Oxford Health NHS Foundation Trust

Operational Plan Document for 2014-16

Oxford Health NHS Foundation Trust

Operational Plan for y/e 31 March 2015 and 2016

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

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Date	20th March 2014

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

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Martin Howell

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Stuart Bell

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Mike McEnaney

Signature

1.0 Executive Summary

Oxford Health Foundation Trust (OHFT) provides community and mental health services for children and families, adults and older adults across Oxfordshire, Buckinghamshire, Wiltshire, Bath and North East Somerset. Health improvements and increasing life expectancy have resulted in steady population growth across this area. The number of people aged over 65 has increased significantly over the last ten years, particularly in rural areas, and is anticipated to continue to rise in the future. The number of people living with one or more long-term conditions in these populations has also risen. The changes in populations and variations in access to services has resulted in a continued growth in demand for health and social care services, particularly inpatient, emergency and intermediate care. OHFT intends to play a leading role in transforming care to meet the needs of our population. Everything we plan to do during the period of this operational plan is designed to enhance patient care: to improve outcomes, experiences and safety for patients at the lowest possible costs.

OHFT, like the rest of the NHS, is facing an extremely challenging financial environment. We already know that the NHS will continue to receive little or no funding growth and is faced with a national efficiency target of at least 4%. The result of this will be reductions in income on existing contracts year-on-year. During 2013/14, we focused on remodelling our services to improve local access to high quality care. As a result OHFT will not achieve its cost improvement target and is forecasting a larger deficit than originally planned. OHFT's financial strategy responds to these challenges, and builds on the firm financial foundations and finds headroom from within existing resources to maintain and improve existing levels and quality of patient care.

Over the coming two to five years we will take a leading role in the development of a sustainable health and social care system to meet the changing needs of patients. During 2013/14 children and families, adult and older adult services have been re-designed to enable patients with specific conditions to have better local access to the most suitable services. Our plan for the coming two years will deliver the benefits of these changes by improving patient outcomes and reducing costs. We will achieve this by working in partnership with other providers across the health and social care system and by rapid adoption of innovative treatments made possible by our close working relationships with academic institutions and industry.

2.0 Strategic Context – The short-term challenge

2.1 Joint Strategic Needs Assessments: Health Challenges

The combined population of Oxfordshire, Buckinghamshire, Wiltshire, and Bath and Northeast Somerset is 1,152,296 and their joint health & wellbeing strategies share very similar priorities. Crucial aims are to give everyone the best start in life, and support them to remain healthy throughout their adult life, working to reduce rates of obesity, smoking, alcohol misuse and infectious disease. Work will be done to reduce the rates of chronic conditions and support those with one or more long-term condition to live independently and manage their own care where practical. For older people, the focus is on helping them to be healthy and independent for as long as possible. A key focus will be to reduce health inequalities in disadvantaged, vulnerable groups in these populations.

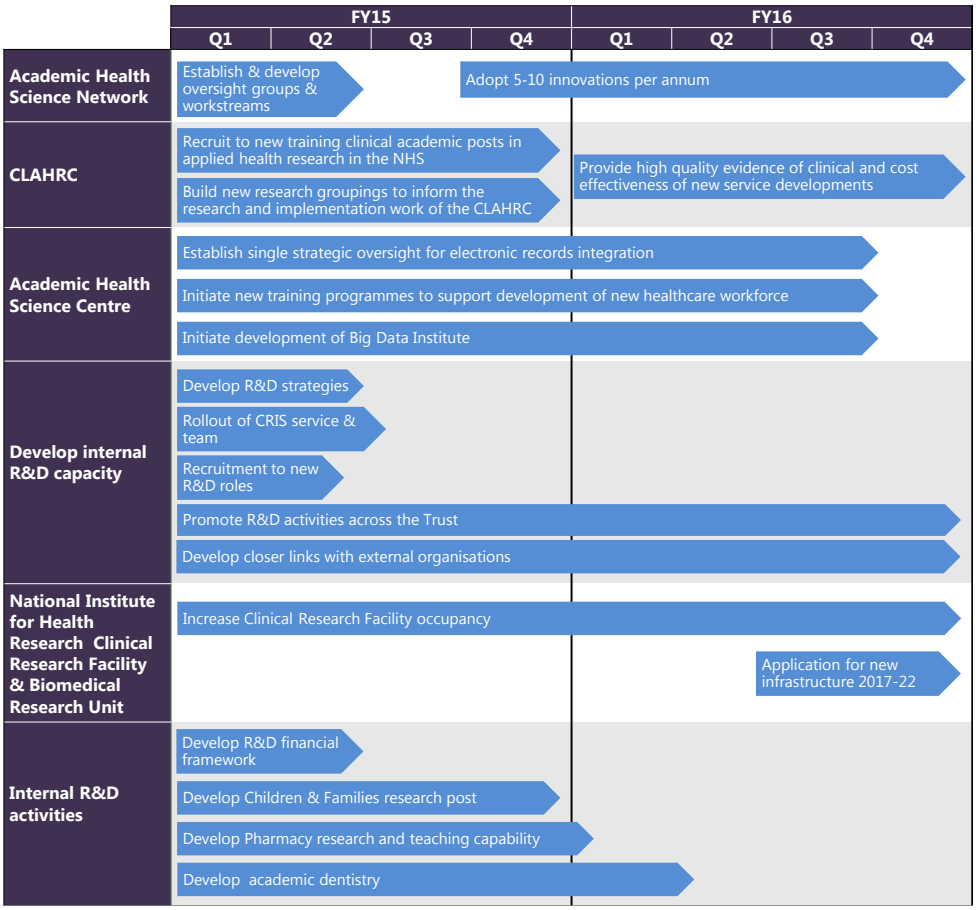
There are significant areas of deprivation in the urban and rural areas in which we work that have a negative impact on people's health and life expectancy. There are also substantial challenges linked to tackling public health-related diseases, associated with rising obesity and alcohol intake, as well as dealing with the prevalence of chronic conditions. Mental health problems such as anxiety and depression are common amongst the communities where we are present and often occur along with some of the most serious social issues; they must be treated with equal parity together with physical health needs.

In the areas we work the number of people aged over 65 has increased rapidly over the last ten years, predominantly in rural districts. Elderly patients account for the majority of healthcare spending, and so this puts increasing pressure on the health and social care system. We are working with people across the entire cycle of care (from home, in communities and hospitals) to provide the best care, in the right locations, at the right times for these patients.

2.2 Innovation, Learning and Teaching

We have strong ties with academic institutions across Thames Valley to benefit the health and wealth of our local populations. We will continue to maximise opportunities to translate research, training and clinical expertise to meet the healthcare challenges of the 21st Century. This will primarily be achieved through involvement and leadership in the Oxford Academic Health Science Network (AHSN), Academic Health Science Centre (AHSC) and Collaborations and Leadership in Applied Health Research and Care (CLAHRC).

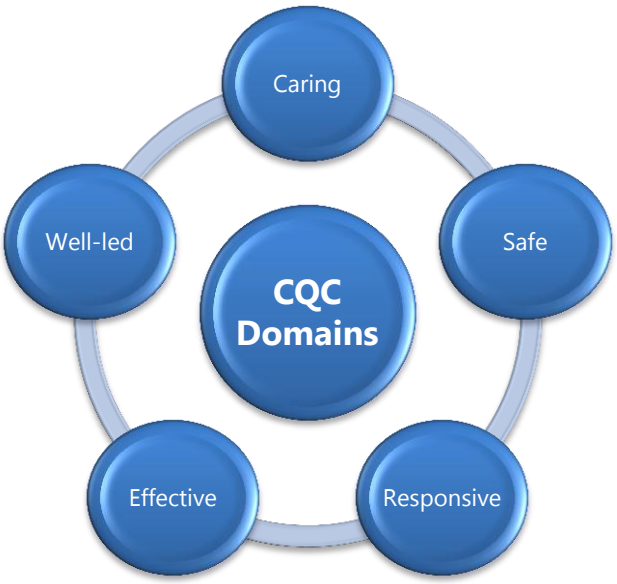
These partnerships focus on areas of real need, including care of the frail elderly, those with chronic conditions and dementia. We are also designing an internal research and development strategy with structures to support these external working partnerships and our internal capacity for research and development. We will continue to develop as a leading teaching centre.



3.0 Quality Plans

Our priority is to provide high quality services for patients and over the last year our resolve has been further sharpened following the findings of the Berwick, Francis and Keogh reports. Our minimum expectation is that patients are safe and protected from harm and it is essential that we are systematic in our reporting, reviewing and learning from incidents throughout the organisation. It is all of our responsibilities to be curious about this information and to create a culture of improvement throughout our organisation.

By measuring the outcomes that matter to patients and the costs to deliver these outcomes we will deliver the best value, most sustainable care. Our remodelled services provide an ideal platform to define and measure outcomes for patient conditions in terms of health status, patient functionality and sustainability. This, combined with the patient level costing tool that we continue to refine, will help us to understand the cost of delivering the right outcomes and support further collaborations and service improvements.



It is clear that for us to deliver high quality care we must have the right staff and staffing levels. We have a number of initiatives as part of our quality plan to support our medical, nursing and associated health professionals through training, rewarding and retaining caring, compassionate and high calibre staff to meet the complexity, demands and numbers of patients.

For 2014/15 the Trust Executive has proposed that the Quality Account should reflect the Care Quality Commission (CQC) domains [above right].

This will enable us to capture and address some of the issues raised through the Francis and Keogh reports relating to effective leadership and governance of quality. The following **four draft priorities** are currently under consultation with staff, patients, commissioners and other stakeholder groups:

1. **Workforce**: ensuring we have the right number of staff with appropriate training and experience, supported by clinical and managerial leadership, and working effectively within teams.
2. **Data**: ensuring we have reliable, accurate and relevant data on the quality and safety of services.
3. **Service remodelling**: continuing the service redesign and pathway remodelling programme, specifically focusing on its quality benefits in terms of improving outcomes, safety and experiences.
4. **Staff engagement** with the quality agenda: ensuring a focus on quality from the front-line to the board, improving quality management processes, and strengthening links between the Board and staff

The main **quality improvement priorities** will be:

1. **Improving Patient experience**; specifically to implement the new patient experience strategy and to deliver mechanisms for soliciting patient feedback, capturing patient stories and using this information to improve services where required.
2. **Outcomes Measurement** focused on what measures are important to patients and enable us to assess the impact of the care we provide as well as the way in which we provide care.
3. Preparing for the new-style **CQC inspections**

Building on these main priorities, the account will detail five **safety-specific priorities** concerning reduction in harm, agreed by the Board of Directors (right):

3.1 Quality Concerns

A monthly report of the internal position by division and location against the **CQC's essential quality and safety standards** is circulated to the Executive Team, Divisional Directors, Clinical Directors, Heads of Service, Heads of Nursing and outcome leads. The report identifies exceptions where internal concerns have been identified and actions to resolve.

Each internal concern is risk rated depending on the impact to patients and the likelihood and frequency of the concern reoccurring. The divisions report progress against the concerns and actions quarterly as part of the assurance process. In addition, each of the Quality Improvement Committees is responsible for monitoring and confirming assurance against identified actions.

As of January 2014 there are no major concerns highlighted and the moderate concerns (amber) are as follows:

Concern	Mitigating Actions
Patient feedback about their experiences on the adults of working age mental health wards *(source: 2013 inpatient survey)*	• Increasing the staffing levels for each shift on every ward • Reviewing the provision and accessibility of information • Pharmacy staff redirecting their time to speak to patients more often • Reviewing the provision of activities on each ward and identifying a Modern Matron and decided Consultant for each ward • Monitor progress through existing patient feedback mechanisms, e.g. weekly 'Have your Say' sessions, Patient Advice and Liaison Service (PALS) surgeries, a formal discharge survey and an annual postal survey for past inpatients
Concerns about staffing levels, leadership and service capacity across the Community Nursing Service.	• Introducing a range of short, medium and long term actions to address the concerns created by an increase in activity and difficulties with staff recruitment • Providing additional support to the service and monitoring the results from the actions monthly

High vacancies and staff sickness across three of the Community Hospitals, raising difficulties with staffing levels.	• Trialling alternative approaches to recruitment and short term sickness is being actively managed • Formalising the central reporting and monitoring of staffing levels from 1 April 2014 to improve access to staffing level information
Gaps identified in compliance with statutory estates and facilities requirements and identification of a competent responsible person for each statutory requirement. Limited assurance on fire risk assessments for community patient sites and non-patient sites.	• Completing a thorough self-assessment against the CQCs prompts for Outcome 10, reported to the Service and Estates Quality Improvement Committee. Compliance with all statutory requirements is to be in place • Management plans in place addressing assurance on fire safety and carrying out work on identified fire risks: carrying out work to ensure all windows in ground floor inpatient areas are safe, work following risks identified through hanging and ligature assessments, and work and re-inspections relating to asbestos
Windows and restrictors reviewed across all patient areas; some remedial work is still to be completed.	• Work to review and take action as necessary has been phased into three stages; the first stage was to review first floor patient areas which has been completed, the second stage is in progress is to review ground floor inpatient areas, the third stage is to be determined by clinical services and is likely to focus on first floor outpatient areas
Hanging and ligature risk assessments across all mental health wards – develop schedule of works to address the high/extreme risks.	• Developing a schedule of works with timescales to address the high and extreme risks
The review of staffing levels has been changed to grey across the majority of inpatient areas, because there is insufficient evidence and assurance.	• Introducing a monthly mechanism from 1 April 2014 to centrally report and monitor actual staffing levels against expected staffing levels for each shift on each inpatient area; to monitor issues and trends and publish results routinely.

