Annual Operational Plan 2017 - 2019
Norfolk and Suffolk NHS Foundation Trust
1.0 Activity Planning

Our Activity Planning continues to respond to the challenges of the Five Year Forward View, driven by improving quality and achieving financial sustainability. We are committed to further integration and alliance across health and social care through Sustainability and Transformation Plans (STPs), playing a significant role in this as we champion parity for mental health in terms of funding and access to services.

In 2016 we moved out of special measures following a CQC inspection which rated us overall as ‘Requiring Improvement’. This has been achieved through our clear vision that we need to build strong foundations of safe and trusted mental health services, which are quality driven, financially sustainable and underpinned by an engaged workforce. We are moving into the second year of our Five Year Trust Strategy (2016-2021) which sets out our vision within three overarching goals.

We continue to listen to our staff, service users, carers and other stakeholders in order to build trust, accountability and responsibility at every level of our organisation.

1.1 Our Trust Strategy 2016-2021

Our mission is to be a champion for positive mental health, by providing safe, effective, trusted services together with our partners. This is supported by our vision: to work together for better mental health. Our mission and vision put Recovery at the heart of what we do and, for us, Recovery means people living the best life they can, with or without a mental health condition.

Our overarching Trust Strategy, 2016-21, sets out what we will do to realise this through achieving our three core strategic goals of:

1. Improving quality and achieving financial sustainability
2. Working as One Trust
3. Focussing on prevention, early intervention and promoting Recovery.

We will deliver these throughout the 2016-2021 lifetime of the Trust strategy. They have been widely disseminated as part of our new strategic planning cycle, and are at the core of workforce objective setting and appraisals.

1.2 Regional Strategy

We welcome the partnership working that STPs engender on the basis that they are a fair, transparent and collaborative approach to improving and ensuring the sustainability of the health system in our area.

The key priorities for NSFT are:

- Parity of esteem for mental health services within our local health systems
- To ensure all aspects of the CQC domains of care are satisfied
- To ensure that sufficient inpatient beds are available within the Trust, avoiding the need for out of area and out of Trust care
- To implement the Five Year Forward View for Mental Health
- To deliver the national standards/targets applicable to Mental Health
- To implement a pricing approach that allows for provider efficiency
- To ensure we can support other providers within the health system with appropriate services, including but not limited to, psychiatric liaison services and dementia care
- To ensure we have clear and well-defined service specifications agreed between providers and commissioners

To deliver quality services we require the right level of funding and resources. Where evidence shows that investment of resource in enhanced pathways creates greater savings elsewhere in the local health and social care system, agreement will be sought from commissioners that we will be funded accordingly.
This means where we are providing a clinical service which has not been commissioned, this will not continue unless appropriately funded and where pathways cannot be developed that are safe and effective within the allocated budget despite every effort, we will seek appropriate funding from commissioners or agree alternative interventions.

1.3 National Strategy 2017-19 ‘must dos’

The nine national priorities set out in 2016-17 remain the priorities for the period 2017-19. As a mental health foundation trust we are working with our commissioners and partners focusing on the following priorities:

- **STPs** – We are committed to implementing agreed STP milestones and agreed trajectories for full achievement by 2020/21, working with both STPs in our area.
- **Primary care** – We are supporting the expansion of Improving Access to Psychological Therapies (IAPT) in primary care through our Norfolk and Suffolk Wellbeing Services.
- **Urgent and emergency care** – We are working towards ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in both STP footprints. A cross-system approach will be developed to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis. Our new out of hours crisis service launches early in 2017 to give children and young people 24/7 access to specialist mental health support in acute general hospitals across Norfolk and Waveney, with work underway in Suffolk.
- **We are committed to delivering in full the implementation plan for the Mental Health Five Year Forward View for all ages.**
- **We are committed to meeting psychological therapies targets so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care through our regional Wellbeing Services.**
- **We are committed to delivering high-quality mental health services for children and young people, with a target that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018. Our Tier 4 CAMHS Unit, Dragonfly, opened in 2016 as part of our commitment to continuously improving services including reducing out-of-area placements.**
- **We are working with commissioners so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral. We are aiming to develop the existing service (14 to 35 year age group) to meet the new standards with further development and expansion of the Early Intervention Teams to offer this service to those aged 36 to 64. The national workforce calculator mechanism shows significant recruitment is required to meet staffing levels and skill mix, for a part year effect in 2016/17 leading to full implementation in 2017/18.**
- **We support increasing access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against the 2017/18 baseline.**
- **We support the commissioning of community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases.**
- **We are implementing a wide range of Quality Improvements to our working practices and acute care environments to help reduce suicide rates in Norfolk and Suffolk against the 2016/17 baseline.**
- **We are working with partners to ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.**
- **We are playing an active role in the wider health care system with a firm commitment to securing baseline...**
spend on mental health to deliver the Mental Health Investment Standard.

- We aim to maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, with due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support. Innovations such as our Memory Assessment Clinics will lead to a standardised dementia care pathway being rolled out.

- We are committed to eliminating out of area placements for non-specialist acute care by 2020/21, and we will implement a single Trust-wide bed management system to support more efficient use of our beds across all of our inpatient units.

