NHS

Central London Community Healthcare

NHS Trust

Operational Plan 2018-2019

*Public Version***

June 2018

*** Public version of the CLCH Operational Plan prepared for NHSI. The public version has certain commercially sensitive sections redacted*

Contents

1 Introduction

This document sets out the 2018/19 Operational Plan for Central London Community Healthcare NHS Trust (CLCH) in the format prescribed by NHS planning guidance. It provides a one-year update to the previously published two-year 2017-2019 Operational Plan. Whilst many aspects of our two-year plan remain relevant and appropriate, there are specific aspects, particularly around activity and finance, which required updating for 2018/19.

CLCH is one of the largest, dedicated community health service providers in the NHS, serving patients in ten London boroughs as well as the county of Hertfordshire. It employs over 3,000 staff working across more than 400 sites, delivering more than 70 services. The Trust has maintained a CQC rating of "Good" and is assigned the highest segment rating "1" in the new National Health Service Improvement (NHSI) single oversight framework (SOF).

The Trust published a new organisational strategy in March 2017 reflecting the priorities of the NHS Five Year Forward View. The strategy emphasises planned and integrated services that meet specific local needs through multi-disciplinary services - delivered in collaboration with our partners. The strategy also describes a geographical focus for the Trust in: North West London (NWL), North Central London (NCL), South West London (SWL) and Hertfordshire.

Looking towards 2018/19, the Operational Plan describes a number of priorities as follows:

- Ensuring we continue to deliver effective community services that maximise quality and value
- Delivering services within our local communities in partnership with primary care and other providers
- Managing the ongoing pressures for contract value reduction across both NHS and Local Authority commissioners
- Controlling agency staff utilisation and spend in line with NHS targets
- Delivering a transformative quality, innovation productivity and prevention (QIPP) programme, and reducing expenditure by £9.5 million in 2018/19
- Continuing to develop our strategic partnership with Capita, who provide a range of back office functions to the Trust.

NHSI control total includes £2.6m STF. The plan details the Trust's budget for 2018/19, including a target surplus of 1.9% of turnover (£4.2 million) in line with the sustainability and transformation fund (STF) control total. The Trust accepted the control total but this requires a substantial QIPP program.

2 Activity planning

As a community healthcare provider, the majority of our clinical activity is funded under block contracts. Associated with each of these contracts is an indicative activity plan (IAP). The IAP is reviewed each year and, for the 2018/19 planning round, we have been working with commissioners to assess activity levels against clinical service lines in order to understand demand and agree appropriate capacity. In general, demand for community services has increased year-on-year, primarily due to the increase in the frail elderly population. The difficulty for CLCH, as a provider, is that commissioners have very limited additional funding to support demographic change and therefore this puts pressure on performance. Additionally, a number of commissioners are seeking reductions in contract values due to financial constraints.

Since April 2016, the CLCH business information service has been managed by Capita - as part of a wider strategic partnership to enhance the efficiency of back office functions. We continue to work with Capita colleagues to improve the robustness of performance reporting, for example activity and key performance indicators (KPIs).

Our activity planning has followed a number of steps:

- Preparation of a service line list showing:
  - Year-to-date (month 6) activity levels outturn for 2017/18 compared with plan
  - A comparison with prior years
  - Adjustments for demographic growth
  - Adjustments for known service changes in year
  - An assessment of waiting times and referral rates in relation to KPI targets
- A review by operational service managers in the context of staffing and resource levels
- A review with commissioners (taking into account any commissioner requests for contract value reductions).

CLCH activity plans for 2018/19 are designed to ensure compliance with all key national targets such as 18-week waits. The Trust has no plans to outsource any activity capacity to independent sector providers.

Activity plans reflect changes relating to known new business tender outcomes only; no assumptions are included in relation to the outcome of potential future bids.

In line with 2018/19 planning guidance, CLCH has worked with commissioners to identify opportunities to expand community services / intermediate care services to reduce hospital length of stay, drawing upon reinvestment funding from acute 'excess' bed day expenditure.

Our Operational Plan takes account of the four sustainability and transformation plans (STPs) covering our service areas - as noted in the following paragraphs that provide some specific points around activity planning pertaining to each of our four operational divisions as follows.

Inner Division
The three Inner London Clinical Commissioning Groups (CCGs) (Central, West London and Hammersmith & Fulham) requested a substantial contract change for 2017/18 and 2018/19 amounting to an 18.4% contract value reduction over two years. CLCH has worked intensively with commissioners to agree service changes and efficiencies to meet this target

The majority of the phase one QIPP programmes agreed as part of 2017/18 plans, where CLCH was the project lead, have been achieved; however, as part of contract negotiations, time frames around certain service area changes unfortunately slipped. Commissioners have requested a continuation of the Tri-borough QIPP programme in 2018/19 – the detail of the schemes for 2018/19 will be developed during the year.

The Inner Division is also pulling together a joint plan with commissioners to create intermediate care beds within the existing Alexandra and Athlone facility. To do this, the Division is looking at the feasibility of converting the Alexandra facility into a dedicated intermediate care unit. This will require redesign of the rehabilitation model and a new workforce model across the bedded units.

South Division

The South Division is now responsible for the delivery of Wandsworth Community Adult Health Services (CAHS) and South West London (SWL) integrated sexual health contracts that went live on 1 October 2017. It is also well into year two of the Merton community services contract, performing strongly against all KPIs, and the inner boroughs' community and specialist dental service. With this strong foothold in SWL, CLCH is in a strong position to be well engaged with the STP processes and initiatives in this area. The Division has director level representation on the multispecialty community provider (MCP) programme board in Merton, as well as the Wandsworth and Merton local transformation board and emergency care delivery board. The Division is a significant stakeholder in the Wandsworth MCP, working alongside its commissioner Battersea Health Community Interest Company (CIC) to support developments in this area.

During the first six months of the Wandsworth CAHS contract, CLCH has been working with commissioners to assess the true activity levels in order to agree caseload and staff capacity priorities for 2018/19. The Division is also in the process of reviewing options for reducing costs whilst maintaining service levels and quality within Merton.

The SWL sexual health service is funded on a tariff basis and we are currently analysing activity levels to assess whether income will meet the forecast set out in the tender submission.

North Division

The North Division is responsible for a range of services across Barnet, Harrow, Brent, Inner London and Hertfordshire. Discussions have taken place with associated commissioners to review performance of 2017/18 against IAPs. Where services have over or under-performed, the reason for this is analysed and adjustments will be made to 2018/19 IAPs as appropriate.

