in order to effectively deliver. However, the £6million saving relating to community services increases the challenge to the Trust's sustainability.

A change from the current Trust form would also support the consolidation of back office functions as envisaged in the STP work, and this is discussed further in 4.9.2.

3.3 Business Growth Opportunities From Our Strategy and the STP

The Board needs to take into account the extent to which activity shifts and developments from the STP may improve our sustainability ie:

- Activity shift from the acute setting
- Expanded shift of activity from the acute setting
- New business

Related scenarios have been worked through in the Long Term Financial Model described in more detail in Chapter 5. The scope and nature of the scenarios which have been modelled are described in Appendix B .

Section 4 Assessment of sustainability

This section sets out:

- the current limitations and challenges to the Trust's sustainability due to small size
- the impact on delivering the requirements of the system plan
- the benefits of change
- limitations of shared services as a solution

4.1 Introduction

The current limitations and challenges to our sustainability – including achieving efficiency, ability to invest, workforce gaps and inadequate infrastructure - are set out below, and the benefits from potential increase in critical mass. These form the drivers for change.

4.2 Delivering Efficiencies

4.2.1 Our current scale of operations does not allow significant scale efficiencies to be delivered year on year, and in turn does not support investment in new service models and technologies. We have already achieved significant cost improvement plans over a number of years but recognise that a significant proportion of these have been non recurrent which impacts on the Trust's underlying position and reduces scope for further efficiencies in future years.

4.2.2 The current profile for the level of efficiency required for the Trust in 16/17 is £4.5m, including £864k being delivered from the full year effects of schemes implemented in 2015/16. Whilst there is a national efficiency requirement on all providers, this is driven higher for the Trust by the following factors;

- Brought- forward efficiency targets from 15/16 met only non-recurrently
- Overheads to be covered due to loss of income and services in15/16
- Internal investment required in the EPR due to no external funding being sourced, and no reserve built up in previous years to support it.

4.2.3 The majority of our services are subject to block contract and the prices do not reflect the cost of delivery. Whilst in previous years, the block contract has provided some security for all parties it is increasingly evident that PbR or tariff type payments will become more the norm. Whilst this may present an opportunity for the Trust to gain full recognition for the demand driven activity for community teams etc, it may also introduce a threat as commissioners benchmark costs for services and seek to reduce the price they pay. To appropriately respond to this agenda and ensure the right level of investment remains with and increases in community services, the Trust needs to develop contracting skills in its corporate and operational teams that it currently does not have.

4.2.4 In the past 12 months the Trust has had some success in winning tenders for new services (eg Dudley School Nurses and the MSK Service for Telford). It is an aspiration of the Trust to continue to develop and expand high quality community services and also to

diversify its income portfolio away from the significant reliance on the two main CCG's in Shropshire, who still represent the lion's share of the Trust's income base at 76%. There are opportunities to develop other sources of income but this will require an increase in business development capacity. A shortfall in our business skills has delayed and made more difficult the move to 'business as usual' where we have won new tenders, such as for MSK and Integrated Community Services.

4.3 Overview: Infrastructure & Overheads

4.3.1 The Trust has worked hard to deliver a sustainable position from which its services are delivered and the Trust has developed a good track record in its management of its core services and finances. This is evidenced in section 5 on finance, and for example, in the steady year-on-year improvement in the Trust's staff engagement and staff survey results. There have been successes in service developments and new contracts won. The team in our Trust, in its widest sense, is incredibly focussed, dedicated and hardworking on behalf of the services we provide. However we have now reached a tipping point where further investment is required in order to manage beyond core 'business as usual'. This impacts on what the organisation can deliver on a day to day basis, and is further described under individual headings below.

4.3.2 The development agenda outlined in Section 3 above is substantial and the contribution our services need to make to the STP needs to be a significant step up from the status quo. Having the infrastructure to maintain our services in a position of strength is vital for the health economy.

4.3.3 However, it is very difficult to support an investment in overheads at a time where efficiencies are at their highest percentage (see section 5) coupled with a requirement to stay within a control total limited by a set of block contract arrangements.

4.3.4 The current level of overheads apportioned to our service costs is running at 13%. This has a challenging impact when costing tenders and bids for new or expanded services and sometimes contributes to pricing the Trust's services out of the market. There is only so much the Trust can do to ensure the overhead costs are as keen as possible but beyond this the scale of the organisation really matters in terms of efficiency and relative cost. For every £10m reduction in the Trust's services, the level of overhead increases by 2% assuming no infrastructure can be released.

4.3.5 We have recently reviewed what are traditionally known as 'back office' functions. The main functions are touched on below and analysed in terms of the particular critical issues within each function. All of these functions are required for an organisation, whether it has a turnover of £50m or £500m. In many cases our "teams" consist in fact of one person and there is no resilience to these arrangements. In some teams numbers appear large because of the need to cover statutory functions (eg finance) or very small and do not effectively cope with emerging additional requirements (eg informatics, clinical audit).

Corporate/Support Services

- Finance
- Workforce/HR
- Organisational Development
- IT and Informatics
- Hotel Services
- Administration Support
- Business Development
- Performance
- Complaints and PALS
- Emergency Planning
- Patient Experience and Involvement
- Assurance (non-clinical)
- Quality
- Communications and Marketing

Benefit of Change

4.3.6 In most cases the benefits derived from being able to operate from within a larger scale arrangement are clear. Independent shared service arrangements could be considered but would be complex and to some extent are self-defeating because they increase the time input required, for robust management and monitoring. It should also be noted that the scale desired at a national level for back office amalgamation is much more significant than two organisations working together in partnership so the Board should note this agenda will eventually have a scale beyond that which we might consider in terms of our current organisational future. For corporate functions any such partnerships should be seen as a first step with potential for more.

4.4 Transformation leadership capacity

4.4.1 Whilst we have some skilled individuals we do not possess the critical mass to deliver larger scale change in both breadth and depth. It has been hard as a small community organisation to attract clinicians in all the key areas, especially doctors, who are skilled at taking a strategic whole health economy view. For services to do more than simply survive, and instead meet the increasing demand for home based care we need a more robust infrastructure than is currently affordable. For example, our business development function is a team of two, with a minimal PMO function; transformation relies heavily on a small cadre of operational managers responsible for all the day to day business and performance of their services, as well as the substantial development agenda. We are reactive and operational rather than having capacity to set the direction in a really forward thinking way. We do not have the resource to develop work which will attract attention and professional credibility at a system/regional and national level, and in turn attract more input.

Benefit of Change

4.4.2 If we had a greater and broader knowledge base we could be much more ambitious and develop home based care with more analytical rigour and service resilience. We would have the 'engine room' capacity to work with the multiple community partners that

the STP requires, and to follow up to ensure delivery. We would be able to contemplate being a vanguard or similar.

4.5 Quality and Clinical Sustainability

4.5.1 Whilst our CQC inspection report does not show any areas of significant concern it does demonstrate that we do not have the capacity to provide consistently good assurance. For example it shows that our ability to take part actively in national/local clinical audits, and change our way of doing things as a result of this intelligence, are severely limited. It shows that our capacity for producing performance level information at team level to help drive improvement is similarly limited.

4.5.2 The most senior nursing roles in our Community hospital inpatient areas and Minor Injury Units are relatively junior (Band 7) and we lack more senior nurse specialist roles in these services. Such roles are not financially sustainable at our current scale, but the absence of them is a significant gap, as they bring the advanced skills to oversee independently the management of complex conditions. This is an investment need which we are unlikely to be able to meet in our current form, and is a real challenge to clinical sustainability.

4.5.3 Our ambition to be consistently good across all our services will be harder to achieve without further investment in the capacity of the quality team. We run the risk of 'burn out' as our relatively small team is tasked with supporting the organisation from a wide-ranging quality and safety perspective.

Benefit of Change

4.5.4 A larger quality infrastructure would enable us to substantially improve our ability to develop and sustain high quality care consistently across the full range of services that we provide. The STP argues that there has to be a safe transition from the current care model which is heavily dependent on beds to reliable community alternatives. Our capacity to deliver consistent quality in all areas simultaneously, including both new and existing services, is therefore key.