3.2 Managing Quality Risks

The **Board Assurance Framework** outlines risks to the delivery of the strategic and annual plan and is routinely reviewed by the Board of Directors:

Key risk	Possible impact of risk	Controls in place
Failure to meet quality standards for clinical care	• Poorer patient outcomes • Poorer patient safety • Poorer patient experience	• Models of care for every service with clear standards of care and standard operating procedures. • Clinical and managerial leaders focussing on achieving standards. • Day-to-day operational management structures, effective team working and application of the Aston approach to team-based working. • Processes to pick-up exceptions and variations and for staff to raise concerns e.g. through whistle-blowing policy. • Improvement initiatives including Productive Wards and the Safer Care Programme. • Patient experience, PALS and staff
Failure to manage change effectively	• Compromised quality and safety during the transition from current to future service models • Compromised staff and stakeholder engagement	• Programme structure including programme Board, workstream groups, programme risk register, robust contingency planning and benefits realisation plan in place

Failure to put effective governance (both corporate and clinical) arrangements in place	• Poor oversight at Board level of risks and challenges • Not achieving strategic objectives • Structures and processes not being in place to maintain the Trust's integrity, reputation and accountability to its stakeholders	• The OHFT Constitution; Council of Governors and Board Standing Orders. • Integrated Governance Framework; Standing Financial Instructions and Scheme of Delegation. • Trust Risk Register and local risk registers at divisional and departmental level; development of Risk Management Strategy; Board Assurance Framework; Trust Secretary.

3.3 Overview of how the board derives assurance on quality of services and patient safety

The Board derives assurance for quality and safety through the following measures:

- Each Executive has a clearly defined portfolio and is individually and collectively accountable for the quality and safety of services.
- Reports to the Board of Directors and the Extended Executive manage the key risks and business of the Trust supported by a Board Assurance Framework and Audit programme.
- Use of the Monitor Quality Governance Framework against which the Board has recently reassessed itself.
- An Integrated Governance structure which oversees all governance and assurance processes. These committees are supported by regular reporting against a range of agreed quality metrics including safety, safeguarding, infection control, clinical effectiveness including National Institute for Health and Care Excellence (NICE) implementation, clinical audit, patient involvement and experience within services as well as the safety and suitability of the physical estate.
- Individual Executives lead on compliance with CQC standards with assurance drawn from five quality improvement committees.
- Effective operational management is overseen through Quarterly Performance Reviews attended by all Executives and two Non-Executive Directors.
- Clinical Engagement and leadership is fostered through involvement of senior clinical leaders in the development of the business plan, reviewing cost improvement programme (CIP) plans to ensure they do not compromise patient care or safety, and in leading the service remodelling.

3.4 OHFT's response to Francis, Berwick and Keogh Reports

Given the significance of the second Francis report, a Board Seminar was held to discuss the findings. The Board of Directors agreed that our response would reflect on what happened, consider the findings for our context and look forward from 2013 and beyond to apply the learning to fit our Trust. Additionally all 290 recommendations were reviewed and 65 which identified as relevant to OHFT, for which responses were agreed for 2013/14 and 2014/15. It is not intended to be an action plan; rather it provides a commentary in broad terms of what we have done or will do.

The Board of Directors agreed a dynamic approach focused on areas for improvement to achieve larger-scale rapid change, rather than managing compliance line-by-line through a detailed action plan. In reviewing the recommendations there were some that were already embedded in the Trust's everyday safety, quality, performance and governance processes and reported on regularly.

The Board of Directors agreed 4 **quality themes** to progress following the presentation of the findings of Francis reports (improving patient and carer experience; improving patient safety; improving clinical outcomes; and delivering effective services). The findings from Francis and the priorities for our Trust were discussed by the Board of Directors, Governors and the Executive, with the wider senior managers and clinical leaders group. The Executive and the Clinical Effectiveness Committee have considered the key lines of enquiry and the main findings from the Keogh mortality review and the subsequent Berwick report. The Trust has adopted the five CQC domains for the

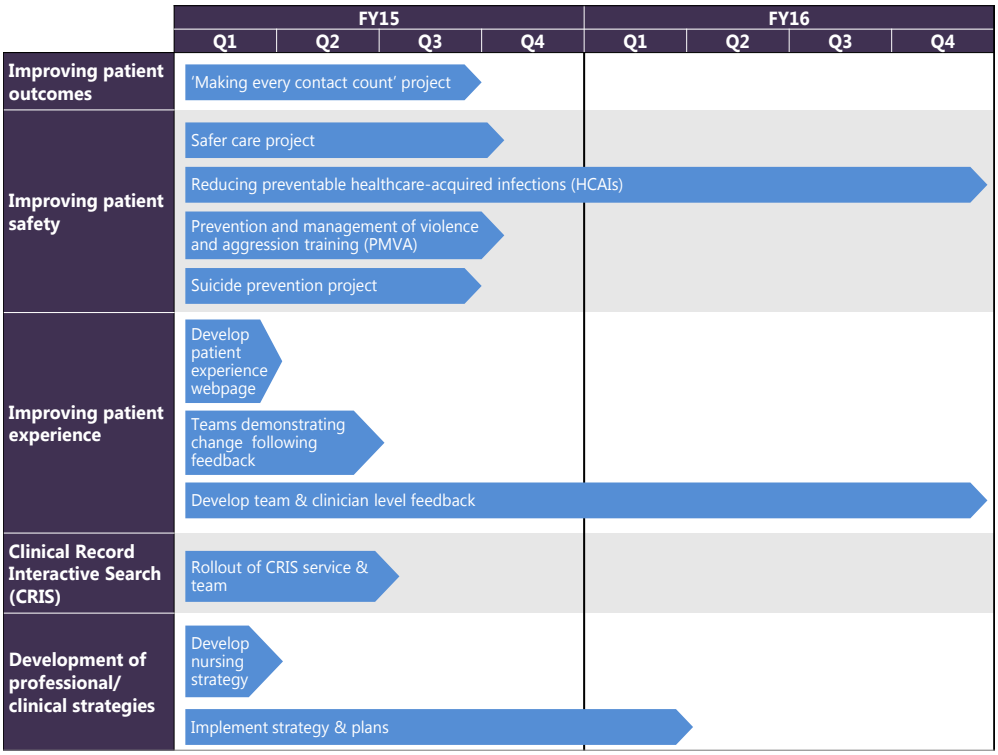
development of the quality priorities for 2014/15 in order better to reflect the findings from the Keogh mortality reviews, specifically the role of the Board in assuring quality, the importance of effective leadership and teamwork, and assurance of reliable and accurate data on quality.

Throughout the year we have continued to engage staff on issues arising from Francis, Keogh and the Berwick Reports. We have shared a letter with all staff on the significance of front line staff being accountable for safeguarding the quality of services and expecting support in this endeavour. We have held discussions with front line staff on what the report means to them. Ward and community teams have given presentations themselves to other staff on the report, its implications for patients we care for, what the report means to them and the changes they have made to their practice.

3.5 Key Quality Plans for FY15 and FY16

Our quality plans are underpinned by three core objectives: to **improve patient safety, clinical outcomes**, and **patient and carer experience**.

The chart below shows the discrete quality plans aligned to the Trust's strategy that aim to embed quality care at the heart of everything we do. The priorities were selected following analysis of national and local contexts and feedback from service users, staff, governors and the Executive.



The Trust has a robust process for reporting, reviewing, grading and investigating incidents, which forms part of the Trust governance process.

Any possible serious incidents are reviewed every week. Through this review, the review of incidents, serious incidents requiring investigation (SIRIs) and service reviews of quality (including the safety thermometer), the following areas have also been identified as **priorities for action**:

- **Reducing avoidable pressure damage**. A very detailed action plan has been developed to improve capacity and processes within district nursing teams to reduce the number of avoidable pressure ulcers and this is likely to form one of the key safety priorities in the quality account for 2014/15.
- **Reducing the number of patients who go absent without leave (AWOL)**. This is now the subject of a safer care project which is reporting into the Safer Care programme board and Integrated Governance Committee.

OHFT is dedicated to ensuring that patients are treated with compassion, dignity and respect at all times, and this endeavour is supported by our core values: to be "caring, safe and excellent.' These values are embedded in OHFT's culture and influence how all our staff work. Following a consultation with patients, their carers and our staff, we have a set of seven **privacy and dignity promises** that our staff adhere to. These include treating patients with respect and compassion, and listening to them as individuals. We will not allow communication issues to become a barrier to understanding and will address patients how they would like to be addressed. We promise that our patients will have access to information and appropriate choices, will know how to access advocacy and support services and will be

made to feel welcome on all our Trust sites. It is important that everyone works together to share best practice. We will therefore use patient and staff feedback to continually refine the work we do to ensure that dignity and respect remains at the heart of our care.

3.6 Impact of quality plans on workforce

The main implications for workforce in relation to the quality plans are associated with enabling staff to attend appropriate training. If staff are rostered to attend a training session then they will need to be backfilled for that shift. There are no workforce implications of any of the above plans in relation to skill mix, numbers of staff (establishment) or qualifications.

3.7 Risks to delivery of key plans and contingency built in

Each project described in the quality plan will have a dedicated risk register which will identify the key risks associated with delivery of project objectives and milestones, and the agreed controls and mitigation. Each project plan will identify contingencies should any of the identified risks occur. Risks to the delivery of the quality plan and their appropriate contingencies are as follows:

	Risk	**Contingency Built into Plan**
Suicide Prevention	Some staff may not be released to attend training during the period of the project. If further funding is not agreed the current post holder will not be available beyond the term of the existing project to provide the required training.	• Reviewing the training schedules and offering more training on site to teams rather than off site training. • Reviewing rostering to provide additional backfill to enable staff to attend. • Courses will be run over extended hours.
Prevention & Management of Aggression Training (PMVA)	Due to the extensive training requirements to deliver a new model and the potential impact on rosters, the Trust may not able to deliver the required training to all appropriate staff within a reasonable timeframe.	
Safer Care Programme	The organisation might not achieve the objectives agreed across the collaborative; due to staffing and resource challenges within teams, and the demands relating to the delivery of new service models. It may not deliver sustainable change (by which we mean changes are embedded and continued after the end of the initial project phase) within existing projects, and may not achieve the required spread across the organisation.	• Reviewing the schedule of safer care projects using a risk based approach relating to issues and incidents across the organisation to refocus attention. • Reviewing capacity within the safer care team and identifying additional resource within directorates.
Improving Patient Experiences	Due to staffing and resource challenges within teams, improvements required as a result of patient feedback are not routinely and rapidly put into place within individual teams and services.	Focusing additional capacity within the corporate quality team to work within directorates and link to other improvement activities, for example productives and safer care.

4.0 Operational Context

4.1 Funding & financial challenges

Contract values will be subject to the national deflator of 1.8%, which includes an efficiency saving of 4%. The Trust needs to reduce its cost base whilst maintaining and improving the quality of care for patients. The track record of the Trust in CIP delivery and financial performance in recent years has been good. However, cost reduction activities have been less successful during 2013/14 as the Trust focused on remodelling its services to provide a platform to improve patient outcomes and reduce costs in the coming operating period. While some transactional cost saving opportunities exist it has become increasingly difficult; and greater opportunities exist through strategic transformational programmes and system-wide changes.

To provide high quality services within this constrained financial climate and increasingly competitive environment significant transformations, innovations and service developments are required within the organisation and across the system. The Trust is well placed to increase its community and mental health service provision to meet the needs of local people closely aligned with the national priorities of providing care as close to home as possible, meeting the needs of elderly people and those living with long term conditions.

4.2 Changes in Commissioning

We are working with other health social care providers and commissioners, as well as using patient and carer input to identify appropriate clinical and patient outcomes and further improve our services. It will be these outcomes that are used to manage our system-wide performances, and payment systems are being developed in line with these. Commissioners are also keen to move care delivery from hospitals to localities and homes and we are working with commissioners and other health and social care providers to achieve this and improve care for patients as a whole. Recent investments in sub-acute interface medicine are good examples of a service development for elderly patients that will improve outcomes in Oxfordshire and contribute to improving the efficiency of our care system as a whole.