In Barnet, the transformation of the current service delivery is imminent through the emerging STP Community Health Integrated Network (CHIN) program, as well as a vision to move towards an integrated adult service provision. Therefore, for 2018/19, while we can set IAPs based on outturns from 2017/18, in-year analysis of the impact of these developing schemes on performance will be required.

In Harrow, now that the service is fully embedded post service handover and with records transferred from SystmOne to Egton Medical Information System (EMIS) complete, the IAP review will center on in-year fluctuations that have occurred - to inform more accurate planning based on in-year actuals and service redesign.

In inner London, the review will focus on our three walk-in-centres and the impact of STP development and local service redesign on these busy services.

In Hertfordshire, we have recently procured a new online testing service that will have potential impact on the attendance in our clinics. An in-year review will be required to ascertain whether we are seeing more patients through this new online system or if activity is being transferred from the clinics to the new online service.

The North Division is also reviewing its use of the single health resilience early warning database (SHREWD) as part of our resilience strategy. We intend to further utilise this system to manage our response to demand fluctuations. If effective, we will extend usage of this database to our other three Divisions.

Children's Division
The Children's Division provides a range of services across ten London boroughs. The majority of these services are commissioned by Local Authorities (LA) with contracts ranging from three to five years in duration.

Inner London Local Authority contracts were extended in July 2017, subject to a requirement for CLCH to make savings. As part of these negotiations, a new performance framework was agreed with many of the national targets having stretch targets applied. This contract agreement has required significant transformation within the health visiting services.

In Barnet commissioners are also proposing an extension to the current contractual arrangement for the provision of the public health nursing services. The proposal is to extend the contract for two years, subject to a reduction in contract value. The Brent 0 to 19 year old service is entering its second year of contract in April 2018.

As stated, the three Inner London CCGs (Central, West London and Hammersmith and Fulham) requested a substantial contract change for 2017/18 and 2018/19 referred to above. Within the Children's Division this has specifically affected the Speech and Language Therapy (SLT) service. The activity plan for the new service specification has not yet been agreed with commissioners from the CCGs and Local Authorities. The activity planning was predicated on a reduction in the direct component of the education health care plans which has slipped due to the changes within the special education needs and/or disability (SEND) structures within the LA.

3 Quality planning

3.1 Approach to quality governance

The Trust executive lead for quality improvement is the Chief Nurse and Chief Operating Officer. The CLCH approach to quality governance is set out in the Trust's quality strategy; "Simply the Best, Every Time: A strategy for the delivery of outstanding care 2016-2020". There are six campaigns:

Three established campaigns:

Campaign	Description	Lead	Co-coordinating council	Enabling strategies
Campaign One **A Positive Patient Experience**	Changing behaviors and care to enhance the experience of our patients and service users	Director of Nursing and Therapies (Patient Experience)	Patient Experience	Patient and public involvement strategy
Campaign Two **Preventing Harm**	Reducing unwarranted variations in care and increasing diligence in practice	Director of Nursing and Therapies (Patient Safety)	Patient Safety and Risk	Risk management strategy sign up to safety
Campaign Three **Smart, Effective Care**	Ensuring patients and service users receive the best evidence based care, every time	Medical Director	Clinical Effectiveness	Continuous improvement strategy Research strategy Clinical framework

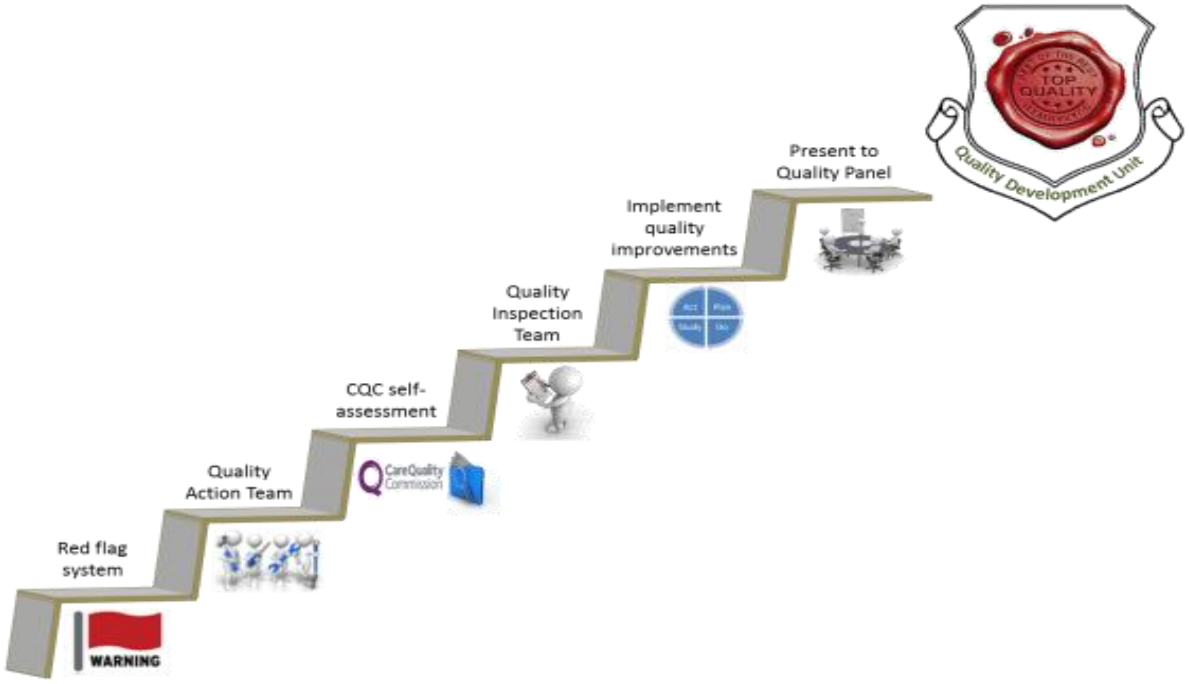
..and three new campaigns

Campaign	Description	Lead	Co-coordinating council	Enabling strategies
Campaign Four **Modeling the Way**	Providing world class models of care, education and professional practice	Chief Nurse and Chief Operating Officer	Education and Development	Education and learning strategy
Campaign Five **Here, Happy, Healthy and Heard**	Recruiting and retaining outstanding clinical workforce	Director of People and Communications	Workforce Partnership	People strategy Leadership strategy Health and well-being strategy
Campaign Six **Value Added Care**	Using enhanced tools, technology and lean methodologies to manage resources well including time, equipment and referrals	Medical Director / Director of Improvement	Getting Better Together	Information management and technology strategy, Quality, innovation, productivity and prevention strategy

The annual Quality Account objectives are based upon the key outcomes described in our quality strategy. Achievement of the strategy is key to our journey to move from a 'good' to 'outstanding' rating with the Care Quality Commission (CQC).