4.6 Workforce

4.6.1 The Board is aware of challenging workforce issues we face, as a consequence in part of our small size together with distance from larger urban centres. We are not always able to recruit and retain the right people to deliver our services and this has resulted in high use of agency staff in some areas, and potentially less continuity of care. In services such as CAMHS, providers are in competition to attract recruits against the background of national workforce shortages, and as a smaller Trust with a smaller workforce, we are not consistently able to offer working patterns which are as attractive as those at a larger provider. For example, a larger service may be able to offer a less onerous rota to cover weekends and out of hours services. Of a total 6.83 consultant posts in CAMHS in July 2016, 3.83 were not substantively filled, and this is a long standing position (in fact an improvement on the past), although there are attempts in progress to address it through a new workforce model.

4.6.2 Our clinical workforce has well-established skills in community care, and are keen advocates for 'home first' and maintaining people's independence at home, in the community. However, they do not possess the full range of highly specialist skills to meet the needs of a broader range of patients with higher levels of acuity or more complex

conditions – as anticipated in the STP and new care models. This requires investment we will struggle to provide. The clinical sustainability of our inpatient services and minor injury units is especially challenged on this basis – see 4.5.2 above. Some of our more rural areas with long travel times to the next urban area struggle to recruit, despite efforts to improve the attractiveness of our employment offer with rotations etc to counteract the view that employment opportunities in a small trust are more limited and less career enhancing.

4.6.3 The Board has very recently agreed our new Workforce and People strategy, setting out an ambitious programme of change, including new roles, new ways of working and the need for an increasingly joined up approach with partners in workforce planning - for example with complementary or more generic roles. As with other infrastructure issues described, the Trust's capacity to deliver on this agenda is limited.

Benefits of Change

4.6.4 If our services were part of a larger entity, especially if that was with commonalty of strategic principle (eg in community) there would be potential to integrate teams for more person centred care, a stronger critical mass for developing clinical skills and quality benefits, and a better chance to address workforce shortages.

4.7 IMT

4.7.1 IM&T is an area which the Trust is currently investing a significant amount of capital and revenue in the form of an electronic patient record system (EPR). In the short term, the investment is set aside to implement but there are ongoing requirements to support this post- implementation which will put pressure on the efficiency agenda for the Trust. The aspects of this can be broken down into two main areas; IT (supporting the technologies deployed) and Information Services (System Design and Business Intelligence

4.7.2 Information Technology: Until 2016/17 the Information Technology team provided a shared service help desk for the Trust and Shropshire County and Telford and Wrekin CCGs. This service was transferred to the CSU on the 1st April 2016 and immediately the Trust was left with stranded overheads for circa £100,000 and a team with less opportunity to gain efficiencies from scale in the way that they had in the past. Now the team are at the minimum required to support business as usual so there are no opportunities to downsize further. The main challenge they now face on the horizon is to find a way to support the mobile technology deployment that is part of the roll out of the EPR system from within the existing resources.

Benefits of Change

4.7.3 It is clear that combining this function with a wider similar service to support team resilience and also to ensure robust out of hours on call arrangements will enable our clinicians to operate to the optimum with the technology we are investing in to support them in the community. This can be done through independent exploration of a shared service that could be suitable or be a by-product of a more meaningful partnership in some form with an organisation as a whole.

4.7.4 Informatics: The Informatics team employed by the Trust work currently with fragmented and old systems which makes reporting throughout the organisation at all

levels difficult. It is an uphill struggle and one which has inbuilt inefficiencies. To some extent these can be reduced in the short term by looking at processes but this will only go so far. The EPR system will be a step change improvement, which is good news. However, the EPR system also has some maintenance requirements which will fall to the Informatics Team which will be new, ongoing and above current business. The current estimates are that the Trust will need to put £150,000 investment into this team to properly support it on an ongoing basis.

In addition, whilst we have the basic ingredients to develop business intelligence with tools such as a data warehouse, we do not have the development capacity in the current team to address the shortfalls we have in reporting and we are not currently able to release time to free up the analytical skills within the team to support operational or corporate services in a way which enables us to use evidence where it may best serve overall development of new services.

Benefits of Change

4.7.5 The scale required as identified above is already above that which is affordable in the organisation. This will put pressure on the Trust's overall efficiency programme in future years to generate the resources internally to afford this. This could be avoided if duplication could be removed through working with a partner on a single data warehouse and sharing the resource for development and analysis.

4.8 Estates

4.8.1 A significant element of our asset base is our estate, which supports day to day operational and administrative functions. As such, a large element of ongoing capital investment is required to address estate maintenance and statutory and mandatory obligations.

4.8.2 Our services currently operate from multiple locations across the county which presents both operational and financial challenges, with 80% of the Trust's estate being leased. The landlord for a number of key Trust sites is NHS Property Services, and we are currently vulnerable to being treated as a middle/low order priority. New cost/charging mechanisms are also proposed which will increase the cost of service overheads significantly. Equally, some of the care we provide is delivered in the wrong setting or in facilities that no longer support optimal care delivery and outcomes.

4.8.3 Ensuring that our facilities are fit for purpose and safe, and can deliver what is required for our service ambitions and those of the STP, has substantial financial implications as we replace existing assets and work to address backlog maintenance. Our current known backlog maintenance requirement has been costed at c. £2m, however in the absence of a robust review of our estate condition against the NHS Premises Assurance Model, this figure is likely to be significantly understated. We do not currently have the capacity and estates service infrastructure to undertake a self-assessment of our Estate and Facilities service to provide the evidence and support the development of a robust action plan.

4.8.4 We have highlighted our intention to develop a sustainable estates strategy to support new ways of working and the new models of care we are developing. The Shropshire Estates Partnership provides us with a greater opportunity to look at how we can develop new integrated service delivery models with a wider range of public sector

partners and deliver new public sector hubs that will better meet the needs of local residents. To support our new model of care and service delivery ambitions effectively from an estates perspective we need to review how we organise and rationalize our estate. This would be done to better effect at a greater scale with key partners of the SEP.

4.8.5 The requirement to invest to meet the backlog maintenance bill, and the deliverables from the emerging estates strategy, will be challenging for the Trust to meet as a stand-alone organisation against the future financial context as described in Section 5 (Financial Strategy and Evaluation).

4.8.6 The Trust has recently refreshed and strengthened its longstanding SLA partnership with South Staffordshire and Shropshire for estates services, to improve capacity in this area, but the Trust's estate development skills and capacity to support the substantial transformational agenda in estates will remain limited if the organisation continues to stand alone.

Benefits of Change

4.8.7 Increasing critical mass would offer beneficial solutions to some of these challenges including shared accommodation allowing rationalisation of estate to reduce overheads, and site integration to benefit patients/service users. There is also potential for increased investment and additional professional estate skills for development.

4.9 Options for Infrastructure Change

4.9.1 Many of the issues above are about the small scale of Trust infrastructure, and it is clear that the Trust needs to address this. IT currently invests circa £10m in its overheads (including estates, premises and governance) More pressure is being brought to bear to take further costs out of the back office in order to support the NHS getting back into balance. At the time of writing the impact of the Carter Review on procurement and NHS Improvement emphasis on shared services increase the profile of this topic.

4.9.2 In order to address this issue the Trust has options ie:

(a) Continue with the existing arrangements but inevitably be forced to reduce the level of internally invested corporate governance. As demonstrated above, the scale of investment already required exceeds that which is in place, and there is no margin to manage the development of services at scale.

(b) Consider a broader range of shared service arrangements which would be managed under a series of Service Level Agreements. This would allow the Trust to maintain a similar level of expenditure on infrastructure, but delivered through a possible further 5-10 service level agreements. The Trust already holds a complex portfolio of service level agreement arrangements. These are legacy arrangements that have been in place to support clinical services through various organisational forms. The Trust cannot avoid such arrangements, but needs to streamline them to avoid the self-defeating situation where they consume more management capacity than if these services were provided in house. This option would create additional burden on an existing set of arrangements which are not comprehensively well managed now.

(c) Gain the benefits derived from a corporate model that operates at a greater scale in order to gain synergies and resilience for the future. The ideal would be to operate corporate and clinical governance at a larger scale within a single management structure. This would provide economies of scale which reduce the impact of efficiencies on clinical services, and avoid the inefficiency of managing a large portfolio of service level agreements.

In this context too, the Board is asked to refer back to paragraph 3.2.7 and the particular challenges faced by the partners in our STP footprint, which raise risks about how effective local collaboration may be, compared to a single governance structure.

