Oxford Health NHS
NHS Foundation Trust

Operational Plan Document for 2017

Oxford Health NHS Foundation Trust

Operational Plan for y/e 31 March 2017

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

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Date	15/04/2016

The attached Operational Plan is intended to reflect the Trust's business plan over the next 12 months. 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:

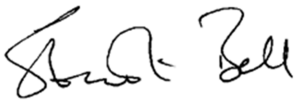
Name *(Vice-Chair)*	Lyn Williams

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 young people, adults and older adults across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset. OHFT accepts the NHS Improvement financial control total for 2016/2017. This plan will deliver a position that improves upon the control total for FY17 and sets out how we will continue to deliver high quality sustainable services and manage the financial position within the control total over the next year. It builds upon our 2015-2016 Operational Plan and sits within our overarching strategy and the developing Sustainability and Transformation Plans. It also outlines how we intend to deliver the vision and recommendations set out in the Five Year Forward View for Mental Health. This plan allows us to establish a foundation for longer term transformation based on the Five Year Forward View, working closely with our health and social care partners in the regions in which we work, through commitment to local Sustainability and Transformation Plans (STPs) with our partners in health and social care. Our plans reflect our commitment to closing the health gap for children, adults of working age and older people and for people with mental health problems, learning disabilities and autism, aiming to achieve parity of esteem between physical and mental health.

Through the OHFT Business Planning process the following 7 priorities for 2016/2017 have been agreed:

1. To make care a joint endeavour with patients, families and carers
2. To improve the quality of care by transforming services
3. To support teams to improve the safety and quality of care they provide
4. To support leaders to maintain a positive culture for teams
5. To ensure Oxford Health NHS FT is high performing and financially viable
6. To lead research and adopt evidence that improves the quality of care
7. To embed and enhance the electronic health record

2.0 Approach to Activity Planning

2.1 Children and Young People

The Children and Young People Directorate plans for 2016/17 are based on activity data and projections, which are being jointly discussed with commissioners in Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath & Northeast Somerset, as well as specialist commissioners (NHS England), in line with expected growth rates.

Demand for many services continues to increase, though further work is required to ensure this is reflected in contracts and captured in our new patient information system – work on this is underway in the Directorate and across the Trust. Robust discussions have begun with commissioners to agree how to meet demand appropriately within the financial resources available. In some services, this includes detailed review of service specifications, which will help us to manage demand.

We are working with third sector partners where possible to help deliver services, such as with Barnardo's and Beat for delivery of the new Buckinghamshire Child and Adolescent Mental Health Service (CAMHS). A key aim of CAMHS is to ensure that the emotional and mental health needs of children and young people are appropriately met at the earliest opportunity with the aim of reducing the likelihood of long-term mental health problems. OHFT worked together with the University of Reading and successfully bid to become one of three Children and Young People (CYP) national IAPT sites which started in November 2011. Whilst the nature of our services is such that no formal winter resilience plan is required, some services such as Community Children's Nursing do have local arrangements to ensure robust engagement with acute colleagues to support their winter capacity. The arrangements for managing unplanned changes in demand are made in agreement with our commissioners and through agreed contract variation mechanisms where appropriate.

2.2 Adults

For Adult Mental Health Services in Oxfordshire and Buckinghamshire the overall referral rates for the Adult Mental Health Teams (AMHTs) for 2014 and 2015 (quarters 1-3) show that there has been an 11% increase in referrals to the services. With this information and with the known developments across the two counties in terms of demographics, housing and infrastructure, it is anticipated that the demand will continue to increase in-line with 2014 to 2015.

However, the caseload sizes of the teams has decreased by 11% for the same period indicating that the number of patients accepted into the service and assessed has decreased despite the number of referrals increasing. This may be apportioned to the 'open' access policy for referrals into the teams following the review of services in 2014 which saw all AMHTs accepting all referrals which are then assessed to see if they are appropriate or signposted to alternative services. This is also due to the review of caseloads ahead of the change of the electronic patient record, where those patients who were no longer requiring services were discharged from the caseloads. The referrals vs caseload figures are not related in terms of activity and demand as the caseload is a snapshot in time against a rolling figure for referrals.

To support the increased demand, and to ensure that the service delivered for patients (and carers) maintains a high quality of care, the Directorate has identified several key lines of services which will be developed to support the current and anticipated activity. These programmes are aligned to, and reflect the key priorities in the Mental Health Five Year Forward View (2016). (See appendices for detail on programmes).

2.3 Older People

The Older People Directorate's business plans outline their anticipated activity and required inputs for FY17. The approach to activity planning is based on the following three areas:

- Rebasing the activity on the Oxfordshire contract, which contains the majority of the demand and cost pressures
- Delivering service reviews in order to maximise productivity and skill mix with current resources. Key examples are the podiatry service and Integrated Locality Teams (ILTs).
- System-wide transformational change of the reablement pathway, community nursing and flow through the urgent care pathway.

Plans for each of these areas are in place and will be updated for this year's contracting period, and each sit under the governance of the Oxfordshire Transformation Board.

Community health and social care services (including GP practices) have a significant role to play in extending services closer to home, enabling more patients with higher complexity of need to be treated closer to home wherever this is clinically appropriate. This approach aligns to health policy of the last ten years, and has significant benefits for patients and their carers in terms of independence and well-being as well as reducing avoidable spend in acute hospital settings and long term care. Cross-system working will be crucial in FY17 to sustain the flow of patients through the health and social care system. Reducing dependency on bed-based care for patients who can be better supported in their own homes is a crucial aspect of the Directorate strategy. Within the Directorate, we are tackling this challenge through integration of locality teams between primary care, social care, community care, and third sector organisations; standardisation of clinical processes; development of clinical skills across all specialties (mental health, therapies, nursing, urgent care and community hospitals); partnerships with the third sector and developing a holistic model of care to meet the physical and mental health needs in our inpatient services. (See appendices for more detail).

In order to maintain our current service provision, the Older Peoples Directorate will continue to focus on recruitment and development of certain key categories of staff including Band 6 nurses, reablement service staff and staff in bed and home-based settings with sub-acute nursing skills, such as community hospitals, Emergency Medical Unit (EMU), Hospital At Home and GP out-of-hours. We will also need to start developing our own medical staff for inpatient settings and the EMUs, and this will be considered as part of the development of bed-based urgent care pathways with our partners.

A workforce development group will be led by the Trust Director of Nursing as part of the Cost Improvement Programme, which will ensure that we have the right training and HR framework to develop our workforce and improve recruitment and retention rates as we move to caring for more complex patients in the community.

3.0 Approach to Quality Planning

3.1 Safety and Quality Improvement Methodology & Governance

During the course of the last 12-18 months OHFT implemented a major programme *IC:5 (Improving Care through five questions)*, to review and improve the care in-line with the 5 Care Quality Commission (CQC) domains:

- Are we caring?
- Are we safe?
- Are we responsive?
- Are we effective?
- Are we well-led?

The main focus of which is to encourage staff to think about what they are doing well and where they are working to improve and deliver the best possible high quality of care to patients, service users and clients now and in the future. IC:5 encourages staff to ask themselves the key questions we know matter most to our patients, which also reflect the national quality standards (called the fundamental standards) applied by the Care Quality Commission (CQC) to assess the quality of services. Through talking with teams and establishing a peer review programme we have heard about some great examples of excellent care and how teams want to keep improving. This programme of improvement is overseen by the Quality Committee into which four quality sub committees report (Governance Structure in appendices) and meets every two months; membership includes the Chief Executive; Medical Director; Director of Nursing and Clinical Standards; Chief Operating Officer, and the Director of Finance (also responsible for HR).

In our Quality Account 2014/15 we described four quality priorities for the year, which were developed in discussion with our clinical Directorates, our Governors, commissioners, and Healthwatch. These are carried forward into 2016/17 and remain key for us because of the nature of the services we provide (for example, prevention of suicide and reduction in the need to use restraint); ones that have an end date beyond the end of the financial year (for example, pathway remodelling); or where we consider we have further improvement to make (for example, patient and carer experience and involvement).

The trust is also committed to ensuring the responsible clinician is known to patients. In our inpatient wards we have signs on all patient doors that tell them who is on their care team (primary, secondary nurse and support workers), and their responsible consultant.

3.2 Our Quality Priorities:

1. ***Enable our workforce to deliver services which are caring, safe and excellent*** *- This will enable the service to be caring, safe, effective, responsive and well led. This builds on last year's workforce priority and the staff engagement priority.*
2. ***Improve patients and carers experiences through involving people in their own care and how services develop*** *- This will enable the service to be caring and responsive. This builds on last year's patient experience priority.*
3. ***Improve quality through service pathway remodelling and innovation -*** *This will enable the service to be effective and responsive. This builds on last year's service remodelling priority.*
4. ***Increase harm-free care*** *- This will enable the service to be safe and effective. This builds on last year's harm reduction priority.*

OHFT's detailed Quality Accounts for 2016/17 are being developed to ensure we have a robust plan in place to address findings from CQC inspections and continue quality improvement across the trust. Development of 2016/17 key performance indicators are in progress, (a summary of 2015/16 are in appendices). To develop the requisite capacity for learning and implementation, a number of current organisational activities will be reviewed. Only those activities that are statutory or add significant value to the organisation, patients and their families will continue.

3.3 Improving Care: Responding to the CQC Inspection

At the end of September 2016 the Care Quality Commission (CQC) undertook an inspection of our services. The CQC has rated Oxford Health NHS Foundation Trust 'good' in three out of five quality measurements – *caring*, *responsive* and *well-led* and 'requiring improvement' in the remaining two, *effective* and *safe*. This gives Oxford Health an overall rating of 'requires improvement' (satisfactory) based on weighted scoring across all services inspected. No enforcement notices were issued and the majority (11 out of 15) of the trust's services were rated 'good' (10) or 'outstanding' (1).

We are very pleased that the 'outstanding' rating was for our children and young people's community service, which includes school health nurses, health visitors and children's community nurses. Improvements are required in *safety* to ensure that across all trust services observe the same high standards.