CLCH's steps to excellence

We know that the best meaning staff and teams can go through periods of challenge and performance can drop. Over the next three years we are concentrating on not only being able to identify at an early stage when things are going wrong, but also putting in a support structure to turn around any poor practice and to celebrate outstanding care. We have found that teams who have gone through difficult times and to whom we have put in extra support to turn around, have not just stopped poorly performing but have in fact become exemplar sites. With this in mind, we have designed a ladder of excellence which gives all teams the opportunity to become a quality development unit.



3.2 Summary of the quality improvement plans (specific areas)

3.2.1 National audits 2018/19 plans

The Trust plans to continue its participation in the National Clinical Audit and Patient Outcomes Programme (NCAPOP) audits during 2018/19. It is a requirement identified in the NHS standard contract and it is one of the key performance indicators that the Trust will participate 100% in all applicable national audits. The current national audits in which the Trust has registered include:

Audit name	Audit description
Chronic obstructive pulmonary disease (COPD)	This audit aims at driving improvements in healthcare service and quality for COPD patients
Sentinel stroke national audit programme (SSNAP)	This audit assesses the quality of the Trust, and delivery of multi-disciplinary inpatient stroke health services. It audits the care provided for patients during and after they receive inpatient care following a stroke
National diabetes foot care audit (NDFA)	This audit is a measurement system of care structures, patient management and outcomes of care for people with active diabetic foot disease.
National audit of intermediate care (NAIC) 2018	The NAIC provides an assessment of progress in community services aimed at maximising independence and reducing use of hospitals and care homes
National audit of hip fracture services (NAHFS)	The audit aims to improve the delivery of care for patients having falls or sustaining fractures through effective measurements against standards and feedback to providers.The Trust may choose to participate in other national audits, including national audits that are not part of the Trust's quality account

3.2.2 Safer staffing

The Trust will continue to:

- Develop models of staffing at a service level including skill mix and safe staffing levels
- Rebase establishments and undertake monthly monitoring of this using agreed key performance indicators
- Continue the implementation and monitoring of compliance with e-rostering across the Trust
- Work in partnership with other healthcare providers to pilot the nurse associate role and the Capital nurse foundation programme
- Develop and implement apprentice roles throughout the Trust
- Invest in workforce transformation to release 'time to care'.

3.2.3 End-of-life care

The Trust will continue to:

- Provide high quality, compassionate end-of-life care

- Ensure the involvement and engagement of all key stakeholders in decisions about end-of-life care
- Ensure the delivery of competent care for patients at the end-of-life

Specific aims include: improving end of life care and patient/carer experience, improving access to end of life care services, improving choice and co-ordination of services and increasing the proportion of patients who are cared for and die in their preferred place of care.

3.2.4 Infection control

The Hygiene Code compliance assessment is completed annually to identify priority areas for development. This was completed in March 2018. KPI's are monitored through proactive healthcare associated infections (HCAI) surveillance, an extensive infection prevention audit programme focusing on clinical practice and the clinical environment and developing and delivering infection prevention education and training to CLCH.

In addition to these core activities, the infection prevention team will be working towards:

- Participating in the regional work to achieve the gram negative blood stream infection (GNBSI) reduction. CLCH is a core member of the commissioning steering group, established in the autumn of 2017 and will undertake post infection reviews of cases of GNBSI in patients who have received care from CLCH and complete a review of catheter associated urinary tract infection surveillance processes including case definition and review tool to ensure that risk factor data is gathered proactively
- Developing guidance on infection prevention in the built environment to support the estates programme and to ensure that new and refurbished clinical premises meet Hygiene Code standards
- Working collaboratively with medicines management to further the antimicrobial stewardship (AMS) agenda in CLCH, building on the programme currently in place in CLCH services. Following the appointment of a specialist antimicrobial pharmacist, work to implement the AMS action plan will be prioritised with key actions to benchmark AMS processes in other trusts, developing the CLCH AMS strategy and setting up the Trust AMS group with membership including a consultant microbiologist. Progress was reported to Quality Committee in February 2018
- Supporting procurement to standardise and rationalise everyday healthcare consumables, to ensure that infection prevention considerations are a core part of the quality assessment of new clinical products used in CLCH
- Supporting new clinical services with implementation of infection prevention policies and procedures by undertaking infection prevention mandatory training, Hygiene Code assessments and implementing infection prevention audit programmes to include review of clinical practice and the clinical environment.

3.2.5 Falls

The falls steering group has three specific areas of focus: assessment of cognitively impaired patients; continence management; and ensuring that appropriate patients are admitted to the rehabilitation units. These areas were identified for focused attention following analysis of incidents.

3.2.6 Sepsis

There is clear evidence that the improved recognition, diagnosis and early management of sepsis is likely to reduce both mortality and morbidity. It is estimated that 10,000 deaths could

be avoided annually across the country. Guidance issued by the national institute for health and care excellence (NICE) on sepsis in 2016 focused on ensuring sepsis is identified at the first opportunity using a "think sepsis" approach. This NICE guideline was disseminated widely and the National Early Warning Score (NEWS) scoring system was introduced in CLCH's bedded areas, in line with guidance for acute hospitals. The Medical Director has agreed further work is required in the out-of-hospital environment and a small clinical group is working this year to develop a set of educational resources to reinforce clinical staffs' awareness, diagnostic capability and management skills regarding this clinical topic.

3.2.7 Pressure ulcers

The Trust continues to utilise a Trust-wide action plan to share learning from pressure ulcer investigations.

3.2.8 National Commissioning for Quality and Innovation (CQUIN)s

CLCH will continue to liaise with NHS commissioners to implement the national 2017/19 CQUIN related to community health Trusts as listed below. However, NHS guidance for 2018/19 states that the proactive and safe discharge CQUIN will not continue for 2018/19 and may be replaced by a local CQUIN - to be agreed.

1. NHS staff health and wellbeing
2. Proactive and safe discharge (suspended for 2018/19)
3. Wound care
4. Preventing ill health by risk behaviours
5. Physical health for people with severe mental illness
6. Personalised care support planning

3.2.9 STP

CLCH has been represented in STP work streams that relate to the four STP areas that we cover. This involvement enables the CLCH strategy to be consistent with the emerging STP priorities, including: moving care from acute to primary and community care environments; reducing unwarranted variation in care standards; promoting clinical excellence; supporting a reduction in acute length of stay; promoting self-management and patient activation and working more effectively across the wider system pathways.

