Looking after you locally

Norfolk Community Health and Care NHS Trust

Annual Plan –Public Version (Jan) 2017/2019

Contents

This is a public version of the Norfolk Community Health and Care NHS Trust 2 year operating plan that was submitted to NHS Improvement on 23rd Dec 2016.

Chapter 1: Approach to Activity Planning

1. Approach to Activity Planning

1.1 Planning Process

Norfolk Community Health and Care NHS Trust (NCH&C) has adopted, and is currently working through, a rigorous, evidence based and inclusive approach to planning with the Clinical Commissioning Groups (CCGs) to inform activity levels for 2017/19. This includes input from the operational services. Consideration is being given to both demographic projected growth, particularly with regard to Community Nursing and Therapy (CNT) and on how to build flexibility into the Indicative Activity Plan (IAP) that allows the transformational change required over the next two years to implement the Sustainability and Transformation Plan (STP). This will need to allow for sufficient timing and resource for changes to workforce numbers and skillsets.

During 16/17 the Trust completed a full service evaluation for CNT and inpatient services. This work has been used as the basis for contract negotiations regarding anticipated activity levels and acuity of patients that the services will need to cater for over the next five years. The contract has been agreed for the next two years and includes additional activity funding for Community Nursing and Therapy Services and a review of bed numbers and safe staffing levels. The Trust is working in partnership with CCGs to populate the IAP schedules. This work includes the following steps:

- An initial activity proposal from the CCGs, incorporating a review of the previous two years' activity levels, including previous winter resilience plans
- A Trust review of the above, considering clinical and operational projections of anticipated changes in presenting demand, expected changes in service delivery or associated guidance, planned transformational change and activity requirements to deliver NHS Constitutional standards including the Referral to Treatment (RTT) target
- Final review and agreement between the Trust and CCGs on activity levels for reflection in the IAP schedules

1.2 Planning outcome: Trust/CCG aligned activity plans

A summary table, depicting the required activity fields in the annual plan activity template is set out below. The required activity fields reflect a proportion of the Trust's service portfolio that are categorised under those headings. Activity figures for 2017/19 are based on 2016/17 outturn with no expected variation.

Activity Line	Service	15/16 Actual	16/17 Forecast Outturn	17/18 Plan	18/19 Plan	19/20 Plan
Total Referrals (GP and Other)	Paediatrics	2044	2909	2909	2909	2909
	Rehabilitation	291	325	325	325	325
	Palliative	112	72	72	72	72
	Total	2447	3306	3306	3306	3306
Consultant led Total 1st Outpatient attendances	Paediatrics	1494	1835	1835	1835	1835
	Rehabilitation	292	331	331	331	331
	Palliative	110	69	69	69	69
	Total	1896	2235	2235	2235	2235
Consultant led Follow up outpatient	Paediatrics	5819	8632	6474	4316	2158
	Rehabilitation	348	370	370	370	370
	Palliative	202	150	150	150	150

attendances	Total	6369	9152	6994	4836	2678
Total Elective admissions (spells)	Excludes Beech and Mill Lodge	1141	993	993	993	993
Total Non-elective admissions (spells)	Excludes Beech and Mill Lodge	2124	2484	2484	2484	2484

NB: The Trust is moving from PAS to SystmOne for data collection for Paediatrics. SystmOne captures clinical advice telephone calls as other activity. These numbers also reflect an increase in demand on this service. (Numbers in green). It must also be noted that the numbers in blue show a 3 year stepped reduction (25% per year) as the Trust moves Paediatric consultants to specialist only - with follow ups for standard medication reviews being carried out by nursing staff.

As part of the 2017-19 contracts the Trust has agreed demographic growth funding with the Commissioners to take account of projected activity increases. In addition, for the key service lines of CNT Services and Community Inpatient Beds the Trust is working with commissioners to agree the extent of CNT and inpatient bed services that can be delivered within the funding levels agreed in the 2017 – 19 contract years.

1.3 Planning for delivery during 2017/19

As noted above the Trust is working with commissioners to agree the extent of CNT and inpatient bed services that can be delivered within the funding levels agreed in the 2017 – 19 contract years. These discussions are based upon the use of Interim Management and Support (IMAS) approved demand and capacity modelling. As a Community Trust, NCH&C was an early forerunner in utilising the IMAS approved models.

NCH&C will continue to try and meet all key operational standards, including the RTT requirement to have no more than 8% of patients waiting over 18 weeks for treatment in consultant-led services. Whilst the Trust is planning for, and expecting to meet all required operational standards, in the unlikely event that any one of these standards is not met the Trust will ensure that appropriate patient choice is offered for alternative treatment. As NHS England is aware the Trust is currently struggling with its paediatric targets but plans are in place to try and rectify this.

If demand were to exceed the levels planned in the 2017-19 contracts due to changes in the local health system's pathways and activity management the Trust would work with Commissioners to enact contractual mechanisms where appropriate to review and respond to the activity growth. The Trust will embed the necessary internal controls to ensure that there is heightened monitoring, and timely response and decision making regarding activity levels experienced during 2017/19.

The earlier mentioned joint work with CCGs will also link where appropriate to the wider health system STP to ensure future activity modelling and financial flows align with partners' plans. It will draw on opportunities to integrate and transform service delivery, reduce unwarranted variation (for example in referral rates) and improve quality. The Trust is currently reviewing with the CCGs the evaluation of the CNT and inpatients to help inform the STP, in particular with regard to the planned acute to community shift of activity.

Within the NHS Operational Planning and Contracting Guidance for 2017-2019 prepared by NHS England and NHS Improvement the nine 'must do' priorities are highlighted and they remain a priority. We believe our plan includes all that are applicable to the Trust and demonstrates our commitment to ensuring that we meet these requirements. We are seeking to actively work with Primary Care in developing new models of care which may include Multispecialty Community Provider (MCP) models. We are also actively engaging with local NHS111 and Out of Hours providers to ensure, where possible, that we are part of the integrated hub models required from the Urgent and Emergency Care Review.