- We will work to deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism. Our Primary Learning Disability Liaison Nurse Service will support primary care and raise awareness, underpinning the reduction in inpatient bed capacity in CCG and NHS England commissioned beds per million population. Our clinical pathways aim to reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.

- We are implementing Quality Improvement plans to improve quality of care, and using tools such as e-rostering to improve efficient use of staffing resources in order to ensure safe, sustainable and productive services.

We will also work with commissioners to agree a Service Development and Improvement Plan to ensure premises are smoke-free by 31 December 2018.

2.0 Sustainability and Transformation Plans (STPs)

We are playing a central role in the implementation of our two local Sustainability and Transformation Plans (STPs); ensuring mental health needs are addressed as part of a whole-person approach to care. The two STPs are being developed with different planning regimes, meaning a different approach to each area, but across both plans we are:

- Working with others in the system-wide response to local health and social care challenges
- Collaborating with the wider health economy, with a commitment to sharing best practice and learning
- Lobbying for appropriate funding for mental health services
- Creating standardised clinical pathways, integrated flexibly at a local level according to need and the chosen local system model.

We share our footprint with seven CCGs across two counties. Our localities are coterminous with each CCG, enabling us to integrate on a local level, reflecting the needs of our diverse communities and wider health system. While each CCG has a different population profile and priorities, they have a shared commitment to achieving integrated care to help meet the challenges around demand, efficiency and funding.

2.1 STP Footprints

We operate across two STP footprints:

**Norfolk and Waveney**, comprising the following CCG areas:

- North Norfolk
- South Norfolk
- Great Yarmouth and Waveney (Waveney is a district of Suffolk)
- West Norfolk
Suffolk, comprising:

- Ipswich and East Suffolk CCG
- West Suffolk CCG
- North Essex

### 2.2 Norfolk and Waveney STP

The outcomes for the STP by 2021 relating to mental health services are based upon a) providing physical, mental and social care through integrated place or locality based teams who work together to help the most vulnerable people manage their physical and mental health better and remain in their community and b) achieving parity of esteem between physical and mental health.

A dedicated Mental Health workstream was formed in August 2016 to maximise the contribution that transformation of mental health services can make to the system’s goals. The system reviewed high level plans and priorities suggested by the workstream which include improvements in acute liaison, crisis resolution, physical health checks for people with mental health needs and plans to radically reduce out of area placements.

This will be achieved through the introduction of new, integrated mental, physical and social care models designed to support those at greatest need at a locality level, facilitated by additional investment. Mental health priorities are:

- Supporting people in the community, reducing the need for acute and residential beds
- Reducing acute activity
- Increased support for people with mental health co-morbidities
- Improved life-long mental wellbeing through early intervention services
- Improved physical health of people with mental health needs through physical health checks
- Improved detection and management of dementia
- Supported patient recovery through psychological therapies
- Training community health staff to better understand mental health pathways
- Increased capacity to support people of all ages in crisis
- Reduced use of acute out of area beds
- Reduced mental health related A&E attendances
- Reduction in frequent attendances by people with a reported mental health condition

### 2.3 Suffolk and North East Essex STP

We have established some key programmes of work to deliver our vision and improve the health and care services. These programmes build on existing schemes that Suffolk teams have been working on, and we are sharing ideas and plans across the footprint to maximise the benefits offered to our patients and the system.

Our aim is that people’s mental and physical health are considered and treated together to recognise that both areas are inseparable to a person’s health and wellbeing. This involves joined up, family focussed responses to all children, young people and families presenting with emotional, behavioural or mental health needs, and a “whole system” approach to the delivery of specific services such as crisis mental health care, psychological therapies for people with long term conditions, suicide prevention, LD Transforming Care and psychiatric liaison.

The STP is based upon providing more resources in communities which will reduce cost and demand in hospitals and improve quality. People will get more support and tools to help look after their own health
needs, supported by local alliances between public and partners providing integrated physical and mental health and social care rooted in local communities.

A key strand of the STP is the mentally healthy communities programme. This focuses on improving mental health service provision and integrating physical and mental health through communities. Mental health priorities include:

- Provision of co-designed, excellent, cost effective and transformational mental health services
- Continuing to improve the diagnosis rate and care plan provision for people with Dementia as part of a wider transformation of dementia services
- Continuing to implement the LD Transforming Care Plans and LD Strategies with a focus upon reducing the reliance on inpatient provision
- Promotion of health, independence, resilience and wellbeing with a stronger focus on improved awareness and identification of people with mental health problems
- Delivery of holistic and integrated mental and physical health responses and support so that needs are considered and treated together
- Developing a skilled workforce focussed on resilience and recovery approaches
- Reduce reliance on inpatient provision, increasing home treatment options, treating people in least restrictive setting including delivering our LD Transforming Care Plans
- Development of outcome focussed services

3.0 Quality Planning

We recognise that delivering quality services, reaching our strategic goals and achieving financial balance requires a structured and disciplined approach. We have embedded our Programme Management Office (PMO), providing us with a structured framework for defining and implementing change.

As part of our PMO governance framework we have established three Strategic Mobilisation Boards: Workforce, Technology and Estates. These implement the Trust’s strategy through active change management and support delivery of the financial and quality improvement plans.