3.2.10 The four priority standards for seven day care

These standards apply to the acute hospital system and are not currently applicable to CLCH.

3.2.11 Mortality

CLCH agreed and published a 'Learning from Deaths Policy' in October 2017 based on the National Quality Board at NHSI 'National Guidance on Learning from Deaths'. Work continues to implement the policy and introduce standard operating procedures, guidance and flow charts. The policy became effective from 1 of January 2018.

The Trust is required to publish information about deaths, reviews and investigations. This is achieved through a quarterly report to the Board meeting in public and includes information about reviews of the care provided to those with severe mental health needs or learning disabilities. From June 2018, the Trust will publish an annual overview of this information in quality accounts, including a more detailed narrative account of the learning from reviews and investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.

3.3 Summary of quality impact assessment process for Quality, Innovation, Productivity and Prevention (QIPP) savings schemes

All QIPP schemes (clinical and non-clinical) are assessed for risks to clinical delivery and quality using a standard template and reviewed in a quarterly panel meeting chaired by the Medical Director and the Director of Nursing and Therapies. During quarter four of the financial year, the quality impact assessment (QIA) process will be linked with the Trust wide annual plan. The ultimate responsibility for 'clinical' sign off of QIPPs lies with the Medical Director and the Director of Nursing and Therapies and no QIPP schemes can be approved in the Trust without sign off at the QIA panel meeting. Meetings are set for each quarter to ensure sign-off of new schemes and continued monitoring of approved schemes. Additional meetings are arranged if required. The QIPPs are specifically assessed against six quality campaigns:

1. Positive patient experience
2. Preventing harm
3. Smart, effective care
4. Modelling the way
5. Happy, here, healthy and heard
6. Value added care

The schemes will need to demonstrate that the service is currently running within the expected parameters of the KPIs for each campaign and these will be monitored on a bi-monthly basis at a QIPP and quality meeting, with the Divisional Directors of Operations and their senior management team, the Associate Directors of Quality and the Director of Nursing and Therapies and the Medical Director. The schemes are either approved with bi-monthly review of monitoring quality metrics; approved and no further monitoring is required; or they are not approved and advice is given as to what needs to be done to gain that approval. Each scheme will also be risk assessed and when the final risk score is agreed by the Medical Director and the Director of Nursing and Therapies it will be placed on the Trust's risk register and monitored monthly at the quality meeting - through various metrics. Any schemes with a risk score of greater than 12 would require robust mitigating actions – any scheme with a risk score of 15 or above would not be approved and would trigger a paper to the Executive Leadership Team (ELT) for wider review. The cumulative effect of the schemes is also monitored and any issues are escalated back to ELT.

Only the Director of Nursing and Therapies and the Medical Director can agree the clinical risk scores based on the risk assessment and no schemes can be confirmed for commencement without approval from the Medical Director and the Director of Nursing and Therapies.

Should the risk profile of a scheme change, a new quality impact assessment would be submitted to the Medical Director and the Director of Nursing and Therapies. Any schemes pending clinical risk rating will default to 'high risk' until this has been completed and this is reflected in the risk register.

During quarter two, the Medical Director and the Director of Nursing and Therapies undertake an assessment of the long-term clinical impact of any QIPPs from the previous year.

Managers are encouraged to seek clinical advice from the Medical Director, Director of Nursing and Therapies, or the Associate Directors of Quality at inception of schemes to maximise the likelihood that they will be supported. The Medical Director and Director of Nursing and Therapies will establish a 'star chamber' model in line with the National Quality Board guidance to resolve any schemes which are not supported.

3.4 Summary of triangulation of quality with workforce and finance

The Trust's Quality Strategy includes a red flag process for the early identification of quality deterioration at individual service level. A monthly list is produced which highlights services which either do not meet two of the key six quality criteria or who have not met one for more than one month. The criteria are:

- Absence of consistent leadership for 2 months or more
- Vacancies over 12%
- Sickness over 5%
- A 10% increase or greater in incidents causing harm
- An increase in complaints
- A reported serious incident or internal serious incident

Following identification of a potential or actual problem, an assessment is made by the Associate Director of Quality for the Division to identify rapid intervention, controls and mitigation. The responsible Associate Director for Quality in conjunction with the Chief Nurse and Chief Operating Officer or the Director of Nursing and Therapies will also determine whether the situation warrants the support of a Quality Action Team (QAT).

Red flag reports are reviewed monthly at Divisional level and quarterly at the Quality Committee. As part of the business planning cycle, each clinical Division undertakes a demand and capacity review and analysis for their services. This work helps to inform the quality schedule for the year and the areas of support needed by each clinical Division.

Prior to completing the workforce and financial plan components of the operational planning process, the Trust ensures that plans are triangulated to reflect the assumptions in the long-term financial model. The workforce plans are signed off by the Chief Nurse and Chief Operating Officer and Medical Director to ensure the plans are compliant with quality requirements. Underpinning these requirements are a suite of quality KPIs which are integrated into the Trust performance dashboard with finance, performance and workforce KPIs.

4 Workforce planning

The Trust vacancy rate at March 2018 was 11.62% with a clinical vacancy rate of 12.14% and like many community healthcare NHS trusts, CLCH faces challenges with the recruitment and retention of staff. The Trust has implemented a number of initiatives to address this however, the problems are national, regional and sector-wide and cannot be resolved in isolation.

The impact of Brexit on staff recruitment and retention is being monitored to assess any emerging trends and actions that may be required.

As part of the comprehensive spending review in 2016, it was announced that fees and bursaries would no longer be paid for student nurses and allied health professionals and that they would be expected to apply for student loans, in line with their peers. Recent announcements have also now been made to cease funding pre-registration nursing via the postgraduate diploma route. The impact of this could be significant in relation to the numbers and demographics of students and the subsequent number of qualified staff entering the professions. As a result of these changes and the implementation of apprenticeships, trusts will be expected to take on a greater role with the planning and co-ordination of nurse training.

Funding for post-graduate training has significantly reduced along with salary support funding for those undertaking specific training programmes (with the aim that these are now delivered as apprenticeships). This will have a significant impact on trusts and is contributing towards the need to work differently and to transform the workforce.