Section 5 Financial Strategy & Evaluation

This section sets out:

- the Trust's past, current and forecast financial performance
- outcomes from long term financial modelling covering 'upside' and downside scenarios
- draws conclusions about vulnerabilities in the Trust's future position

5.1 Introduction

As part of an assessment with regard to sustainability it is important to consider the past, current and potential future of the organisation in terms of financial performance. The development of a Long Term Financial Model has been undertaken by the Trust in order to support longer term financial planning. The output of this modelling has been included in this chapter as it needs to be considered in light of what it may say about the Trust's sustainability in the future.

This section of the report therefore presents:

- the Trust's historic financial performance for 2013/14 to 2015/16
- the planned financial performance for the current outturn year, 2016/17
- and forecast financial performance for 2017/18 to 2021/22 under a number of different scenarios.

5.2 Historic Financial Performance

This section shows the financial performance of the Trust over the last three years[1]. It demonstrates consistent delivery of the financial requirements of the Trust's regulators and to some extent this is a strong track record in comparison to the overall financial performance of the NHS over this time. It has to be noted however, that the underlying performance of the Trust has not been fully addressed on a recurrent basis, as further comments in the report with regard to technical financing to underpin surpluses and non-recurrent achievement of CIP's leave the Trust's overall financial health weaker than the headlines may indicate.

[1] This information reconciles to the Trust's audited accounts

5.2.1 Income & Expenditure

The Income & Expenditure position is shown in the table below.

	Actual 2013/14 £m	Actual 2014/15 £m	Actual 2015/16 £m
Income			
Protected/mandatory clinical income	72.1	71.8	74.5
Non-protected/non-mandatory clinical income	0.1	0.1	0.1
Other operating income	4.0	3.5	4.4
Total income	76.2	75.4	79.0
Expenses			
Employee benefit expenses	-53.5	-53.7	-55.9
Drug expenses	-1.9	-1.8	-1.5
Clinical supplies & services expenses	-6.9	-7.1	-7.9
Shared services expenses	-0.4	-0.4	-0.4
Staff travel expenses	-1.9	-1.6	-1.5
Other expenses	-10.1	-8.7	-8.7
Total operating expenses	-74.7	-73.3	-75.9
Operating surplus/(deficit)	1.5	2.1	3.1
Impairment losses	-0.2		
Depreciation	-1.2	-1.1	-1.1
PDC dividend		-0.5	-0.5
Retained surplus/(deficit)	**0.1**	**0.5**	**1.5**
Retained surplus as a % of income	**0.1%**	**0.7%**	**1.9%**

Table 1: Historical Income & Expenditure

The Trust has delivered a surplus each year in line with the targets agreed with the Trust Development Authority (TDA).

Items of note within this period include:

- A reduction of £1.1m in income and associated costs in 2014/15 through Health Improvement and Help to Quit services being decommissioned.
- An increase of £1.5m in income and associated costs in 2015/16 from the new Dudley School Nursing contract
- An increase of £0.9m in income in 2015/16 relating to an agreed capital to revenue transfer; this resulted in an equivalent increase in the Trust's surplus in this year.

5.2.2 Statement of Financial Position

The Statement of Financial Position is shown in the table below.

	Actual 2013/14 £m	Actual 2014/15 £m	Actual 2015/16 £m
Non-current assets			
Property, plant & equipment	19.3	19.7	21.8
Trade & other receivables	0.1	0.1	0.1
Total non-current assets	19.4	19.8	21.9
Current assets			
Inventories	0.5	0.5	0.4
Receivables	3.2	2.9	3.9
Cash	5.7	5.8	5.7
Total current assets	9.4	9.2	10.0
Current liabilities			
Payables	-6.8	-6.8	-7.2
Provisions	-0.5	0.0	-0.1
Total current liabilities	-7.3	-6.8	-7.3
Total assets employed	21.5	22.2	24.6
Taxpayers equity			
Retained earnings	16.8	17.1	18.5
Public dividend capital	1.5	1.5	0.6
Revaluation reserve	3.2	3.6	5.5
Total taxpayers equity	21.5	22.2	24.6

Table 2: Historical Statement of Financial Position

The Trust has maintained a strong cash position due to the surpluses achieved each year.

The most notable change during the period relates to an increase of £1.9m in property, plant & equipment in 2015/16 due to the annual revaluation of assets.

5.2.3 Capital Expenditure

Capital expenditure is shown in the table below.

	Actual 2013/14 £m	Actual 2014/15 £m	Actual 2015/16 £m
Maintenance	-0.4	-0.8	-0.7
Non-maintenance			
IM&T wi-fi roll-out		-0.1	

IM&T EPR system			-0.4
	0.0	-0.1	-0.4
Donated assets	-0.1	-0.1	-0.2
Total capital expenditure	**-0.5**	**-1.0**	**-1.3**

Table 3: Historical Capital Expenditure

Capital expenditure is broadly in line with annual depreciation resulting in minimal change to asset values. In 2015/16 the Trust's investment in the Electronic Patient Record system (EPR) began and will continue over a number of years.

5.2.4 Cash Flow

Cash flow is shown in the table below.

	Actual 2013/14 £m	Actual 2014/15 £m	Actual 2015/16 £m
Surplus/(deficit) from operations	1.0	1.9	3.0
Movements in working capital *(inventories/receivables/payables/provisions)*	-1.1	-0.5	-0.5
Net cash inflow/(outflow) from operating activities	-0.1	1.4	2.5
Purchases of property, plant & equipment	-0.5	-0.9	-1.2
Cash flow before financing	-0.6	0.5	1.3
Public dividend capital received/(repaid)	0.5		-0.9
Dividends paid		-0.4	-0.5
Net cash inflow/(outflow)	**-0.1**	**0.1**	**-0.1**
Opening cash balance	5.8	5.7	5.8
Net cash inflow/(outflow)	-0.1	0.1	-0.1
Closing cash balance	5.7	5.8	5.7

Table 4: Historical Cash Flow

The Trust has maintained a healthy cash balance over the entire period, roughly equivalent to 28 days of operating expenses.

5.2.5 Risk Ratings

During 2013/14 and 2014/15 all Trusts were monitored against a Continuity of Service Risk Rating (CSRR) which was based on liquidity. From 2015/16 this measure was replaced by the Financial Sustainability Risk Rating (FSRR) which also focussed on delivery of agreed income and expenditure plans.

Annual risk ratings achieved are shown in the table below.

	Actual 2013/14 Rating	Actual 2014/15 Rating	Actual 2015/16 Rating
Continuity of Service Risk Rating (CSRR)	4	4	N/A
Financial Sustainability Risk Rating (FSRR)	N/A	N/A	4

Table 5: Historical Risk Ratings

A rating of 4 was achieved for each year which is the highest possible rating. This is due to the Trust's strong cash position and the Income & Expenditure surpluses achieved.

5.2.6 Cost Improvement Programme (CIP)

The Trust has a strong record of CIP delivery, albeit delivering elements of the programme non recurrently each year. For the three financial years, between 1 April 2013 and 31 March 2016, the Trust has delivered £10.3m against its planned CIP of £9.9m. It is this track record due to strong financial control and management processes that has contributed to the Trust's financial risk rating of 4.

It is notable that a significant proportion of the 2015/16 CIP target (62%) was delivered non-recurrently and was carried forward to 2016/17, increasing the risk associated with an already challenging efficiency programme.

CIP achievement is shown in the table below.

	Actual 2013/14 £m	Actual 2014/15 £m	Actual 2015/16 £m
CIP Plan	2.5	3.5	3.9
CIP Achieved			
Recurring	0.8	2.1	1.5
Non-recurring	1.7	1.8	2.4

Total CIP achieved	**2.5**	**3.9**	**3.9**
Over/(under) achievement	0.0	0.4	0.0
CIP achieved as a % of costs	3.3%	5.0%	4.9%

Table 6: Historical CIP

All CIP schemes undergo a formal Quality Equality Impact Assessment to ensure there are no adverse effects on safety and patient experience. Where risks exist, the scheme has only been allowed to proceed if sufficient mitigating actions have been put in place. Further reviews are undertaken through the various internal Committees and performance forums to provide additional assurance.

5.3 Current Year Forecast Financial Performance (2016/17)

This section shows the forecast financial performance of the Trust for the financial current year.

5.3.1 Income & Expenditure

The forecast Income & Expenditure position is shown in the table below.