3.4 Quality Concerns:

Areas requiring improvement, many of which we are already aware and addressing, include:

- Patient and carer involvement in care planning
- A strategy for patient involvement in service design and delivery
- Consistency in the robustness of clinical risk assessments
- Staff confidence in using the new CareNotes electronic patient record system
- Bed management processes and discharge planning

The CQC also noted that some of our older estate, especially inpatient mental health settings at the Warneford Hospital, was outdated for the delivery of modern mental health care. The trust has long been aware of the challenge of operating from Victorian buildings and in recent years has developed the Whiteleaf Centre in Buckinghamshire and the Highfield Adolescent Unit in Oxford as exemplars of purpose built 21st century mental health care. A working group is currently developing options for future development of the Warneford Hospital site in particular to better address modern health care needs. Other areas of for further work are around:

- Improving how we record and demonstrate patients' involvement in their own care planning.
- Ensuring consistent high quality records of care plans and assessments.
- Continuing our work to implement a new end of life care pathway and monitoring the impact of this work.
- Continuing to monitor and respond to increasing demands on staff specifically in community services.
- Reviewing 'blanket' restrictions on some wards for example allowing all patients free access to garden areas.
- Tightening monitoring arrangements around equipment including resuscitation equipment and trust labelling for 'To Take Out' medicines.
- Continuing to work with staff to ensure all mandatory training including specifically resuscitation is completed.

3.5 Our Approach to Quality Improvement

Over the past five years OHFT has implemented various quality improvement projects to enhance patient safety, improve the quality of care and develop effective team-working skills including:

- Leading Improvements in Patient Safety Programme (LIPS).
- Senior Leadership for Safety Programme.
- South of England Patient Safety Mental Health Collaborative.
- Productive Care Series.
- Safer Care Programme.
- Effective Team-based working.
- Improvement Champions Programme.

This work provides the foundation upon which to build the capability and capacity for change across the organisation. An approach that supports teams to improve the safety and quality of care they provide is being developed for FY17 and beyond. The methodology adopted is rooted in the Institute for Health Improvement (IHI) Method for Improvement (fig.1) and the adoption of measurement for improvement techniques.

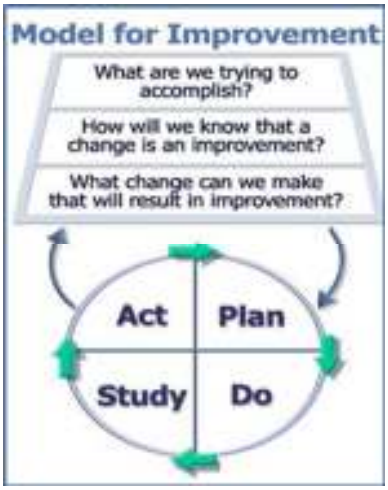


Fig 1. *Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A practical Approach to Enhancing Organizational Performance (2nd edition) San Francisco: Jossey-Bass Publishers; 2009*

3.6 Focus on Well Led Elements

Since the publication of our two-year operational plan (April 2014) and the five-year strategic plan (June 2014) the Trust has used a range of channels to engage with staff. It is important that everyone working in the Trust feels informed about its direction and able to contribute to achieving our goals – creating a positive organisational culture. We continue to review and develop our engagement processes to consider how we can improve.

The trust has begun to establish staff equality and diversity networks to focus on Black and Minority Ethnic (BME), Lesbian, Gay, Bisexual and Transgender (LGBT) and Disability issues. The purpose of these networks is to recognise and value diversity in teams and to create a community of support and the infrastructure for engaging with staff in a meaningful way on related equality initiatives and highlight issues facing staff and patients in relation to equality. OHFT has signed up to Stonewall's 'Diversity Champions' part of which is a requirement to undertake a Workforce Equality Index (WEI) audit. We are also in the process of signing up to the Workfoce Race Equality Standard (WRES).

We have established Senior Leaders and Linking Leaders groups that come together three to four times per year. These groups are a broad multi-disciplinary leadership group that review and analyse current and future contexts and support the development of strategies to tackle some of the complex challenges we face. The Linking Leaders groups made up of ward managers, team managers and assistant managers, modern matrons, training clinicians, practice leads and support service leads meet each quarter in Oxford, Aylesbury and Swindon and focus on contributing to the development of joint plans and sharing learning of good practice identified in peer reviews. A recent linking leaders group have developed actions to improve specific areas from the staff survey and collaborated to develop the OHFT patient engagement strategy.

Over the course of the last two years the group has focussed on topics such as leading complex organisations, realising the potential of the next generation electronic health record and creating a culture of innovation. We have hosted guest speakers from the CQC and Patient Opinion and examined how to deliver value-based care. In March 2015 the focus for this group was developing collective

leadership with support from Professor Michael West and the summer of 2015 Professor Charles Vincent was keynote speaker at our conference about safety and quality improvement. In March 2016, both groups came together with key note speaker Professor Gary Ford discussing service improvement over his career and group discussions on the key issues for our workforce, and how challenges can be met.

3.6 Sign up to Safety

The trust is preparing to join the 'Sign up to Safety' campaign in the coming months, aligning with our trusts quality priorities, with particular emphasis on Priority 3:' *Increase harm-free care'*:

3.1 Prevention of suicide.
3.2 Reduce the number of patients who are absent without leave.
3.3 Reduce the number of avoidable grade 3 and 4 pressure ulcers.
3.4 Reduce harm from falls.
3.5 Reduce the need for restraint and monitor the use of seclusion.
3.6 Improve physical health management of patients.

3.7 Seven Day Services

The **Children and Young People** Directorate already delivers seven day services in several areas e.g. Community Children's Nursing, CAMHS outreach (OSCA), and inpatient services. There are currently no requirements to deliver universal or therapy services on a seven day model.

The **Adults** Directorate teams have been working seven days a week over the past 18 months. The AMHTs will move nearer to the agreed model by returning to the treatment teams only working from 9 – 5pm seven days a week thus giving greater capacity during these hours with the assessment function providing extra support and step up care between 7am – 9am and 5pm and 9pm. Changes to the Urgent Care Mental Health Pathway will enable us to support more individuals out of hours (9pm – 7am) who are in crisis. This will also ensure that the patient is seen by the right person at the right time.

The **Older Peoples** Directorate has successfully addressed all of the issues around ensuring that the right services are working seven days a week. The focus for FY17 is how we integrate seven day working across multi-organisational pathways to maintain responsiveness to patient need whilst delivering effective and efficient pathways. The Directorate is seeking to take a transformational approach in terms of major clinical pathway redesign.

3.8 Quality Impact Assessment

The Trust has integrated strategy, business planning and Cost Improvement Programme (CIP) in order to align the major strategic change programmes for the coming years. The CIP and processes have been re-structured into 5 main programmes and the Chief Operating Officer (COO) is the CIP Director. A re-focussed Programme Management Office (PMO) with a dedicated Cost Improvement Programme Manager is coordinating the processes and overseeing their development and delivery of plans including assessment for strategic fit, ease of implementation, risk exposure, clinical and quality assurance and financial value.

Every CIP project lead is required to work with its project team and clinical lead to complete a clinical quality risk assessment that identifies potential benefits, dis-benefits and mitigating actions for patient experience, clinical effectiveness, patient safety and workforce (including staff safety).

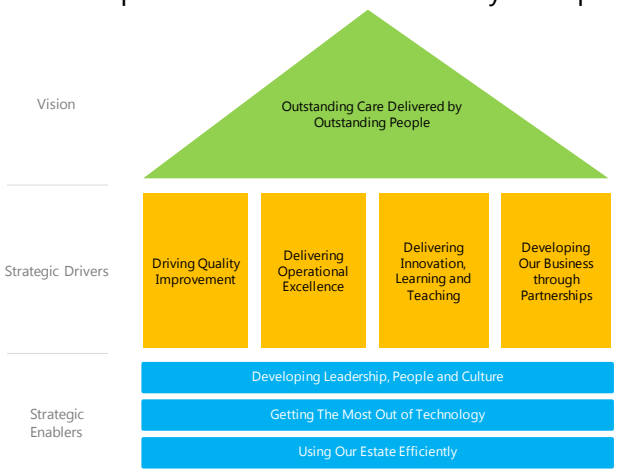
Given the Trust's relative efficiency, the challenges it has experienced in delivering high levels of CIP the Board of Directors chose to set a realistic but challenging target of £5.1m in FY16 CIP and in FY17 this increases to £6.5m. A number of changes have been made this year to the CIP that have increased the grip, oversight, assurance and delivery.

Cost Improvement Programme: Governance

Executive leadership of the CIP is under the Chief Operating Officer (COO) because the delivery of most CIP requires transformation of the 'engine room' of the organisation. The Trust has a clear monthly process for reporting CIP development and delivery into the Board of Directors through a framework that sets out key roles and responsibilities, terms of references and reporting timescales. (See the appendix).

Each project is required to develop and submit a project brief that outlines key information about the CIP schemes including what it aims to achieve, planned savings, key milestones and a clinical and quality risk assessment. These projects are developed with project team, finance and clinical input and approved at Directorate senior management team level during confirm and challenge meetings. As with any major business change or investment, projects are required to follow the approval processes outlined in our standing financial arrangement.

The CIP Delivery Group (Terms of Reference in appendix) meets monthly and acts as a scrutiny board. It is chaired by the COO and attended by Director of Finance, Medical Director and the Director of Nursing and Clinical Governance. It reviews the overall progress of CIP and challenges service and clinical directors where schemes are under-delivering or savings are unidentified to support recovery. It is also responsible for reviewing recommendations for new schemes and agreeing resourcing to initiate projects. In addition each year separate clinical assurance panels are arranged for the Medical Director and Director of Nursing and Clinical Governance to scrutinise in detail the clinical impact assessments of each project within the workstream. In the future this will be incorporated into the CIP Delivery Group processes. Successful delivery of transformations requires a high level of support, leadership and engagement across the Trust. The CIP reports monthly to the Board of Directors.



3.9 Triangulation of Indicators

We use our strategic framework (right) to provide structure in the development of our plans and align them and our objectives with our strategy. This framework helps us to organise our plans, using a consistent method and language throughout the organisation.

Each of the drivers and enablers within our business plan has been translated into overarching strategic goals and objectives. Three key strategic drivers/enablers have been identified for triangulation using the associated goals and key performance indicators (KPIs):

- Driving Quality Improvement
- Delivering Operational Excellence
- Developing Leadership, People and Culture

Updates against plans and performance against KPIs will be measured and reported quarterly at the Board of Directors as part of the business plan and performance management process. The KPIs are under development alongside the development of the quality account and the review of performance management framework. KPIs under consideration are available in the appendix.