3.1 Approach to Quality Improvement

Dr Jane Sayer, Director of Nursing and Quality is the Trust executive lead for quality improvement.

The Trust has recently been inspected by the CQC and has received a rating of ‘Requires Improvement’ in October 2016. A quality improvement plan based on the feedback has been developed to address the areas of non-compliance with the fundamental standards.

The second stage will be a plan to improve the Trust overall rating to good or outstanding, focussing on the separate core services and the specific actions required to ensure an excellent service as well as continuing to maintain the progress already made. Our approach will incorporate intelligence from the mental health trusts which are currently rated as excellent, feedback from the CQC in any follow up inspections and attention to service user and carer feedback.

3.1.1 Quality Improvement Governance

Our Quality Governance Committee has delegated authority from the Board of Directors to oversee the quality and patient safety agenda. Membership includes leaders from all service areas and key executive directors and is chaired by the Trust Chair. The Committee triangulates data from the services, CCGs and external bodies and monitors performance against the quality dashboard, agreed with our commissioners and regulators.

The Board of Directors receive an overview of trends and activity on a quarterly basis. We use standardised agenda templates from Board to ward for patient safety meetings, and localities summarise issues from their teams to the monthly Quality Steering Group, ensuring we have consistent focus and standardised reporting.
Peer inspections and thematic inspections provide additional assurance that quality standards are met, and these involve colleagues from CCGs, service users and carers.

3.1.2. Quality Improvement Capacity and Measurement

The Programme Management Office supports transformational plans, and a key priority for 2017 is the development of the Trust’s Quality Improvement (QI) approach. We will draw on the experience of other Trusts to develop our approach, and build on previous training in QI and project management, particularly with the intention of supporting quality improvement clinical leadership.

Quality is measured through a dashboard. This is being developed into an integrated report with finance and performance in order to monitor the impact of quality changes more widely.

3.2 Quality Improvement Plan

Our Trust has a comprehensive Quality Improvement Plan developed with the CQC with a range of measures being implemented in the two year period. The plan particularly focuses on safe staffing, mental health standards, serious incidents, patient experience, national CQUINs and consistency with STPs. The plan includes:

- Ensuring sufficient staff are employed and trained to provide care to meet patient needs at all times.
- Completion of ‘Fresh eyes’ ligature and line of sight assessments to provide a Trust-wide approach.
- Review of acute accommodation to meet DoH and MHA guidelines including mixed-sex accommodation and seclusion facilities.
- Fully embedding and exploiting Lorenzo as our single clinical system to protect patient safety and enhance care provision.
- Developing the quality of mortality reviews and how this impacts on working with other health providers in supporting service users physical and mental health needs. Nationally, such work is in relative infancy and the Trust is linking with other providers and DOH to develop this work.
- Structuring serious incident investigations to enable the Trust to examine events where people experience significant harm or unexpected death. The Trust is committed to ongoing development of the skills and processes to get the most learning out of such events in order to support safety and quality.
- Following national CQUIN indicators relating to improving physical healthcare to reduce premature mortality in people with SMI; improving staff and wellbeing; improving flu vaccination uptake by front line clinical staff; improving services for people with mental health needs who present to A&E; transitions out of Children’s and Young People’s Services.

3.3 Quality Impact Assessment process

All Quality Improvement Plans (QIPs) and Cost Improvement Plans (CIPs) have a Quality Impact Assessment (QIA) which is signed off by the Director of Nursing and Medical Director to ensure any impact on services is known and mitigated. These are shared with commissioners as part of their quality governance meetings and assurance process.

A Trust-wide QIA master template has been developed and approved by the Executive team. The template summarises the impact on service users, carers and staff using the Trust’s 5*5 risk matrix. Our Quality Impact Review Group review all proposed QIAs to provide a detailed (independent to the project team) level of scrutiny for new proposals.

The QIA is an integral part of the Project Initiation Document (PID). The PID itself covers project outcomes, project delivery description, key stakeholders, initial key performance indicators (KPIs) and milestones and identified resources and risks. The individual QIAs are developed collaboratively between the project lead and
clinical lead, with support from the Programme Management Office. If there is no clinical lead identified, then this role will be filled by the Medical Director or Director of Nursing.

The completion of the QIA may draw attention to additional elements required within the PID, or to previously unidentified costs. This process continues until the team involved agrees that the PID and QIA are complete, and the Project Lead and Executive Sponsor and either the Medical Director or Director of Nursing have signed it off.

The completed PID and QIA are submitted together to the relevant mobilisation board (Workforce, Estates and Beds or Technology). As part of the project documentation the QIA has to be reviewed and recorded that all open risks have been actioned in line with the original assessment.

3.4 Triangulation of Indicators

We use a quality dashboard to report monthly against a series of KPIs. The dashboard is reviewed monthly at the Quality Governance Committee where the data is triangulated with reports from the responsible senior manager. The dashboard is also reviewed at locality performance review groups. Locality staff interrogate the data in order to understand what the issues are and then make plans for any necessary changes.

The dashboard is triangulated with audit data where appropriate, linked to peer reviews and spot-checked within teams to provide the qualitative element.

We have a plan to introduce balanced scorecards to summarise information and ensure that improvement plans are cohesive and responsive.