Over the coming two years we will work support the introduction of an **outcomes-based approach to commissioning** (OBC). This means that focus will be on the results or outcomes of services in terms of what they achieve for the patients, rather than simply the number of activities carried out. The focus for OBC is mental health and services for older people. We will work closely with all of the key stakeholders in Oxfordshire to implement a joint plan. For older people services we are working with Oxford University Hospitals Trust (OUHT) to agree risk adjustments, outcomes for contract management, incentives and develop service integration. For mental health we are working closely with provider partners to agree risks, outcomes and service integration for outcomes-based contracts.

4.3 Competition and Commissioning Priorities

The contracting negotiation process for 2014/15 now includes the development and agreement of the quality schedule as part of the core contract discussions. This includes Parts A and B which are national operational and quality requirements. Each commissioner also separately negotiates Part C which is a local quality schedule reflecting **local quality priorities** or objectives. Similarly, the development and agreement of local Commissioning for Quality and Innovation payments (CQUINs) has been included in the core contract discussions.

We remain focused on retaining the services that we currently provide within our current geographical areas. We are aware of the benefits and risks competition brings having recently lost the contract to provide contraception and sexual health services in Oxfordshire but won the contract to provide Health Visiting in schools.

We will focus on increasing our market share in areas where we have expertise that patients will benefit from. In line with our strategy, we will consider a number of large tenders that are due to be advertised in the coming two years. In total there are 35 contracts that are due for renewal in the coming year with a total value in excess of £170m; these include community services, children and family services, specialised services and corporate services.

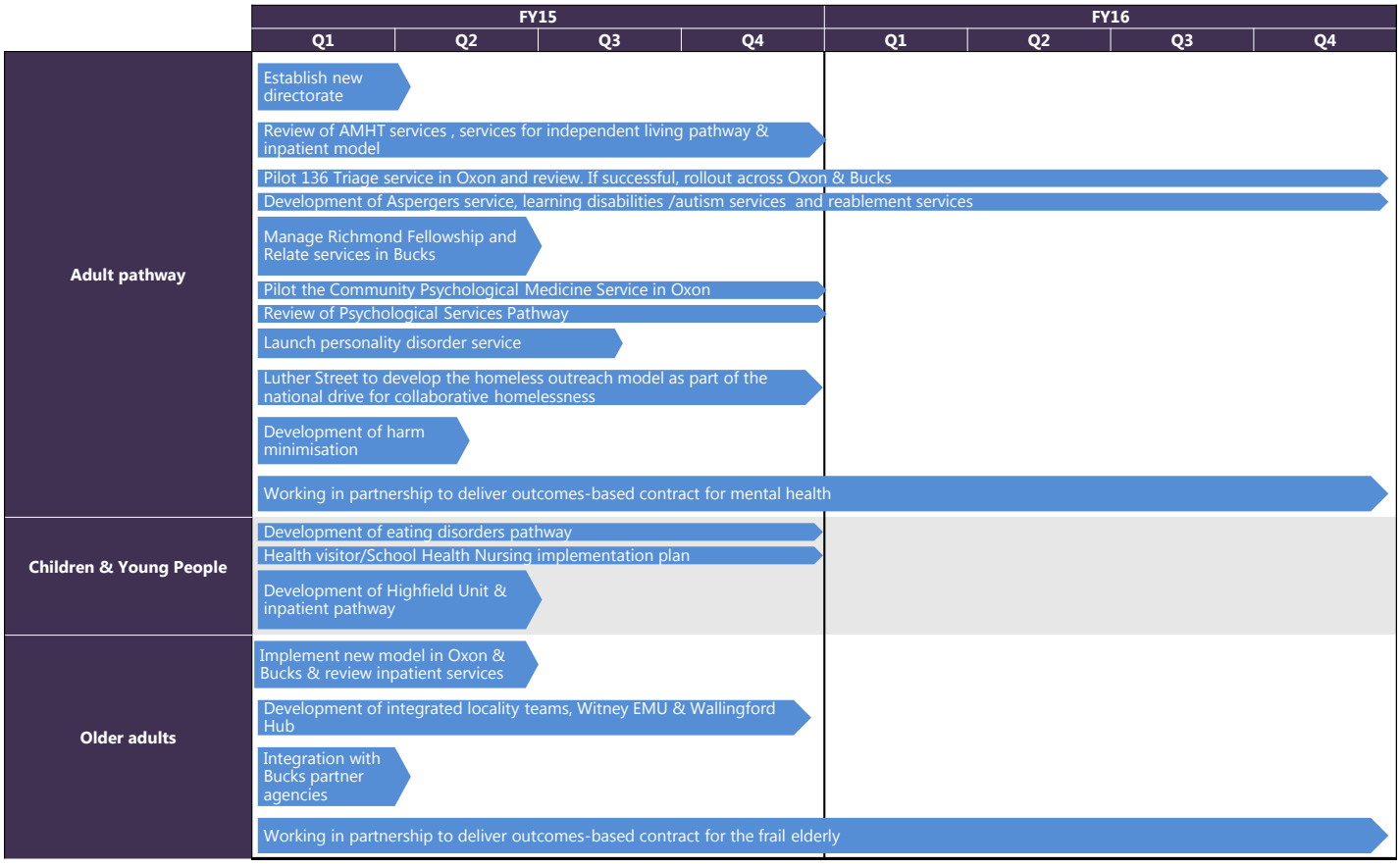
5.0 Operational requirements and capacity

In 2013/14 we embarked on a large programme of work across the four clinical divisions. Services were remodelled in order to deliver integrated health and social care services that are efficient and appropriate, and maximise the opportunities and benefits of local 24-hour, seven day per week multidisciplinary care. Twelve overarching care pathways are under development as part of this work.

Care Pathways	Children & Young People	Adults	Older Adults
Maternal Health	✔	✔	
Neuro-developmental	✔	✔	
Children's complex & multiple needs	✔		
Eating Disorders	✔	✔	✔
Long Term Conditions	✔	✔	✔
Psychosis	✔	✔	✔
Mood Disorders (Bipolar, Anxiety, Depression)	✔	✔	✔
Personality Disorders	✔	✔	✔
Addictive Behaviours	✔	✔	✔
Complex Conditions / Frail Elderly			✔
Dementia			✔
Palliative and End of Life Care	✔	✔	✔

As of 1 April 2014, these pathways will sit within four new structures: **Children and Young People, Adults** (including adult mental health and specialised services), **Older Adults** and **Business Development and Partnerships**.

Our operational plans for FY15 and FY16 aim to realise the benefits of our remodelling by organising care around the patients' needs. We will deliver coordinated local care as part of the whole system working with other providers of health and social care to ensure that the patients receive the right expertise at the right time. We will also ensure that impacts in terms of outcomes and not just activities are systematically measured and reported.
A summary of our operational business priorities FY15 and FY16 can be found below:



5.1 Anticipated activity and demand

The clinical divisions have presented their anticipated activity for FY15 and FY16 under the new structures, and will be looked at in turn. Overall, activity across all services is expected to either remain at a constant level or increase, although this is difficult to fully anticipate.

5.1.1 Children and Young People

The capacity commissioned will remain the same for the Child and Adolescent Mental Health Services (CAMHS) activity in all of our contractual areas, as plans are set for the period of the contract and there is no contractual service review planned for FY14 and FY15. Contract variation discussions are underway but there are no implications on capacity. However, demand for the services has been steadily increasing with a 15% rise at month 10 in FY14 compared to FY13 for all Children and Young People's services.

5.1.2 Adults

The current services operational across the counties are Crisis Acute Services, Assertive Outreach Teams and Community Mental Health Teams. These teams are being brought together to reduce the number of handoffs and to create a seamless pathway for patients, relatives and key stakeholders in receiving assessment of their mental state and ongoing treatment. The introduction of these new five Adult Mental Health Teams (AMHTs) will see staff coming together to deliver the existing functions under one locality team from April 2014. The AMHTs will move to a seven days a week service with an assessment and treatment function, night assessment function and day services in Oxford, Banbury, Aylesbury and Chiltern as an alternative to admissions.

Further new services were introduced at the beginning of 2014 which will be embedded throughout 2014/15; these include a Street triage team, Psychiatric In-reach Liaison (PIRLS), Emergency Department Psychiatric Liaison (EDPS) and a Community Psychiatric Medicine Service (CPMS).

The table below shows the expected activity for the AMHTs and day services in FY15. This remains the same across all services compared to FY14.

Service	**Team**	**Planned patient contacts/year**
Buckinghamshire AMHTs	Aylesbury	24,294
	Chiltern	33,157
Oxfordshire AMHTs	North West	21,339
	South West	21,893
	City & North East	27,683
Day Services	Aylesbury Day Service	2,375
	Chiltern Day Service	2,375
	North & West Day Service	2,375
	City & North East Day Service	2,375
		137,866

It is unlikely that demand for Specialised Services will reduce in the coming year. The commissioner of specialised services, NHS England, is not intending to fund increases in capacity although this may change subject to the national capacity planning work.

Commissioning changes potentially favour independent sector providers as activity may be reconfigured from the NHS to under-occupied facilities. The service continues to engage in dialogue with the NHS commissioners regarding the plans for a new Assertive Discharge Service designed to reduce length of stay for patients.

5.1.3 Older Adults

There is an anticipated increase in acuity, complexity and volume of demand for Older Adults services. For example, demand for Community Hospitals increased by 21%, for district nursing by 20% and for musculoskeletal services by 15% in FY14. Following the continuity of care audit all services are reviewing their demand and capacity models for FY15, to ensure that we are best aligning capacity against seasonal, predictable variation in patient need and demand, and to evidence the gap between funded capacity and actual patient needs. Demand is identified using bed occupancy and patient contacts, using annual and monthly outturn data.

During contract negotiations for FY15, commissioners are asked to decide how they will address quantified gaps where actual patient need and demand is significantly higher than contracted and (block) funded activity. There are three service portfolios where there is a significant gap between demand and funded capacity:

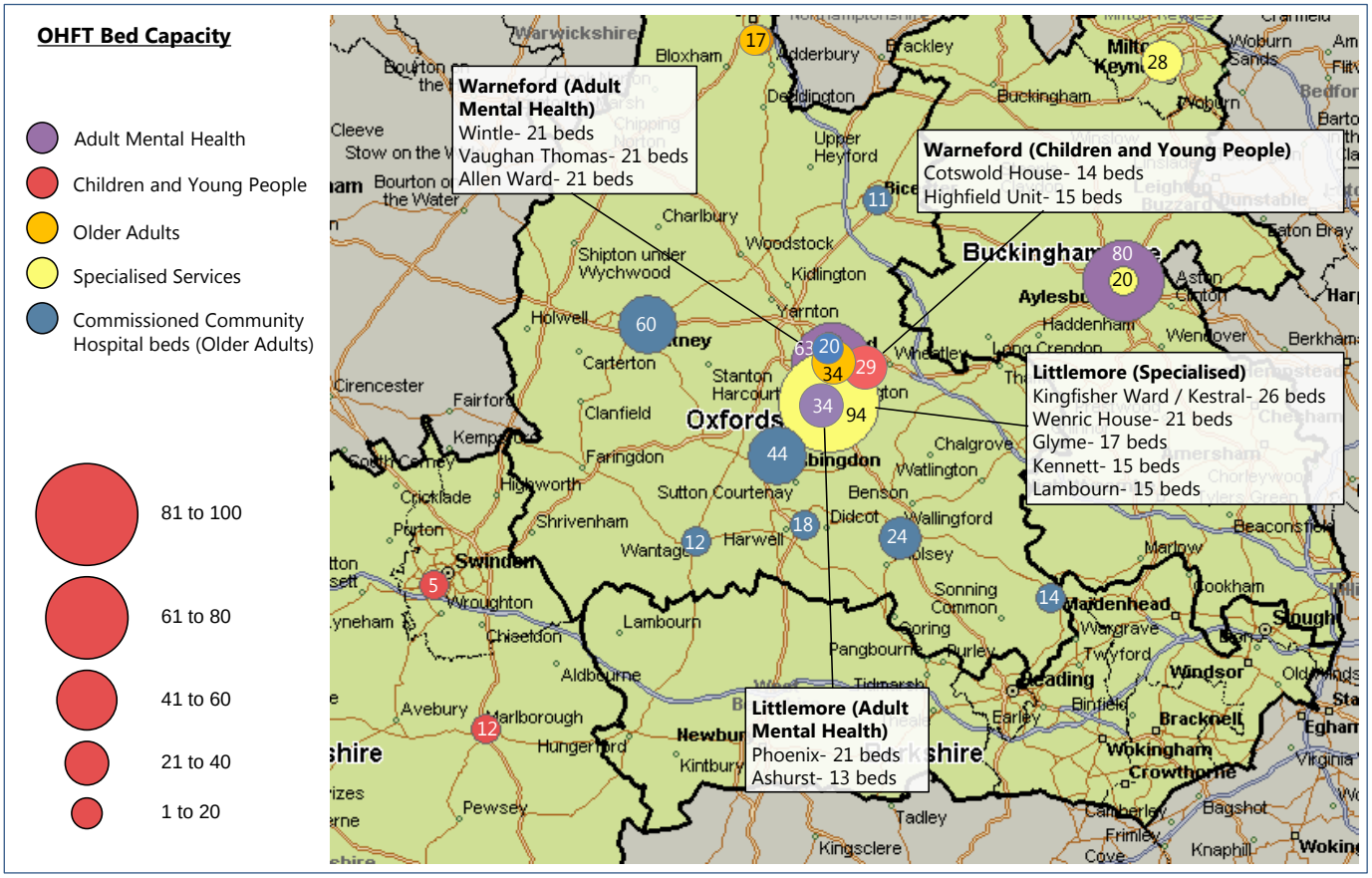
- **Community nursing**, particularly district nursing, where there is a 20% gap between funding and actual demand.
- **Community Allied Health Professionals**, where an investment of £800k is required to enable the service to meet the 12 weeks Referral to Treatment standard, given the current level of patient demand
- **Community hospitals** - increased nurse to patient ratios to be compliant with the Shelford model (as per Francis recommendations), and increased medical cover to reflect the significant change in patient acuity, instability and complexity (as demonstrated by Shelford and Hurst analysis).