4.0 Approach to Workforce Planning

4.1 Clinical Engagement in Workforce Planning

Workforce planning at OHFT has been developing over the last two years and some top level workforce analysis has been undertaken. The trust has been successful in a bid for support to develop this work and has been awarded a grant to employ additional resource to develop robust and sustainable workforce plans for the whole Trust and to improve and develop the relationship with clinical managers to ensure the appropriate clinical engagement.

This team is developing links with key strategies developed in the trust for example the OHFT Nursing Strategy 2016-2019. This reaffirms that workforce planning nationally has underestimated the need for nurses. The removal of the cap on recruiting students to nursing degrees may offer some opportunity to increase placements. This will require attention to a number of issues and will drive changes in recruitment and attraction, improved arrangements for retention and development of new career pathways and associated development.

The HR Directorate has been structured to be customer facing in that it provides a Senior HR Business Partner (SHRBP), and a small team of HR staff supporting each of the clinical Directorates and the corporate functions. Each SHRBP team works closely with their relevant Directorate on all HR issues including organisational change, clinical pathway developments and the associated workforce planning issues.

The Trust Workforce Strategy aligns with the organisation's need to Attract, Retain, Perform, Develop and Engage good quality staff (both clinical and non-clinical). The Workforce Strategy approved by the Trust Board in November 2015 outlines various strategies around these including Values Based Recruitment and a revised and renewed Performance & Development Review. The strategy document details internal and external impacts such as issues associated with national skills shortages and national and local economics.

4.2 Workforce Planning Governance

Currently individual workforce plans are developed within each Directorate and are reviewed by Chief Operating Officer. When workforce plans are developed they will feed into the Workforce Strategy and are presented to the Executive Team and Board.

There is however scope for further development of the governance to assure that these plans are developed consistently and evolve into an overall plan which is reviewed by the Trust Board, and outcomes monitored appropriately at senior level. Currently there also is a requirement for workforce planning information to be provided, externally to Health Education Thames Valley (HETV).

4.3 Links to Clinical, Local Health and Care System Commissioning Strategies

The Trust strategy aims to show how our Trust will deliver healthcare to the highest standards of safety and quality. It is implicit therefore that the same principles are considered in the development of trust workforce plans. These plans are developed in line with the clinical strategy associated with each operational directorate and in line with strategic drivers. Research has been undertaken both within and external to the Trust, reviewing the local situation and strategic plans of all bodies that have an impact on OHFT. It has been found that there is a need to make connections and draw upon the expertise of the excellent work that is being undertaken, both within and outside our organisation.

4.4 Local Workforce Transformation Programmes and Productivity schemes

In November 2015 the Health Education England Thames Valley senior leadership team approved a framework to support implementation of the transformation programmes outlined in their Local Delivery Plan (2015/16). All the transformation programmes require robust workforce planning. HEE TV has invested in supporting workforce planning to develop capacity and capability. A workforce planners' network group is being supported in skill development in early 2016. The transformation programme steering groups are developing areas of work that reflect the workforce transformation element of transformation programmes in health and social care. These groups will evolve as we work more closely with and align system transformation boards as they develop in Thames Valley and will support the development of STPs.

4.5 Workforce Development and Innovation Projects

Following a robust bidding process HEE TV is supporting a number of projects that will help the delivery of Health Education England's Mandate within the local setting of Thames Valley. The successful projects were those that helped achieve strategic objectives and aimed to deliver care closer to home and /or integrated and person-centred care. The projects are outcomes-focused, innovative and demonstrate improvement and value for money through leadership or workforce development or the dissemination of good practice through education and training.

4.6 E-rostering and Agency Staffing

In 2015/16 a new workforce management system was implemented across all inpatient units and trialled in 4 community teams. During 2016/17 the Trust will continue to build on this implementation embedding the use of the system and working with teams using the management information available to deliver efficiencies in staffing whilst ensuring patient and staff safety. In 2016/17 the Trust will review the trial in community teams and develop a further implementation plan based on the findings.

A centralised bank is being introduced in April 2016 to expand the numbers of bank staff and manage all temporary staffing requirements for units on the Workforce Management system. It is anticipated that this will release time for staff on units to deliver clinical care whilst providing the Trust with additional control over the use of temporary staffing, enabling a switch from agency to bank workers, a reduction in costs and increase in quality. The Trust is also reviewing the terms and conditions for bank workers and substantive employees working additional hours to ensure that they are fair and support a

switch of staffing from agency to bank whilst remaining affordable. A review of the centralised bank will take place in June 2016, after which any further rollout will be considered.

4.7 Local Education and Training Board Alignment

The trust is working in partnership with local HEIs and HEE TV to ensure that our student placements are of a high quality. We are endeavouring to increase our placement capacity in order to support the growing demand nationally for qualified nurses in adult services and mental health nursing in particular. We are also working with the Local Education and Training Board (LETB) to increase the placement capacity to support undergraduate paramedics as part of their degree programme. We are engaged in the national Return to Practice (RTP) campaign and offer re-entrants the opportunity to have a clinical placement within the trust as part of their RTP programmes. The trust has also worked with the local LETB regarding work to increase the numbers of Health Visitors within the system and will be embarking on a similar project for district nursing.

4.8 Triangulation of Quality and Safety Metrics with Workforce Indicators

A range of workforce metrics are reviewed on a regular basis. These include staff turnover, sickness absence levels, agency and flexible staffing use, vacancy rate and safe staffing reports as well as Health & Wellbeing issues. The Recruitment Team proactively works with managers to develop plans to fill "hard to fill" vacancies. The "Business Area Review" process involves the HR team reviewing each metric for every service in its Directorate and developing action plans to address areas of concern with local line management. These reports and actions are shared with Directorate management teams and are reviewed monthly by senior HR Staff.

HR form part of the Directorate Senior Management Teams and the metrics are reviewed regularly at that level also. The same metrics reviewed in Business Area Reviews form the basis of regular reports to the Executive Board. The Trust produces weekly reports on Safe Staffing for inpatient services. The Recruitment Team provide a weekly narrative detailing recruitment activity and agency use activity in each inpatient service to demonstrate whether line managers are taking appropriate actions to address staffing issues. These reports are reviewed at senior levels in the Trust Weekly Review Meeting and Operations Senior Management Team meeting. Triangulation of data is also undertaken weekly, which addresses safety related incidents, with HR disciplinary casework to identify links between patients and staff members and themes which need to be addressed.

In relation to quality, the HR function fully participates with the Trust's Quality Committee and its subcommittees to ensure that workforce plans are aligned to quality and safety requirements. The data available from the Workforce Reports enables analysis of causes of sickness absence which allows responses to be developed. (For example, during 2015 MSK physiotherapy was piloted in the Older People's Directorate to address the high levels of musculoskeletal related sickness absence. This was hosted in the Occupational Health Department. The ongoing provision of this service on a permanent basis is to be considered.

4.9 New Workforce Initiatives as part of the Five Year Forward View

The Five Year Forward View (FYFV) calls for "a shift towards a relentless focus on prevention" supporting the individual and family to manage their own healthcare and integrating care pathways. In developing workforce plans in clinical areas this requires further attention in working with primary and secondary care, social care and voluntary organisations to form integrated care partnerships across health & social

care. In line with the FYFV, the patient voice is important to our workforce planning. We have undertaken to facilitate focus groups from different sectors of our user groups to gather opinions on the services that they experience. These opinions will inform our workforce planning as part of our equality and diversity assessment.

4.10 Balancing Agency Rules with Appropriate Staffing Levels

The Trust is working closely with the NHS Collaborative Procurement Partnership and agency suppliers to negotiate agency rates within the price caps introduced by NHS Improvement. Where there is significant clinical risk Service Directors are required to authorise overrides which are reported and scrutinised on a weekly basis by the Executive team. It is anticipated that the maturation of the recently implemented e-rostering system and the introduction of the centralised bank will strengthen the Trust's ability to manage staffing effectively within the agency rules introduced. New agency supplier agreements were agreed in 2015 for nursing and medical staffing groups using the NHS Collaborative Procurement Partnership's LLP frameworks and in 2016/17 the Trust plans to negotiate new supplier agreements for non-clinical, non-medical and other clinical staffing groups using existing national framework agreements.

4.11 Systems to Regularly Review and Address Workforce Risk Areas

Risk registers are in place across all parts of the Trust and are monitored as part of the Trust governance arrangements and form part of the Board Assurance Framework which is reviewed regularly at the Trust Board meetings. Workforce risks will continue to be monitored through the clinical Directorate and HR risk process. Recruitment is a Trust risk and is a key focus at Board Level and is monitored closely. The national staff shortages as well as high cost of living in the Oxfordshire and Buckinghamshire area are issues already identified, and various pieces of work have been started to address these. Turnover is increasing and there is constant local competition to attract staff. A Recruitment Action group has been set up, with clinical Directorate representation to identify, agree and prioritise areas requiring attention. A workforce equality analysis assessment tool needs to be applied to all workforce plans to ensure that our workforce meets the needs of the population in terms of equality and diversity – this work is in its infancy with initial meetings arranged.

5.0 Approach to Financial Planning

OHFT is facing a challenging financial future. We already know that the NHS will continue to be faced with a national efficiency target of between 2% and 3% per annum leading directly to reductions in income on existing contracts each year. With the majority of our services being under block contracts, there is no allowance for payment for the expected continued increases in activity which put additional strain on our ability to maintain financial sustainability. In the regions we provide services, the funding allocation to CCGs is significantly below the national average per head of population and this shortfall is borne largely by the non-acute service providers.

For 2016/17 Oxfordshire Clinical Commissioning Group (CCG) received an increase in year on year allocations at £49.7 million (7.3% increase) compared to 2015/16. Based on the guidance that "CCGs must increase their spending on mental health by at least as much as the increase in their allocation" and to achieve parity of esteem we expect 7.3% more on mental health spend in Oxfordshire from Oxfordshire CCG. The two CCGs in Buckinghamshire, our other major CCGs, also received an increase in year on year allocations; Aylesbury Vale at £9.3 million (4.3% increase) and Chiltern CCG at £16million (4.8% increase) compared to 2015/16.

CCG	2015/16 (£000)	2016/17 (£000)	Change (£000)
Oxfordshire	679,763	729,492	49,729
Aylesbury Vale (Bucks)	215,854	225,169	9,315
Chiltern (Bucks)	337,608	353,943	16,335

The combination of the historically low revenue allocation to OHFT contracts, the increasing activity, and the increasing complexity of conditions makes the achievement of a breakeven position difficult. The relatively high level of efficiency already achieved by OHFT (national reference cost of 87 in 2015, 13% more efficient than the average Trust) makes the delivery of CIPs to the level required to offset the national efficiency target extremely challenging and, combined with the low levels of income received, make financial sustainability very difficult.