4.0 Workforce

Our workforce planning is informed by our Workforce and Organisational Development Strategy 2016-21. The strategy has been developed with staff, service users and managers and focuses on an engaged, skilled and responsive workforce. It aligns with our Trust Strategy, our Clinical Strategy and our STPs, and is in line with the Draft Mental Health Workforce Strategy recently published for consultation by Health Education England. An important driver of the strategy is improving the accountability of management within the trust.

4.1 Key aspects of our Workforce Strategy

- Developing existing and new roles, with clear career pathways, for example, using the Talent for Care Framework as a route to registered clinical professional roles, coupled with working closely with educational providers to develop more innovative and service relevant training opportunities with accelerated pathways for those with appropriate experience and qualifications (e.g. flexible nurse training, graduate pathway).

- Using technology to support a more efficient and responsive workforce, for example, mobile working in the community.

- Ensuring we use our existing workforce in the most cost effective way, supported by e-rostering and job planning.

We undertake an annual review of our five year workforce plans to ensure these reflect opportunities, challenges and organisational changes. We include engagement with managers in considering service activity plans for the next year. We engaged with over 100 operational managers through our Senior Management Engagement Forum (November 2016) which particularly explored opportunities for role innovation given national skills shortages. This event was co-facilitated by Health Education East of England.

4.2 Workforce changes 2017-19

We are supporting a range of workforce changes in service areas including:

Suffolk – redesign of Learning Disability Services for East and West Suffolk, redesign of Children and Young People’s Services, review of 24/7 access, redesign of Rehabilitation and Recovery pathway.

Norfolk – Early Intervention/IAPT service developments; relocation and expansion of CAMHS Tier 4 services, implementation of Norfolk & Waveney’s Local Transformation Plan (LTP) produced collaboratively by Norfolk’s
CAMHS Strategic Partnership; establish Compass Outreach and PIMHS Sustainability projects as an integrated business-as-usual approach; service redesign for Learning Disability Services for children and young people in Waveney, provision of improved seclusion and de-escalation facilities across medium and low Secure Services, development of perinatal mental health service.

Changes will be implemented with regard to our key demand and supply factors:

- Skills shortages across the Trust mirror national skills shortages, in particular registered nurses (16.08%* vacancy rate) and doctors (15.74%* vacancy rate). The position is, however, exacerbated in some areas with geographical challenges and, additionally, for West Suffolk, cost of living pressures.

- A mature workforce age profile.

- Changes in skill mix, for example, replacing long-standing vacant Consultant posts with Advanced Nurse Practitioner posts (where appropriate) and building our Assistant Practitioner workforce to provide experience and skilled support to inpatient areas and a pipeline for development through a flexible nursing pathway to become registered professionals.

- Changes in education commissioning and the removal of bursaries for nursing students create uncertainty in terms of future workforce supply.

- Based on current commissioned places, even if all places are filled and there is no attrition, this is not sufficient supply to meet our skills needs, hence our focus on a more innovative approach to our future workforce.

- Significant organisational change including expansion (e.g. national investment in our Children, Families and Young Persons services) and contraction (e.g. Secure Services and Norfolk Recovery Partnership, both resulting from commissioning decisions).

- Impact of the apprenticeship levy from April 2017.

- Uncertainty regarding the impact of ‘Brexit’ on our workforce and future retention and supply of non-UK staff given 8.7% of our workforce is not of UK nationality.

Our forecast out-turn for 2016/17 and our plans for 2018/19 year end are summarised in the table below. These take into account additional investment in Early Intervention, DCLL, ADHD and Perinatal services and the removal or skill-mixing of a small number of long-standing vacant posts, for example, some medical vacancies that have been difficult to recruit to being converted to Advanced Nurse Practitioners and/or Physician Associates. There is an increase to non-medical clinical staff of 101 whole time equivalent (wte). This results in an overall increase of 94 wte clinical and -17 wte in non-clinical. Through the management of temporary staffing demand and recruitment to our vacancies, our plans aim to reduce bank and agency temporary staffing by equivalent to 123 wte temporary staff.

<table>
<thead>
<tr>
<th></th>
<th>Forecast Out-Turn</th>
<th>Plan</th>
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<tbody>
<tr>
<td></td>
<td>2016/17 Average</td>
<td>2018/19 Year-end</td>
</tr>
<tr>
<td>Substantive Non-Medical Clinical Staff</td>
<td>2,397</td>
<td>2,498</td>
</tr>
<tr>
<td>Substantive Medical and Dental Staff</td>
<td>200</td>
<td>193</td>
</tr>
<tr>
<td><strong>Total clinical</strong></td>
<td><strong>2,597</strong></td>
<td><strong>2,691</strong></td>
</tr>
<tr>
<td>Substantive Non-Medical Non-Clinical Staff</td>
<td>941</td>
<td>924</td>
</tr>
</tbody>
</table>
This year the Trust has reallocated some staff between support to clinical staff and NHS infrastructure support as for certain groups we believe that they should sit in NHS infrastructure support due to the nature of their roles.

4.3 Workforce Efficiency

Our workforce plans are developed in close liaison with finance and staffside colleagues (draft plans were discussed at our Trust Partnership Meeting in June 2016) and approved by the Executive Team to ensure they are sufficient to deliver safe and quality care as well as being affordable. This process is supplemented by reviews of staffing levels throughout the year, for example, in response to any issues highlighted by safer staffing reports or where other performance or quality indicators might suggest there is an issue.