In 2018/19, the Trust will be holding a number of shared governance workforce events with the aim of developing 'Towards 2023' – the new CLCH nursing and allied health professions (AHP) workforce strategy. As part of this, the Trust will be reviewing and considering key elements including the role of the nurse associate, apprenticeships and advanced practice and how this fits into the Trust's vision for the future.

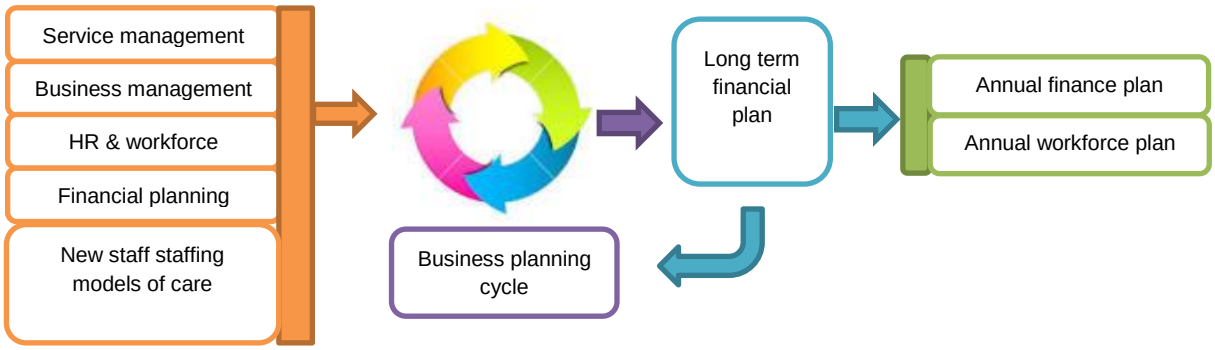
4.1 Approach, support and governance

The Trust's strategy outlines the need for CLCH to continue to invest in the clinical and non-clinical workforce, ensuring that clinical skills are at the forefront and that our staff can work safely and independently in the community. In addition, the strategy recognises the need to invest in retention initiatives that support staff health and wellbeing, encouraging career development and celebrating diversity and skills as part of the aim to ensure that the Trust is a great place to work.

The Trust has a people strategy - developed in partnership with our Joint Staff Consultative Committee (JSCC). This strategy focuses on achieving our vision of 'Great Care Closer to Home' and outlines how its enabling workforce strategies align to Trust's priorities and the Lord Carter review of operational efficiency.

The Trust has a clinical strategy which highlights the growth in demand for our services driven by increases in the older and younger populations that the Trust serves. The local STPs' workforce strategy developments, new models of care and pathway redesign are at a very early stage. The challenges in respect of workforce supply for key roles are common to all. The strategic direction outlined in the 'Five Year Forward View' suggests more care will take place in the community, supported by seven day services which would imply workforce growth and investment. However, such growth has not been translated into clear commissioning intentions in 2017/18.

Workforce planning and the assessment of workforce information are built into the annual business planning cycle – which is adjusted throughout the year in response to system changes. Specific guidance and advice on legislative conditions, safer staffing, supply market analysis and current professional group developments is fed into the planning cycle with clinical operational management. This in turn drives the short, medium and long-term financial planning of the organisation encompassing services and the Trust's priorities. However, as a community trust in a dynamic contracting environment with significant movements of staff from winning and losing bids, accurate forecasting and performance against plan in the medium to long-term is challenging and complex. For example, in 2016/17 we unexpectedly lost our award winning integrated community independence service, which was transferred to three separate providers. Equally we have a proven track record of successfully bidding for new services (e.g. Merton Community Services and Wandsworth Community Services) which have impacted on the size and complexity of the Trust.



As the Trust's business planning process is clinically led, it identifies skills gaps through its training needs analysis, led by the Director of Nursing and Therapies in conjunction with the education and training team. Each service discusses their training needs with their teams and completes a learning needs analysis template. The findings are then discussed at the Trust's 'Modelling the Way Forum', which enables a Trust-wide understanding of any needs required and where the focus for training and development is needed.

Workforce data is viewable by managers through 'Qlikview' who are able to drill down from Directorate to Clinical Business Unit (CBU) to team level. Workforce data is included in the monthly Divisional reports, discussed at Divisional meetings and performance meetings with clinical, quality, human resource and finance input. The integrated finance and performance report presented at the Trust's Finance Risk and Investment Committee (FRIC) contains workforce, finance and clinical quality information on Trust-wide and Divisional performance across key performance indicators.

4.2 Key changes, cost, quality, efficiency and improvement programmes

4.2.1 Agency staffing

The Trust remains resolutely focused on reducing its use of agency staff. For 2016/17 the Trust delivered an end-of-year position of £15.8 million within our targeted £16.4 million ceiling (down from a close of 2015/16 posting of £22 million). At the close of the 2017/18 period, the Trust had spent a significantly lower amount (£6.4 million) on agency, despite increasing the number of services provided during the financial year. Regular meetings, reviewing performance linked to the annual plan, are led by the Chief Executive Officer and the Chief Nurse and Chief Operating Officer to ensure that the Trust is risk assessing plans for a safe reduction in agency usage. This is supported by international recruitment, 'switching' agency staff to bank or permanent roles, tight monitoring and (where necessary) reductions in service provision. This will continue to ensure that the targeted ceiling for 2018/19 is achieved in a safe fashion and the Trust continues to improve its performance on continuity of compassionate care to patients and financial control.

The Trust is fully committed to the NWL agency and bank initiative aiming to reduce agency spend through coordinating e-rostering, improved agency management and sharing bank staff.

4.2.2 Apprenticeships

The Government is committed to achieving three million apprenticeship starts in England by 2020. The Trust has set out a clear strategic framework for a new approach to the recruitment and development of staff within the apprenticeship strategy (2017). This outlines the Trust's commitment to increase the number of apprenticeship opportunities in order to help people to 'Get In' to community healthcare; 'Get On' and develop their skills and career and 'Go Further' into professional and managerial roles. As part of this strategy, the Trust has been successful in its application to become a training provider for

specific apprenticeship programmes.

The Trust is involved and contributing in a 'trail blazer' group looking at the district nursing apprenticeships with a view to this being submitted to the Institute for Apprenticeships (IFA) in February 2018. In addition, the Trust is involved in the 'trail blazer' for the development of health visitor, school nursing, occupational and sexual health apprenticeship standards.