Chapter 2: Approach to Quality Planning

2 Approach to Quality Planning

2.1 Introduction

As a Trust rated 'Good' by the Care Quality Commission (CQC), NCH&C takes pride in the delivery of high quality, efficient and effective services in line with the NHS Constitution and the standards of quality and safety published by the CQC. For 2017/19, the Trust will set out its quality priorities based on the needs of the local population and in line with the NHS mandate. The priorities will be set out in a quality improvement plan for the year which will include our quality goals and Commissioning for Quality and Innovation indicators (CQuIN) targets agreed with commissioners, key risks inherent in the plan and their mitigations.

The Trust does not expect to have any avoidable deaths. The Trust has a panel to oversee any deaths and this has been informed by the Mazars Report. The Trust commenced the annual publication of all unexpected deaths, following a review in January 2016.

2.2 Our approach to quality improvement

2.2.1 Methodology

The Trust's improvement methodology is rooted in its annual planning cycle and supported by a number of techniques and systems. Annually the Trust reviews its performance, evaluating national and local drivers and engaging staff, stakeholders and the public in identifying its annual quality goals and objectives. Annual priorities are created in line with the Trust's values and strategic objectives, including our Health and Care strategy. Each year there is a specific annual priority with the heading 'Improving Quality' and the content is informed by staff and patient involvement, assessment of current delivery and drawing from lessons learned and identified areas of improvement from clinical audits or our quality programmes. The Trust has recently rolled out the Quality Champions programme to provide staff with the skills to make quality improvements. It also links to Your Voice Our Future, our staff engagement platform to create a culture of engagement and continuous improvement. Your Voice Our Future is a social media style platform that encourages staff to have their say in shaping their future with members of the executive leading on a themed area of improvement.

The Trust supports these processes through a substantive change team, with expertise in methods such as LEAN, Theory of Constraints, and various forms of project management. In the coming year, the Trust intends to continue to promote a culture of learning, improvement and engagement and extend further cohorts of the Quality Champions Programme.

2.2.2 Learning from others

We link with the Integrated Urgent Care Network and are an active participant in the Community Trust benchmarking network which helps us learn from other areas. This learning is cascaded through the organisation to assist and inform future development. The Director of Nursing and Quality is the named executive lead for quality improvement.

2.2.3 Learning from our experience

The Trust promotes an open, learning and safety culture as part of its improvement methodology. In the coming year this will involve improving reporting and investigations of incidents and supporting patients, families and carers who have been involved. The Trust is proud of its safety record and has never had a 'never event'. The Trust has an action plan in place to implement the recommendations from Francis 'Freedom to Speak Up' guidance and has reviewed policies as a result. We have 'Freedom to Speak Up' Guardians and publish lessons learned in our monthly safety and quality newsletter.

2.2.4 Research and development

The Trust is one of the most research-active community trusts in the country and has an embedded research function. The Trust's Research Strategy aims to increase the level of research being undertaken into providing care closer to people's homes and outside of traditional care settings. The Trust is also developing its Specialist Services Research Strategy to improve the efficiency and effectiveness of rehabilitation services. The Trust is a pilot site for introducing Patient Research Ambassadors and accelerating innovation is a key element of our Research Strategy.

2.3 Quality Improvement Governance

The Trust's executive lead for quality is the Director of Nursing and Quality. She is supported by the Medical Director who provides independent scrutiny on all areas of quality.

NCH&C's Quality Governance Framework raises the profile of quality for the Trust Board. Planning and driving continuous improvement exists within this overarching framework. Assessment against the framework provides the Board with assurance around the effective, sustainable management of quality improvement within the Trust. A number of systems and initiatives contribute to the Trust's quality improvement governance systems, which include:

Annual Quality Goals: The Trust's quality goals are developed as part of the annual planning process. The quality goals are identified through a staff engagement strategy and inform the practice of each member of staff across all three domains of quality. The goals reflect the demographics of the community served by the organisation and are focussed to mitigate the effects of the Trust's top patient safety incidents. The Trust's performance against the annual quality goals are reported quarterly to the Trust Board.

Quality Improvement Initiatives: A range of quality improvement initiatives are also identified during the annual planning process and the development of the quality goals. These initiatives underpin the quality goals and are a key element of the Quality Improvement Strategy.

Commissioning for Quality and Innovation (CQuIN): CQuIN Leads within the Trust are responsible for the delivery of the required quality improvements and innovation with progress being reported to a monthly steering group and quarterly to the Trust Board.

2.4 Quality Improvement Strategy and Plans: Delivering quality

NCH&C's Quality Improvement Strategy (2016/18) aims to ensure we are providing safe, harm free, compassionate care to patients. To do this we will plan our quality improvements by identifying our quality improvement goals, formulating an intervention, defining success metrics and putting a plan into action. The strategy also describes the organisation's methodology to improve quality and patient safety. All quality themes will be reviewed and revised as required during the planning period.

The Trust's quality improvement themes for 2016/18 are:

- Activities relating to CQC compliance – Moving from "Good" to "Outstanding"
- Delivering the annual quality goals
- Meeting the CQuIN indicators
- Activities relating to Harm Free Care (NHS safety thermometer)
- Delivering the 'Sign Up to Safety' pledges
- Participating in the 'Freedom to Speak Up' campaign
- Ensuring learning from patient safety incidents

The Quality Improvement Strategy ensures that we build on the quality of our service provision in support of delivery of the Trust's 5 year Health and Care Strategy, which aims to:

- Ensure care is shaped around the person it is for and is delivering what is important to them
- Ensure people have as few separate visits and consultations as necessary (to manage costs and to stop people having to tell their story over again)

- Ensure NCH&C joins up health and social care services for the benefit of people using them
- Ensure NCH&C can provide health and care support within the money available to it

2.4.1 Top three quality priorities for 2017/19

The Trust's top three quality priorities for 2017/19 are to:

- Work towards improving the Trust's CQC Compliance rating from 'Good' to 'Outstanding'.
- Implement the Health and Care strategy which sets out how the Trust will deliver quality, patient-centred care locally.
- Demonstrate safe, effective services and improve patient experience through delivering the Trust's quality goals, CQuINs and quality improvement initiatives.