In 2017-19, we will continue to focus on workforce efficiency in the following ways:

- Effective people management to support our staff to be the best they can be in their roles
- Implementing our Workforce Strategy operational implementation plans to reduce sickness absence and to improve recruitment and time to hire. This includes the implementation of a new applicant management system in early 2017 and a more collaborative and cost efficient approach to recruitment to key posts, supported by the use of social media
- Review our skill mix as vacancies arise and through workforce redesign as services are reviewed
- Improving rostering efficiency and maximising the benefits achievable through electronic rostering
- Reducing temporary staffing demand including a review of our approach to managing additional observations
- Building our temporary staffing bank by extending the types of roles covered by this and ensuring our pay rates are competitive to increase the migration of agency workers and the sign up of substantive staff
- Exploring collaboration with other organisations where this is in the best interests of our patients as operational STP plans are developed
- Optimisation of the benefits of electronic job planning which is due to be fully implemented from April 2017

5.0 Governors and Members

Following the merger of Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Trust on 1st January 2012 the constitution of the newly formed Norfolk and Suffolk NHS Foundation Trust was amended to create the following elected governor constituencies:

<table>
<thead>
<tr>
<th>Service User</th>
<th>Carer</th>
<th>Staff</th>
<th>Norfolk Public</th>
<th>Suffolk Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Norfolk</td>
<td>1 Norfolk</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2 Suffolk</td>
<td>1 Suffolk</td>
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</tbody>
</table>

Transitional arrangements were put in place for the first year and since then approximately one third of seats are elected each year. In practice, as governors sometimes resign before their term is complete more (or fewer) than a third of seats are actually available each year. Elections take place in November / December with
governors taking up their seats from 2nd February each year. We also have Partner Governors with the University of East Anglia, University of Suffolk, Norfolk County Council and Suffolk County Council.

The election process is underway for the intake of governors for 2017. Nominations opened on 02.11.16 and the results will be declared on 30.12.16. The following seats are open for election this year:

<table>
<thead>
<tr>
<th>Service User</th>
<th>Carer</th>
<th>Staff</th>
<th>Norfolk Public</th>
<th>Suffolk Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Norfolk</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

5.1 Governor recruitment, training, development, and engagement

Governor recruitment is supported by a communications plan which includes writing personally to every member who has expressed an interest in standing as a governor inviting them to an information session. There is a comprehensive training and development programme for governors covering their statutory role, the wider NHS and social care system, and the work of the Trust. This training is evaluated and is updated each year following a training needs assessment. The Trust employs a full-time membership and engagement officer who organises a wide range of public and member engagement opportunities linking in with community events. Of particular note are two half day conferences held each year by the Council of Governors on topics of interest to members. These attract up to 200 members to each event.

5.2 Membership strategy

The membership strategy is overseen by the Trust Member and Governor Development Subgroup. There is a targeted approach to member recruitment to balance the demographic profile of membership to the population. We maintain a presence at local community events such as One Big Multi-cultural Day, LGB&T Pride, Disability Day and the Suffolk Indian Mela. In the coming year we are planning to refine our ‘offer’ so that the benefits of membership are clearer to potential members.

6.0 Finance

6.1 Summary financials

The NHS continues to face significant financial challenges. Provider sector performance declined sharply in 2015/16 to a year end deficit of £2.5billion and demand for services continues to rise. In order to ensure financial viability and sustainability of services, every health and care system has been required to deliver a Sustainability and Transformation Plan to 2021. Other financial measures have been implemented to drive improved financial performance with effect from 2016.

As part of the process to strengthen and improve financial performance NHS Improvement and NHS England require two-year operating plans that deliver the Sustainability and Transformation Plan visions.

All NHS Trusts and Foundation Trusts have received a financial control total which will be delivered for 2017/18 and 2018/19. The Board has confirmed acceptance of the control total which is £1.147m deficit in 2017/18 and £0.864m surplus in 2018/19. Sustainability and Transformation funding of £1.3m is included within this financial position.

The acceptance of the control total requires acceptance of the agency ceiling (£10.783m in both planning years and the same ceiling as 2016/17), which the Trust will accept as part of this planning process.
Table 1 – Income statement

<table>
<thead>
<tr>
<th>Top Summary</th>
<th>Outturn</th>
<th>Plan 2017/18</th>
<th>Plan 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>EBITDA</td>
<td>7.0</td>
<td>10.7</td>
<td>12.4</td>
</tr>
<tr>
<td>Net Surplus / (Deficit)</td>
<td>(4.8)</td>
<td>(1.1)</td>
<td>0.9</td>
</tr>
<tr>
<td>Total assets employed</td>
<td>116.4</td>
<td>115.2</td>
<td>116.1</td>
</tr>
<tr>
<td>Cash balance</td>
<td>9.5</td>
<td>10.2</td>
<td>9.9</td>
</tr>
<tr>
<td>CIP</td>
<td>10.0</td>
<td>10.0</td>
<td>8.4</td>
</tr>
<tr>
<td>Capex</td>
<td>(4.8)</td>
<td>(8.2)</td>
<td>(8.0)</td>
</tr>
<tr>
<td>Risk rating</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>

The assumptions in the plan include a small increase in clinical income due to inflation, an increase in income for the ‘Mental Health Investment Standard’, a CIP target of £10m and a decrease in temporary pay premium. Outturn figures for 2016/17 referenced in this paper and the template relate to Month 7 forecast outturn. The plan risk rating is 3, with the best rating being a ‘1’ and the worst a ‘4’.