Improving efficiency and productivity continues to be a priority for OHFT. During recent years, we self-invested in and focused, after consultation with our commissioners, on remodelling our services to improve integration, local access to high quality care and 7-day working, however, going forward, further transformation will require financial support from the CCGs. Discussions have commenced with our CCGs and other health system providers to create 5 year Sustainability and Transformation Plans that prioritise the health of the regional populations above organisational objectives, the impact of which on OHFT's short term financial position is not yet known.

5.1 Financial Sustainability Plan

The development of the FY17 Financial plan looks beyond FY17 and into later years in order to develop a Financial Sustainability Plan (FSP). This will set out how OHFT will achieve financial sustainability in the longer term and with the immediate aim of maintaining cash balances to remain a going concern and the longer term aim of returning to breakeven and a Financial Sustainability Risk Rating of 3.

The FSP forms an integral part of the OHFT's overall planning process for FY17, including development of the OHFT Business plan. The programme for development of the FSP was communicated to the Board in October, presented to the Finance and Investment Committee in November 2015, and has been submitted to Monitor. Progress against the development programme is being monitored weekly by the Director of Finance and the weekly Executive meeting will receive an update. Monitor, as a result of their recent investigation into OHFT, monitor our progress with the FSP with particular attention being paid to the development of detailed CIP for the FY17 plan.

5.2 Financial forecasts

The OHFT's original draft financial plan for FY17 was developed as part of the FY16 planning round; a summary of the key financial metrics is shown in this table.

	Original Plan FY17
EBITDA	**£9.7m**
EBITDA margin	*3.3%*
I&E Surplus/(Deficit)	**(£2.4m)**
I&E Surplus margin	*-0.8%*
CIP	**£8.0m**
Cash Balance (year-end)	£10.3m
Capital Expenditure	**£5.0m**
FSRR	2.0

5.3 Comparison to original plan

The Trust's Long Term Financial Model (LTFM) is updated on a monthly basis to reflect in-year performance and in addition has been fully updated for the following:

- FY16 forecast outturn reduced from the planned £5.4m deficit to forecast deficit of £0.4;
- A reduced national efficiency requirement of 2%;
- Total Inflation uplift of 3.1% (£6.9m) split as follows:

Pay	2.0%	£4.4m	to cover pay awards, increments and changes to NI and pensions
Drugs	4.5%	£0.1m	this is initially taken to contingency reserves
Non-pay	3.4%	£2.5m	this represents the balance of the total 3.1% uplift, this is not allocated to budgets but is taken to contingency reserves

- The above efficiency requirement and inflation uplift results in a net national inflator of 1.1% (3.1% inflation less 2% efficiency uplift) NOTE: the inflation uplift has been applied in line with planning guidance.
- Capital receipts of £0.5m (delayed from FY16, previously assumed as nil for FY17);

5.4 FY17 key financial assumptions

The FY17 plan includes the following assumptions:

- CIP target of £6.5m (originally £8.1m, uncertainty in the timeliness of system-wide schemes.)
- Additional revenue contribution from commissioner income of £2.5m (originally £5.0m, uncertainties due to the priority given to system-wide integrated plans).
- No significant self-investments in service developments.
- Capital investment of £7.0m (includes £2.0m deferral from FY16)

The key headlines for the final FY17 plan compared to previous versions of the plan are as follows:

	Final FY17 Plan (April)	*Draft FY17 Plan (February)	**Original FY17 Plan (May 2015)
EBITDA	**£10.0m**	**£10.0m**	**£9.7m**
EBITDA margin	*3.3%*	*3.3%*	*3.3%*
I&E Surplus/(Deficit)	**(£2.4m)**	**(£2.4m)**	**(£2.4m)**
I&E Surplus margin	-0.8%	*-0.8%*	*-0.8%*
CIP	**£6.5m**	**£6.5m**	**£8.0m**
Cash Balance at year-end	£10.1m	£12.5m	£10.3m
Capital Expenditure	**£7.0m**	**£5.9m**	**£5.0m**
Risk Rating	2	2	2

* Draft plan submitted to Monitor (February 2016)
** Original draft FY17 plan prepared as part of the FY16 planning process (May 2016)

Since the draft plan was submitted in February 2016, further refinements have been made to reflect £3.2m of cash receipts being deferred to FY18/FY19 in relation to the disposal of the Manor/Tindal sites and a further £1.1m of capital investment being carried forward from FY16 to FY17.

EBITDA at £10.0m is £0.3m higher than the original draft; the net result of improved FY16 outturn and a lower national efficiency revenue reduction factor offset by a lower contribution from additional commissioned healthcare revenue and lower CIP. The lower revenue contribution and CIP reflect the uncertainties surrounding the system-wide integrated plans where the priorities of the health systems may impact upon the speed with which OHFT can return to a financial breakeven position. The deficit remains the same at £2.4m. The above table shows the plan for a deficit of £2.4m, after allowing for a contingency reserve of £4.3m. The plan would deliver a FSRR of 2*. **(The Monitor plan template calculates the FY17 risk rating as a 3, as it assumes the Trust will exceed its FY17 plan (because the Trust exceeded plan in FY16). This is an error in the template.)*

The plan is fundamentally determined by the following two key elements:

- CIP of £6.5m (2.2% of cost).
- Additional revenue contribution of £2.5m.

In summary, the plan requires a total benefit of £9.0m to be achieved through a combination of efficiency improvements and contribution from additional revenue. The Trust's Budgetary Control Policy sets a minimum contingency reserve requirement of 1%, which equates to approximately £3m. The draft plan is set within the required level at £4.3m.

The level of CIP must be realistic and achievable in the context of both OHFT's FSP to return to a breakeven position and the priority being given to integrated system-wide planning and performance. Notwithstanding OHFT's existing high level of efficiency (RCI 87), additional plans will continue to be developed with particular emphasis on health system efficiencies and FY18 financial performance.

The level of additional revenue contribution, planned at £2.5m, will depend on successful contract negotiations in relation to cost and activity pressures and service developments.

5.5 Capital Investment

Planned investment is mainly limited to compliance of estate with some investment required to rationalise the estate as part of the CIP. There is no investment in new estate to replace that which is too old, such as the Warneford hospital. The outline capital programme is summarised below:

- Operational Estate: rolling programme of works to maintain infrastructure, address sustainability and prioritised risks, including ward upgrades/refurbishments;
- Electronic Health Records: maturation and enhancement 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 schemes: includes capitalisation of PFI costs and medical equipment.

5.6 Risks and Opportunities

Apart from the challenging economic environment within which the Trust continues to operate, the main risks facing the Trust during FY17 include:

- FY16 outturn is worse than the current forecast (lower recurrent CIP);
- the requirement for the continued delivery of significant efficiency savings;
- the national efficiency requirement may be higher than the 2% assumed in the base plan;
- development and delivery of the required level of CIPs for FY17, especially delays due to system-wide working;
- securing additional revenue contribution from commissioners;
- ongoing cost pressures of agency staff, out of area treatments and drugs costs;
- the inability to flex resource to demand in a timely manner for cost & volume contracts (e.g. Reablement);

Key opportunities include:

- FY16 outturn (recurrent position) is better than the current forecast;
- pay uplift for OHFT may be lower than the 2.0% assumed in the base plan;
- CIP achievement above target;
- Improved contract for reablement services to better reflect activity levels and quality.

The Trust will continue to develop its mitigation plans to address downside risks in order to meet its financial objectives but the scale of the financial challenge is not being under-estimated.

6.0 Link to the emerging 'Sustainability and Transformation Plan'

OHFT is actively collaborating with our partners in health and social care to develop 5-year sustainability and transformation plans in the footprints we provide care. In Oxfordshire, a set of principles (set out below) have been developed to enable transparency and a shared vision for the future.

About these principles

- These principles have been agreed by Oxfordshire Clinical Commissioning Group, Oxford University Hospitals Foundation Trust and Oxford Health Foundation Trust.
- The purpose is to set out the guiding principles we will use to agree contracts for 2016/17 and develop the 5 year Sustainability and Transformation Plan.
- The principles will be reviewed during 2016/17.
- We will involve the GP Federations in these discussions.
- We will bring together a small group of executives and non-executives to oversee the delivery of our operational plans.

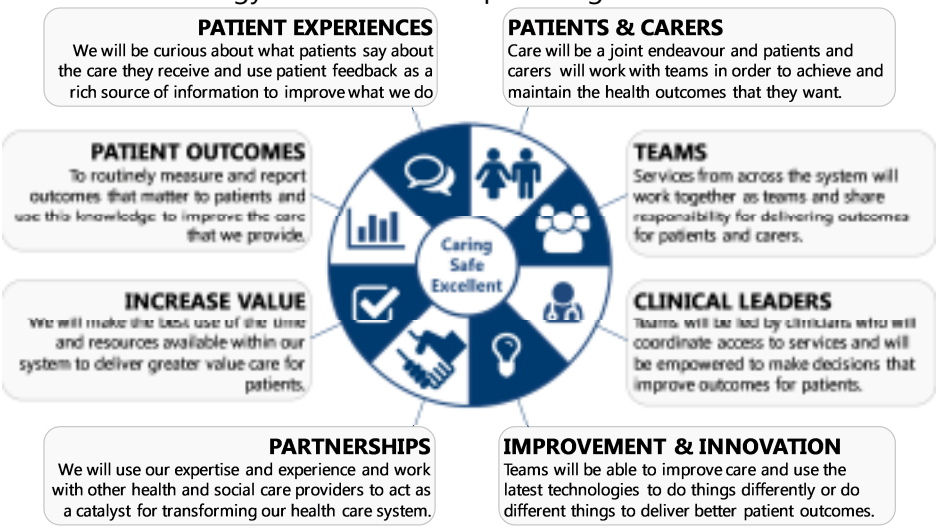
Behavioural Principles

- We are all working to a common goal of providing the best care for our patients within the resources available to us. Care should be provided close to people's homes when safe to do so and financially viable.
- There will be total transparency between us in sharing operational and planning information on operational pressures, quality issues and finance.
- Parity of esteem is important to all stakeholders.