The extent to which these issues can be addressed through the FY15 contract negotiations will determine the actions taken by the teams in FY15 and FY16 to provide a safe service with high quality patient outcomes.

5.2 Required capacity and beds

OHFT currently operates our services out of 25 freeholds, 59 leased/licenced and 75 informal properties (mainly general medical service and other general practice premises). We have a total capacity of 416 inpatient beds, and are also commissioned for 203 community hospital beds. We are commissioned by episodes of care as opposed to bed numbers in our community hospitals across Oxfordshire, for which we are currently 30% above block contract.

The map below shows the distribution of our inpatient and community hospital beds across Oxfordshire and Buckinghamshire:



5.2.1 Children and Young People

There are no current plans to increase the bed capacity or the services overall for Children and Young People services in FY15 and FY16. However, the demand for CAMHS inpatient beds is more than our capacity and so waiting lists to manage the demand when capacity is unavailable have been introduced, and OHFT is supporting the NHS England review of CAMHS Tier 4 services. The demand for Eating Disorder beds fluctuates through the year, and when demand is higher than capacity the units hold waiting lists and clinical decisions are made as to who can be admitted next.

5.2.2 Adults

There are no anticipated changes to the demand on our Adult Mental Health inpatient units in FY15 and FY16. The table below outlines the capacity of each ward based upon the number of bed days available in 2014-15.

Ward	Available bed days	Occupancy (%)
Kimmeridge (now Sapphire)	7300	116%
Portland (now Ruby)	7300	95%
Allen	7665	98%
Phoenix	7665	104%
Vaughan Thomas	6570	79%
Wintle	5840	107%
Ashurst (PICU)	4745	89%
Mandalay (now Amber)	7300	95%
	54,385	**97.8%**

Some wards show occupancy of over 100%. This is because a patient can be admitted to an already occupied bed if the occupying patient is on a period of leave. Both patients are counted towards the occupancy total.

However, the service aims to reduce the number of beds available in 2014 by approximately 16, which would see one ward being closed. This would see a reduction of 5,840 beds days available which would in turn increase occupancy to 99%. This will be achieved through the use of improved alternative to admission services provided within the AMHTs and revision of the day hospital use along with reviewing the Support into Independent Living (SIL) Pathway to ensure patients are able to access accommodation and support upon discharge.

The Psychiatric In-reach Liaison (PIRLS), Emergency Department Psychiatric Liaison (EDPS) and Community Psychiatric Medicine Service (CMPS) activity is based upon the number of referrals from GPs therefore it is not possible to estimate the activity and capacity for the FY15 and FY16 period. The activity for the Early Intervention in Psychosis (EIP) and Personality Disorder services are based upon contractual agreements with the local Clinical Commissioning Groups (CCGs). These are still to be agreed for FY15 and FY16.

In FY15 and FY16, Specialised Services do not expect to increase the bed capacity. The long-term vision is to reconfigure medium secure services in Specialised Services, so that the Marlborough House medium secure services are centralised at the Littlemore site in Oxford; however this will only happen once a suitable ward is available. Small configuration changes to reduce the size of the Marlborough House Watling ward from 20 to 18 beds and an additional bed in the Woodlands Low secure unit is currently planned. An options appraisal has been produced by the service for further consideration in determining the estates solution. The expected capacity of Specialised Services over the next two years therefore remains at 142 beds, spread over nine wards.

5.2.3 Older Adults

There are currently two types of inpatient beds for older adults: in community hospitals and mental health beds. A critical issue for resolution in FY15 is the reduction in older adult mental health inpatient beds by a third in line with service remodelling and consultation. As previously outlined, this remodelling work will enable increased staffing in community teams to enable Older Adult Mental Health to move from a 5-day-per-week service to a 7-day-per-week service, including extended hours, increased rapid response, and an increased staff-to-patient ratio on the wards.

Average length of stay has already reduced from an average of 100-days down to 70-days in FY14, and improved discharge planning will reduce this to 50-days in FY15. This will enable us to increase patient throughput and deliver the same number of patient episodes through a reduced bed number, and fund service enhancement.

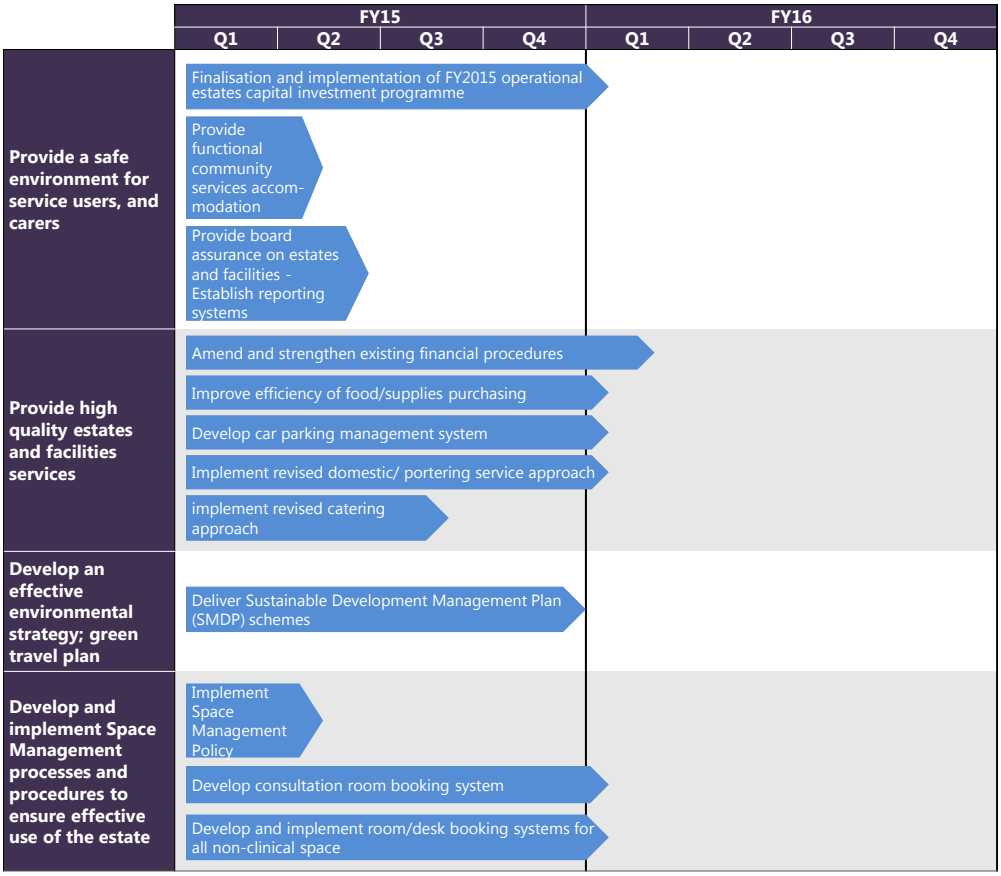
A review of community hospital beds, in terms of function, location and number, is planned for the coming year. This is part of a whole system, commissioner-led review to determine the medium and long-term function, location and number of community hospital beds. Currently beds are unevenly distributed across the county, and a variety of unit sizes (ranging from 11 beds to 60 on each site) does not support high value, sustainable care in the long-run.

The shift in patient need and demand (ageing demographic) and limited long term viability of the current estate within the available financial envelope means that this is a critical strategic issue for Oxfordshire. A key objective is to encourage and support commissioners in undertaking this review and actioning its recommendations.

5.2.4 Estates Plans

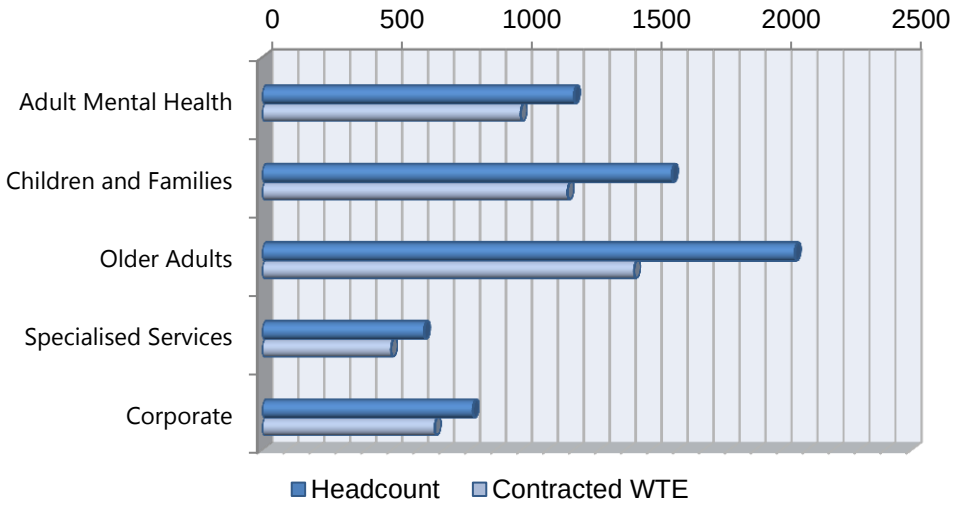
We aim to ensure that our estate will continue to be safe and appropriate for use as our plans are implemented. Specific projects will look at improving aspects of cleanliness, comfort and catering over the next two years.

An environmental strategy is under development that will ensure our estate carbon emissions are as low as possible and our waste management and recycling processes are improved. Finally, our estate must be cost-effective and occupancy maximised. Our plan looks to provide suitably located, functional community services accommodation to support our home/community care service models, allowing care to be delivered closer to home.



5.3 Workforce requirements

As of January 2013, OHFT employs a headcount of 6275 staff and a contracted WTE of 4770.23. Our Corporate workforce includes our supporting functions, including HR, Learning & Development, Research & Development, Estates, IT and Finance. It also contains our medical directorate, and nursing and clinical governance teams. The following section outlines the required workforce input as a result of anticipated demand over FY15 and FY16, according to the old divisional structure. Overall, there are no significant changes predicted.



5.3.1 Children and Young People

Workforce changes in the new Children and Young People directorate may arise as a result of new tenders. Potential tenders that would increase workforce requirements are Children's Community Services in Wiltshire and Buckinghamshire.

An increase in workforce is anticipated for School Health Nursing and Health Visiting services. They have associated national training programmes as part of Department of Health initiatives, and we are nationally recognised for growing and training the workforce in these areas. The Health Visiting initiative "Call for Action" trajectory is 123.6 WTE Health Visitors by 2015, and our service is currently over-performing on a current trajectory of 116.4 WTE. Recruitment is underway to the Services Specialist Practitioner degree course starting in September 2014 to ensure sustainability post-2015.

There is a need to improve the eating disorders inpatient workforce and develop the skill mix due to the nature and complexity of patients for admission. Patients are presenting increasingly frail and physically compromised, and so the workforce planning for this service is to increase the skills in naso-gastric feeding, phlebotomy and employment of acute nursing to complement the mental health nursing, by approximately 2 WTE.

5.3.2 Adults

The workforce figures for Adult Mental Health in FY15 and FY16 will remain constant, and whilst numbers may decline through natural wastage the directorate aims to work to the optimal levels indicated. Through the use of mobile working initiatives, it is envisaged that an increased number of staff on the new adult pathway will be able to complete work remotely through devices such as iPads.

Only minor changes to workforce in Specialised Services are expected in FY15 and FY16. New additional services that are likely to become operational during FY15 include the personality disorder gatekeeping service within the probation service and a community personality disorder pathfinder service. Both of these services require a minor increase in staffing (less than 20 employees) and therefore will not be a major challenge for the service. There has been a recent focus on ensuring that the staff genders match those of the patients to improve engagement and involvement. This is a particular issue with Psychology and Occupational Therapy staff. General Nursing and support workers do not represent any major challenges.