In 2014, the CQC completed a detailed review of NCH&C services and judged them to be 'Good', meaning the services are performing well and meeting the CQC's expectations. We have robust clinical governance structures and processes in place, overseen by the Medical Director, Director of Nursing and Quality and ultimately the Trust's Chief Executive. Following this inspection we had improvement plans in place for the 'must do, should do and could do' recommendations. These actions are now complete. We now have a 'good to outstanding plan' which is based on looking at features from outstanding Trusts and taken the key themes from this to formulate our plan. A number of lower priority actions have also been identified to support NCH&C's ambition to achieve an "outstanding" rating at subsequent CQC inspections. These inform the Trusts activity in 2017/19.

In November 2015, Monitor assessed the Trust against the quality aspects of the 'NHS Well-Led Framework'. Overall the Trust was awarded a score of 4.5. Monitor was fully assured that the Trust Board actively engages with stakeholders on quality, operational and financial performance.

2.4.2 Supporting seven day service provision

NCH&C is committed to working with Commissioners and partners to extend hours of service delivery to best meet population need. As a proactive aspect of current service review, or new service development, extended access to services is a key consideration as part of the planning and review process. NCH&C already has an extensive range of services working seven days per week across Norfolk and Suffolk.

The Trust is working via the A&E Delivery Board and Capacity Planning Groups to jointly develop plans. The Trust's performance thus far in regards to delayed transfers of care is good and it intends to improve performance even further with joined up systems. Within the Service Delivery Improvement Plan (SDIP), the Trust is committed to a joint review to map service provision across 7 days to review with Commissioners opportunity to further extend service provision. A central aspect of the Trust's SDIP with Commissioners for 2016/17 is also a joint work plan to review Inpatient Bed, Community Nursing and Therapy (CN&T), and Virtual Ward provision; with opportunity to evaluate current provision, and collaboratively review future models of care. This will identify future priorities. As a result of the current evaluation of the CN&T service the Trust has identified key work streams that will need to take place over the next 12 months. The Trust is collaborating with community pharmacies in 2016/17 to ensure they are considered an integral part of the patient pathway.

2.5 Monitoring quality

2.5.1 Approach to triangulation of indicators

The Board seeks to triangulate quality, workforce and financial indicators through its routine reporting channels. A detailed Integrated Performance, combined Cost Improvement Plan (CIP) and Change Report are presented at the monthly Finance and Performance Committee and in turn reported to the Trust Board. NCH&C contributes to a benchmarking network that reviews quality, financial, workforce and performance measures. Quality and workforce indicators are cross-referenced in the bi-monthly Quality Impact Assessment (QIA) dashboard which is reported to Quality Risk Assurance Committee (QRAC). This incorporates safety and performance indicators as well as indicators around staff engagement derived from the rolling programme of short staff surveys within the Trust.

2.5.2 Key indicators

The Integrated Performance Report covers operational performance targets, such as Referral to Treatment, as well as activity against plan. It also includes quality indicators, e.g. safety indicators, including serious incidents, and patient experience, including complaints and Friends and Family Test results. Workforce indicators include sickness, training and appraisal rates, as well as vacancies and turnover. Headline financial metrics, for example CIP performance are also included. These metrics form the basis of further lines of enquiry that target specific services or themes.

The Board uses benchmarking and wider information to identify areas of improvement. Benchmarking is used to compare productivity, to calibrate CIP schemes, or to identify high performing organisations to share best practice with. External benchmarking, combined with internal triangulation, enables the targeting of interventions to improve performance and to hold managers to account. The Board uses comparison of demand, performance, system challenges and financial drivers to identify opportunities to develop new services and to remodel existing services such as our in-patient units.

2.6 Quality Impact Assessment (QIA) process

The Trust has an established, robust and structured approach to Quality Impact Assessment (QIA) approval, monitoring and assuring all CIP projects, including workforce schemes. The Trust also engages Commissioners in this process. QIA processes are built into CIP planning; all plans are ultimately assessed and approved by the Director of Nursing and Quality and the Medical Director. This approach has been approved by the Board and reviewed by Monitor, the CQC and the Trust Development Authority (TDA). Price Waterhouse Coopers in their Internal Audit function reviewed CIP governance processes in 2016 and confirmed in their report 'That the Trust has a mature PMO in place with controls and processes that are designed in line with best practice'. They also identified that all our structures processes and governance were fit for purpose.

2.6.1 Identification and assessment of cost improvement programmes

NCH&C seeks to involve staff and services in identifying opportunities for cost improvement. This happens through formal workshops and engagement events as well as through routine team meetings and operational management. The Trust also seeks to identify opportunities through working with other organisations and using benchmarking data.

2.6.2 Board QIA process

NCH&C uses a 'gateway' process to approve CIP schemes:

Gateway 1: gives basic approval to work up an idea with the initial scope, assumptions and finances described.
Gateway 2: develops detailed finances, milestones, risk log and initial QIA. The QIA is developed by the relevant service ops leads and for high risk discussed with the Director of Nursing and Quality and Medical Director. All CIP schemes are tested against an ethical framework.
Gateway 3: final approval to deliver including project and benefits realisation plans and Equality Impact Assessment.

2.6.3 In-year monitoring of QIA

Change projects for cost savings and quality improvement are overseen by a fortnightly Transformation Programme Board. The Board and the Finance and Performance Committee receive a monthly report on the progress of the change portfolio. On a quarterly basis the Board's Quality and Risk Assurance Committee (QRAC) reviews a quality dashboard which illustrates any impact relating to the delivery of CIP through trends in performance measures as well as any issues raised through ongoing QIAs. The Trust has a Programme Management Office (PMO) function that supports the co-ordination, approval and monitoring of CIP schemes. Each scheme has a named executive sponsor and an operational lead that provide updates via the PMO. Quarterly updates are provided to commissioners at the Care Quality Review meeting to ensure openness and feedback.