Contracting Principles

- 2016/17 is the first year of our System Transformation and the decisions we take in setting 2016/17 contracts will be consistent with our developing 5 year strategy (or at the very least not be taking us in the wrong direction).
- The growth which the CCG has received in 2016/17 will be used to help us transform our system of care delivery.
- There is one pot of money and our collective task is to get the best value from that pot. Our aim will be to maximize value and take out "high cost low value" activity where possible.
- We will agree the priorities for improving the quality of services and the resources to be invested in these priorities.
- Our investment decisions will be consistent with our developing 5 year strategy.
- Investment (defined as funding above 2015/16 plans) is dependent on agreed service changes being identified and delivered.
- Each organisation will achieve the financial control totals which are set by regulators. For the CCG this will be to achieve a 1% surplus.
- Financial risk in year will be a shared responsibility. The system will take collective responsibility to support each individual organization in taking necessary action to achieve their own financial duties.
- There will be a shared responsibility for redesigning pathways.
- Financial plans and contracts will be underpinned by agreed operational and capacity plans.
- Planning and contracting will reflect both the modelled impact of demographic changes and the need to meet the NHS Constitution standards.
- The transactional burden of contracting will be reduced to those activities that can be shown to add value or are inescapable external requirements.

The OHFT strategy has been developed in light of the national and local contexts. Our strategy identifies how we will meet growing demands of ageing populations and increasingly complex needs of people living with multiple long-term conditions, and mental health conditions.



Close partnerships with a range of social and health care providers are necessary to achieve the outcomes that people want. Public expectations about convenient access to and choices of services are high and we must do everything we can to reduce health inequalities in the communities we work in.

Our strategy describes how we will work together, as a system, to meet these needs within an increasingly challenged financial climate. It outlines how we are working with patients, carers and their families in partnership with other care providers. We are reviewing our services to deliver high value care by innovating, using the latest technologies, doing different things or doing things differently to deliver the best outcomes for patients at the lowest costs.

The most successful organisations are those that work with others to deliver the best value care for patients and to benefit the care system as a whole. Our strategy clearly demonstrates our commitment to working as a system as we judge our success not by how well we compete with others but by how well we collaborate with them.

The most efficient and highest quality care is caring, safe and excellent. Doing the right things routinely and having the right people working at the top of their licence throughout the full cycle of people's care is the best value. There are several early examples of the key role OHFT is playing in leading transformation within the system it works.

6.1 Integrated Ambulatory and Urgent Care Model

We have been selected as most capable provider in partnership with Oxford University Hospitals Trust (OUHT) to deliver a modern, integrated system of care for older people and people with long-term conditions in Oxfordshire. The transformations underway to form integrated locality teams working closely with social care and GP Federations are already beginning to show signs of better coordinated local care. The recent example of the benefits of this joint working to reduce delayed transfers on care in Oxfordshire is testament to the commitment of all of the health and social care partners.

6.2 Voluntary Sector Partnerships

The Oxfordshire Mental Health Partnership is a partnership delivering mental health care to adults between OHFT and five third-sector partners in 2014: Oxfordshire Mind, Response, Restore, Elmore Community Team and Connection Floating Support. This is a model of care focussed on recovery to

deliver greater value and can be expanded into other areas. This partnership allows us to work closely with patients, families and carers to deliver outcomes that patients want to achieve at lower costs and deliver more flexible, needs-led approaches to mental health.

In Buckinghamshire the CAMHS model of care working with Barnado's and BEAT has shown that by working together with voluntary sector it has been possible, in a short period of time to radically change how care is delivered. This in turn has resulted in improved experiences and better value care in Buckinghamshire and is a model that we would like to expand in other services and other counties.

7.0 Membership and Elections

The Trust believes there is enormous organisational gain to be had from seeking people's insights on healthcare that encourage change for the better, and it is through our membership alongside a Community Involvement Framework that we will aim to understand the needs of the communities we serve. Over the next 12 months the Trust will engage with a diverse range of members across constituencies in a drive to ensure membership is more representative, informed and engaged, and to develop membership information that is widely and easily accessible. The Trust recognises the need to maintain an accurate, informative membership database to support effective communications and engagement with members and will review a range of options to enhance this.

In recent years the Trust has achieved objectives set out in the Strategic Plan Document 2014 -19. The Trust website has been redesigned to be more people focussed, user-friendly and accessible on smartphones and tablets and its ongoing development now involves a wider range of stakeholders. Trust social media channels including Facebook, Twitter, YouTube and LinkedIn have been relaunched with increased use of interactive communications, video and partnership working on campaigns and initiatives. This has attracted greater audiences supporting our aim to listen, learn, respond & improve.
Events to support wider engagement include the launch of the Oxfordshire Mental Health Partnership with five local charities, regular Health Matters talks on key health issues in partnership with Oxford Brookes University and others, as well as our AGM and Staff Recognition Awards. Effective governor elections have been run across constituencies, using innovative online election material and voting for the first time in 2015. For the staff constituency, regular Linking Leaders conferences were held across all counties to support delivery of effective patient care, organisational learning and improvement.

Over the next 12 months, the Trust will deliver targeted communications to engage members and promote membership to staff, patients, public, carers, and stakeholder organisations across the community and voluntary sector. This includes a program of Health Matters membership events throughout the year and increased collaboration with Oxford Health directorates and the third sector. A campaign to recruit governors launched in February 2016 in preparation for the governor elections which will be driven by a communications and engagement campaign to raise awareness of the upcoming elections and will include two aspirant governor evenings in Oxfordshire and Buckinghamshire. The election process will be administered by the Electoral Reform Services (ERS). A governor development day will run on completion of the elections to provide for induction of new governors, and training to new and existing governors will be delivered through a newly launched Training and Development programme with the opportunity to also attend targeted training offered by NHS providers. Our plans will enhance opportunities to deliver engagement between governors and membership with support from the Trust.

With Corporate Social Responsibility, Patient and Public Involvement (PPI), membership, fundraising and volunteering all focused on Oxford Health reaching out into the community, to organise the effort and impact, we will coordinate the activities and ensure everyone can see the benefits of 'getting involved' with Oxford Health.

8.0 Board Declarations

See main finance, activity and workforce template.

9.0 Appendices:

A: Adults Activity Planning

Referrals 2014 and 2015 (Q1-3)

Referrals to AMHT Assessment Teams - 2014/15 - Q1, Q2 and Q3										
TEAM	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**TOTAL**
Aylesbury Assessment Team	137	141	118	137	124	117	124	123	110	**1131**
Chiltern Assessment Team	155	156	151	130	124	139	154	136	129	**1274**
City and NE Oxon Assessment Team	129	174	164	158	151	171	186	196	200	**1529**
North and West Oxon Assessment Team	110	102	108	117	104	128	151	130	106	**1056**
South Assessment Team	73	86	82	102	97	100	115	114	86	**855**
Grand Total	**604**	**659**	**623**	**644**	**600**	**655**	**730**	**699**	**631**	**5845**

Referrals to AMHT Assessment Teams - 2015/16 - Q1, Q2 and Q3										
TEAM	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**TOTAL**
Aylesbury Assessment Team	117	110	130	140	128	146	149	154	129	**1203**
Chiltern Assessment Team	144	143	184	160	156	178	194	174	182	**1515**
City and NE Oxon Assessment Team	150	170	184	176	141	163	229	217	179	**1609**
North and West Oxon Assessment Team	113	116	132	164	121	132	149	132	120	**1179**
South Assessment Team	110	95	113	115	108	111	118	108	104	**982**
Grand Total	**634**	**634**	**743**	**755**	**654**	**730**	**839**	**785**	**714**	**6488**

Adult Mental Health Teams (AMHTs)

During 2016, AMHTs will be moving to a Flexible Assertive Community Team (FACT) model using smaller sub-teams, within their treatment functions, which are aligned to specific GP surgeries within certain geographical areas within the AMHT catchment areas. Through reducing the wider area covered by the teams, it allows the sub-team to have a knowledge and understand of the needs of all the patients in their areas. The models create continuity of care for patients and enable staff to work collaboratively to ensure each patient receives the necessary care and support they need, when it is required.

The psychological services will also be integrating into the AMHTs in late 2016 which will see all referrals come through a single point of access for adult services in both counties. Although this will reduce the access points to the service by having a clearly defined referral route for referrers, it will increase demand on the services initially who have to triage these individuals.

Oxfordshire Mental Health Partnership (OMHP)

The OMHP will be introducing a Single Point of Access in 2016 for all patients accessing the partnership organisations. This approach will see a standard assessment carried out for all

referrals to identify which service is best placed to support the needs of the patient. This will ensure that there is no duplication of services and therefore increase capacity.

This will support the additional demand in Oxfordshire though the introduction of the psychological therapies referrals as well. In Buckinghamshire, over the next year, we will be looking at developing partnership models that will support Buckinghamshire patients.

Early Intervention in Psychosis Service

In line with the changes to the response times for individuals with first episode psychosis, the EIP service have adapted their service models in both counties to ensure that there is continuity of service delivery to meet the new 2 week target for assessment into treatment. To support the increase demand on the service, a recruitment drive has been underway and will be re-assessed during 2016/17 to ensure that the teams are meeting the target each month.

Mental Health Urgent Care Pathway

One area of development for the service in 2016/17 is the unification of the current services provided out of hours and into the acute hospitals; our Emergency Department Psychiatric Services (EDPS) in Oxfordshire and the Psychiatric In-Reach Liaison Service (PIRLS) in Buckinghamshire, the Street Triage teams in both counties, the Night Teams (working across the AMHTs/Inpatient Services) in both counties and the SCAS mental health controller working in the 111/999 call centre.

These services already operated across similar areas and often interlink depending upon the needs of the service user however, through working to bring these together into a clearly defined pathway; it will improve access for referrers and service users and provide clear links into the wider services for those patients who need support.

Improving Access to Psychological Therapies (IAPT)

In Oxfordshire, our IAPT service continues to work in partnership with Oxfordshire Mind and now with Principal Medical Limited (PML) to support service individuals who are experiencing anxiety and depression and helping them to move forward through the use of talking therapies.

In Buckinghamshire, the IAPT service is already working alongside a number of partners and will be furthering these in 2016/17 through working with key provides of physical lifestyle interventions to support individuals with such conditions as weight management, diabetes and COPD. Through working in partnership, the services are able to offer a wider range of support to clients and ensure that those who need an intense level of psychological support receive the appropriate treatment at the right time.