The key assumptions included within the plan are outlined on the following pages. The provider workforce plans have been complied by Finance and HR working together to ensure consistency in approach and are approved by both the Finance Director and Director of Strategy and Resources. The CIP plans are approved at the Executive level with regular reporting to the Board and its subcommittees. Quality Impact Assessments are completed for all plans and signed off by the Director of Nursing and the Medical Director.

6.2 Financial forecasts and modelling

Table 2 – Income summary

<table>
<thead>
<tr>
<th>Income breakdown</th>
<th>Outturn</th>
<th>Plan 2017/18</th>
<th>Plan 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>£m</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norfolk CCGs</td>
<td>74.7</td>
<td>79.4</td>
<td>79.4</td>
</tr>
<tr>
<td>GY&amp;W CCG</td>
<td>30.4</td>
<td>31.4</td>
<td>30.6</td>
</tr>
<tr>
<td>NHS England</td>
<td>18.1</td>
<td>18.6</td>
<td>18.6</td>
</tr>
<tr>
<td>Suffolk CCGs</td>
<td>63.7</td>
<td>65.5</td>
<td>65.5</td>
</tr>
<tr>
<td>Clinical Partnerships</td>
<td>9.5</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td>Clinical income for the Secondary Commissioning</td>
<td>2.2</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Other clinical income</td>
<td>5.2</td>
<td>8.1</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Clinical income, sub-total</strong></td>
<td><strong>203.8</strong></td>
<td><strong>213.5</strong></td>
<td><strong>213.0</strong></td>
</tr>
<tr>
<td>Research and development income</td>
<td>1.0</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Education and training income</td>
<td>3.0</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Misc. other operating income</td>
<td>4.7</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Non clinical income, sub-total</strong></td>
<td><strong>8.7</strong></td>
<td><strong>6.6</strong></td>
<td><strong>6.6</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>212.5</strong></td>
<td><strong>220.1</strong></td>
<td><strong>219.6</strong></td>
</tr>
</tbody>
</table>
Net inflation of 0.1% (2.1% inflation less 2.0% efficiency requirement) has been included within the plan, being £0.2m. There has been no inflation assumed for 2018/19. This is in line with national requirements.

CQUIN funding of 2.5% (£2.5m for CCGS) is included within the plan for both years. The plans assume full achievement and no contingency has been provided. Recovery in 2016/17 is predicted to be 93% across all Commissioners as reported at month 8.

Claire Murdoch (National Mental Health Director, NHS England) refers in her guidance letter dated November 2016 to “I would draw to your attention, the Mental Health Investment Standard (formerly Parity of Esteem). This requires Mental Health investment to be uplifted in line with other investment. This uplift must not supplant other investment for new developments.” In line with this guidance the Trust included £3.7m of ‘Mental Health Investment Standard’ income in the first version of the Annual Plan (submitted in November).

Since the initial submission the plan has been updated and Suffolk CCGs have provided £1.3m of Mental Health Investment Standard monies (MHIS) in the contract offer. Norfolk CCG’s have not confirmed any MHIS money however they have offered £4m of development monies for which there are associated costs.

The plan does not include any income or costs relating to the Five Year Forward View (5YFW). However it is expected that our financial plan will be uplifted for the SYFV investments as these are agreed throughout the year.

The plan assumes additional income of £3.4m in 2017/18 (£0.2m in 2018/19) outlined in the efficiencies section, which is separate to the Mental Health Investment Standard monies discussed above.

The reduction in non-clinical income is largely due to non-recurrent income which has not been budgeted in 2017/18. It is likely that Research and Development income and Misc Operating Income will be higher as the year progresses but there will be corresponding costs associated with this income.

STF funding of £1.3m has been included in the plans for 2017/18 and 2018/19 and is contingent on the Trust meeting the control totals. This is included in NHS England income in Table 2 above.

6.3 Expenditure

A summary of expenditure is shown in Table 3 below.