2.7 Top three risks to quality

The current top three risks to quality are:

Implementation of the Health and Care Strategy If NCH&C fails to implement the Health and Care Strategy there is a risk that the Trust will not have a sustainable model of care to support service delivery over the next five years.
Mitigation: This risk is owned by the Director of Nursing and Quality. A project manager has been deployed to develop and deliver the implementation plan and five work streams have been identified as pillars of the Health and Care Strategy.
Medical staffing If NCH&C fails to recruit to the Trust's medical staffing model then the quality and performance of service delivery may be compromised. This risk reflects a national shortage of doctors and local challenges in attracting medical staff to East Anglia.
Mitigation: This risk is owned by the Medical Director and managed by a rolling recruitment plan and the employment of short-term locums to cover service gaps.
Unsustainable demand If demand for services increases over and above that which is funded then the quality of services may deteriorate, creating activity pressure over the five years of the financial model.
Mitigation: This risk is owned by the Director of Finance and managed via contractual escalation which is triggered by activity variation thresholds. Mitigations include the robust negotiation of 2016/17 activity and funding to meet demand, establishment of cost and volume for some services, and close monitoring of demand and capacity throughout the year.

Chapter 3: Approach to workforce planning

3 Approach to Workforce Planning

3.1 Introduction

Ensuring NCH&C has a workforce with the right skills, delivering care in the right place, at the right time and matching capacity to the demand on services is integral to the Trust's approach to workforce planning. Workforce planning happens systematically, on an annual basis as part of developing annual plans and informing higher education commissioning. The Trust is unique within community trusts in having IMAS accredited capacity models in place that are regularly reviewed with, and by, clinicians as well as a number of other tools to support workforce planning.

The ambition to develop, recruit and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right location to deliver NCH&C's vision of transformed care is clearly stated in the Trust's Health and Care and Workforce strategy.

The Board has an approved workforce plan in place as part of its five year Integrated Business Plan (IBP). This was re-appraised in the 2016/17 planning round to ensure that it meets the latest relevant workforce guidance, incorporates a review of safer staffing levels and the latest round of CIP planning. It is aligned with the Long Term Financial Model (LTFM) and approved by the Trust's Medical Director and Director of Nursing and Quality.

The Workforce Strategy was signed off by the Board in September 2016 and consists of 5 strategic themes. These are Put Values First, Demonstrate Effective Leadership, Transform our Workforce, and Grow our Community and Responsive HR. Under these themes sit actions to be taken and maintained by the Trust. The themes link to the Health and Care Strategy and Sustainability & Transformation Plan.

The Health and Care Strategy agreed by the Board demonstrates a commitment to changing the structure of the workforce to meet the changing needs of the population. The Trust has well established apprenticeship and assistant practitioner programmes and is a pilot site for the flexible work-based learning programme for nurses. This demonstrates a clear intention to grow and develop its staff in recognition of the recruitment challenges nationally, and in the Eastern region specifically. The development of the Health and Care Strategy included engagement with partners, including commissioners, to ensure a consistent approach.

3.2 Local workforce transformation programmes and productivity schemes

The Trust continues to transform its models of delivery to provide services where and when patients need support and to make adjustments to its workforce to ensure success. Its efficiency and improvement plans are reviewed with commissioners so that the Trust can align its plans against expectations. The IMAS demand and capacity model is an operationalised tool that is used to assist in effectively managing capacity. As part of the approval process, and ongoing management of change programmes, the impact on staff is identified and monitored. QIAs identify where there may be both positive and negative impacts on staff with a focus on mitigating and improving negative consequences. Staff engagement, throughout both the scoping and implementation period, is strongly encouraged and time is provided within operational rotas to support this.

The Trust's workforce plan seeks to identify ways to adjust its workforce model to ensure the skills and competencies required in the future are available. The plan is formed across organisational boundaries by developing the workforce across health and social care. Within Community Nursing and Therapy services, there are defined competencies in place that allow for the full utilisation of unregistered staff to support more than one professional group, for example nursing and occupational therapy. These will continue to be developed for other professional groups.

Working alongside commissioners, the Trust is re-designing pathways to provide care closer to home. The Trust is responding to efficiency drivers across the system in order to maximise resources and redeploy staff to support the new models. There have been, and will continue to be, consultations with staff to ensure feedback is taken in to consideration. Recognising the potential impact on staff wellbeing at a time of extreme change, the Trust has a Board approved Health and Wellbeing Strategy for the staff. It includes an agreed action plan for improvement following a full assessment of the organisation using the Workplace Wellbeing Charter. There is a working group in place made up of subject matter experts, trade union representatives and staff who have an interest in health and wellbeing to deliver the Strategy.

3.3 Effective use of eRostering & Reduction in reliance on agency staffing

'HealthRoster' and 'BankStaff' are eRostering systems used within the Trust to roster staff to a safe and appropriate skill mix, duty requirement and clinical demand for the service. The Roster Management Policy supports utilisation of existing staff and the management and control of bank and agency spend by giving managers visibility of staff contracted hours in a fair and consistent manner. The eRostering tool is in place across the Trust and supported by a training programme in effective rostering. The Trust has also had an internal audit on workforce planning and deployment. This was 1 point above low risk and actions are on track. Good rostering as well as effective recruitment processes minimise the need for agency/unnecessary agency staff. Recruitment timescales are monitored at board level and benchmarking undertaken with other Trusts. They have been reducing and compare favourably. NCH&C has an agreed staffing model with systems in place to monitor staffing levels on a shift by shift basis. Any issues in relation to staffing levels are either managed locally, escalated by phone to the on-call system or through the use of the Trust's risk management system. Staffing levels are reported monthly via Unify and to the QRAC. Twice yearly reviews of Safer Staffing levels are carried out and reported to the Trust Board. We continue to publish monthly safer staffing details on the Trust's website. The use of eRostering has supported the Trust in reducing its reliance on agency staffing. The Trust has introduced robust measures to ensure every staffing option is explored prior to agency use. The Trust has an internal Temporary Worker Service that provides bank staff. This service is being optimised and expanded in order to provide additional resilience. Local market conditions continue to prevent the Trust from being able to recruit locum doctors at rates below the caps.