Primary Care Mental Health

This is a possible service development in the coming year and discussion have commenced with the Oxfordshire and Buckinghamshire Commissioners. This would support GPs in ensuring that only those patients needing secondary care and who are more complex would be referred into the AMHT SPA

Forensic services
During 2016/17 we will be exploring the allocation of beds to low and medium secure. The service is undertaking a review to understand how the pathway could function in a stepped model that best fits the needs of individual patients. This is in response to a rise in demand for medium secure services and the step down support to those patients who are moving on from forensic services.

The commissioning model is likely to move from a central NHS England contract to local commissioning and this may give the forensic service more ability to be more flexible around what they can provide.

Capacity and Beds
The acute capacity has not changed over the past few years although we are seeing an increase in demand. Work is being undertaken within OMHP and the other services as mentioned above to support patients in the community thus reducing the demand on the current bed stock.

B: Older People Activity Planning

Integration: *By embedding and extending Integrated Locality Teams (ILTs) across Oxfordshire, between primary care, social care and community healthcare and third sector organisations, we will enable a timely holistic response for patients, allowing for a single point of access reaching a broader range of services and working across organisations. The primary urgent care pathway will be revised with local partners, integrated locality teams and community services to provide unscheduled care to the population of Oxfordshire, working with partner organisations for urgent care.*

Standardisation of clinical processes*: Ensuring that our holistic care pathways meet the escalating complexity of patient need and we are responding equitably seven days a week, will require consideration of the clinical evidence base (for example mental health clusters and professional standards)*

Clinical skills: *In order to best equip our workforce to manage the ever more acute and unstable clinical presentations in the community, we must continually develop clinical skills across all our specialties (mental health, therapies, nursing, urgent care and community hospitals). By streamlining our clinical governance and performance processes, minimalizing duplication of reporting and enabling our clinical leaders to access the data they need, when and where they need it, we can maximise clinical facing time.*

Partnership working: *We must work closely with the third sector to deliver high quality and sustainable care. In FY17 the directorate will build upon the pilot funded by the Cabinet Office for Circles of Support delivered in partnership with Age UK.*

Develop a holistic model of care *to meet high physical health and mental health needs in our inpatient services following the co-location of City community hospital with the older adult mental health wards at the Fulbrook Centre.*

Oxford Health NHS
NHS Foundation Trust

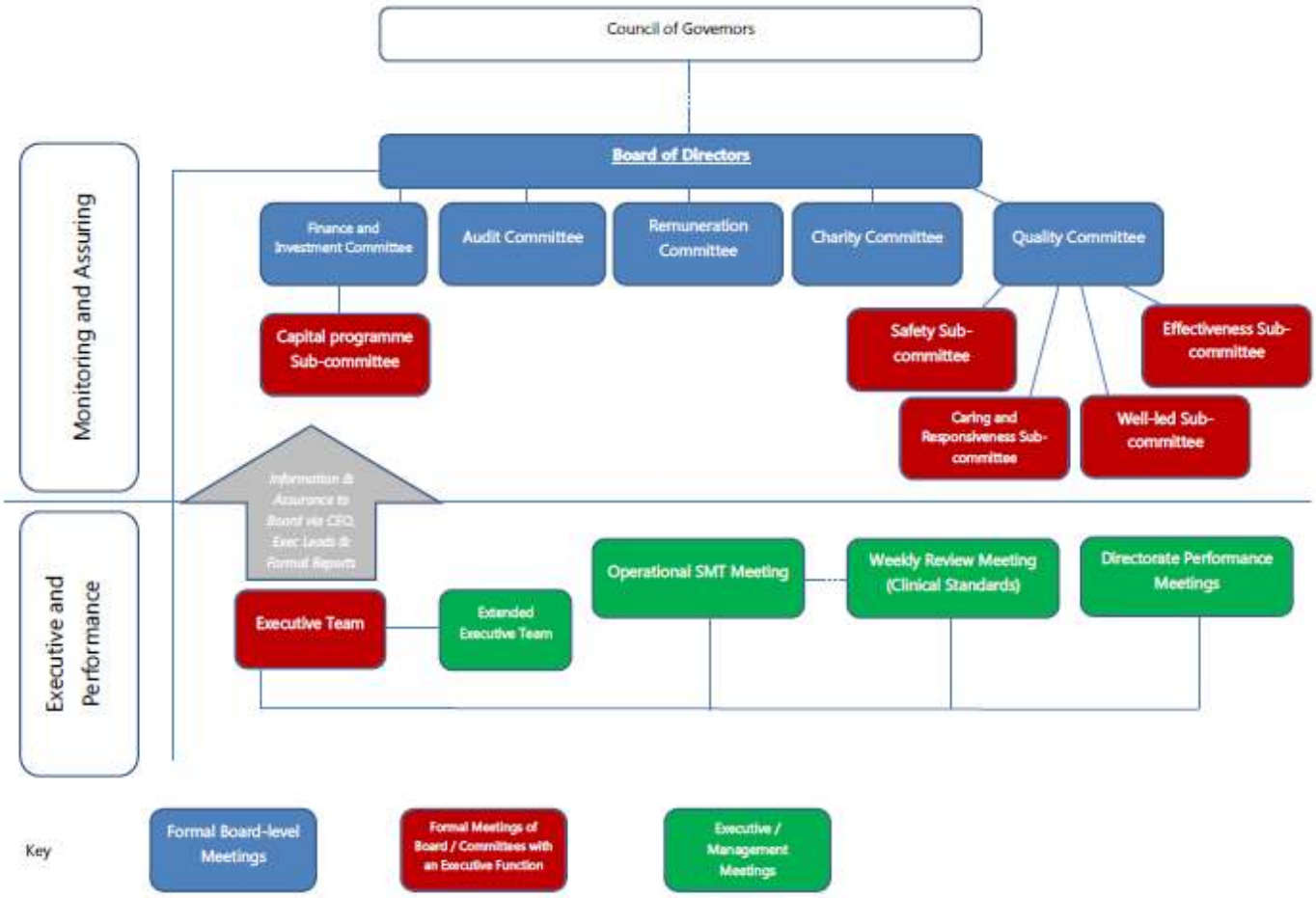
C: CQC Inspection Sept/Oct 2015 Summary

CQC Inspection Sept/ Oct 2015: Summary of Ratings and Key Issues

- Overall rating 'Requires Improvement', understanding from the Head Inspector that we are in the upper quartile of this bracket.
- No enforcement actions
- 16 reports: 15 core services assessed and 1 trust wide report
- 10 out of 15 core services received an overall rating of good and 1 core service received an overall rating of outstanding
- For 55 out of 75 ratings we achieved good or outstanding (73%) (15 core services x 5 domains each) (excluding the trust wide overview report)

Core Service	Overall Rating	Domain Rating				
		Safe	Effective	Caring	Responsive	Well led
Trust wide	***Requires Improvement***	***Requires Improvement***	***Requires Improvement***	***Good***	***Good***	***Good***
CAMHS wards	Good	Good	Good	Good	Good	Good
CYP Services	Outstanding	Good	Outstanding	Outstanding	Good	Good
CAMHS community	Good	Requires Improvement	Good	Outstanding	Good	Good
Luther Street GP	Good	Requires Improvement	Good	Outstanding	Outstanding	Good
AMHTs	Requires Improvement	Good	Requires Improvement	Good	Good	Requires Improvement
Rehab mental health ward	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Adult acute mental health wards and PICU	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement
Forensic wards	Good	Good	Good	Good	Outstanding	Good
Health based places of safety	Good	Good	Good	Good	Requires Improvement	Good
Urgent care services	Good	Requires Improvement	Good	Good	Good	Good
Community Hospitals	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
OP mental health wards	Good	Requires Improvement	Good	Good	Good	Good
OP Services	Good	Requires Improvement	Good	Good	Good	Good
End of life care	Good	Good	Requires Improvement	Good	Good	Good
OP CMHTs	Good	Good	Good	Good	Good	Good

D: Approach to Quality – Governance



E: Approach to Quality – Governance

Board Committees and their membership 2016

Finance and Investment Committee

Lyn Williams	Non-Executive Director (Chair)
Martin Howell	Non-Executive Director and Trust Chair
Stuart Bell	Chief Executive
Mike McEnaney	Director of Finance
John Allison	Non-Executive Director

Audit Committee

Alyson Coates	Non-Executive Director (Chair)
Lyn Williams	Non-Executive Director
Anne Grocock	Non-Executive Director
Sue Dopson	Non-Executive Director
John Allison	Non-Executive Director

Quality Committee

Martin Howell	Non-Executive Director and Trust Chair (Chair)
Stuart Bell	Chief Executive
Clive Meux	Medical Director (Vice Chair)
Mike Bellamy	Non-Executive Director
Ros Alstead	Director of Nursing and Clinical Standards
[Yvonne Taylor	Chief Operating Officer – during 2015, for Jan-Feb 2016 will be Pauline Scully as Interim Chief Operating Officer]
Mike McEnaney	Director of Finance
Anne Grocock	Non-Executive Director
Jonathan Asbridge	Non-Executive Director

The Board

Martin Howell	Non-Executive Director and Trust Chair
Anne Grocock	Non-Executive Director
Lyn Williams	Non-Executive Director
Mike Bellamy	Non-Executive Director
Alyson Coates	Non-Executive Director
Stuart Bell	Chief Executive
Ros Alstead	Director of Nursing and Clinical Standards
Clive Meux	Medical Director
[Yvonne Taylor	Chief Operating Officer – during 2015, for Jan-Feb 2016 will be Pauline Scully as Interim Chief Operating Officer]
Mike McEnaney	Director of Finance
Sue Dopson	Non-Executive Director
Jonathan Asbridge	Non-Executive Director

Sir John Allison	Non-Executive Director

Charity Committee

Anne Grocock	Non-Executive Director (Chair)
Alyson Coates	Non-Executive Director
Lyn Williams	Non-Executive Director
Ros Alstead	Director of Nursing and Clinical Standards
Yvonne Taylor	Chief Operating Officer