	Forecast 2016/17 £m
Income	
Protected/mandatory clinical income	74.7
Non-protected/non-mandatory clinical inc	0.1
Other operating income	3.3
Total income	78.1
Expenses	
Employee benefit expenses	-53.3
Drug expenses	-1.1
Clinical supplies & services expenses	-8.7
Shared services expenses	-0.4
Staff travel expenses	-1.4
Other expenses	-10.5
Total operating expenses	-75.4
Operating surplus/(deficit)	2.7
Depreciation	-1.3
PDC dividend	-0.6
Retained surplus/(deficit)	**0.8**
Retained surplus as a % of	**1.0%**

income	

Table 7: Current Year Forecast Income & Expenditure

The Trust's projected performance forecasts delivery of a retained surplus of £0.8m which equates to a 1% surplus based on a turnover of £78.1m. It should be noted that this surplus position is inclusive of £0.7m Sustainability and Transformation Funding, and as such £0.1m is delivered by the Trust's financial performance. Access to the Sustainability and Transformation Fund remains subject to delivery of financial performance and access standards throughout the year. The most significant risk to delivery of planned financial performance in 2016/17 remains the delivery of the CIP which is currently rated as high risk in terms of both value and delivery of schemes.

5.3.2 Statement of Financial Position

The forecast Statement of Financial Position is shown in the table below.

	Forecast 2016/17 £m
Non-current assets	
Property, plant & equipme	22.9
Trade & other receivables	0.1
Total non-current assets	23.0
Current assets	
Inventories	0.4
Receivables	3.2
Cash	5.1
Total current assets	8.7
Current liabilities	
Payables	-6.3
Provisions	0.0
Total current liabilities	-6.3
Total assets employed	25.4
Taxpayers equity	
Retained earnings	19.3
Public dividend capital	0.6
Revaluation reserve	5.5
Total taxpayers equity	25.4

Table 8: Current Year Forecast Statement of Financial Position

As described in paragraph 3.3 the Trust is planning for a significant level of capital expenditure in 2016/17 which therefore results in a reduced forecast cash balance at the year-end.

5.3.3 Capital Expenditure

Forecast capital expenditure is shown in the table below.

	Forecast 2016/17 £m
Maintenance	-1.1
Non-maintenance	
IM&T EPR system	-0.8
IM&T mobile working	-0.4
	-1.2
Donated assets	-0.1
Total capital expenditure	**-2.4**

Table 9: Current Year Forecast Capital Expenditure

Planned capital expenditure for 2016/17 is higher than in previous years following the Trust's investment in its new EPR system and associated mobile working. Investment in the EPR will generate both efficiencies and service transformation, in support of delivering the Trust's short and long term objectives and Clinical Strategy.

The capital programme is funded entirely through internally generated funds, due to cash balances being generated in previous years.

5.3.4 Cash Flow

Forecast cash flow is shown in the table below.

	Forecast 2016/17 £m
Surplus/(deficit) from operations	2.6
Movements in working capital *(inventories/receivables/payables/provisions)*	-0.2
Net cash inflow/(outflow) from operating activities	2.4
Purchases of property, plant & equipment	-2.4
Cash flow before financing	0.0

Dividends paid	-0.6
Net cash inflow/(outflow)	**-0.6**
Opening cash balance	5.7
Net cash inflow/(outflow)	-0.6
Closing cash balance	5.1

Table 10: Current Year Forecast Cash Flow

As stated above, the main movement in cash is as a result of the additional planned capital expenditure. Despite this investment, the cash balance at the end of the period remains strong at £5.1m.

5.3.5 Risk Ratings

The forecast risk rating for 2016/17 is again a rating of 4, the highest possible rating, due to the healthy cash position and the Income & Expenditure surplus.

5.3.6 Cost Improvement Programme

Forecast CIP achievement is shown in the table below.

	Forecast 2016/17 £m
CIP Plan	3.7
CIP plan as a % of costs	4.7%

Table 11: Current Year Forecast CIP

The under achievement on a recurrent basis in 2015/16, along with the additional CIP requirement as a result of the investment in the Trust's EPR system has subsequently led to another challenging year in 2016/17. It should be recognised that the delivery on a recurrent basis remains demanding and as such is reflected as high risk in the monitoring return submissions to NHSI.

5.4 Long Term Financial Model

The development of a Long Term Financial Model has been undertaken by the Trust in order to support longer term financial planning. The outputs of this modelling has been included in this chapter as it needs to be considered in light of what it may say about the Trust's sustainability in the future. Modelling the future is not an exact science, but the information provided below broadly describes potential scenarios, some more familiar than others. This information supports a longer term view of the Trust's likely financial performance but also, by paying attention to the assumptions built in to the models,

conclusions can be drawn as to how fit for purpose the organisation is in terms of scale to take on change.

5.4.1 Approach & Data Sources

In order to assess the financial viability of the Trust, NHSI's approach to business and financial planning has been applied, using the Long Term Financial Model (LTFM). The model takes the current Income & Expenditure position, the Statement of Financial Position and the Cash Flow statement, and projects them forward for the next 5 years using a number of assumptions.

The historic figures are taken from the audited accounts.

Several versions of the model have been produced:

- A base case which projects the current position forward and is considered the Trust's most likely scenario over this period.
- Three downside models – each reflecting possible risks when delivering the financial plan
- Three service developments – reflecting possible significant developments for the Trust

5.4.2 Key Assumptions

The base case financial model is based on the following assumptions:

- Inflation and efficiency in line with the planning assumptions included within the recently submitted Sustainability and Transformation Plan (STP).

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Income					
Tariff inflator	2.3%	2.0%	2.0%	2.9%	2.9%
Tariff efficiency factor	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
Net income inflation	0.3%	0.0%	0.0%	0.9%	0.9%
Costs					
Employee benefits	2.0%	1.6%	1.6%	2.9%	2.9%
Drugs	4.6%	3.6%	4.1%	4.1%	4.1%
Other non-pay	1.8%	2.1%	1.9%	2.0%	2.0%
Capital	3.2%	3.2%	3.1%	3.1%	3.1%

Table 12: Inflation & Efficiency Assumptions

- Delivery of an income and expenditure surplus of £0.5m in 2017/18 (increased from an internally generated surplus of £0.1m in 2016/17) and £0.8m (1% of turnover) from 2018/19 onwards.
- Full delivery of all CIPs from 2016/17 on a recurring basis.

- No activity changes in respect of population growth or changes in demand have been included.

5.5 Future Years Forecast Financial Performance

This section shows the forecast financial performance of the Trust for the next 5 years.

5.5.1 Income & Expenditure

The forecast Income & Expenditure position is shown in the table below.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Income					
Protected/mandatory clinical income	74.9	74.9	74.9	75.6	76.3
Non-protected/non-mandatory clinical income	0.1	0.1	0.1	0.1	0.1
Other operating income	2.6	2.6	2.6	2.6	2.6
Total income	77.6	77.6	77.6	78.3	79.0
Expenses					
Employee benefit expenses	-52.9	-53.0	-53.0	-53.6	-54.3
Drug expenses	-1.1	-1.2	-1.2	-1.3	-1.3
Clinical supplies & services expenses	-8.8	-9.0	-9.2	-9.4	-9.6
Shared services expenses	-0.4	-0.4	-0.4	-0.4	-0.4
Staff travel expenses	-1.5	-1.5	-1.4	-1.5	-1.5
Other expenses	-10.2	-9.7	-9.6	-9.4	-9.2
Total operating expenses	-74.9	-74.8	-74.8	-75.6	-76.3
Operating surplus/(deficit)	2.7	2.8	2.8	2.7	2.7
Depreciation	-1.6	-1.4	-1.4	-1.3	-1.3
PDC dividend	-0.6	-0.6	-0.6	-0.6	-0.6
Retained surplus/(deficit)	**0.5**	**0.8**	**0.8**	**0.8**	**0.8**
Retained surplus as a % of income	**0.6%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**

Table 13: Future Years Forecast Income & Expenditure

This forecast shows an increase in turnover and expenditure in line with the inflation assumptions detailed previously. In addition, it demonstrates an increase in the retained surplus over the five year period to one which equates to 1% of the Trust's turnover; in line with standard NHS business rules. This increase in retained surplus is achieved through increasing the Trust's planned efficiency programme over this planning period.

It should be noted that the reduction in the retained surplus from the 2016/17 position of £0.8m to 2017/18 of £0.5m is a result of two factors. Firstly, the assumption that the Sustainability and Transformation funding received in 2016/17 is non-recurrent, and secondly, that the Trust progress towards the 1% surplus in line with standard business rules is achieved incrementally during 2017/18 and 2018/19.