3.4 Triangulation of quality/safety metrics with workforce indicators to identify areas of risk

The Board currently receives a bi-monthly workforce report which contains metrics on sickness absence, turnover etc. Any further staffing issues for the consideration of the Board are raised through the Trust's risk management system and early warning trigger scores. These are presented in the monthly report from the Director of Nursing and Quality. The Director of Nursing and Quality and the Director of Integrated Care also present an operations report to the Board which highlights any staffing issues.

All risk, including workforce risk, is managed in accordance with the Trust's Risk Management Strategy. The Trust uses an Early Warning Trigger Tool, corporate and local risk registers to monitor and manage risk. The Board's Quality Risk

Assurance Committee (QRAC) reviews individual risks on Board Assurance Framework (BAF) at each meeting and the Corporate Risk Register quarterly. QRAC is the lead committee for reviewing the Trust's entire risk profile and has particular focus on quality and workforce risks. The Finance and Performance Committee takes the lead in reviewing sustainability risks and the Executive Director Team and Risk Group review the BAF monthly. The Audit Committee undertakes a quarterly review of how the BAF is operating in practice to ensure that it is fit for purpose. The Board reviews the BAF on a quarterly basis to scrutinise the adequacy of the controls, assurances and actions in place and planned.

The Trust has an established, robust and structured approach to the QIA approval, monitoring and assurance of all CIP projects which include workforce schemes. QIA processes are built into CIP planning with all plans being assessed by the Director of Nursing and Quality and the Medical Director. This has been approved by the Board and reviewed by Monitor, the CQC and the TDA.

3.5 Plans for new workforce initiatives

NCH&C has a number of new workforce initiatives agreed with partners and funded specifically for 2017/19. The Trust is working on shared apprenticeships with social care and the local mental health trust. The Trust has entered into a formal sub-contract arrangement with Voluntary Norfolk to fund four Volunteer Coordinators. The volunteers will be fully integrated into the Trust's health and social care teams.

In 2016/17 the Trust has implemented 'Your Voice, Our Future', which provides the opportunity for staff to suggest changes within the Trust to enhance patient care, engagement and overall satisfaction. These suggestions are rated on popularity by staff before being presented for response and consideration of any funding decisions. Key actions include reviewing our behaviour framework and developing a leadership charter, improving IT and systems as well as responding to a range of specific issues raised by staff.

Chapter 4 – Approach to Financial Planning

4 Approach to Financial Planning

4.1 Introduction

The Trust has ended month 8 2016/17 slightly ahead of the surplus/deficit trajectory contained within the revised annual plan submitted to NHS Improvement on 29th June 2016. Month 7 saw two things happen for the first time this financial year:

- The Trust has moved into a year to date surplus position; and
- On a normalised basis the Trust has delivered an in-month surplus.

These achievements result from the considerable efforts of staff from right across the Trust to both develop and implement financial recovery plans. However there is a long way still to go in order to deliver the £1.77M surplus control total committed in the revised annual plan. With only 3 months left in which to do so, the pace of improvement needs to increase further and significant risks remain which may continue into 2017/18 and beyond. In addition there is a further risk of significant stranded costs from the decommissioning of the Children's Residential Short Break service at the end of this year.

Delivering the committed level of 2016/17 surplus remains contingent upon:

- Achieving a successful resolution to the funding of the First Dressing Initiative on our Suffolk contract; and
- Successfully operating the new variable payment mechanisms contained within the 2016/17 contracts in respect of significant levels of excess activity for Community Nursing and Therapy in Norwich. This will secure funding to cover the incremental costs being incurred in dealing with excess demand. At this point it looks likely that the Trust will secure £420k from this which is less than the amount the Trust had been looking to recover.

In light of the combination of the magnitude of the remaining risk in respect of these contingencies and the recent decommissioning development referred to above, the Trust Board is considering making an application to change its forecast outturn for 2015/16 away from the control total at the quarter 3 reporting point.

The revised annual control totals proposed for the Trust in 2017/18 and 2018/19 of £2.033M surplus and £2.107M surplus respectively require the Trust to hits its 2016/17 commitments and improve further still.

	2016/17 £M	2017/18 £M	2018/19 £M
Control total including STF Funding	1.770	2.033	2.107
STF - General element indicative allocation	0.770	0.788	0.788
Control total pre STF Funding	1.000	1.245	1.319
Increase on previous year		0.245	0.074
% Increase on previous year		24.5%	5.9%

The Trust has agreed contract funding for 2017/18 with Norfolk CCGs, but is not yet able to confirm that the contract with Suffolk will continue beyond September 2017. The Norfolk contract provides the Trust with funding reflecting additional workload in CNT services and recognition of demographic growth. This totals £1.354m in 2017/18 with a further £0.5m in 2018/19.

The Trust Board accepts the need for delivery of the £2.033M and £2.107M control totals in 2017/18 and 2018/19 respectively in its final planning submission, subject to the caveats to delivery of the 2016/17 surplus described above and recognising that such a commitment carries even greater levels of risk than that experienced in 2016/17. Delivering this commitment will require the Trust to take on **both** significant additional risk and an extremely demanding CIP target. The Trust will seek to take full advantage of efficiency opportunities (including lessons from the Carter review, controlling agency spend, effective procurement and opportunities on a system-wide basis identified within the STP) and deliver those CIPs already identified. The Trust recognises the importance of sound financial management to the delivery of sustainable high quality clinical services.