The Trust continues to engage in four pilot sites to look at the implementation of the nurse associate role across England which should help to develop the skills of the workforce that can support new skill mix models in the community. In three sites the Trust is employing partners and in the fourth as a placement provider. All partnerships are being closely monitored via Health Education England and the Trust continues to regularly attend forums to discuss the progress and shared learning from the pilots.

The Department of Health have recently announced that an additional 5,000 nursing associates will be trained through the apprenticeship route in 2018, with an additional 7,500 being trained in 2019. As part of the work to develop our future workforce, the Trust is considering how this role is supported and integrated into services.

4.2.3 Development programmes

As part of the capital nurse programme, NWL has developed a capital nurse foundation programme building on the existing preceptorship and retention initiatives. The Trust has been successful in implementing rotational programmes within a number of areas including: urgent care/rapid response/primary care and community and specialist nursing.

These programmes are focusing on 'growing our own staff' supporting staff to develop skills in a supported and structured programme and gain exposure in a number of areas relevant to the specialist environments within which they will be working.

The Trust has implemented a number of development programmes including a band five fast track programme initially focusing within community nursing with the aim of reducing vacancies and supporting retention. The structured work-based training programme includes preceptorship, clinical competencies, clinical supervision and leadership training. Having been in place for a year, an evaluation has now been completed which described how the programme has provided newly qualified nurses with a unique opportunity for guaranteed career progression.

4.2.4 Primary and community care academy

CLCH has received funding from Health Education England to establish an academy through which community and primary care nursing education and development will be delivered. The academy will work in partnership with a university to design and deliver future learning and education programmes which support the new models of care as outlined in the Five Year Forward View. This will include providing joint programmes of learning for community and nurses in general practitioner (GP) practices. The Academy will co-ordinate the training of over 60 nursing associates and apprentice degree nurses over the next two years.

5 Financial planning

An analysis of CLCH financial delivery over the last five years in terms of QIPPs and income and expenditure (I&E) shows a strong track record, of which we are proud. We recognise, however, that in common with many other NHS providers the "low hanging fruit" has largely disappeared and both the operational and financial climate is now more challenging for organisations such as ours, which

has consistently delivered surpluses, year-on-year. Equally we recognise the need for a viable NHS that can live within its means and so we will strive to innovate, improve and engage as we take forward our transformation programme over the coming year. This document provides a refresh of the two-year plan produced in 2017/18 focusing on 2018/19.

The Trust is planning for a surplus of £4.2 million for 2018/19, having achieved a year ending surplus of £6.9m in 2017/18, in line with the control total set by NHSI which the Trust accepted. The 2017/18 surplus included £3.6m of STF funding and the 2018/19 plan incorporates £2.6m of STF funding. Within the budget the Trust has planned for national inflation pressures for pay and non-pay. To achieve the target surplus further work is needed in relation to fully identifying the QIPP programme for the next year as well as managing identified cost pressures and investments to an affordable level.

The Trust income plan is based on agreed contracted levels with adjustments made for agreed impacts of contracting intentions of commissioners. The Trust has made provision for potential loss of contribution as the transformation programme is anticipated to continue in inner London services to support commissioners funding challenge. The Trust also anticipates that as a result of STPs significant investment will be required in community services to support the out of hospital strategy leading to increased income in future years. No income has been recognised within our plan at this stage as this remains unsupported by contracts.
In previous years the Trust has invested capital in technological development as well as estate and equipment. This investment is now benefiting service delivery and realising value for money for the Trust. However, the investment in the next year is planned to be related to care planning and scheduling technology as well as continuing emphasis on invest-to-save estates and service reconfiguration schemes including some technology developments. Plans are underpinned by robust financial forecasts and modeling and are consistent with the strategic intent of the STP as we understand them at this stage.

5.1 Financial forecasts and modelling

The Trust's 2018/19 financial plan has been informed by the organisation's two-year 2017-19 Operational Plan, which drives the Trust's activity, workforce and finance plans. CLCH's financial strategy focuses on the following key priorities:

- Delivering continued future income and expenditure surpluses through achievement of a net surplus margin over the planning period; in 2017/18 the target was 2.4% due to stretch targets (uplifted to a 3.2% surplus with the award of bonus and general distribution STF funds at year end) and a reduced surplus target applies in 2018/19 of 1.9% in line with control totals for the Trust issued by NHSI
- Delivering consistently good levels of Earnings Before Interest, Tax, Depreciation and Amortization (EBITDA)
- Maintaining segment one status in the NHSI Trust segmentation analysis
- Delivering a significant contribution to QIPP through clinical and corporate transformation programmes
- Investing in estates and service redevelopment schemes and building on existing information management and technology (IMT) investments to continue achieving significant improvements in clinical quality, service cost reductions and service transformation to ensure we provide a sustainable service to our patients and commissioners

The Trust budget for 2018/19 will achieve a surplus of 1.9% of turnover (£4.2 million):

£'000 Trust financial statements	2017/18 outturn	2018/19 plan	2019/2020 plan
Income	216,588	225,213	225,620
Operating Costs	-203,428	-213,227	-213,033
EBITDA	**13,160**	**11,987**	**12,587**
EBITDA %	*6.08%*	*5.32%*	*5.58%*
Capital charges	-6,277	-7,800	-8,400
Surplus	**6,883**	**4,187**	**4,187**
Surplus %	*3.2%*	*1.9%*	*1.9%*
Cash	8,777	8,529	8,529
Capital programme	7,187	5,340	3,840
QIPP target	9,740	9,474	8,315

The Trust I&E, cash flow and balance sheet has been modelled based on assumptions and provisions laid out in this paper. The Trust currently scores 1 overall against financial metrics under the Single Oversight Framework (1 is the highest score and 4 is the lowest) as seen below. The only category where the Trust does not score a 1 is on the plan for agency spend. This is due to the Trust challenging the allocated cap for agency spend in 2018/19 of £6 million as it fails to recognise the full effect of the new services acquired by the Trust during 2017/18:

Ratio	2017/18 **Outturn**	2018/19 **Plan**
Capital Service Cover rating	1	1
Liquidity rating	1	1
I&E Margin rating	1	1
Variance From Control Total rating	1	1
Agency rating	1	3
Overall Rating	**1**	**1**

The Trust is reporting more than £2 million recurrent under achievement against 2017/18 planned QIPP of £9.7 million. In monetary terms, the Trust must achieve £9.5 million in QIPP against previously planned £7.8 million in 2018/19. The Trust has included all known assumptions relating to its income contracts and cost changes. The plan is in line and includes known and relevant developments coming out of STP planning, for example a new locality model in Barnet.