5.5.2 Statement of Financial Position

The forecast Statement of Financial Position is shown in the table below.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Non-current assets					
Property, plant & equipment	23.0	23.0	23.0	23.1	23.3
Trade & other receivables	0.1	0.1	0.1	0.1	0.1
Total non-current assets	23.1	23.1	23.1	23.2	23.4
Current assets					
Inventories	0.5	0.5	0.5	0.5	0.4
Receivables	3.3	3.2	3.1	3.2	3.3
Cash	5.3	6.1	7.1	7.7	8.3
Total current assets	9.1	9.8	10.7	11.4	12.0
Current liabilities					
Payables	-6.3	-6.2	-6.3	-6.3	-6.3
Total current liabilities	-6.3	-6.2	-6.3	-6.3	-6.3
Total assets employed	25.9	26.7	27.5	28.3	29.1
Taxpayers equity					
Retained earnings	19.8	20.6	21.4	22.2	23.0
Public dividend capital	0.6	0.6	0.6	0.6	0.6
Revaluation reserve	5.5	5.5	5.5	5.5	5.5
Total taxpayers equity	25.9	26.7	27.5	28.3	29.1

Table 14: Future Years Forecast Statement of Financial Position

Key changes within the Statement of Financial Position over this period are increases to Retained Earnings and Cash, both of which are the result of the year on year increasing Income & Expenditure surplus. Forecast property, plant & equipment and working balances (inventories, receivables and payables) show minimal movement.

5.5.3 Capital Expenditure

Forecast capital expenditure is shown in the table below.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Maintenance	-0.9	-1.2	-1.3	-1.3	-1.4
Non-maintenance					
IM&T EPR system	-0.2				
IM&T mobile working	-0.5				
	-0.7	0.0	0.0	0.0	0.0
Donated assets	-0.1	-0.1	-0.1	-0.1	-0.1
Total capital expenditure	**-1.7**	**-1.3**	**-1.4**	**-1.4**	**-1.5**

Table 15: Future Years Forecast Capital Expenditure

Forecast capital expenditure for 2017/18 is higher than in the later years as the Trust continues to invest in the new EPR system and associated mobile working, funded entirely through internally generated resources.

From 2018/19 onwards it is expected that capital expenditure in each year will broadly match depreciation resulting in little change to asset values.

5.5.4 Cash Flow

Forecast cash flow is shown in the table below.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Surplus/(deficit) from operations	2.5	2.7	2.8	2.6	2.6
Movements in working capital *(inventories/receivables/payables/provisions)*			0.1		
Net cash inflow/(outflow) from operating	2.5	2.7	2.9	2.6	2.6

activities					
Purchases of property, plant & equipment	-1.7	-1.3	-1.3	-1.4	-1.4
Cash flow before financing	0.8	1.4	1.6	1.2	1.2
Dividends paid	-0.6	-0.6	-0.6	-0.6	-0.6
Net cash inflow/(outflow)	**0.2**	**0.8**	**1.0**	**0.6**	**0.6**
Opening cash balance	5.1	5.3	6.1	7.1	7.7
Net cash inflow/(outflow)	0.2	0.8	1.0	0.6	0.6
Closing cash balance	5.3	6.1	7.1	7.7	8.3

Table 16: Future Years Forecast Cash Flow

As stated above, the main movement in cash is as a result of the year on year Income & Expenditure surplus. Under the base case scenario the Trust's cash balance is expected to be strong throughout the entire period and reach £8.3m at the end of the period.

5.5.5 Risk Ratings

Forecast risk ratings for the planning period are shown in the table below.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Financial Sustainability Risk Rating (FSRR)	4	4	4	4	4

Table 17: Future Years Forecast Risk Ratings

A FSRR of 4 is again forecast for the future years due to both the healthy cash position and the expected Income & Expenditure surplus.

It should be noted that proposals outlined in NHSI's Single Oversight Framework consultation document mean that the FSRR is likely to change in the near future and performance will be monitored against new finance and use of resources metrics. As details are not yet known the FSRR continues to be calculated.

5.5.6 Cost Improvement Programme

Forecast CIP achievement is shown in the table below.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
CIP Plan	1.8	1.0	1.2	1.2	1.3
CIP plan as a % of costs	2.4%	1.3%	1.6%	1.6%	1.7%

Table 18: Future Years Forecast CIP

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Loss of CQUIN income					
Income	77.2	77.2	77.2	77.9	78.6
Operating expenses	-74.9	-74.8	-74.8	-75.6	-76.3
Operating surplus/(deficit)	2.3	2.4	2.4	2.3	2.3
Non-operating expenses (depreciation/dividend)	-2.2	-2.0	-2.0	-1.9	-1.9
Retained surplus/(deficit)	**0.1**	**0.4**	**0.4**	**0.4**	**0.4**
Cash balance	**4.9**	**5.3**	**5.9**	**6.1**	**6.3**
Loss of service					
Income	71.6	71.6	71.7	72.3	72.9
Operating expenses	-70.2	-70.0	-70.0	-70.6	-71.1
Operating surplus/(deficit)	1.4	1.6	1.7	1.7	1.8
Non-operating expenses (depreciation/dividend)	-2.2	-2.0	-2.0	-1.9	-1.9
Retained surplus/(deficit)	**-0.8**	**-0.4**	**-0.3**	**-0.2**	**-0.1**
Cash balance	**4.1**	**3.8**	**3.6**	**3.2**	**2.9**
CIP non-delivery					
Income	77.6	77.6	77.6	78.3	79.0
Operating expenses	-75.4	-75.8	-76.4	-77.8	-79.2
Operating surplus/(deficit)	2.2	1.8	1.2	0.5	-0.2
Non-operating expenses (depreciation/dividend)	-2.2	-2.0	-2.0	-2.0	-2.0
Retained surplus/(deficit)	**0.0**	**-0.2**	**-0.8**	**-1.5**	**-2.2**

Cash balance	**4.9**	**4.7**	**4.1**	**2.5**	**0.1**

Table 18 details the Trust's CIP requirement based on the planning assumptions included within paragraph 4.2. It is notable that it is assumed that CIP delivery will be achieved in full and on a recurrent basis in every year from 2016/17 which remains a significant challenge. The anticipated CIP values are lower than those targeted by the Trust previously as they assume no additional local investment, over and above the EPR which is already committed, and are based purely on national planning assumptions.

5.6 Downside Analysis

The Trust has modelled three downside scenarios to understand their impact upon the base case. These are:

- CQUIN income: £0.4m non-achievement and assumed costs continue;
- Loss of service: assumed unsuccessful tender of existing service with an income base of circa £6m – assumption that TUPE applies but direct costs associated with admin staff remain as well as no mitigation of continued overhead costs;
- CIP delivery: 52% recurrent delivery only in each financial year with mitigation from the delivery of non-recurrent CIP's during the period.

Whilst a full model can be made available the following tables highlight the impact of the various downside scenarios individually on the combined Income & Expenditure, as well as cash position.

Table 19: Individual Downside Analysis

The table below then presents the cumulative effect of all of the downside scenarios on the Income & Expenditure, cash flow and financial risk rating over the five years.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
<u>Effect on surplus/(deficit)</u>					
Base case surplus/(deficit)	0.5	0.8	0.8	0.8	0.8
Loss of CQUIN income	-0.4	-0.4	-0.4	-0.4	-0.4
Loss of service	-1.3	-1.2	-1.1	-1.0	-0.9
CIP non-delivery	-0.5	-1.0	-1.6	-2.3	-3.0
Consolidated downside surplus/(deficit)	**-1.7**	**-1.8**	**-2.3**	**-2.9**	**-3.5**
<u>Effect on cash balance</u>					
Base case cash balance	5.3	6.1	7.1	7.7	8.3
Loss of CQUIN income	-0.4	-0.8	-1.2	-1.6	-2.0
Loss of service	-1.2	-2.3	-3.5	-4.5	-5.4
CIP non-delivery	-0.4	-1.4	-3.0	-5.2	-8.2

Consolidated downside cash balance	**3.3**	**1.6**	**-0.6**	**-3.6**	**-7.3**
Effect on FSRR					
Base case FSRR	4	4	4	4	4
Loss of CQUIN income	3	3	3	3	4
Loss of service	2	3	3	2	3
CIP non-delivery	3	3	2	1	1
Consolidated downside FSRR	**1**	**1**	**1**	**1**	**1**

Table 20: Consolidated Downside Analysis

The total impact when all scenarios are assumed amounts to a £4.3m deterioration in the Income & Expenditure position by the end of the five year forward plan, taking the forecast net surplus of £0.8m to a forecast net deficit of £3.5m.