4.2 Financial Forecasts and Modelling

The Trust is planning to achieve the £2.033M and £2.107M control totals for 2017/18 and 2018/19 respectively. This is a challenging target given the context that:

- The underlying plan (excluding STF) for 2016/17 was a £1.0M NHS reported surplus, some of which is being delivered through non-recurrent means. The Trust only moved into a year to date surplus position and recorded its first normalised in-month surplus (both including STF funding) in month 7 2016/17.
- Commissioners will be undertaking a number of procurements and service reviews with the potential for further disinvestment over the period until the end of 2018/19.
- The Trust is planning to increase its level of general contingency to manage risks arising in-year by approximately £0.8M to £2.0M which includes the risk of not achieving the 0.5% CQuIN risk reserve of £0.4m.

Planning to achieve these control totals also requires the Trust to take on significant levels of additional levels risk, beyond the already substantial level of risk in the 2016/17 commitments:

- The main contract for the provision of community services in Suffolk (for which the Trust provides services to the consortium partners as a subcontractor) expires on 30th September 2017. A Prior Information Notice in respect of this service has recently been published. The Suffolk contract accounts for over 16% of the Trust's budgeted revenue from patient care activities in 2016/17.
- The Trust's CIP target for 2017/18 is £5.6m. To put this into context, the Trust delivered £5.7M of recurrent CIP savings in 2015/16 having seen recurrent CIP levels fall from £7.4M in 2012/13 to £3.6M in 2014/15 as opportunities were progressively exhausted. The Trust currently expects to deliver £3.1m of recurrent CIP savings in 2016/17. Plans approved through gateways 2 and/or 3 of the Trust's controlled process are (pre-risk adjustment) currently expected to deliver £3.6M of recurrent savings in 2017/18, however when adjusted for risk, the figure drops to £2.9M.

4.3 Efficiency Savings for 2017/18

The Trust has approved plans in place that are expected to deliver £3.6m of recurrent CIP in 2017/18 a further £3.5m to the end of that period in the pipeline. On the face of it therefore 60% pipeline conversion will be sufficient to meet the £5.6m requirement in 2017/18. However we recognise that the Trust is now planning much more complicated schemes than has been the case in the past, with longer lead times, greater levels of uncertainty, initial investment requirements and additional stakeholders/organisations having an influence over delivery. To take account of this a risk-adjusted view of expected delivery from approved schemes has been prepared. This suggests a £2.9m delivery from currently approved schemes which would then require 80% pipeline conversion.

4.3.1 Focus on cost reduction

As a community provider the Trust recognises the challenges across the system for its patients, its partner providers and commissioners. The Trust understands the financial challenges that the local system faces and is taking an active role in working with partners to develop more holistic solutions to the efficiency requirements, through the Norfolk and Waveney Sustainability and Transformation Plan, the Norfolk Provider Partnership and the Norfolk One Public Estate Partnership Board.

Our drive to continually improve services within the financial backdrop has resulted in a collaborative approach with commissioners to re-design and re-develop services to meet needs

The Trust will continue to work closely with Norfolk County Council to further integrate teams, systems, structures and processes with social care to join up services for local residents. The Trust will also continue to implement its Health and Care Strategy which seeks to build on voluntary sector support, ensure we have a workforce that is fit for the future and implement ways to empower patients through enabling self-care and use of technology.

The Trust has a recurrent efficiency target which is reviewed annually with targets set for each directorate across the organisation. There is a defined and embedded process for managing and tracking the delivery of changes and cost improvements in order to produce efficiency across the Trust. As new ideas are identified they are captured, documented, and approved, before resources are invested into developing them into a plan. Ideas may originate from any staff member, from either an operational or corporate perspective. Once the idea is approved at Gateway 1 for development, an executive sponsor and scheme lead are identified at the outset to ensure that accountability, engagement and priorities are agreed.

Plans are developed and refined through a series of gateways which hones high level ideas into more detailed plans. This is done by defining and scoping the deliverables, expected benefits, milestones, risks, assumptions, constraints and detailed financial modelling.

This process also includes the QIA described earlier. The final checkpoint at Gateway 3 is the approval mechanism for having met all the considerations for the scheme to be implemented.

This is a robust process and as previously stated has been signed off by PwC as a mature PMO process. Historically it has resulted in a very high success rate of delivery against the plan. However we recognise that the Trust is now planning much more complicated schemes than has been the case in the past, with longer lead times, greater levels of uncertainty, initial investment requirements and additional stakeholders/organisations having an influence over delivery. It is unlikely therefore that the success rate of delivery against plan will be quite as high as it has been in the past. For this reason, a risk-adjusted view of expected delivery has been prepared as described above.

In the event that the implementation of the project changes, a change control process is in place. All change is reviewed by the Transformation Programme Board made up of executives and key individuals from around the Trust whose role is to ensure progress and remove any blockages.

4.3.2 Lord Carter of Coles

Although Lord Carter's work to date has focussed on acute organisations, the Trust has taken a keen interest in the developments.

Lord Carter's initial conclusion that workforce management and productivity must be addressed also holds true for the Trust. Indeed, pay makes up a bigger proportion of the Trust's cost base (73%[1]) than it does for the NHS provider sector as a whole (63%). Similarly Lord Carter's second conclusion that all items of non-pay expenditure must be addressed also holds true for the Trust.

The Trust's top five non-pay items[1] are:

- General supplies and services (27.4% of non-pay costs)
- Clinical supplies and services (22.3% of non-pay costs)
- Depreciation (11.7% of non-pay costs)
- Transport (11.2% of non-pay costs)
- Premises (9.4% of non-pay costs)

Estates Management and Procurement will therefore continue to be key elements in the Trust's efficiency programme.