F: Approach to Quality - Governance

External Accreditations and External Peer Reviews

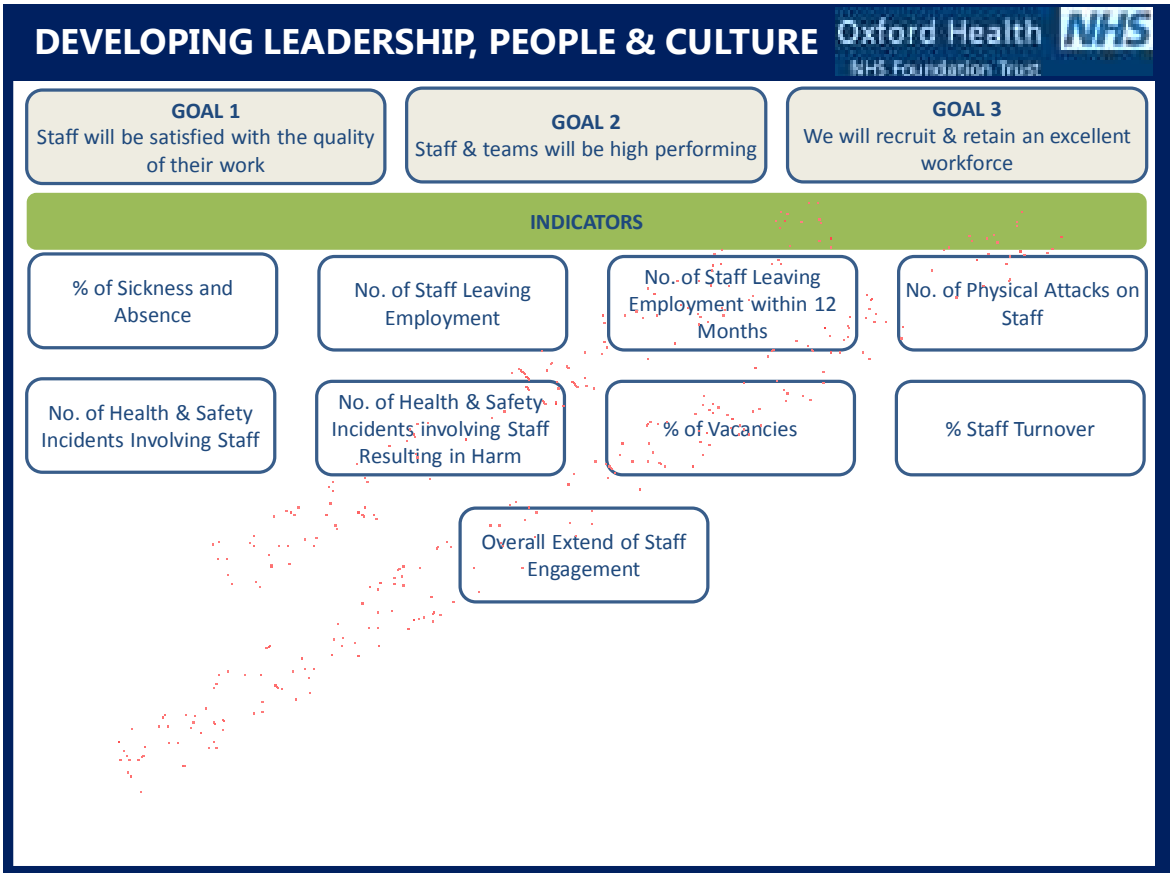
The below update of the external accreditation and external peer reviews currently achieved or being worked towards (highlight in grey) is reported at least six monthly to the quality sub-committee Effectiveness.

Accreditation	Body	Service	Comments
Memory Services National Accreditation programme (MSNAP)	The Royal College of Psychiatrists	Memory service clinics Oxon and Bucks	Accreditation awarded Oct 2015 until Oct 2017. Central Oxon– Excellent South Oxon – Excellent North Bucks- Excellent South Bucks – Accredited North Oxon – deferred till Jan 2016
ECT	The Royal College of Psychiatrists	Whiteleaf Centre, Aylesbury	Accredited to April 2017 (review decision 3rd April 2014)
ECT	The Royal College of Psychiatrists	Warneford Hospital, Oxford	Accredited to Jan 2017 (review decision 15th Jan 2014)
Quality Network for Inpatient CAMHS	The Royal College of Psychiatrists	Marlborough House, Swindon	Currently a member. And receive annual external review.
Quality Network for Inpatient CAMHS	The Royal College of Psychiatrists	Highfield, Oxford	Currently a member. And receive annual external review.
Community of Communities	The Royal College of Psychiatrists	Oxfordshire Complex Needs Service	Renewed accreditation in April 2014 to 3rd April 2017.
Community of Communities	The Royal College of Psychiatrists	Buckinghamshire Complex Needs Service	Accreditation completed every 3 years.
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	Marlborough House, Milton Keynes	Annual peer review
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	Woodlands, Aylesbury	Annual peer review
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	The Oxford Clinic, Wenric and Thames House	Annual peer review
UKMi (UK Medicines Information)	UK Medicines Information	Trusts Medicines Information Department	Awarded following audit in 2009
Quality Network	Royal College of	Cotswold House,	Awarded excellent (accredited

Accreditation	Body	Service	Comments
for Eating Disorders (QED)	Psychiatrists Centre for Quality Improvement	Marlborough	till Jan 2017) Next review November 2015
Triangle of Care member (carers)	Carers Trust	All services	The Trust became a member in June 2014 and achieved 2 gold stars in Dec 2015.
Quality in Dental Service Award	British Dental Association	Salaried dentist service	Dec 2014 achieved accreditation for three years.
Safe Effective Quality Occupational Health Service (SEQOHS)	SEQOHS	Occupational health team at Oxford Health NHS FT	Accreditation achieved in March 2015
Quality Network for Eating Disorders (QED)	Royal College of Psychiatrists Centre for Quality Improvement	Cotswold House, Oxford	Accreditation achieved in 2015 Rated Excellent
Accreditation for inpatient mental health services (AIMS)	The Royal College of Psychiatrists	Adult mental health wards	All the adult acute and rehab wards (7 wards) achieved accreditation in July 2015
Accreditation for inpatient mental health services (AIMS-PICU)	The Royal College of Psychiatrists	PICU	Ashurst achieved accreditation in December 2015 for 2 years until full interim self review
Quality Network for community CAMHS	The Royal College of Psychiatrists	Oxford City CAMHS	Team will go for re-accreditation in next cycle in 2015/16.
Quality Network for community CAMHS	The Royal College of Psychiatrists	Buckinghamshire OSCA	Team will go for re-accreditation in next cycle 2015/16.
Quality Network for community CAMHS	The Royal College of Psychiatrists	Buckinghamshire learning disability team	QNIC review with a Cycle 5 completed in June 2010. Team going through re-accreditation.
UNICEF baby friendly breastfeeding status	UNICEF	Health visitors service	Achieved stage 1 of BFI in May 2015 which is in addition to the certificate of commitment and are now working towards stage 2, assessment due on 3rd and 4th Feb 2016.
Psychiatric liaison accreditation network (PLAN)	The Royal College of Psychiatrists	Emergency Department Psychiatric Service Oxfordshire	Application submitted to PLAN. Self-assessment completed in Dec 2014 and visit in Feb 2015.
Accreditation for	The Royal College of	Older People mental	The wards have started

Accreditation	Body	Service	Comments
inpatient mental health services (AIMS) Older People	Psychiatrists	health wards	internals reviews to work towards accreditation – application for accreditation to be made in April 2016.
Imaging Services Accreditation Scheme	UKAS selected to deliver and manage Imaging Services Accreditation Scheme	x-ray services hosted at Abingdon, Bicester, Witney and Henley Community Hospital sites	OUH manage staff and equipment through SLA from April 2014. OUH carrying out a two year programme (including the community hospitals) to prepare through self-assessment and then apply for external accreditation in June 2016.

G: Approach to Quality: Key Performance Indicators



H: Approach to Quality – CIP Governance

Governance	Meeting	Frequency	Purpose	Membership
Trust Governance	Board of Directors	**Monthly (4th week)**	To seek assurance from the Executive on overall Trust position and to agree any actions for outliers based on recovery plans	Executive Non-Executive Trust Secretary PMO
Programme Governance	CIP Delivery Group	**Monthly (3rd week)**	Overall update on Trust CIPs. Seek assurance on delivery of projects and **scrutinise outliers** based on recovery plans.	COO, DoF, MD, DoN, PMO (core) Service Directors Clinical Directors Project Leads
Directorate Governance	Directorate Confirm and Challenge	**Monthly (2nd week)**	Overall update on all Directorate projects and challenge project managers on outliers. Recovery plans to be completed.	Service Directors Clinical Directors Service leads Project Managers Finance Performance Information
Project Governance	Project Meetings	**Weekly**	Project progress, financial & performance trends, risks & mitigations. Working with service leads to transform services inline with project objectives	Project Manager Service Lead Finance Performance Information

Information flow using standardised PMO templates

Confirm and challenge performance

I: Approach to Quality – CIP Delivery Terms of Reference

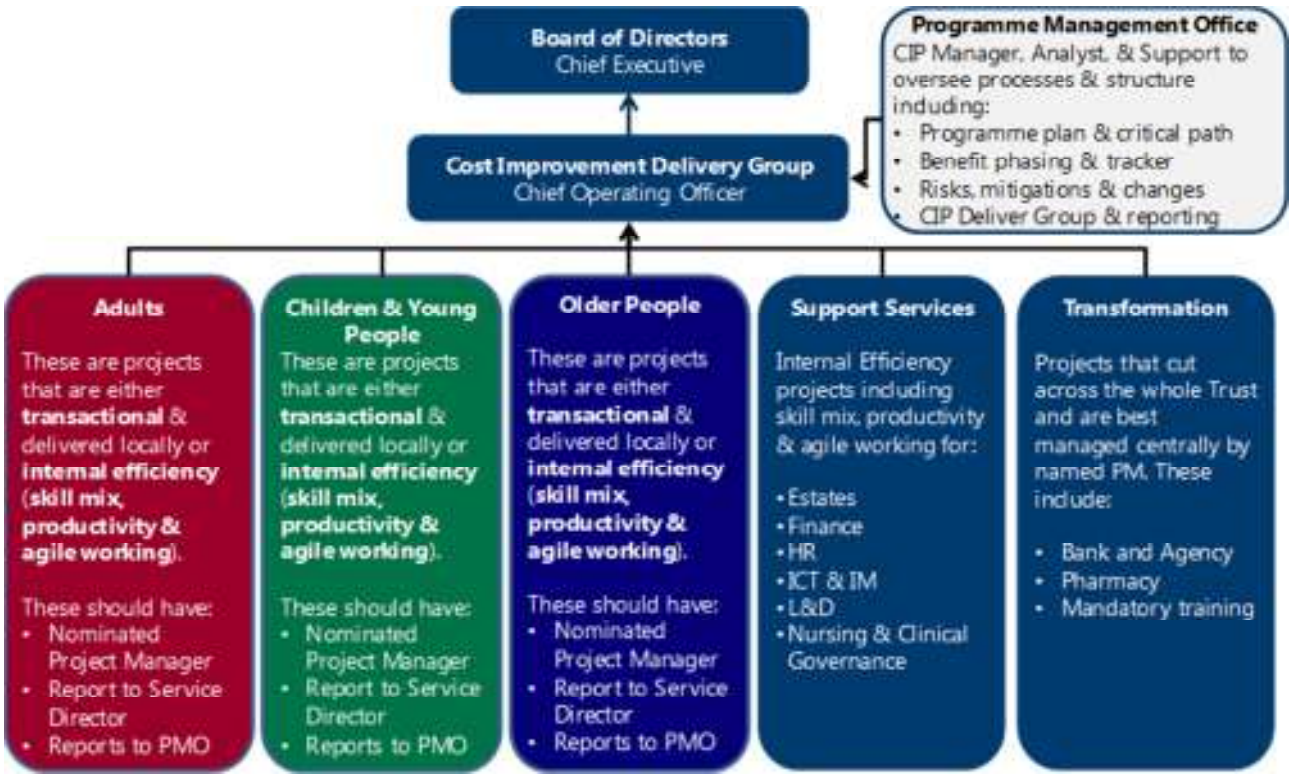
Cost Improvement Programme (CIP)
Delivery Group: Terms of Reference