The cumulative impact is a reduction in cash of £15.6m by year 2021/22, from a base case forecast of £8.3m to a downside case forecast of £7.3m overdrawn. In terms of financial risk rating, the Trust's performance reduces to 1 predominately due to the deficit positon and overdrawn cash balance.

Under each of the downside scenarios no mitigations are modelled nor are any reductions in clinical or corporate staffing assumed.

5.7 Service Developments

The Trust has considered three service development scenarios (explained in more detail in Appendix B):as follows:

- **Activity shift from the acute setting**
- **Expanded shift of activity from the acute setting**
- **New business**

These are aligned to current thinking in regard to the STP but will require further definition as the STP work progresses and clarifies detail.

5.8 The **'activity shift from the acute setting'** scenario reflects the assumed transfer of activity from acute providers relating to A&E attendances and admission avoidance. This model assumes a 3% growth in MIU activity although no activity growth above the 2017/18 figure for admissions avoidance. Income assumptions are based on appropriate tariffs. Costs associated with an increase in indirect costs and corporate overhead have been excluded on the basis that no additional infrastructure support is considered necessary.

The table below shows the income and expenditure, as well as the cash position, as a result of this development.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Activity Shift from the Acute Setting					
Income	80.3	80.3	80.3	81.1	81.8
Operating expenses	-77.5	-77.4	-77.4	-78.3	-79.1
Operating surplus/(deficit)	2.8	2.9	2.9	2.8	2.7
Non-operating expenses (depreciation/dividend)	-2.2	-2.0	-2.0	-1.9	-1.9
Retained surplus/(deficit)	**0.6**	**0.9**	**0.9**	**0.9**	**0.8**
Cash balance	**5.5**	**6.4**	**7.4**	**8.1**	**8.7**

Table 21: Service Developments Analysis – Activity shift from the acute setting

Under this scenario the Trust's surplus is increased marginally compared to the base case (approximately £0.1m improvement per annum), together with a corresponding improvement in the cash balance over the period.

5.9 The **'expanded shift of activity from the acute setting'** scenario builds on from the previous development above and assumes an additional 2% growth in both Integrated Community Services and Interdisciplinary Teams activity for all years. This additional growth reflects a position where the impact of the proposed health improvement initiatives, identified in the Community Fit outputs, are not realised within the 5 year period thereby resulting in increased community activity.

It is assumed under this scenario that additional clinical and corporate management posts would be required. Infrastructure costs totalling £0.9m have therefore been assumed over the five year period to support this development which equates to circa 1.5 W.T.E. rising to 4.5 W.T.E. by 2021/22.

The following table highlights the income and expenditure, as well as the cash position, as a result of this scenario.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
Expanded Shift of Activity from the Acute Setting					
Income	80.6	80.8	81.1	82.2	83.2
Operating expenses	-77.8	-77.9	-78.4	-79.5	-80.6
Operating surplus/(deficit)	2.8	2.9	2.7	2.7	2.6
Non-operating expenses (depreciation/dividend)	-2.3	-2.1	-2.0	-2.0	-2.0
Retained surplus/(deficit)	**0.5**	**0.8**	**0.7**	**0.7**	**0.6**
Cash balance	**5.4**	**6.2**	**7.1**	**7.7**	**8.0**

Table 22: Service Developments Analysis – expanded shift of activity from the acute setting

This model shows a reduction in surplus of £0.2m by 2021/22 and a reduction in cash of £0.3m compared to the base case. This is due to the impact of the estimated national tariff efficiencies detailed within table 12 not being removed from the cost base relating to this scenario.

5.10 The **'New Business'** scenario models a successful bid for the provision of Health Visiting services to complement an existing service currently provided by the Trust.

This model includes additional indirect costs and back office infrastructure support of circa £0.8m per annum, which equates to approximately 5 W.T.E. across clinical and corporate management and administration functions.

The table below shows the income and expenditure, as well as the cash position, as a result of this development.

	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m
New Business					
Income	81.9	81.9	81.9	82.7	83.4
Operating expenses	-78.8	-78.6	-78.8	-79.7	-80.4
Operating surplus/(deficit)	3.1	3.3	3.1	3.0	3.0
Non-operating expenses (depreciation/dividend)	-2.2	-2.1	-2.0	-2.0	-2.0

Retained surplus/(deficit)	**0.9**	**1.2**	**1.1**	**1.0**	**1.0**
Cash balance	**5.8**	**7.0**	**8.3**	**9.2**	**10.0**

Table 23: Service Developments Analysis – New Business

When compared to the base case, this model shows an increase in the retained surplus in every year of the model which results in an overall increase in cash of £1.7m over the period.

5.11 Conclusions

The modelling above has been carried out to give the Board a line of sight over a range of things that 'could' happen in the future, with a principal focus on change in clinical services. The base case, downsides and generation of new business models are simpler to derive than the two upsides regarding moving services to be delivered more in the community (ie those aligned to current thinking with regard to the STP).

The two upside STP cases are very much a working model and the assumptions are based on plans that require much further definition than those available at the time of writing this report. However, they do have merit in providing a view about the potential financial impact of such a change. It should be seen as the start of the dialogue which will need to be continued within the governance of the STP to support the services we provide that need to support this change to the health care provision in Shropshire.

The range of impact on the Trust's I&E position as a result of this modelling based on Yr5 figures goes from the most material downside of a deficit of £2.2m (CIP downside) to an upside of a surplus of £1m from the most material upside (new business upside).

So, what does this tell us?

It tells us that the base case shows that 17/18 will be the most challenging in a steady state environment as CIP's remain high and there is a step change required to increase the Trust's surplus to 1% which can only be achieved incrementally over 2 years.

It tells us that steady state (base case) does demonstrate that using the headline assumptions used in the recent STP financial planning, the organisation can continue to deliver a reasonably consistent financial performance over a five year period. However, this should be considered alongside and a judgement made regarding;

- the likelihood that there will be no change, or challenge to 'business as usual' over the period, and
- the other models which consider change either in terms of risk or opportunity to understand how sensitive to change this position is.

It tells us that the Trust is more vulnerable to downside risk with stranded costs being the key factor.

It tells us that continued non- recurrent delivery of CIP over time has the most potential to deteriorate the financial position.

It tells us that if any or all of our downside risks occur, the Trust will continue to struggle to maintain a sustainable financial position and that any mitigation required will impair corporate infrastructure further.

It tells us that upside models do not materially impact on the Trust's overall turnover, nor the I&E position, although cash balances continue to grow.

It tells us that the scale of additional income in the upside models will not provide the opportunity to upscale governance much more than that currently in place. The most these models afford is 5 extra staff. We have previous modelling assumptions based on benchmarking that the Trust's income would have to reasonably increase by between £15-20m, or more, to be able to sustain a step change in corporate and clinical governance infrastructure.

It tells us that the Trust would not have the ability to support the requirement to pump prime any upside change. All upside models ignore the fact that pump priming may be required in terms of capital, revenue or management capacity. The STP Board will need to make decisions about moving activity into community settings but it can be concluded from this modelling that there is no capacity within the Trust's current financial infrastructure to able to do this independently.

Section 6 Strategic Risks

6.1 There are significant risks to consider if the Trust continues in its current form. We are very unlikely to be able to deliver effectively the community offer which is critical to the system-wide plan. Our small infrastructure and limited scope for investment make it very unlikely we can deliver the ambitious development programme, with consistently high quality community alternatives on a range of fronts, at the pace needed. Failure to deliver the developments, and attract the accompanying income, risks a further decline in our size. Although the Trust can continue to deliver a reasonable financial performance if 'steady state' applies, our financial vulnerability in any downside is clear. That brings the risk of adding to the local economy's existing financial problems. We may not be in immediate crisis, but there is a prospect of a gradual but 'vicious circle' of decline.

6.2 In considering whether to decide that the organisation is not sustainable, the Board will want to consider the risks in what may follow such a decision, and how those risks can be mitigated, in discussion with NHSI. A lengthy process to agree the future organisational form is very likely to compromise services because staff are unsettled by uncertainty and recruitment becomes more difficult. For example, a wide competitive procurement process may have the potential to prolong the process, and hold up the required pace for delivery of the system transformation change

Section 7 Conclusion

7.1 We are facing a range of substantial challenges to the clinical and financial sustainability of the organisation, which are likely to increase with time.