Whilst the Trust accepts that the Carter review has focussed on the acute sector, it is already beating three of the five Estate metrics targets set out in Lord Carter's final report:

	NCH&C	Community Trust Median	Carter Target April 2017
Total Estates and Facilities Running Costs per m2	£259.71	£287.84	£319.00
Non-clinical use of space	23.3%	36.5%	35% Maximum
% Unoccupied or underused space	8%	TBC	2.5% maximum
Cleaning costs per floor area	£37.46	£32.14	£38.00
Food cost per patient meal	£4.92	£4.61	£2.70

Existing actions within the Trust's Estates Strategy and CIP are addressing both non-clinical use of space and unoccupied or underused space.

4.3.3 Agency Rules

The Trust has performed well in meeting agency rate caps, agency worker wage caps and requirement to use approved framework agency suppliers. Local market conditions prevent the Trust from being able to employ locum doctors at rates within the caps. It is also extremely difficult locally to recruit doctors on a substantive basis. The Trust is currently working on implementing the 6-step guidance on reducing reliance on medical locums.

Meeting the £2.714m agency spend ceiling has proven much more challenging given the Trusts already relatively low rate of agency use and the magnitude of the reduction (2015/16 agency spend £4.127m). The Trust had initially proposed a £3.421m plan for agency spend and remains concerned that the ceiling has been set inappropriately for a Trust that is already in the top quartile for agency costs accounting for a low percentage of overall pay expenditure (3.6% compared to regional average of 6.8% as at month 06). We continue to pursue every possible opportunity to minimise agency spend including:

- Establishment of agency spend targets at Business Unit level and monitoring performance against this;
- Establishment of a Vacancy and Agency Approval Panel whose authorisation is required for any agency appointment or extension exceeding 1 month in duration;
- Working collaboratively with other NHS provider organisations across Norfolk and Suffolk to tender for Non-Medical, Non-Clinical agency staff;
- Introducing a direct engagement model for medical agency staff;
- Restructuring some functions to reduce their reliance on the use of agency staff through bolstering substantive teams;

[1] Trust Accounts 2015/16

- Making improvements to improve the utilisation of our internal bank service including allowing bank staff to electronically self-book onto shifts they want to work;
- Exploring opportunities to structure projects to enable management consultants to be engaged rather than employing agency workers.

Agency spend continues to fall month on month and whilst the Trust has improved its run rate in 2016/17 and is closer to the £2.714m annual ceiling, the Trust remains of the view that the target was set too high compared with the Trust's already good performance in this area and thus difficult to achieve. We believe an agency ceiling target of £3.071m is more appropriate and is consistent with the lowest monthly spend we have achieved this year.

4.3.4 Procurement

Cost savings in 2016 - 17: Significant cost improvements have been made in the following areas:

- Electronic Patient Records – 5 year contract cost reduction of £260k by re-profiling the contract term, to take advantage of price breaks
- Prosthetic Services and Associated Devices – 5 year contract cost reduction of £330k by re-tendering the service
- External Audit – 5 year contract cost reduction of £125k by tendering for a new service
- Incontinence products – Home Delivery Service – 3 year contract cost reduction of £765k by re-sourcing the service. Savings were taken on product substitution and transportation costs
- Non-medical, Non-clinical Agency staff – a procurement exercise will complete in January 2017.
- General and Confidential waste – a procurement exercise will complete by 31 March 2017
- Fleet Insurance – a procurement will complete by 31 March 2017
- Laundry – a procurement will complete by 28 February 2017
- Further efficiency savings were achieved by implementing a call off order for IT "commercial off the shelf" Software – reduction of procurement process lead time of 72%.

Cost savings 2017 - 19: In this period, NCH&C Procurement plans are:

- Electricity;
- Non-Patient Transport;
- Beds and Mattresses;
- White paper;
- Uniforms; and
- Translation services.

4.4 Capital Planning

The Trust's Estates Strategy 2013–2018 sets out clear plans for the development of the Trust's estate through investment in the reduction of backlog maintenance and the implementation of an estate rationalisation programme. Completion of midterm review during 2016-17, has established an endorsed continuation of the completion of the current strategy, and recognising the introduction of wider estate development and investment as part of the emerging collaboration within the Trust integration with NCC Adults Social Care services and the introduction of system working under the Norfolk & Waveney STP. The community estate managed by the Trust includes a substantial tenant base, and increasingly is required to deliver opportunities to collocate integrated operational service delivery and other health care providers. Community Estate continues to offer capacity for emerging solutions to other health care provider needs across Norfolk.

The Trust is widely engaged in the development of NHS estate as a core part of local efforts to best use public sector estate. This includes:

- Membership of the Norfolk Asset Forum, through which utilisation and development of Norfolk public estate is improved. The Trust has been a prominent health sector contributor to this forum.
- Membership of the One Public Estate (OPE) Board in Norfolk, through which substantial collaborative property solutions are being enabled.
- Operation of an estate work stream delivering integration of operational locations between health and social care teams.

- Contributing to the Commissioning Estate Strategy across Norfolk and in turn to the emerging STP strategy for improvement of health estate. This has included identifying key estate requiring development and improved utilisation, and agreeing disposal opportunities reflected in the Trust's Estate Strategy.
- Introduction of information systems that assist the Trust in managing and improving asset utilisation by the effective scheduling of resource and the review of performance information.
- Development and delivery of Estate and IM&T Strategies that has mobilised the workforce enabling flexible approaches to service delivery and changes to occupancy standards.
- Initiation of a cost improvement project to identify improvement opportunity for clinic scheduling within teams, to result in improved asset and workforce efficiencies.

The plan outlined above remains core to the Trust's strategy for wider engagement in the local health system and improvement of the estate through adopting a leading role in the development and delivery of Estate tasks within the STP. Moving forwards the Trust continues to work with other system providers forming the Norfolk Provider Partnership and others, through which a wide range of system improvement is being sought. The Trust will lead the development and coordination of the estate strategy to achieve improved utilisation and the development of improved clinical facilities for patient care.