Introduction

The Trust is committed to delivering significant levels of savings while maintaining high quality, caring, safe and excellent services. In order to do this the Trust must place a larger emphasis on well-managed programmes and projects from conception to completion with increased levels of scrutiny on quality, operational performance and financial indicators.

A programme consisting of 5 major workstreams and a programme management office is being established under the executive leadership of the Chief Operating Officer (COO).

The programme will be structured as follows:



The CIP Delivery Group (CIP DG) meeting is a key delivery meeting within the Cost Improvement Programme.

1. <u>Purpose</u>

The purpose of the CIP Delivery Group is to oversee the delivery of all CIP schemes through:

- Monitoring development of the organisation's Cost Improvement Programme and all of its workstreams.
- Being responsible for monitoring quality assurance and management of risks and issues related to CIP.
- Performance managing the delivery of the CIP plan.

The CIP DG will report directly to the Board of Directors to provide assurance against the delivery of the CIP.

2. Terms of Reference

- Receive reports on and review delivery of all schemes from each of the CIP workstreams following Directorate Confirm and Challenge meetings (DCC).
- Establish reasons for under-performance of the CIP schemes and identify appropriate support for enabling recovery.
- Agree robust Recovery Plans with Service and Clinical Directors that have been designed by Project Managers to resolve underperformance in any areas described above, providing appropriate challenge, scrutiny and support.
- Review recommendations for new schemes and identify Programme and Project Managers and resources to initiate the project.
- Review recommendations of the PMO on priorities and resource allocations associated with the Programmes in scope and endorse as appropriate.
- Review risks, issues and quality impact assessments and agree escalation and mitigating actions where necessary.

3. Core Membership

The CIP DG will operate using a Scrutiny Panel who will support & challenge workstream leads as defined below. Core membership of the Scrutiny Panel consists of:

- Chief Operating Officer (COO)
- Director of Finance
- Director of Nursing and Clinical Standards
- Medical Director
- PMO

Review delivery of current CIP schemes:

- Service Directors and Clinical Directors (by exception where milestones or benefit delivery are at risk) and optional supporting staff, including General Managers, Business Managers, Finance Managers and Service Improvement Leads.

Review recommendations for new CIP / transformation schemes:

- Leads will present the business case for new Transformational schemes, supported by specific staff where required, including General Managers, Business Managers, Finance Managers and Service Improvement Leads.

4. Co-opted members

Directorate and workstream leads with responsibility for CIP schemes that are underperforming and have been selected for detailed discussion by the CIP DG. The PMO will advise each Directorate or workstream lead which areas will be subject to detailed discussion prior to the CIP DG. The Directorate or Workstream Lead may invite key associated project members to attend this discussion.

5. Chair and Deputies

The Chief Operating Officer will Chair all CIP DG meetings and the Director of Finance will deputise in their absence. Deputies for other core member should be found provided to attend the meetings.

6. Frequency and duration of Meetings

Meetings will be held monthly prior to the Board of Directors meeting (calendar in appendix).

7. Quorum

Two from the Executive Team attendees. All Directorate and Workstream Leads of underperforming projects are expected to attend CIP DG or advise of a deputy **minimum of 2 days** prior to the meeting.

8. Administrative Support

The Programme Support Officer of the PMO will provide administrative support to the CIP DG and distribute the actions, recovery notes and minutes.

9. Reporting Arrangements

The CIP DG will report directly to Board of Directors on progress to date for CIP (and identified and new business cases). It will also reassure Board of Directors over the progress of any Recovery Action Plans to support under-performing areas.

10. Review

The CIP DG Terms of Reference will be reviewed in full on an annual basis by the CIP DG.

11. Frequency of meeting

CIP DG will meet monthly for no more than 2.5 hours; this may change depending on the delivery of cost improvement.

Oxford Health NHS
NHS Foundation Trust

When	Meeting	Who Organises	Who Attends
1st working day	PMO request CIP updates from Project Leads	PMO	N/A
8th working day	Finance update tracker	Finance	N/A
From 9th working day and prior to CIP Delivery Group	Confirm and Challenge meetings	Directorates	Service Director, Clinical Director, Service leads, Project Managers, Accountants and Performance Leads
Prior to Trust Board	CIP Delivery Group	PMO	COO, DoF, MD, DoN, PMO (core group) By invitation: Service Directors, Clinical Directors and Project Leads
Executive Meeting before Trust Board	Executive Meeting	Trust Secretary	COO
Last Wednesday of the month	Board of Directors	Trust Secretary	COO
See calendar	FIC	Trust Secretary	COO

Month	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T
January								4	5	6	7	8			11	12	13	14	15			18	19	20	21	22			25	26	27	28	29						
February								2	3	4	5	6			9	10	11	12	13			16	17	18	19	20			22	23	24	25	26			29			
March		1	2	3	4			7	8	9	10	11			14	15	16	17	18			21	22	23	24				29	30	31							
April					1			4	5	6	7	8			11	12	13	14	15			18	19	20	21	22			25	26	27	28	29						
May									3	4	5	6			9	10	11	12	13			16	17	18	19	20			23	24	25	26	27						
June			1	2	3			6	7	8	9	10			13	14	15	16	17			20	21	22	23	24			27	28	29	30						
July					1			4	5	6	7	8			11	12	13	14	15			18	19	20	21	22			25	26	27	28	29						
August	1	2	3	4	5			8	9	10	11	12			15	16	17	18	19			22	23	24	25	26				30	31							
September				1	2			5	6	7	8	9			12	13	14	15	16			19	20	21	22	23			26	27	28	29	30						
October								3	4	5	6	7			10	11	12	13	14			17	18	19	20	21			24	25	26	27	28			31			
November		1	2	3	4			7	8	9	10	11			14	15	16	17	18			21	22	23	24	25			28	29	30							
December				1	2			5	6	7	8	9			12	13	14	15	16			19	20	21	22	23					28	29	30					

Glossary of Terms

- **AHP** - Allied Health Professional
- **AHSC** – Academic Health Science Centre
- **AHSN** – Academic Health Science Network
- **AIMS** - Accreditation for Inpatient Mental Health Services
- **AMHT** - Adult Mental Health Team
- **BAF** – Board Assurance Framework
- **BI** – Business Intelligence
- **BME** – Black and Minority Ethnic
- **CAMHS -** Child and Adolescent Mental Health Services
- **CapEx** – Capital Expenditure
- **CCG** – Clinical Commissioning Group
- **CIP** – Cost Improvement Programme
- **CLAHRC -** Collaboration for Leadership in Applied Health Research and Care
- **CMHT –** Community Mental Health Team
- **CoSSR -** Continuity of Services Risk Rating
- **CPA** – Care Programme Approach
- **CQC** - Care Quality Commission
- **CQUIN** - Commissioning for Quality and Innovation
- **DTOC** - Delayed Transfers of Care
- **EBITDA** – Earnings before interest, taxes, depreciation, and amortization
- **EDPS** - Emergency Department Psychiatric Service
- **EMU** - Emergency Multidisciplinary Assessment Unit
- **FFT** - Family and Friends Test
- **FOT** – Full-year out-turn
- **FSP** – Financial Sustainability Plan
- **FSRR** - Financial services risk and regulation
- **HCAIs** - Healthcare-acquired infections
- **HETV** – Health Education Thames Valley
- ***IC:5*** - Improving Care through five questions
- **IHI** - Institute for Health Improvement
- **ILT** - Integrated Locality Team
- **I & E** – Income & Exenditure
- **KPI** - Key Performance Indicator
- **LETB** – Local Education and Training Board
- **LGBT –** Lesbian, Gay, Bisexual, Transgender
- **LIPS** - Leading Improvements in Patient Safety Programme
- **LOS** - Length of Stay
- **LTFM** - Long Term Financial Model
- **MHLDDS** - Mental Health and Learning Disabilities Dataset
- **MHMDS** - Mental Health Minimum Data Set
- **MSK** - Musculoskeletal
- **NGEHR** - Next Generation Electronic Health Record, or 'CareNotes'
- **NHSE** – NHS England
- **NIHR** – National Institute for Health Research
- **OD** - Organisational Development
- **OBC** – Outcomes-based Contract
- **OHFT** – Oxford Health Foundation Trust
- **OMHP** – Oxford Mental Health Partnership
- **OSCA** - Outreach Service for Children & Adolescents
- **OUH** - Oxford University Hospitals NHS Trust
- **PBR** – Payment by Results
- **PDC** - Public Dividend Capital
- **PLC** - Patient Level Costing
- **PIRLS** - Psychiatric In Reach Liaison Service
- **PMO** - Programme Management Office
- **SHRBP** - Senior HR Business Partner
- **SLR** - Service Line Reporting
- **SMT** - Senior Management Team
- **UO** –University of Oxford
- **WEI** - Workforce Equality Index
- **WRES** - Workfoce Race Equality Standard