**Table 3 – Expenditure breakdown**

<table>
<thead>
<tr>
<th>Expenditure breakdown</th>
<th>Outturn 2016/17</th>
<th>Plan 2017/18</th>
<th>Plan 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>(165.8)</td>
<td>(161.3)</td>
<td>(161.2)</td>
</tr>
<tr>
<td>Drugs</td>
<td>(3.1)</td>
<td>(3.0)</td>
<td>(3.1)</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>(0.4)</td>
<td>(0.5)</td>
<td>(0.5)</td>
</tr>
<tr>
<td>Secondary Commissioning</td>
<td>(7.0)</td>
<td>(6.7)</td>
<td>(6.7)</td>
</tr>
<tr>
<td>Education and training expense</td>
<td>(0.6)</td>
<td>(0.9)</td>
<td>(0.9)</td>
</tr>
<tr>
<td>Consultancy costs</td>
<td>(0.1)</td>
<td>(0.0)</td>
<td>(0.0)</td>
</tr>
<tr>
<td>Premises</td>
<td>(10.6)</td>
<td>(10.5)</td>
<td>(10.4)</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>(0.3)</td>
<td>(0.5)</td>
<td>(0.5)</td>
</tr>
<tr>
<td>Misc. other Operating expenses</td>
<td>(16.4)</td>
<td>(24.9)</td>
<td>(22.7)</td>
</tr>
<tr>
<td>PFI</td>
<td>(1.2)</td>
<td>(1.2)</td>
<td>(1.2)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(7.2)</td>
<td>(7.3)</td>
<td>(7.0)</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>(212.7)</strong></td>
<td><strong>(216.7)</strong></td>
<td><strong>(214.2)</strong></td>
</tr>
<tr>
<td>PDC</td>
<td>(3.7)</td>
<td>(3.7)</td>
<td>(3.7)</td>
</tr>
<tr>
<td>Loss on disposal of assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other non operating expenses</td>
<td>(0.9)</td>
<td>(0.9)</td>
<td>(0.9)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>(217.3)</strong></td>
<td><strong>(221.3)</strong></td>
<td><strong>(218.7)</strong></td>
</tr>
</tbody>
</table>
Pay inflation of 2.4% (£3.9m) has been included in the plan for 2017/18. This has been calculated on an individual staff basis. Pay inflation for 2018/19 is assumed to be £3.5m. Pay inflation includes the national pay award and the cost of increment increases.

Employee costs overall are expected to reduce from 2016/17 to 2017/18. This is driven by CIP’s and a reduction in temporary staffing. However there is significant investment from Norfolk CCG’s in new developments offsetting against this.

There is also a significant technical movement of £7.5m between pay and non-pay costs for services received which are now classified as non-pay. This change has occurred to match the FTC’s.

Last year an allowance was made for premium payments for all nursing, corporate and locum medical agency staff based on forecast expenditure, this has not been included in the 2017/18 plans as it is expected that these can be managed within overall permanent staffing budgets, and this has been proved to be the case in 2016/17.

There is £0.3m included in the plan for non-pay inflation; from an analysis of our 2016/17 this should be adequate to cover any inflationary uplifts. There are also additional costs in the plan relating to the Apprenticeship levy (£0.7m). Of the £0.7m apprenticeship levy £0.5m is included in pay costs. Every opportunity to bid for funds associated with the apprenticeship levy must be taken. This will include the cost of training.

Expenditure on Out of Trust placements for 2016/17 is forecast at £3.3m. The agreement with Norfolk and Waveney CCGs is to adopt a risk share approach pending the outcome of the bed review (a commissioned external review due in Q1 2017/18). The outcome of bed review will be available in February and a joint action plan will be agreed between NSFT and the CCGs. In the meantime, the CCGs have agreed to fund the ‘Out of Trust’ costs above budget in the period April to June 2017. There will need commitment from all parties to deliver the agreed plan.

6.4 Reserves
Contingency within the plan totals £0.9m, this includes:
- £0.2m CQC costs
- £0.1m General provision
- £0.1m Contract Contingency
- £0.2m Hellesdon site move
- £0.3m Cost pressures reserve

£0.6m of these costs are classified as contingency in the template and £0.3m are classified as ‘Other non-pay inflation’.

6.5 Capital expenditure
Capital expenditure supports the Trust’s plans to improve the quality of the service provided as part of the estates strategy as well as upgrades, systems developments and spend on disaster recovery within the ICT strategy. The expenditure will be funded from depreciation.

There are no planned asset disposals included in the template.
6.6 Statement of financial position and cash flow

Table 4 - Financial position and cash flow

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus(deficit) from operations</td>
<td>(0.2)</td>
<td>3.4</td>
<td>5.4</td>
<td>149.0</td>
<td>147.9</td>
<td>146.9</td>
</tr>
<tr>
<td>Non-cash flows in operating surplus/(deficit)</td>
<td>7.2</td>
<td>7.3</td>
<td>7.0</td>
<td>17.0</td>
<td>16.2</td>
<td>16.0</td>
</tr>
<tr>
<td>Operating cash flow</td>
<td>7.0</td>
<td>10.7</td>
<td>12.4</td>
<td>(32.4)</td>
<td>(34.2)</td>
<td>(34.6)</td>
</tr>
<tr>
<td>Increase (decrease) in working capital</td>
<td>4.9</td>
<td>1.3</td>
<td>(1.6)</td>
<td>(17.2)</td>
<td>(14.7)</td>
<td>(12.3)</td>
</tr>
<tr>
<td>Increase (decrease) in non current provisions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Investing activities</td>
<td>(5.3)</td>
<td>(5.5)</td>
<td>(5.4)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest Paid</td>
<td>(0.4)</td>
<td>(0.4)</td>
<td>(0.4)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dividend repaid/received</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Loan repaid</td>
<td>(1.1)</td>
<td>(1.1)</td>
<td>(1.1)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other financing activities</td>
<td>(4.1)</td>
<td>(4.4)</td>
<td>(4.4)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net Cash inflow/outflow</td>
<td>1.1</td>
<td>0.7</td>
<td>(0.4)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Opening balance</td>
<td>8.5</td>
<td>9.5</td>
<td>10.2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Closing balance</td>
<td>9.5</td>
<td>10.2</td>
<td>9.9</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The year-end cash position remains consistent between the 3 periods as shown in the table above.