Chapter 5 – Sustainability and Transformation

5 Working to deliver the 'Sustainability and Transformation Plan' (STP)

5.1 Introduction

NCH&C received a 'Good' rating from the CQC following its inspection reported in December 2014. By contrast, other local NHS organisations, both commissioners and providers, find themselves challenged financially or in performance. Accordingly, NCH&C has an important role in influencing system sustainability and transformation, particularly as an Out of Hospital, community provider. Indeed, the Trust has ambition to influence this change not just through delivery of efficiency gains, but of whole-scale transformation supporting progression to 'New Models of Care' as outlined in NHS England's Five Year Forward View.

5.2 Norfolk and Waveney STP

The health and social care system in Norfolk and Waveney is unsustainable in its current form. Commissioning health services is the responsibility of five different CCGs, which in turn work with a number of Health Trusts, three acute hospitals and a social enterprise which delivers community health care. Social care is commissioned by Norfolk County Council and delivered by more than 800 provider organisations, the majority small and community based.

Norfolk and Waveney Health and Care Partnership (NWHCP) has been established to share resources and expertise, reduce unnecessary bureaucracy and, crucially, to plan and implement significant structural and cultural change that is essential to meet future challenges. The NWHCP includes representation at CEO/Chair level from all health provider trusts, including the county's hospitals and CCGs, Norfolk County Council (which takes in Public Health) and Norfolk's main independent care provider body. NCH&C has been instrumental in bringing this group together and will play a key role in the identified work streams. The Partnership has been proactive in establishing a programme governance structure, ensuring active partner engagement in driving strategic change. This is underpinned by a commitment to share resource to support this change. To demonstrate the commitment from NCH&C the Chief Executive chairs 2 of the work streams currently in progress.

The Partnership has devised a set of 5 Guiding Principles to which the boards of all participating organisations have agreed. This will inform the range of work streams that will underpin system sustainability work. The principles have been chosen to ensure patients and service users are central to the plans:

- **Preventing Illness and Promoting Well-Being** - Strong community services aligned with local authorities and the third sector support independence and increase resilience
- **Care Closer to Home** - People are supported to live with maximum independence, with improved access to primary and secondary care, and supported by thriving links to the third sector.

- **Integrated working across Physical, Social and Mental Health** - Integrated working across all system interfaces is co-ordinated to deliver holistic care with reduced duplication and gaps in care
- **Sustainable Acute Sector -** Out of hospital services will reduce demand at the front door, and assist discharge processes to maintain capacity within the acute system
- **Cost-effective services -** Delivered within the finances available

By 2020/21 the citizens of Norfolk and Waveney will receive their health and social care, and some district/borough services, from a cohesive integrated system. Patients and users will receive seamless care coordinated between different provider organisations. The system will be user-focused, delivering high quality and safe services, comparable with the best in the country. Operating in a coordinated way, eliminating inefficiency and waste, and striving for more effective delivery methods will ensure optimal resource usage. This means constituent member organisations and the Norfolk and Waveney health and social care system will be financially balanced and able to invest in further improvements.

A number of work streams are already established and described below. A consistent, accepted narrative that can be easily articulated to both internal and external stakeholders has been developed.

STP alignment with Trust Transformation Plans	
Prevention & Well-Being	**To do this we will work with partners to** • Target obesity and diabetes • Secondary Prevention – Optimising Healthcare • Improve the prevention, detection and management of major chronic illnesses. • Increase individual and community capacity for self-care through Patient Activation. • Development of a Social Prescribing model that enhances access to more appropriate community support mechanisms, reducing dependency on core health & social care services for N&W's most deprived areas.
Primary, Community & Social Care	**To do this we will work with partners to** • Assist to enable Primary Care at Scale • Improve access and capacity • Integrated Out of Hospital Teams including social care and mental health • Sustainable Social Care for all • Provide an integrated service tailored to local needs that manages Long Term Conditions (LTCs) closer to home • Support independence of residents • Enable local provision that is focussed on the community and responsive to individual and local needs and assets with commonly agreed outcomes across the footprint
Mental Health	**To do this we will work with partners to** • Integrate physical and mental health care • Support more people in the community at an earlier point, reducing the demand on acute care and mental health acute beds • Reduce suicide and self-harm • Increase recording of dementia, improve access to support and reduce use of residential and acute care • Support community and primary care to provide mental health support at an early stage • Increase community based treatment for children and young people (addressed separately through the LTP) • Reduce acute hospital use for people of all ages with reported MH problem, including children and young people and dementia
Acute Services	**To do this we will work with partners to** • Assist in reducing acute activity • Improve demand management (supporting the out of hospital and prevention work streams to deliver admission avoidance schemes) • Reduce length of stay by improving the process of care • Ensuring acute clinical service sustainability at an STP footprint level across the key nominated

specialty areas and their interdependencies
- Specialty sustainability
- Acute process improvement reducing avoidable bed days
- Reduce NEL activity and reduced variation in practice will ensure RTT standards are met

5.3 Suffolk

In Suffolk, discussions around the future system are being driven through the Integrated Care Programme Boards for each of the two CCGs with a view to creating an Integrated Care Organisation. The vision for this work is developing but extends from a previous health and care review. NCH&C's role is to work with the acute trusts in delivering the current contract for community services, which runs from October 2015 for up to two years, and to actively participate in the emerging discussion. The Suffolk STP footprint covers Suffolk and North Essex.

Glossary

NCH&C - Norfolk Community Health and Care NHS Trust

CCG – Clinical Commissioning Group

CN&T – Community Nursing and Therapy

IAP – Indicative Activity Plan

STP – Sustainability and Transformation Plan

IMAS – Interim Management and Support

MCP – Multi-speciality Community Provider

CQC – Care Quality Commission

CQuIN – Commissioning for Quality and Innovation Indicators

SDIP – Service Development Improvement Plan

CIP – Cost Improvement Programme

QIA – Quality Impact Assessment

QRAC – Quality Risk Assurance Committee

TDA – Trust Development authority

(Monitor and the TDA became part of NHS Improvement from 1st April 2016. NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.)