5.3.3 Older Adults

Based on turnover and retirement, we will focus on recruitment and development of 10-12% of our WTE year-on-year to maintain current service provision. Hot spots are band 6 district nurses, Oxford Reablement Service staff and staff in bed and home based settings with sub-acute nursing skills (i.e. community hospitals, Emergency Medical Unit (EMU), Hospital At Home, GP out-of-hours etc.) The other workforce development is a shift from contracted to employed medical cover for community hospitals which has been under development during 2013-14 and will be embedded during 2014-16.

5.4 Staff engagement and ways of working

The service remodelling work impacts not only how services are delivered to the patients, but how our staff work together. Each directorate has several measures in place to allow our staff to deliver the best care possible.

5.4.1 Children and Young People

The Children and Young People directorate are developing management across the services through a Leadership Programme for Children and Young People's Improving Access to Psychological Therapies Programme. This encourages the culture of clinicians and managers working together to deliver leadership and change.

5.4.2 Adults

The Adult directorate will continue to support the development of staff through the use of the 'Leading the Way' programme which provided managers and future stars with an overview of management and leadership elements to allow them to support their teams. The directorate has also introduced a 'Planning for the Future' course designed for the senior leadership of each team. These sessions are designed to develop the team so they can work together to provide leadership to their individual teams with a shared understanding of the goals and ways to achieve the necessary outcomes. The directorate is also plans to rollout **value-based interviewing** and review the customer awareness training to ensure all staff understand the value and importance of customer care.

All staff were involved in the changes in services to ensure they understood the reasons behind the changes and how these would be implemented. During the past year, care clustering has been introduced which uses identified care packages for patients depending upon their needs. A full training need analysis will be carried out as these care

packages are finalised to understand which skills are required to carry out the interventions associated and the skill mix of the different teams involved.
It has also been important to recognise the achievements of staff. The introduction of the Divisional Awards has been an opportunity for staff to nominate their colleagues and themselves for different awards recognising the work they do. To ensure the services are aware of the work the senior management team undertake, the director has a blog to share important information and provides regular updates through this forum on the work underway.

The senior management team has created a performance monitoring area displaying all the key deliverable performance areas. These are shared with the teams which set out the expectations. We also involve service users and carers during service redesign and change to ensure their participation in shaping the future of the services. It is the combination of service change, leadership, involvement and engagement which is helping the directorate shape the future culture of the services.

5.4.3 Older Adults

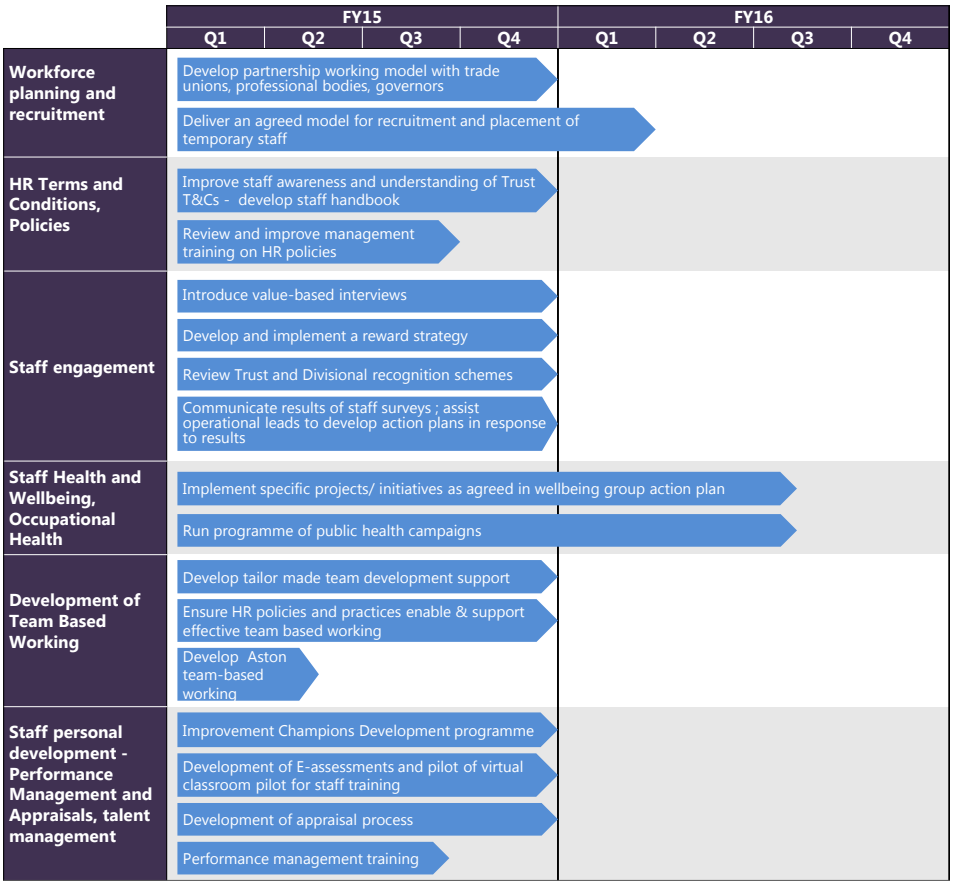
There is an over-arching objective in the Older Adults directorate to enhance **clinical leadership** in order to drive and oversee increased clinical competencies and governance to meet the needs of complex needs of patients in a community setting. Key actions include:

- Review and restructuring of the clinical leadership to align to service remodelling and directorate restructuring. This is expected to include provision of a professional lead for social care and creation of the clinical lead for allied health professions, as well as review of current clinical leadership to ensure it has the capacity to lead clinical transformation and the safety programme for the directorate.
- Re-development of the existing clinical governance team to increase its capacity and focus on working with services to drive enhancements in the quality of care and in patient outcomes.
- Ongoing development of clinical models of care, including rapid translation of research into practice, and driving research in service innovation through use of the CLAHRC.
- Development of a skills lab and clinical competency education programme and advanced practitioners skills
- Transfer of clinical competencies between mental health and physical health services to drive holistic care, especially for older people, and those with long term conditions.
- Embedding of personalisation of care, including co-production of care planning with patient, personal health budgets and self-managed care.

5.4.4 Trust workforce plans

In order to support changes to our workforce over the next two years, we have a comprehensive workforce, learning and development strategy in place to support our operational plans.

We want all our staff to be caring, safe and excellent in their day-to-day work. OHFT's workforce strategy looks at how the organisation can attract and then retain the best staff, through efficient recruitment processes and workforce planning. In order to then retain staff, the strategy focuses on staff development, engagement, rewards and wellbeing. Specific projects will look at team-based working and development of clinical leaders to encourage high performance from all our staff.



5.5 Matching the Levels of Demand

The inputs required by our services in FY15 and FY16 have been identified, but is important for our services to be able to flex according to changes in demand.

The newly established AMHTs in the Adults directorate will operate a team approach to patient care which will see each patient receive an identified care coordinator who can introduce them to other colleagues that will be able to provide further input into their care when the patient is requiring a higher level of support, such as at a time of crisis. It is this teamwork approach, along with the flexibility provided to the teams through shift patterns, which will allow them to review the periods when demand increases and thus staff the service accordingly. Care clustering also allows the service to understand the skills required to support patients which will ensure that each patient receives the right care at the right time. This, in turn, will lead to providing efficient services which will be more convenient for patients and allow more patients to be seen if necessary.

The Children and Young People services have workforce development plans in place to ensure that we have the skills mix and capacity to deliver at times of increased demand. This is supported by an extension of working hours of children's community services to provide care in to the evenings and an acute care pathway which ensures that young people are treated at home where possible. An integrated clinical and operational leadership approach to management across physical, mental and public health services will help to ensure that staff collaborate across traditional service barriers and provide an integrated approach to meet the needs of children and young people. A systematic review of productivity in all services will take place over FY15 to ensure that all Children's services remain as efficient as possible.

The resources requirement to meet the objectives of the Older Adults directorate is a fundamental element of the transformation programme. The reduction in older adult mental health beds is an example of change to shifting resource from bedded care to community care to meet demand. The acute skills staff training programme will support staff to meet the demand for specific skills and competency in the community. The requirement to meet increased demand in services like community therapies will be met through working seven-day weeks, therefore offering more appointments over weekend or evenings. This will provide greater flexibility for the patients and fewer DNAs (did not attend). Many of the community services will offer 7-day provision.

Establishing the culture of personalised care and self-care will enable staff to focus on supporting patients who require sub-acute care or who have complex health needs which require intensive support. Finally, the competency training for staff to manage patients who require sub-acute care in the community will be provided to a wide range of staff. This establishes teams of staff who have certain generic skills, which means there will be a reduction in handovers and so greater efficiency and productivity overall.

5.6 Analysis of key risks

<u>Workforce & Leadership</u>

- To avoid problems resulting from an insufficient skill mix with the Adults services, the leadership team has been reviewed to ensure that each service has an operational, quality and clinical leadership in place. As each AMHT has a separate assessment and treatment function, those staff working in each area must have the necessary skills required to undertake the work; for the assessment function staff receive advanced assessment skills training to ensure that patients are assessed appropriately. This will lead to improved patient flow through the service allowing more referrals to be accepted as productivity increases and the patient experiences improve.
- Challenges for the Children & Young People's workforce include the recruitment and retention of specialist staff, for example in Health Visiting and CAMHS. Some of our services are commissioned for the staff and a skill associated to them and the workforce must be continually trained and developed for this. The directorate works to ensure robust succession planning is in place to maintain a low turnover and retain specialist staff.
- There is a risk that the new AMHTs might not be able to cope with demand and deliver safe and effective care. To mitigate this, reviews of the AMHTs and the new clinical model in both the community and inpatient services are planned at the six and twelve month implementation period. This will ensure that any issues which are identified can be reviewed and solutions identified to rectify any problems experienced. It will also

ensure that the predicted activity for each AMHT is monitored to ensure that the services are operating within their capacity and patients are not delayed in receiving care.

- Challenges facing the Older Adults directorate include recruitment of specialist medical and nursing knowledge for EMU's and Community Hospitals, specialist skills for community staff to enable patients to receive "one stop shop" assessment and support, and staff retention as the directorate moves to 7-day working. A shift in culture following the adoption of new ways of working in multidisciplinary teams may be a risk, which would affect OHFT as well as other providers and the voluntary sector. A final risk, linked to patient experience, is the shift in the local population adopting self-care and personalisation.
  These risks are mitigated through tight programme and project management; through partnership working with local organisations and voluntary sector; staff engagement and involvement through the changes. There will be development of local networks with patients, carers, GPs and providers to establish local community engagement and inclusion.

Demand and capacity

- There is a risk that the Adult services will be unable to safely manage the number of admissions versus the beds available. A reduction in beds is proposed, which means that the service will run at 95% occupancy to ensure emergency admissions can be managed. With the changes occurring with the community AMHTs, where services will be working 24/7 from the 1st April 2014, all localities will have staff providing treatment into extended hours and at weekends which is not currently available. In terms of bed capacity, the AMHTs will be reviewed to understand how their productivity has changed in September 2014 to understand whether they have improved bed capacity by having the extended hours of operation. In conjunction with this, the inpatient wards have seen the introduction of ward based consultants and from April 2014, each ward will have a dedicated modern matron who will work together to review / create and maintain capacity within our bed stock. As the ward based consultant is a new role, this will also be reviewed in September 2014 to understand if the bed capacity has been improved through their available and presence on the wards.
  In addition to this, the development of a slow-stream rehabilitation unit, which will take those patients who require longer term treatment within an inpatient setting, will take place within the rehabilitation pathway. This will free up beds on the acute wards. Once this has been implemented towards the end of 2014, a review will take place six months thereafter to understand this impact on bed capacity ahead of deciding whether a unit can be closed. We will also be working with the SIL pathway to identify nursing placement-type accommodation to ensure patients are discharged from the acute ward in a supported and timely manner thus increase bed capacity across the wards.
- Children and Young People services anticipate an increase in demand for services but no change in commissioning (approximately a 20% increase in referrals from previous year trends). Demand for Health Visiting is at risk of increasing due to national programmes and promotion. The risks associated with this increase in demand are that further capacity is not commissioned, leading to increased waiting times and reduced patient experience and satisfaction. This may lead to increased patient complaints and a risk to staff morale and wellbeing.

Commissioning and income

- Oxfordshire commissioners are currently developing their Maternal Health pathway. One intervention is a service for pre-conception up to one year in age. This could potentially remove health visitors from the current service to establish and support the new pathway, but the implication of this is not currently known.
- Children and Young People services are facing a risk of segregation of their pathways following the introduction of specialist commissioning. The risks are an increase in average length of stay, distance from the patient's home as commissioning is on a national level and a risk if national commissioning pass the commissioning responsibility back to CCGs. The separation of inpatient wards from the community teams in terms of contracting and commissioning has a negative impact on integration of the clinical pathways. Income generation for inpatient services has ceased due to specialist commissioning as all capacity is bought in one contract. There is a risk of further efficiencies applied by NHS England to the bed cost price which is currently causing financial pressures. The directorate is currently working with commissioners to extend contracts beyond the original expiry dates of March 2015 and where contracts are continuing through tendering awards. This affects seven different tenders.
- A specialised pre-discharge unit has not been included in the specifications for services commissioned by NHS England.