7.2 The Trust's clinical strategy sets out a set of transformational developments, which are vital to deliver the STP ie the 'community offer'.

7.3 In its current organisational form the Trust is not able to deliver the scale of transformation required at pace. As a result of the Trust's small size, there is inadequate infrastructure and ability to invest in order to bring about the change needed. Our quality and clinical systems are compromised by small size, and by limitations in workforce. This brings into serious doubt our ability to deliver in a timely way a set of consistently high quality community alternatives to acute care – a fundamental requirement for the Shropshire system and STP. Achieving year on year efficiencies from a small base adds to the challenge.

7.4 Our financial analysis and modelling show we can continue to deliver a reasonably consistent financial performance in 'steady state', but if all or any of the modelled downside risks occur, the Trust will struggle to maintain a sustainable financial position. That will worsen the financial position of the local health economy, which is already under pressure. The upside models do not have a material impact on turnover, and do not allow much increase in our governance/infrastructure. Notably, there is no capacity to 'pump prime' any shift in activity, to support early implementation of the community offer.

7.5 The Trust is not in an immediate sustainability 'crisis', but our assessment shows it is not clinically or financially sustainable to deliver what is vitally needed for the future. A prompt decision on sustainability will optimise the opportunity to make the changes needed to support the STP. It is also a huge and valuable opportunity to bring new strengths into our local economy.

Section 8 Recommendation

The Board is asked to:

- Decide whether members support their earlier conclusion that the Trust is not sustainable in its current organisational form, based on the further analysis provided in this report.

- If the Board decides it is not sustainable, agree that the information here be passed to NHSI for its consideration and approval, with a view to a Sustainability Board being formed, and next steps taken to identify the alternative organisational options.

APPENDIX A: TRUST CLINICAL STRATEGY 'PLAN ON A PAGE'

Plan on a Page

Shropshire Community Health NHS
NHS Trust

CLINICAL STRATEGY 2016-19

Excellent care at the heart of our community

Trust Goals

- To deliver high quality care
- To support people to live independently at home
- To deliver integrated care
- To deliver sustainable community services

Corporate Objectives

- Safe
- Caring
- Effective
- Responsive
- Well-Led
- Designed around the patient
- Increased range of services
- Making best use of technology
- Delivered in sustainable environments
- Financial Sustainability

Aim: We will work closely with our health and social care partners to give patients more control over their own care and find necessary treatments more readily available.

Meeting the needs of our population: Improvements in life expectancy, population growth, supporting frailer people, multiple long-term conditions, supporting independence

Transformation Priorities

- New models of care supporting a shift of services from acute to community setting
- New roles and skills to deliver new models of care
- Expansion of admission avoidance and care coordination services
- More efficient ways of working optimising effective and efficiency
- New technologies for health records and mobile working

Key Deliverables

- Development of Community Hubs
- Development of Urgent Care
- Teams Around the Practice and Integrated Community Services
- Development of the CAMHS Service

Community Based Models of Care

Designing Services With Patients and Carers

Integrated Care Through Partnerships

- System-Wide Transformation
- Shared Principles for Change
- Shared Concepts of Care
- Rural and Urban Solutions
- Improving the Clinical Quality of our Services
- Care Coordination
- Prevention and Well-being
- Getting it Right for Patients, Service Users and Carers

Improving Lives in Our Communities

APPENDIX B: FUTURE SERVICE DEVELOPMENTS REFLECTED IN THE LONG TERM FINANCIAL MODEL (SEE SECTION 5)

B1 Service Developments

The most significant development for community services is the impact of the local System Transformation Plan. Within our Long Term Financial Model we have described three service developments:

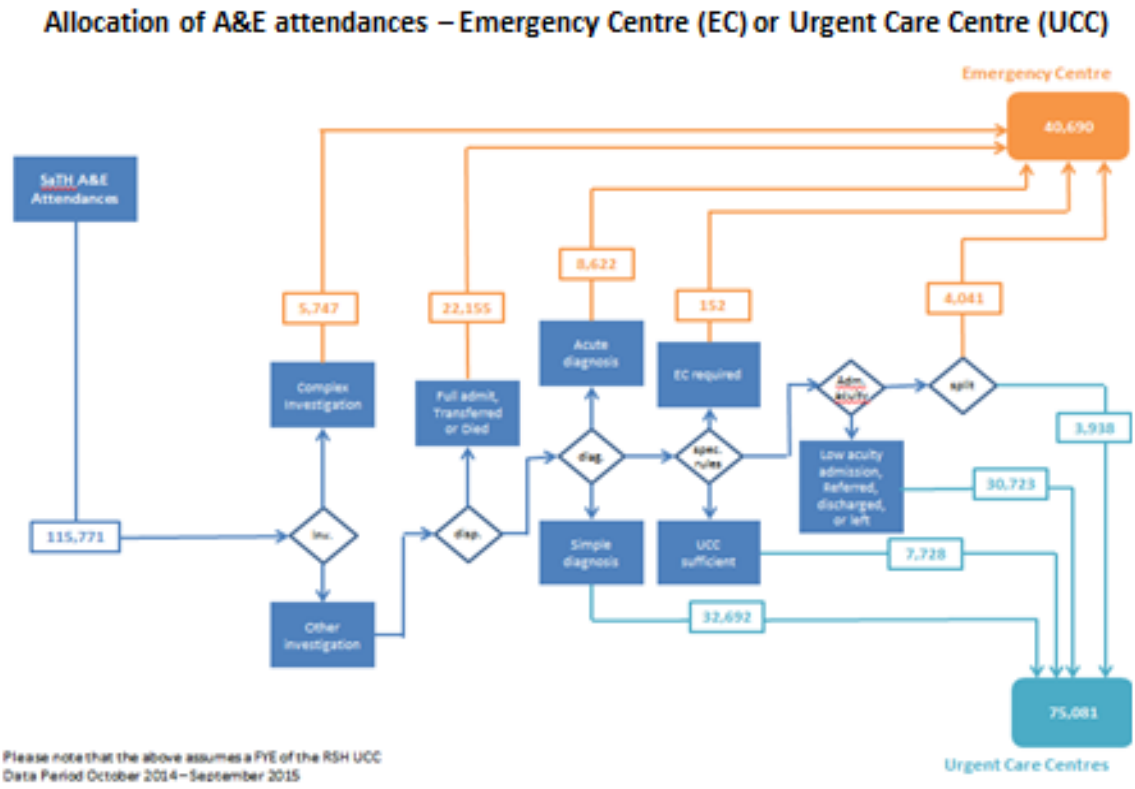
- Activity Shift from the Acute Setting
- Expanded Shift of Activity from the Acute Setting
- New Business

An overview of each of these developments, and the underlying assumptions, is described below and also discussed within Section 5 on Finance.

B2 Activity Shift from the Acute Setting

The Future Fit Programme identified activities that would result in a shift from the acute service, previously referred to as 'the Acute Left Shift'. In conjunction with the Shrewsbury and Telford Hospital we have identified a level of activity and have used this to inform our modelling.

B2.1 A&E Attendances



Source: information provided by SaTH based on the Future Fit algorithm.

The development of Rural Urgent Care Centres (RUCC) is required to enable a transfer of non-emergency attendances from the 2 Accident and Emergency Departments in Shrewsbury and Telford to the existing Minor Injuries Units in Oswestry, Ludlow, Bridgnorth and Whitchurch. A 3% year on year growth assumption has been applied in line with the Acute Strategic Outline Case assumptions.

To support the expansion of the Rural Urgent Care Centres we will need to extend the opening hours and the range of services within each of the units. Within our workforce model we have assumed the service will be delivered by enhanced practitioners, supported by nursing and healthcare assistant roles.

B2.2 Admissions Avoidance

The Future Fit Programme also identified a reduction in acute admissions through a range of demand management and avoidance schemes.

Activity Shift Projections

	Future Fit	Acute SOC
Outpatients avoidance	-27,236	-27,236
Outpatients interaction	-4,476	-4,476
Elective DC and IP avoidance	-1,865	-1,865
Elective DC and IP interaction	+492	+492
Non-elective avoidance	-2,706	-2,706
Non-elective ICS avoided	-953	-953
Non-elective LTC avoided	-1,165	-1,165
Non-elective interaction	-2,065	-2,065
Non-elective other avoided	-15	-15
A&E increase due to demography	+2,295	+3,476

Source: information provided by SaTH based on the Future Fit planning assumptions.