5.1.1 Income:

As the 2018/19 plan forms the second year of two-year signed contracts, the Trust has agreed contract variations with commissioner where appropriate to recognise the costs of delivering increased demands for our services and the level of QIPP developed by commissioners. The Trust does not expect significant changes in Herts Valley, NHSE Specialised Commissioning and NHSE Public Health contracts. CWHHE contracts may be subject to in year variation as and when commissioner QIPP initiatives are agreed through joint transformation programmes. The remaining NHS services such as Merton and Harrow are already covered by multi-year contracts. The Trust acquired further new contracts during 2017/18, of these, the Wandsworth CAHS, Wandsworth and Richmond 0-19 and Brent 0-19 services are multi-year contracts. The SWL sexual health contract is on cost per case basis.

5.1.2 Tariff inflator:
As per planning guidance we have planned for 0.1% increases in tariffs, which reflect 2.1% cost inflation (allocated to specific reserves as per section below) minus the implied efficiency requirement 2.0%. In calculating the impact we have excluded income commissioned by local authorities and other non CCG related commissioners due to the risk in agreeing inflationary increases, as well as CCG contracts with fixed contract values in place.

It should be noted that this follows the guidance to omit the impact of the impending enhanced pay award to NHS staff in the plans.

5.1.3 Business cases:
The Trust will continue to work with commissioners on business cases to support system cost reductions, if approved such cases with be subject to in year contract variation to increase our contracted income.

5.1.4 Summary planning assumptions:
The planning assumptions identified in the table below reflect the Trust's long term financial plan based on the two-year planning guidance published in October 2016:

Implied efficiency	2017/18	2018/19
Tariff	0.10%	0.10%
Pay and pensions (including drift)	2.10%	2.10%
Non Pay (excl. drugs)	1.60%	1.60%
Capital costs	3.50%	3.10%
Drugs	2.90%	2.70%
Implied efficiency	**-2.00%**	**-2.00%**

5.1.5 Committed expenditure:
- **Pay award 1% (of pay budget)** – Pay inflation has been based on the latest planning guidance. The Trust has assumed that any increase in the national pay award beyond one percent will be funded through increased income for all services including local authority commissioned services.
- **Incremental drift 0.9%** - The Trust has calculated 0.9% of total pay budgets as per our establishment.
- **Non-pay 2%** - The Trust has assumed 2% of non-pay budgets in line with the planning guidance issued by the NHSI. Each service will review their expenditure and identify specific contractual responsibilities relating to inflation to apply for funding, an increase will not be automatically applied to all non-pay budgets.
- **Revenue consequences of capital investment** – The Trust has based its assumption on the anticipated cost of financing the updated trust capital investment programme including the information technology strategy.

5.1.6 Risks:
There are several risks relating to the budget for 2018/19:

- **QIPP** – The Trust has identified QIPP schemes to the value of £7 million, equating to 74% of the in-year target. 54% of the identified schemes are rated as low risk, with a further 33% at amber and 13% high risk. This risk will be mitigated through further detailed work on those identified schemes as well as further work by the Director of Transformation and operations

directors to identify further schemes. Non-recurrent programmes and delayed investment will also be used to manage the position in year.

- **Commissioner affordability** – The Trust has now negotiated the majority of income offers with NHS commissioners; there are some outstanding points around agreement of the level of outturn funding with CWHHE which are being finalised.
- **Liquidity risk** – The combination of increased capital spend and the risk of QIPP under delivery may present a risk to the Trust's liquidity. This will be mitigated through detailed management of debtors and creditors and cash forecasting to identify if external financial support is required which could place the Trust into a higher risk category with NHSI.

5.2 Efficiency savings for 2018/19

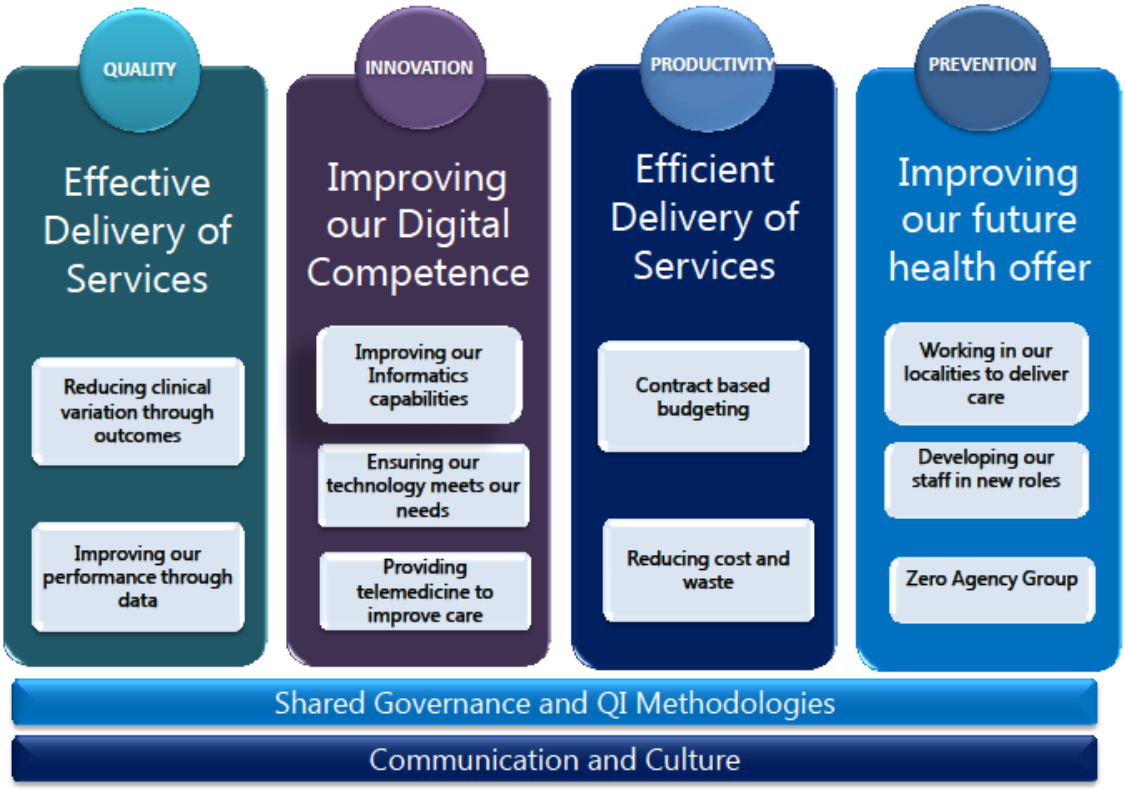
The Trust has a strong track record in QIPP delivery. A notable achievement is the reduction in corporate costs both from outsourcing of back office functions to Capita, and in-house reductions to bring costs in line with NHSI benchmarks. However, the savings programme for the future needs to be reshaped as the task becomes increasingly challenging each year, and our ability to find recurrent savings has reduced. Therefore the approach to delivering QIPP will be to:

- Invest in recruitment and retention to reduce our reliance on agency and bank staffing
- Maximise income through rigorous recovery and exploring new income streams
- Release the full benefits of previous investment in technology i.e. mobile working and the Allocate system which will increase the productivity and cost efficient allocation of our staff
- Review all our contracts to ensure they are commercially viable, covering costs and making the required 1% surplus
- Build on our partnership with Capita to explore additional opportunities for cost reduction and income generation
- Use our estates rationalisation programme to reduce costs whilst investing in clinical and administration facilities for staff and patients
- Develop a comprehensive procurement programme that ensures we can demonstrate best value
- Review our processes to streamline workflows and improve the management of capacity and demand
- Development of new roles and skill mix reviews, aiming to increase clinical facing time wherever possible

Transformation programmes

During 2018/19, the Trust is introducing a comprehensive change programme - the CLCH way. It focuses on four key change initiatives, each with a number of distinct projects to deliver change and ensure the benefits from investment are released. Benefits include making better use of resources, evidencing the effectiveness of our services through clinical outcomes, increasing the use of technology by staff and patients, and developing new roles and models and care for the future.

The key elements are shown below:



The change programme is supported by continuous improvement methodologies that are being spread and embedded throughout the Trust. The programme is being supported by a centralised project management office (PMO) function, and delivery of some projects is shared with our partner Capita. The creation of a single integrated change programme will help to ensure:

- Projects are coordinated to maximise the use of available resources
- A consistent approach to project management with a particular focus on delivery of benefits
- Projects are managed collectively to support delivery of the Trust's strategic objectives.

5.3 Capital planning

We have a two year capital programme at £5.3 million of expenditure in 2018/19 and £3.8 million in 2019/20.

6 Engagement with STPs

The Trust delivers services in four STP areas due to the geographic spread of services. These STP areas are:

- North West London
- South West London
- North Central London
- Hertfordshire and West Essex

The strategy places emphasis upon place based delivery of services through working in partnership with other providers and our service users to deliver care. The Trust recognises that there is always a requirement to deliver value as part of integrated working, and to this end has a robust QIPP delivery schedule that maximises quality and reduces cost. However the Trust also believes that by working in partnership, we are able to provide improved pathways through integration, reducing unwarranted variation and ensuring we can maximise resources for care delivery.

With these principles in mind, the executive team ensures that the Trust is able to support local STP goals through careful co-ordination of Trust leadership resources. We have created capacity for discussion of STPs between managers at every available opportunity to discuss developments and ensure the senior team is sighted on updates as they become available. We thus have standing items at our weekly executive leadership team (ELT) meetings and our monthly senior management meeting as well as a regular STP item at Board. We will also ensure that any additional or extraordinary briefing sessions that are required will be prioritised as STPs seek to make rapid decisions to enhance progress. The Board is kept informed of development and plans in a timely manner with non-executive colleagues also engaged in relevant STP forums and meetings.

There is a requirement for operational and corporate Divisions to actively work on integrated care. Specifically the areas of strongest focus for the Trust are:

- Building local multidisciplinary teams (MDTs) in localities
- Supporting the development of models of primary care homes
- Pathway redesign to deliver discharge to assess pathways (ensuring patients can access care in the community, rather than remain in an acute bed when this is not clinically indicated)
- Workforce redesign at scale
- Digital redesign at scale

To ensure the link between our operating plans and the STPs is maintained, we have embedded the main aims and future developments of each STP within the bottom-up planning process that we have adopted. This process requires each of our CBUs across our four operating Divisions to write their own plan and within this, explicitly link their plan to those of their associated STP. These plans are then aggregated into Divisional plans and cross-checked with our corporate and quality services to ensure that operating Divisions will have access to the support they require.

In this way we have ensured that our services at the CBU level are informed by the requirements of the STP and as the system control totals are agreed, this will stretch to include individual budget lines to ensure financial alignment as well.

6.1.1 Impact on CLCH planning

The STP areas that we work within have developed plans to support the delivery of sustainable healthcare locally.

We note the emphasis on prevention and self-care. This is an area where CLCH is strong and we already run several services which focus upon education and longer term management of health. These include preventative services such as health visiting and school nursing through treat and prevent services such as sexual health and weight management to the higher end of acuity such as a series of long term conditions services which focus on educating the patient for them to best maintain their independence. We look forward to supporting our STPs in enhancing this across the system in the future.

We note that each of the STPs recommend a significant enhancement to the GP federations of each area to offer a strong and credible voice for primary care in a system. As a close partner to primary care in all the systems in which we work we heavily endorse this move and have already sought to work more closely with our GP colleagues. To this end we have signed memorandum of understanding (MOUs) with some of the federations we work with and seek to sign similar agreements with all of them over the next six months as we better understand how we can work together toward the STP goals.

Finally, each of the STPs considers how systems will progress under the new care models or other organisational forms such as accountable care partnerships. This is another area in which CLCH has remained heavily involved and several of our borough or larger commissioner groups have signaled a clear intent to move toward such a model. CLCH has been working with systems to understand how we play a key role in such a development and will continue to act as a willing and able partner.

In summary, we have put the STP process at the heart of our own internal planning process to ensure that they have the relevant consideration. Furthermore, we have created capacity, both in terms of management resource and also time at key meetings to discuss and respond to developments as required. We are confident that as the STP process continues we will maintain our ability to act as core partner in our role as community services expert.

7 Foundation Trust (FT) application

The CLCH FT application process was suspended in January 2016 following the merger of Monitor and the Trust Development Authority (TDA) to form NHSI and the national pause in the FT programme.

Since then, CLCH have continued to meet regularly with NHSI and have kept them informed on our performance, progress and developments.

There are certain features of FT status that would be of benefit to CLCH including the ability to form new corporate entities such as joint ventures and subsidiaries, and the ability to raise capital. The absence of these freedoms means that the Trust is excluded from certain business opportunities that it would like to pursue. The Trust will therefore assess options for any future FT process when announced and continue to keep the FT membership database, with regular publications about CLCH.