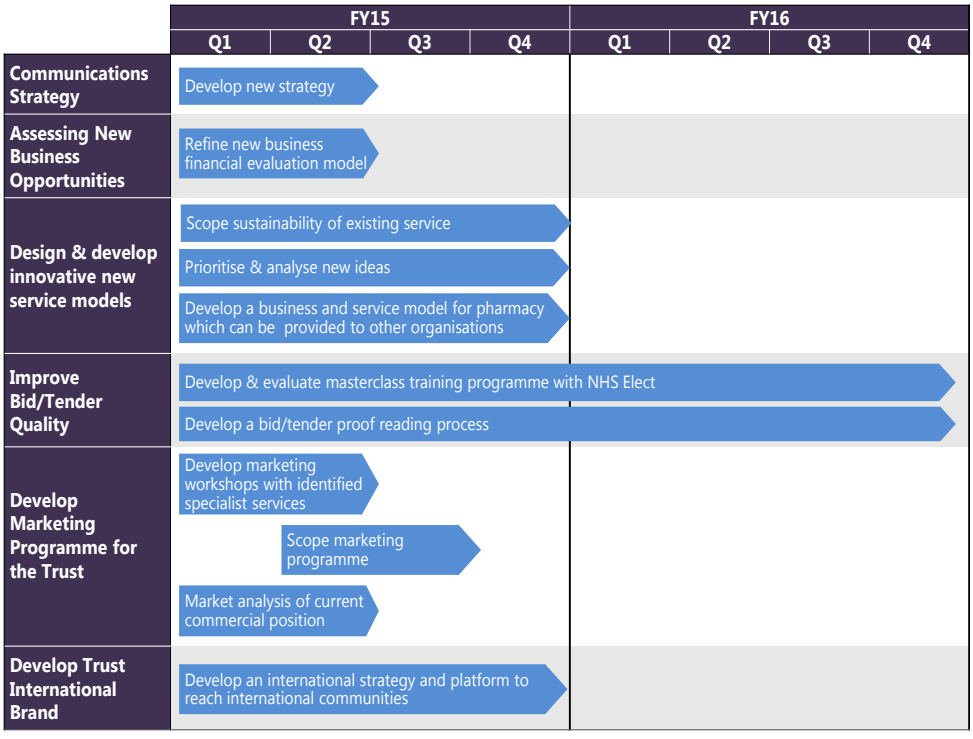
Service delivery, quality and performance

- There is a risk that the Adults services may fail to meet their Key Performance Indicators (KPIs)/contractual agreements with the CCGs. The services will be able to identify any early signs of problems in performance and practice, and allow actions to be put in place to address these through the introduction of a new performance matrix to monitor key areas for each pathway. Along with the overall matrix, each pathway (Community and Acute services) will have their own set of KPIs which includes the essential standards (such as CQC Outcomes, CQUIN, Risks, Monitor targets) to monitor each pathway against. This will provide assurance that the teams are meeting the necessary targets and flag any concerns early. Workforce data is also included within the performance monitoring data to ensure staffing levels are maintained to run the services safely.
- Adults' services will be rolling out the safety collaborative across all AMHTs and wards to continue to ensure that measures are in place to monitor the patient experience and where issues arise/are identified, actions can be taken swiftly to improve them. A single measure in place for all areas will allow comparisons between sites to be monitored closely and best practice to be shared where appropriate.
- The delivery of the Older Adults programme is dependent on the development and implementation of multi-organisational care pathways to streamline care delivery and reduce duplication for patients. Although this presents a challenge for all organisations, the requirement is firmly embedded in contracts and the positive development of admission avoidance and discharge pathways have established confidence in the benefits of the partnership working to achieve the pathways.
- Estates may not be fit for purpose in the long-term to comply with relevant Specialised Services specifications. A lack of modern facilities will become a threat in the event of a re-tender of Specialised Services. A lack of ward space, finally, will result in the service being unable to operationalise the Assertive Discharge Unit. There is a risk concerning the future security designation of the Women's Enhanced Low Secure service in FY16.

5.7 Developing our Business

In order to continue to deliver existing services and grow it is paramount that we continue to improve the quality for patients. Concurrently over the next two years, the Trust will improve the quality of bids and tenders through staff training and process improvements. We are continuing to develop non-NHS services in order to generate additional income that can be reinvested back into our services and contribute to our cost improvement programme.

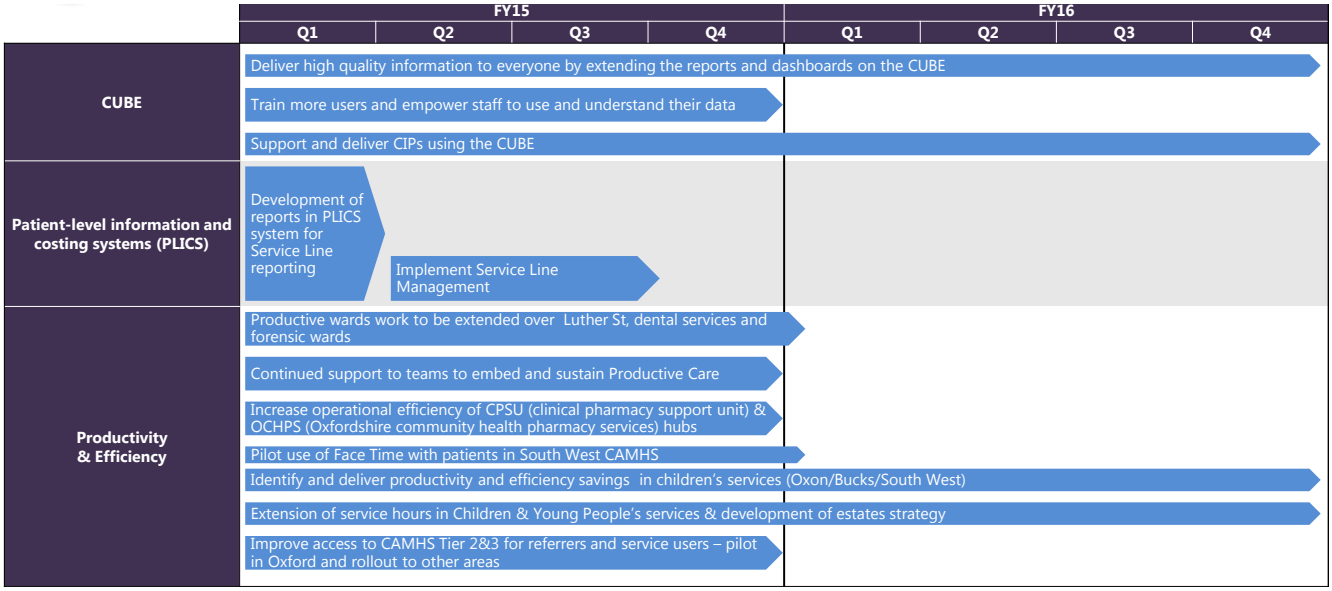
Our plans include the development of Extra Contractual Referrals Rehabilitation Beds, and development of Occupational Health Services, private oral surgery and Diabetes Training. We will also develop our international work through partnership, consultancy and training. A market analysis of our current commercial position will advise future bids, allowing us to respond to our competition and ensure we remain a preferred provider of multiple services across a wide geography. Work is on-going to improve OHFTs public relations and, with the appointment of a new Head of Communications, to develop a robust communications strategy, and develop our image locally, nationally and internationally, and our brand and position in the market place.



5.8 Productivity

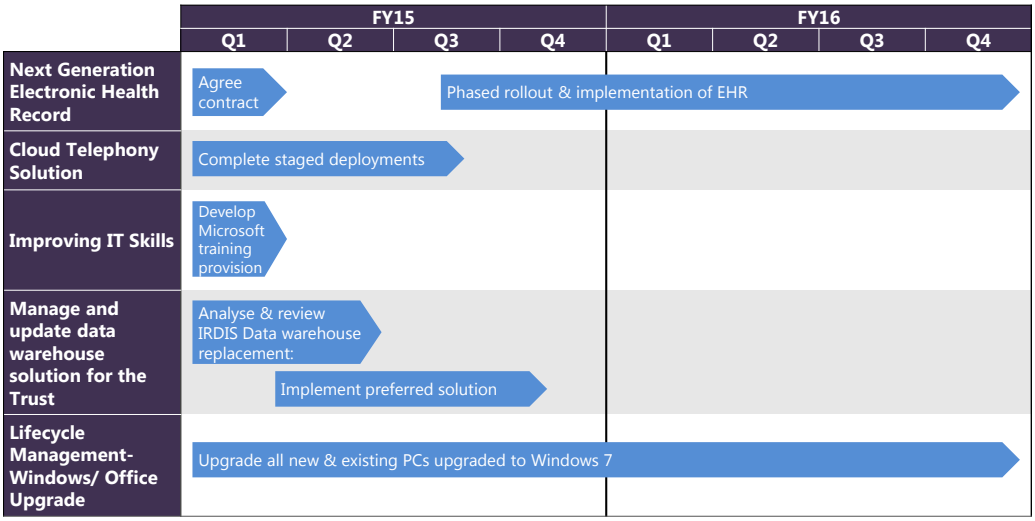
Given the increasing patient demand and the ongoing fiscal constraints within the NHS, productivity is a key objective to deliver safe care within the available resources. Increasing the productivity of our services was a key aim of the service remodelling work in the previous year. Each directorate aims to deliver productivity increases and a working group has been established to oversee a programme of interdependent projects. Each directorate is identifying and prioritising the services or care pathways to begin to benchmark using existing information. It is fundamental that clinical leadership is embedded in small groups for services or pathways to lead the delivery of better value care – care that delivers high quality outcomes at lower costs.

There will be a systematic and ongoing review of relevant productivity metrics and actions. The programme will develop strong links with the implementation of the next generation electronic health record (EHR), mobile working, business intelligence and patient level costing projects. The programme will also take into account the impact of such clustering in mental health and outcome-based contracts. In the long-run it will be essential that clearly defined care processes for patient conditions are in-place, understood and the costs and impacts are routinely measured to deliver increased productivity. The table below outlines our priorities which will enable us to become more productive and efficient in what we do:



5.9 Information Technology

Our IT strategy aims to provide the right technology for our patients and staff in order to achieve the best quality outcomes. Training will be delivered where necessary to ensure that staff are proficient against defined IT competencies. The IT business applications, systems and tools will be designed to meet the business challenges of the Trust.



The most significant development will be the next phase development of our Next Generation Electronic Health Record, which contains the information that our staff need to deliver high quality care, and patients and carers need to manage their own care more effectively. This will enable clinical staff to increase the time that they spend with patients and

reduce a great deal of administrative burden over the coming two years.

6.0 Cost Improvement Programme

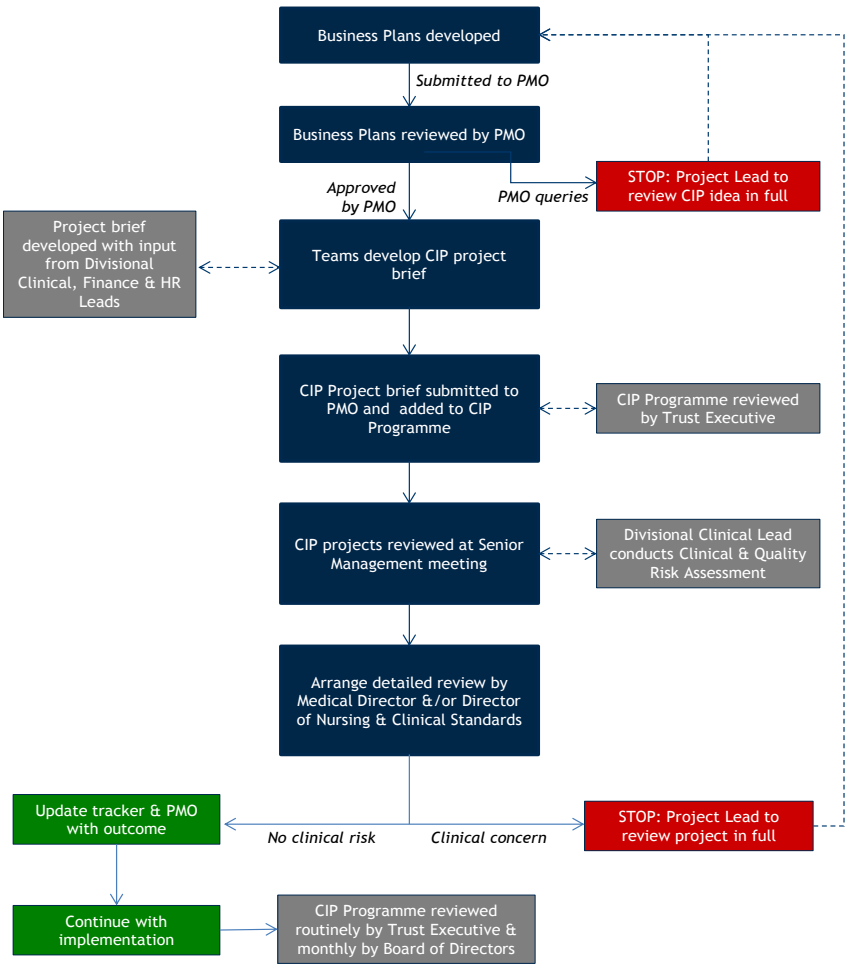
A Programme Management Office (PMO) has been in place since 2010 and is responsible for the coordination and development of the trust strategy and business plans. A key component of this is the ongoing development, assurance and delivery of the Cost Improvement Programme (CIP). The PMO works with management teams to ensure that projects are developed and successfully implemented and benefits are realised either from complex transformational programmes or of direct savings from 'transactional' plans.