The final year end cash balance is above an appropriate operational level of cash (approximately 15 days of operational cash equals £8.4m). However careful cash management will be required over 2017/18 particularly. The cash-flow assumes that a £10.0m CIP target will be delivered and that the planned mix of CIP (between recurrent and non-recurrent) is achieved.

6.7 Plan Risk Rating

The Trust has a predicted Plan Risk Rating of 3 as follows:

Table 5 - Planned Risk Rating

<table>
<thead>
<tr>
<th>Planned risk rating</th>
<th>Outturn 2016/17</th>
<th>Plan 2017/18</th>
<th>Plan 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Service Cover rating</td>
<td>4.0</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Liquidity rating</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>I&amp;E Margin rating</td>
<td>4.0</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Variance from control total</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Agency rating</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Financial Sustainability Risk Rating</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

The Trust has a predicted Plan Risk Rating of 3. The ratings have changed since last year and the ratings are now 1 to 4 with 1 being the highest. The area where the Trust is weakest from a Plan Risk rating perspective is liquidity levels due to the cash position. The plan risk rating before overrides at the end of 2017/18 and 2018/19 is a ‘2’. However because the liquidity rating is a 4 the override trigger is put into place which results in a maximum 3 rating overall.

6.9 Agency Rules

The Trust is committed to ensuring that spend on agency use is contained within the cap imposed by NHS Improvement (NHISI) and to that end has implemented the following action plans to manage and monitor that spend:

- The majority of agency appointments are now made within recognised frameworks and have seen a reduction in rates across all clinical groups including recommended caps as introduced by NHISI in 2015.
• The establishment of an agency Task and Finish Group to identify actions to tackle excessive agency expenditure.

• The implementation of increased pay rates of qualified bank nursing rates to entice staff to register with the Trust’s bank staff and so alleviate the need to allocate shifts from an agency to an internal bank pool.

• Weekly monitoring to Executive staff of agency cap rates to monitor where these are occurring and to enforce take up of fixed term contracts as NHS payroll engagements.

The biggest challenge to the Trust is the inability to secure permanent recruitment of senior medical staff due to geographical location and market availability. This is being closely monitored and a series of recruitment drives and initiatives are being considered.

6.10 Procurement

The Trust is committed to following the recent guidance from NHSI on procurement both in terms of establishing a core set of NHS products to be used by all NHS provider Trusts as well as working jointly with neighbouring NHS providers (both Acute and Community) to secure best deals in terms of prices and buying power. Work has already commenced on this and expects to see cost reductions on a number of expenditure headings over the coming months.

6.11 Risks and mitigations

The key risks to delivering the 2017/18 plan are:

• The required savings plans are significant, particularly in 2017/18 and there are some CIP schemes where the Trust is still defining the exact savings.

• Agency costs and our ability to contain staffing costs within budget levels.

• Budget holder’s ability to manage within budget.

• Further work is required relating to the cost of the SYFV to understand the implications for future plans.

• Maintaining cash at a sufficient operational balance.

• A sense of urgency to address some of the issues which end up as a financial pressure.

To mitigate against this:

• The Trust is confident that it can meet the CIP levels in 2017/18 as the process is underpinned by a more stable and effective PMO that was introduced following the Financial Recovery Plan review. In addition the Trust Board has reviewed the PMO and the governance arrangements and strengthened the model.

• There is a robust process of embedding ideas into operational plans and a continuous process of identifying new pipeline CIP ideas, which has not been previously managed in this way, enabling the planned CIP level. The Trust has initiated a benchmarking exercise to allow for further ideas to be generated. The Trust will deliver £10m in 2016/17 (including income CIP) and therefore £10m in 2017/18 is viable. CIPs in relation to this target are already in progress (see Efficiencies section). In extremis a further mitigation would be to review and hold vacancies as a last resort, should planned CIP delivery fall behind schedule.

• Whilst there is a risk share approach to Out of Trust placements we have to address the outcome and recommendations from the bed review when it reports in February. This is key to keeping our costs under control.
• Contingency reserves of £0.9m are included in both years of the plan.

• The Trust is playing a very active role in the STP process and the financial consolidation is being led by the Trust which will aid the further understanding of CCG income and associated additional costs.

6.12 Capital planning

Following on from last year our capital programme for 2017/18 takes account of the need to target those areas identified by recent CQC recommendations in terms of patient quality and safety. Consideration has been given to the Trust’s Estates and ICT strategies to maximise the use of limited resource and maximising asset disposals where appropriate. The current plans do not recognise any immediate asset disposal over the coming twelve months but we are working on a longer term strategy for this over the next five years. At present the Trust does not foresee any need at this stage to submit any business cases to NHS Improvement (NHSI) for investment case approval. The Trust is however reviewing the plans for asset disposals (where appropriate in line with service requirements) and a comprehensive review of remaining asset lives. These pieces of work will be carried out in the light of the STP work streams aimed at maximising NHS Estates usage in conjunction with our fellow NHS providers.