2

The following activity included within the above that directly relates to Community Teams was considered to be:

Non-elective avoidance	2,706
Non-elective ICS avoided	953
Non-elective LTC avoided	1,165
Non-elective other avoided	15
Total	4,839

To provide the level of out of hospital care required to achieve this level of avoided admissions this we need to expand our existing Integrated Community Service (ICS) Team.
The figures in the model reflect an absolute volume shift and therefore do not include any further growth after 2017/18.

B2.3 Service Delivery Assumptions

- Activity currently seen in A&E, which will transfer out to the MIUs, is based on activity data provided by SaTH's Sustainability Project Lead who is the lead for the acute SOC business case.
- MIUs / RUCCs will be open from 8am to 8pm – analysis of activity figures indicates the number of patients in the departments after that time is minimal.
- Diagnostics (Blood, Urine and Plain Film) will be available between 8am and 8pm.
- An arbitrary figure to reflect imaging costs has been included based on 10% of patients requiring a scan.
- Income has been based on a 'referral' tariff which has been derived from the existing contract and associated level of activity.
- ICS staffing assumes a split of 60% nursing and 40% therapy.

B3 Expanded Shift of Activity from the Acute Setting

In addition to the activities shown above we have modelled the impact of an ongoing increase in demand for these services associated with local demographics.

B3.1 Demographic Growth

The Community Fit Programme Phase 1 Outputs described three aspects of demographic growth that were modelled to predict the future use of health and care services;

- Population size: Will the population of Shropshire and Telford grow or shrink by 2019?
- Population Age Profile: Will there be more or fewer older people by 2019?
- Age Specific Health Status: Will older people be more of less healthy in 2019?

In addition the Phase 1 Outputs identified the impact on existing activity for two scenarios, an 'Optimistic Scenario' and a 'Pessimistic Scenario'. The optimistic scenario described a significant reduction in the demand for community services following the successful outcomes associated with future health improvement initiatives i.e. the impact of improving the health status of the local population.

Whilst in the longer term health and wellbeing initiatives will deliver improvements, at this point in time we feel that it is very unlikely that any planned interventions could reduce demand within the 5 year LTFM timeframe. For the purpose of this service development we have assumed a 2% growth, above the 2017/18 activity level, in the workload of the community nursing team (within the ICS) and the integrated multi-disciplinary teams (IDT).

B3.2 Service Delivery Assumptions

All of the assumptions stated in A3.1 above plus:

- Health improvement initiatives could reduce demand in the longer term however, will have a minimal impact during the 5 year period of the LTFM.
- The 2% growth included for the Integrated Community Service (ICS) activity and the existing IDT activity reflects change associated with population size, health status and ageing.
- Income figures for growth on existing services (that are commissioned on block) have been based on cost of additional investment plus 10% contribution.
- Staffing costs include £100k, rising to £300k, for additional investment in corporate resource to deliver and sustain service development.

B4 New Business

B4.1 Tender Opportunity

A tender is expected shortly for the provision of health visiting services in Dudley and this is an opportunity that we would wish to pursue.

We currently provide a School Nursing Service in Dudley. The Team is based within secondary schools across the Borough. The School Nursing Service takes over their care from the Health Visitor at school entry. Child health records are handed over to the school nursing service from the Health Visitor and remain with the School Nursing Service until young people leave school or sixth form.

The anticipated tender for health visiting services provides an ideal opportunity expand services out of county and would also complement the existing school nursing service that we provide.

At this time there is no indicative information available from Dudley so the income and costs etc. have been based on the indicated level of service required (Dudley JSNA). Full costs have been assumed on the basis that the premises and associated running costs will be charged by the relevant owner of the facilities.

B4.2 Service Delivery Assumptions

- Service provision is ongoing i.e. successful retention of the service if the service was re-tendered in the future.
- Zero growth in activity for all categories.
- TUPE arrangements are expected however pay costs have been modelled using SCHT data as no other information is available.

Shropshire Community Health NHS
NHS Trust

Appendix B

Dale
Bywater Executive Regional Managing Director Cardinal Square
10 Nottingham Road
Derby DE1 3QT
Tel: 0300 123 2540

13 October 2016

Mike Ridley
Chairman
Shropshire Community Trust
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL

Dear Mike

I am writing in response to your letter of 2 September 2016 setting out the Board's discussion on the future organisational sustainability of Shropshire Community Trust.

It was most helpful that you provided such a thorough sustainability review, along with the detail of the LTFM and minutes of the Board discussions. This comprehensive set of information has been used to inform NHSI's own analysis and discussions in relation to the matter.

It is clear that the Trust's guiding principle in this work has been to deliver an improved community offering for your local population which is aligned with the emerging STP priorities and plans. I would like to personally thank the Board for taking such an objective, balanced and pragmatic stance in its deliberations.

I can confirm that NHSI is in agreement with your assessment that the Trust in its current form lacks the critical mass and infrastructure to deliver the ambitious programme of change in Shropshire's community services in the coming years.

Our Gateway process requires the establishment of an NHSI-led Sustainability Board as a next step, this would include the Trust along with CCG and NHSE partners. Ahead of this process being initiated I would like to meet with Jan Ditheridge (Chief Executive) to discuss the way forward within the next few weeks.

My team will be in touch to arrange the session but if you have any specific queries in the meantime please contact either myself directly or Fran Steele (Delivery and Improvement Director).

Continued……..

I would like to thank you once again for the forward thinking stance the Board has taken in this matter, and I look forward to working with you to arrive at an organisational form which is best placed to deliver new and sustainable community models of care.

Yours
sincerely

Dale Bywater
Executive Regional Managing Director (Midlands and East)

Appendix C

Stakeholders – Communications Delivery Plan

Stakeholder Group	Group/Individual	Action	Responsibility	Date
Patients, services users and public	Public	Press release and info on website (including social media)	AR	23 Nov
		Newsletter article	AR	16 Dec
	Patient and Carer Panel	Share briefing pack	MD	22 Nov
Staff	All staff	Message from Jan Ditheridge and Mike Ridley	AR	21 Nov
		Staff Zone webpage	AR	25 Nov
		Discuss at events	AR	Dec→Feb
		Team meetings	Team Leaders	21 Nov→
		Board member visits, drop-ins and briefings	Directors	22 Nov→
	Leaders	Discuss at CTLG	JD	17 Nov
	Trust Board	Discuss and approve at Trust Board	Trust Board	24 Nov
Key Partners	STP/Partner CEOs and Chairs	Direct Briefing	JD	By 16 Nov
		Report and cover letter	JD/JT	21 Nov
	Local NHS	Share press release with comms leads	AR	23 Nov
	Local authorities	Share press release with comms leads	AR	23 Nov
	Volunteers/LoFs	Issue letter and offer briefing	JT	22 Nov
Planners and Commissioners	GPs/CCGs	Issue press release to GPs (via CCG newsletter)	AR	22 Nov
		Share press release with comms leads	AR	23 Nov
	NHS England Area Team	Share press release with comms leads	AR	23 Nov
	NHS Improvement	Share comms material for comment and approval	AR	16 Nov
		Share press release with comms leads	AR	23 Nov
Political	MPs	Direct Briefing for Philip Dunne	RF	9 Nov
		Share press release	AR	21 Nov
	Local Authority	Briefing pack to Ludlow Councillors (TH, AB and KC)	JD	22 Nov
		Send press release to Health & Wellbeing Chairs	AR	22 Nov
		Council Leaders – share press release	AR	23 Nov
		HOSC Chairs – Letter and invite to Board meeting	AR	21 Nov
		Share press release with all councillors	AR	23 Nov

Media	Local media (such as Shropshire Star and BBC Radio Shropshire – plus)	Issue press release	AR	23 Nov
		Offer briefing and interviews	JD/AR	23 Nov
		Manage other enquiries reactively	AR	23 Nov→
	Regional/National/Trade Media	Manage enquiries reactively (apart from HSJ)	AR	23 Nov→
Professional Bodies	Trade Unions/Professional Associations	Discuss with JNP	JD	22 Nov
	Professional bodies (e.g. Royal Colleges)	Manage any enquiries reactively	AR	23 Nov→
Scrutiny and Regulation	Healthwatch	Letter and invtie to Board meeting	JD	21 Nov
	CQC	Send press release to Tim Cooper	AR	21 Nov