In 2011 and 2013 respectively the Trust delivered 88% and 83% of its targets. However, the CIP performance has been deteriorating in the last eighteen months and for FY14 it is forecasting to deliver only 40% of its target. This was due to a conscious decision taken to focus management efforts on a review and redesign of operational services. The first phase of this redesign is due to be completed on 1 April 2014, and the intention is that it will enable a transformation in the way staff operate and their efficiency in caring for patients.

6.1 Linking Business Planning and Cost Improvement

As with many health and social care providers in England OHFT faces a significant challenge to reduce its costs while maintaining or improving the quality outcomes for patients. In previous years we have delivered its CIP programme as individual, largely transactional projects. However, we have gradually moved towards greater collaborative planning to design more long-term, transformational programmes.

Since January 2013 the trust has integrated business planning into the CIP development cycle in order to align the major strategic change programmes for the coming years. The PMO has coordinated this process and assessed plans for strategic fit, ease of implementation, risk exposure and value. This has culminated in a CIP that comprises transformational plans (from business planning and service remodelling), impacts of full year effects from existing projects, and transactional (less complex) projects. The programme will continue to develop through FY15 and FY16.



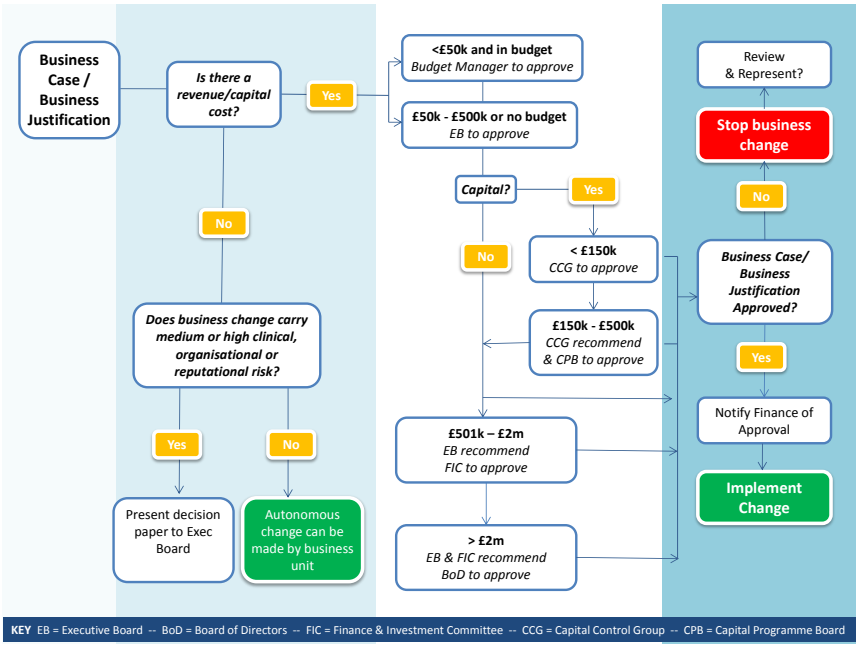
As part of the embedding of integrated planning processes a senior strategic management team including clinical, nursing and managerial leads from across the organisation has been established. It meets regularly to refine and develop plans ensuring dependencies are identified and managed.

6.2 Clinical and Quality Assurance Processes

The process for clinical and quality assurance is outlined left. The programme is governed rigorously and maintained through routine reporting, with a keen focus at Executive and Board level. This provides clarity over what the expected benefits of projects are and drives mitigating actions when needed. A robust planning process also aids CIP delivery, beginning early, allowing appropriate time for scoping and revision of projects before they are committed to the programme.

Successful implementation of the processes also requires a high level of support, leadership and engagement across the Trust. Every CIP project lead is required to complete a clinical quality risk assessment that identifies potential benefits, disbenefits and mitigating actions for patient experience, clinical effectiveness, patient safety and workforce (including staff safety).

6.3 CIP Management and Assurance



The Director of Finance is the CIP Director and there are executive leads for each element of the business plan, some of which will either directly deliver cost improvement or collectively deliver benefits that will include cost improvement. CIP responsibility runs throughout the organisation and there have been routine communications, presentations and workshops to inform people of the challenge and to reinforce responsibility for implementation of schemes. Project documentation commits specific leads and project support by name to each plan. As with any major business change or investment, projects and programmes are required to follow the approval processes outlined in our standing financial arrangement.

The PMO scrutinises and manages risks and issues at a programme level, escalating this as necessary and offering support internally. There are monthly CIP meetings as well as quarterly business plan highlight reporting and CIP reporting is contained as part of the financial reporting for the Trust Executive and Board of Directors.

Generally, once a plan has been assured and agreed by the extended executive group a budget holder is responsible for the agreed level of saving and unless there are exceptional circumstances is expected to mitigate any shortfall from within their area of operations. Throughout the life of this strategic plan we aim to continue to drive savings, especially from improved productivity and efficiency that are currently not labelled as CIP projects. These will contribute to the contingency and to future years' CIP plans, reducing the pressure on annual programme generation. The PMO will continue to coordinate the administration and portfolio of strategic projects for the Executive Board in order that it has sight of all major projects in the Trust and can incorporate benefit management projects as required.

Some of the major transformational schemes over the next two years include:

- **Productivity improvements** along clinical pathways following service redesign. Process mapping and measurement, linked to outcomes and costs, supported by integrated Business Intelligence systems. The aim will be to reduce costs and maintain or improve clinical outcomes.
- Delivering the benefits of our **Next Generation Electronic Health Record**. Using latest technology to improve staff productivity, allow greater flexibility, easier administration and more mobile working and increase clinical time with patients.
- **Increasing mobile working** will enable us to effectively reduce the estate that we use and reduce distances and times that staff travel to and from central bases or locality hubs.
- **Reducing unnecessary administration** to allow clinical staff to work to the top of their licenses spending more time with patients and to reduce the costs of administration.

7.0 Financial Commentary

7.1 2013/14 Financial Performance

The Trust has a strong track record of delivering against financial targets, and has historically met all of its key financial targets in each year. 2013/14 was a more challenging year, with a significant CIP target and the major transformation of services; against this background the Trust has continued to deliver a normalised surplus and is forecasting the following results:

- A £3.4m Income Statement surplus before impairments of £7.5m
- EBITDA of £13.4m, giving a 4.7% margin
- A year-end cash balance of £22.5m, in line with plan
- A Continuity of Service Risk Rating of '3', which is in line with plan

The Income Statement is a forecast deficit of £4.1m after impairments of £7.5m, which is £0.9m below plan. Excluding impairments, the forecast position is a surplus of £3.4m against a plan of £4.3m. EBITDA is forecast to be £13.4m against the plan of £14.8m.

The main reasons for the adverse EBITDA position are:

- shortfall in delivery against the cost improvement plans;
- staffing costs pressures due to higher than planned activity levels in mental health inpatient wards, community hospitals and community nursing services ;
- an under-performance on community services re-ablement contract;
- partly offset by favourable corporate budget performance and release of unutilised reserves.

The adverse Surplus position is due to the adverse EBITDA position partly offset by profit on asset disposal and lower than planned public dividend capital PDC liability and depreciation charges.

7.2 Financial Outlook

The economic and financial environment will continue to remain challenging into FY15 and beyond with a 4% national efficiency challenge resulting in a net deflator and a real term reduction in income. In addition, the Trust's main commissioner is facing a significant deficit in FY15 and a challenging financial position into FY15.

The financial strategy for the Trust has been produced in response to this challenging environment, to find headroom from within existing resources to maintain and improve existing levels and quality of patient care. It is built on the firm financial foundations laid by the Trust in the previous years, since becoming a Foundation Trust. The Trust will continue to be proactive in responding to the harsh economic climate and the impact on public service funding, through:

- Robust financial governance
- Targeting reductions in overhead costs, including support service functions
- Ensuring real health gain in all investments
- Driving increased productivity and quality with no net increase in funding
- Planning for the delivery of cash releasing efficiency targets at significant levels
- Mitigating financial risk through forward planning and contingencies.

The Board of Directors approved the FY15-FY19 Financial Plan and FY15 budget at its March meeting. The financial plan for FY15 and FY16 reflects the challenging financial environment and CIP agenda. Key highlights are:

- Normalised surpluses of £1.0m in FY15 and £2.0m in FY16, giving a normalised surplus margin of 0.4% and 0.7% respectively;
- Normalised EBITDA margin of 4.6% in FY15 and 5.1% in FY16 ;
- The requirement for cash releasing efficiency savings of £23.2m during the next two years;
- Capital investment of £18.3m over the next two years;

- A minimum Continuity of Service Risk Rating of '3'.

Target	FY15	FY16
EBITDA – normalised	**£13.1m**	**£14.2m**
Normalised EBITDA margin	*4.6%*	*5.1%*
I&E Surplus	**£0m**	**£1.5m**
I&E Surplus – normalised	**£1.0m**	**£2.0m**
Normalised I&E Surplus margin	*0.4%*	*0.7%*
Cost Improvement Programme	**£10.5m**	**£12.7m**
Cash Balance (year-end)	£19.5m	£17.0m
Capital Expenditure	**£10.8m**	**£8.0m**
CoSRR	3	3

7.3 Key Assumptions

In accordance with the national planning framework for 2014/15, FY15 includes an efficiency requirement of 4.0% offsetting the inflationary uplift of 2.2% for pay and prices, giving a net 1.8% deflator. It is expected that the national efficiency requirement will remain high in the following years and 4.0% has been used as a planning assumption for FY16.

Key Assumptions:

Pay
- 1.0% uplift for national pay awards in FY15 and FY16.
- Pay reserve to be held until the impact of incremental drift pressures on budgets is determined.

Non-pay
- 8% uplift for drugs and NICE developments, 2.5% uplift for clinical supplies and 5.8% uplift for other non-pay costs.
- Non-pay inflation contingency has been held in reserve to offset any price increases in non-pay should they arise.

Patient care Income
- National efficiency targets are expected to be higher than the gross cost of NHS inflation leading to a net deflator in tariff; assumed 1.8% deflator in FY15 and FY16.

Non-patient care income
- Other Income, R&D and Education and training income is assumed at nil inflation.

Financing costs
- Depreciation and interest payable increase from FY15 following the completion of the Whiteleaf capital development that became operational at the end of FY14.

7.4 Income and contracts

Total income falls year-on-year as the planning assumption is for the national efficiency saving requirement to be greater than funding for NHS inflation, resulting in a net annual deflator. No significant additional income is planned

in FY15 or FY16. CQUIN funding is included at 2.5% across all patient care contracts. The Oxford Pharmacy Store income target has been set on the basis of their latest business plan FY15.

Commissioners are applying the national deflator of 1.8% for non-acute providers, compared to 1.5% for acute providers in recognition of additional costs incurred by acute providers following the Francis and Keogh reviews. The Trust is challenging the application of differential deflators, which equates to c. £0.75m of income for the Trust, on the basis that non-acute providers are also required to respond to these reviews and resulting in additional costs being incurred.

The latest contract position for the Trust's main commissioners is outlined below:

7.4.1 Oxfordshire CCG (OCCG)

The transition from PCTs to CCGs has been challenging nationwide, and Oxfordshire is facing financial and organisational challenges as the new commissioning organisations become established. The contract negotiation has been delayed due to uncertainties around the CCG's financial plan and the contract enveloped available to providers. The Mental Health and Community contracts expire on March 31st 2014 and are subject to full renewal. An outcomes-based approach to commissioning is under development.

The contract envelope proposed for the Mental Health contract is £46.3m and for the Community Contract is £68.2m, with some issues still to be clarified. It is clear that a deflator of 1.8% and CQUIN at 2.5% have been applied, and in addition OCCG are seeking to impose a further 3% reduction and a requirement for £2.3m QIPP savings across the two contracts. Service cost pressures of c. £4.5m identified by the Trust are in continuing discussion.

7.4.2 Buckinghamshire CCGs

The FY15 contract is based on FY14 contract rollover with additional investment of £0.18m for IAPT and £0.2m for PIRLS on a risk/gain share basis. A 1.8% deflator has been applied but is being challenged by the Trust. Department of Heath funding for Complex Needs is reducing by 50% in FY15 and ceasing in FY16. The CCG has decided not to match this funding. This creates a £90k cost pressure for the Trust requiring services to be redesigned to meet available funding with a full review undertaken in Q1. The CCG intention is to contract for 3 years, but on a 1 year rolling contract so the revised national contract can be brought in annually.

7.4.3 NHS England (NHSE)

NHSE Wessex Area Team commission the Trust to provide Forensic Services and CAMHS and Eating Disorder inpatient and related day patient services. NHSE is planning national capacity reviews across many of the services that they commission, so they are not contracting for any additional capacity in FY15. The contract for FY15 will therefore be based on the same activity levels as FY14 with the national deflator and CQUIN applied. In addition, they have agreed to an additional £0.4m of funding to support specific cost pressures in the service in Wiltshire. There is also an ongoing negotiation in respect of CAMHS inpatient prices, as they benefitted from a one-off discounted price for FY14.

7.5 Service Developments

Reflecting the expectation of a real terms reduction in funding and increasing demand for services, especially for people with complex needs and within an ageing population, significant transformations, innovations and service developments are required across the organisation in order for us to continue to provide high quality services within this constrained financial climate and increasingly competitive environment.

There are no significant new service developments planned for FY15 at this stage, although the Trust will explore any opportunities which arise during the year that are consistent with the Trust's strategic aims and objectives.

7.5.1 Transformation

Across the Operational Service Divisions a major programme of Service Remodelling work is underway. The programme aims to maximise the opportunities and benefits of integrated care 24 hours, seven days per week. Three care pathways have been developed and are being implemented – services for children and young people, adults and older adults. These pathways cross traditional age boundaries, and 'managing transitions' is one element of work across the pathways. The aim for a locality based model of service delivery, operating within a whole system

approach to working with partners including the third sector. The service remodelling programme focuses on improving quality and safety and providing an improved patient experience and outcomes. The service remodelling that is being implemented will provide for significantly improved services and service delivery for the benefit of patients and will provide the foundation for improving efficiency and delivering productivity gains in FY15.

7.5.2 Activity

Reflecting the year-on-year reduction in income and the increasing demand for services, especially for people with complex needs and within an ageing population the Trust has responded with the significant transformations of services through its programme of service remodelling. As a result of this, the Trust is well placed to increase its community and mental health service provision to meet local commissioning intentions which are aligned with the national priorities of providing care as close to home as possible and meeting the needs of the population with long term conditions.

In terms of market share, the Trust's focus is to retain and improve services within our current geographical areas. Increasing market share will focus on areas where we have expertise and where we can bring benefit to patient care.

The Trust's existing commissioners have not given notice of any significant changes in commissioning patterns or demand for activity. The Trust's forward plans do not therefore anticipate any significant shifts in activity during FY15 and FY16, as reflected in the Trust's detailed activity profile in the financial planning template.

7.5.3 Whiteleaf Centre

In March 2012 the Trust Board of Directors approved the business case for the Manor House project which presents a comprehensive reprovision of Adult, Older Adult and Specialist mental health services currently based at the Tindal Centre and Cambridge House in Aylesbury, and the John Hampden Unit in Stoke Mandeville. The Project also covers the relocation of other mental health services which are currently located on the Manor House and Tindal sites, but would be better sited in the community. This includes the decommissioning of the associated properties for subsequent disposal by sale or lease termination. This is a 'significant' investment which has been through the Monitor assessment process.

The approved capital investment was £42.8m; the development was completed under budget and became operational at the end of FY14. The investment supports the Trust's strategy of 'delivering operational excellence' and releases surplus land for disposal in FY15.

7.5.4 Clinical Research Information System

£125k of new costs are included in FY15 for the development of a Clinical Research Information System.

7.5.5 Other contract changes

The forward plan includes a number of minor service changes as a result of contract changes agreed in FY14 or effective from FY15.

7.6 Costs

An Activity Based Budgeting approach was adopted for FY15, resetting budgets using standard pay points and based on outturn performance, trends and information being developed on cost drivers so that budgets are clearly linked to activity. The resulting budgets are more aligned to service delivery and performance and this approach will continue to be developed during the next year.

As a result of this exercise, operational risks and cost pressures have been clearly defined for FY15; risk mitigation plans have been developed alongside contingency reserves and these will be closely monitored during the year.

The key assumptions regarding cost inflation uplifts in the Forward Plan are summarised in the table (right):

	FY15	FY16
Pay	1.0%	1.0%
Drugs	8.0%	8.0%
Clinical Supplies	2.5%	2.5%
Other Non-pay	5.8%	5.8%

Total pay costs are planned to reduce year-on-year as a result of the Trust's Cost Improvement Programme, reducing from £206.1m in FY14 to £197.5m in FY16, reflecting the national efficiency requirement. Pay awards have been assumed in line with national guidance, equivalent to 1.0% of total pay costs in FY15 and FY16.

Non-recurring costs have been included in the financial plan in relation to the Trust's programme of organisational change: FY15 £1.0m and FY16 £0.5m. A general contingency reserve has been created equivalent to 0.7% of operating costs in FY15 (1.1% in FY16).

Depreciation and interest charges increase from FY15 as a result of the Whiteleaf capital development.

The key risk is the under-achievement of CIPs. The Trust has modelled the impact of an under-achievement of CIPs in FY15-FY16 on the key financial metrics, and has robust arrangements in place to mitigate against this. The Trust is planning to create 'headroom' by aiming for a level of CIPs above the target required in the respective year and, in addition to this, the Trust has created a general contingency reserve which can be released to off-set any under-achievement.

The Trust has been developing Service Line Reporting and cost drivers for each cost centre, and is currently implementing a Patient Level Costing system which will 'go-live' in FY15. This will provide the Trust with a greater understanding of its cost base and the relationship of costs with activity and income, and the highlight the relative financial contributions made by respective service lines.

7.7 Cost Improvement Programme

In FY14 the Trust is forecasting to deliver £4.5m of efficiencies against a target of £11.3m. The FY14 shortfall has been managed through non-recurrent mitigations and unutilised reserves.

Plans are being developed to deliver the FY15 CIP target of £10.5m; this represents 3.8% of operating costs. There is an increased focus on developing plans that are longer term and strategic, and more transformational in nature. Business plans have been developed by all operational divisions, which have been used to define the major transformational projects that will contribute to the successful delivery of cost improvements and at the very least maintain the high quality of our services. To mitigate to some extent the impact of CIP targets on operational services, all corporate back office and estates functions will be required to deliver a significant proportion of CIPs over the next two years.

CIPs for the next 2 years total £23.2m (FY15 £10.5m and FY16 £12.7m). A 0.7% contingency reserve has been created in FY15, and 1.1% in FY16, as mitigation against the under-delivery of CIPs.

7.8 Capital Investment

The Trust recognises the importance of providing services from high quality premises and has a capital investment programme of £18.8m over the next two years.

Capital investment will be focussed on addressing estate condition and compliance issues and maintaining its existing infrastructure to ensure that Trust assets remain 'fit for purpose' to support the provision of high quality services. In addition to its estate infrastructure, the Trust will continue to invest in information technology and information systems to ensure high quality data, and as a way of facilitating improvements and adding value.

In order to make best use of resources for the provision of patient services, the Trust took ownership in FY14 of community services property previously owned by Oxfordshire CCG. The value of the assets transferred to the Trust from NHS Oxfordshire on 1 April 2013 was £39m.

The capital programme will be financed mainly through cash generated from operations (depreciation and surpluses) supported by planned surplus land sales of £4.2m in FY15.

Planned investment is focussed on areas to ensure compliance and sustainable use for the next ten years, including ward environmental works, in the context of the Trust's service remodelling (transformation) plans whilst longer term

plans are developed regarding the Warneford re-provision and Forensic services. The outline capital programme is summarised below:

£m	FY15	FY16
Operational Estate	5.3	5.4
Whiteleaf Centre	0.8	0.0
Windrush City Community Hospital	1.1	0.0
Electronic Health Records	0.7	0.0
Information Technology	1.7	1.4
Other minor schemes	0.7	0.7
Contingency	0.5	0.5
Total Investment	**10.8**	**8.0**

- Operational Estate – rolling programme of works to maintain infrastructure, address sustainability and prioritised risks, including ward upgrades/refurbishments;
- Whiteleaf Centre – final stages of scheme regarding relocation/alternative accommodation for specific services;
- Windrush – relocation of City Community hospital from to John Radcliffe Unit (owned by Oxford University Hospitals NHS Trust) to the Trust's own Windrush ward;
- Electronic Health Records – replacement of Trust's existing system
- Information technology – rolling programme of PC additions/replacements, server/network upgrades and strategic projects including mobile working, telehealth and telephony
- Other minor schemes – includes rolling programme of medical equipment replacement

7.9 Cash

The cash strategy is to:

- Maintain a liquid ratio of not less than 15 days in any quarter
- Maintain a cash balance of not less than £5.0m
- Limit external borrowing for capital investment

Year-end cash balances are forecast to be £19.5m at the end of FY15 and £17.0m at the end of FY16.

The Trust's had a Working Capital Facility (WCF) of £20m in FY14 that expired on 30th September 2013 and in light of new regulatory assurance framework that became effective from 1st October 2013, which removed the requirement for such facilities, the Trust decided not to renew its WCF from October 2013 onwards.

Continuity of Service Risk Rating (CoSRR)
Under the CoSRR, the financial plan delivers an overall rating of '3' in each of the financial years.

Financial Risks and Opportunities
Apart from the challenging economic environment within which the Trust continues to operate, the main risks facing the Trust during FY15 include: the requirement for the continued delivery of significant efficiency savings; continuing to deliver high quality services to patients in accordance with contracts agreed with commissioners; and delivering a substantial capital investment programme on time and within budget. The Trust has modelled various downside scenarios to consider the impact of these risks; the Trust has plans in place to deliver its financial objectives for FY15 and mitigation plans to manage these risks.

Income	£m	Impact	Likelihood	Action and Mitigation
Loss of existing contribution to overheads e.g. due to 3% reduction in Oxford contract envelope	1.0	high	high	Rigorous contract negotiations. Increased understanding of cost drivers.
Full impact of 3.5% PDC Dividend on PCT assets transferred April 2013	1.3	high	medium	Proactive identification of mandated funding and discussions with DoH/Monitor regarding accounting treatment
Contract under-performance: Eating Disorders & CAMHS	0.5	low	low	Services to evaluate delivery potential and prioritise effort. Rigorous performance reporting and monitoring.
Contract under-performance: Reablement service	0.5	low	medium	Services to evaluate delivery potential and prioritise effort. Rigorous performance reporting and monitoring.
Loss of existing contribution to overheads due to contract retenders	0.5	low	low	Rigorous review of any competitive retenders. Increased understanding of cost drivers.
Costs	**£m**	**Impact**	**Likelihood**	**Action and Mitigation**
Under delivery of CIPs	2.0	high	high	Develop detailed plans, robust governance and management arrangements, and management throughout the year. Contingency reserves released.
Unplanned cost pressures arising during year or cost of developments higher than planned	0.5	low	low	Rigorous in-year management. Contingency reserves released; increased CIP savings.
Cash	**£m**	**Impact**	**Likelihood**	**Action and Mitigation**
Capital receipts: achieve below planned levels	1.0	medium	medium	Active management of receipts. Careful balance of I&E and asset management to deliver the capital programme.

In addition, there are a number of opportunities that OHFT will explore:

Income	£m	Impact	Likelihood	Action
Deflator agreed at 1.5% and not 1.8%	0.7	medium	low	Active lobbying of NHS England and CCGs.
Additional contribution from extra funding secured through contract negotiations or winter pressures money	£1.0	medium	low	Robust negotiations with commissioners.
CQUIN income secured, releasing risk contingency	1.0	medium	medium	Services to evaluate delivery potential at minimum cost and prioritise effort. Rigorous performance reporting and monitoring.
C&V contract over-performance (subject to contract negotiations)	0.5	Low	medium	Services to evaluate delivery potential and prioritise effort. Rigorous performance reporting and monitoring.
Additional contribution from new business	0.5	Low	medium	Continue to horizon scan for new opportunities. Maximise contribution to overheads
Cost	**£m**	**Impact**	**Likelihood**	**Action**
Inflationary pressures lower than planned e.g. pay award	1.5	high	medium	Rigorous in-year management and assessment of cost drivers.