Oxford Health NHS Foundation Trust

# Operational Plan Document for 2018 & 2019

# Oxford Health NHS Foundation Trust

## Operational Plan for y/e 31 March 2018 &2019

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


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| **Date** | 06/01/2017 |

**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:**

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| **Name** *(Chair)* | Martin Howell |

**Signature** 

**Approved on behalf of the Board of Directors by:**

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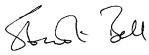
| **Name** *(Chief Executive)* | Stuart Bell |

**Signature** 

**Approved on behalf of the Board of Directors by:**

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| **Name** *(Finance Director)* | Mike McEnaney |

**Signature** 

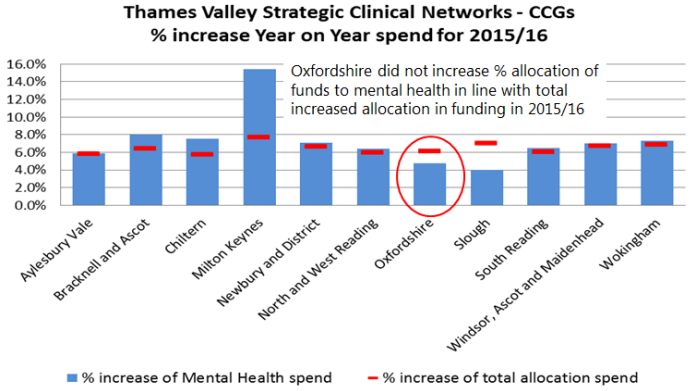
## 1.0 Executive Summary

Oxford Health Foundation Trust (OHFT) provides community and mental health services for children and young people, adults and older adults across Oxfordshire, Buckinghamshire and Child and Adolescent Mental Health services in Swindon, Wiltshire, Bath and North East Somerset.

OHFT accepts the NHS Improvement financial control totals for 2017/18 and 2108/19. This plan is dependent upon improving the revenue OHFT receives for its services, in particular progress with achieving parity of esteem for mental health. In order to establish an underlying breakeven position for the two years in addition to the increased revenue OHFT plans to deliver a challenging Cost Improvement Programme (CIP). OHFT has consistently reduced its costs and between 2012 and 2016 has saved over £36 million.

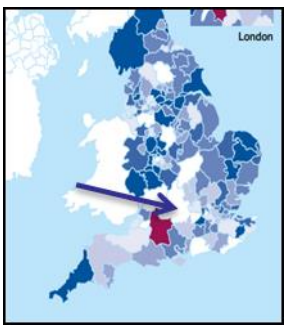
Given the low allocations to the CCGs in our area and the low funding of our services, achieving breakeven is in itself a highly challenging target. It builds upon our 2016-2017 Operational Plan and sits within our overarching strategy and the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP).

The Thames Valley Strategic Clinical Networks analysis of 2015/16 CCG funding for mental health showed Oxfordshire in particular did not increase the percentage allocation in line with its total allocation. The National Mental Health, Dementia and Neurology Intelligence Network (NMHDNIH) also showed that Oxfordshire has one of the highest excess under-75 mortality rates for adults with serious mental illness in the Thames Valley region.




Mental health accounts for 23% of NHS activity but NHS spending on secondary mental health services is equivalent to just half of this. As a result of low allocations for CCGs in the Thames Valley region spending (per PRAMH-weighted capita) has been shown to be some of the lowest in the country.

The FYFV for Mental Health sets a clear ambition to achieve parity of esteem by 2020-21. The NHS in England has committed to the biggest transformation of mental health care across the NHS in a generation, **pledging to help more than a million extra people and investing more than a billion pounds a year by 2020/21**. It builds on the £280 million investment each year already committed to drive improvements in children and young people's mental health and perinatal care. (Five Year forward View for Mental Health). This plan sets out how we intend to deliver transformations in mental health in-line with the FYFV and some of the required investments.




In Oxfordshire our community services have continued to develop strong links with partners from primary care, acute care and social services to deliver care differently and improve access for people with long-term conditions and frailty. The demands for services are significant and the challenges of providing modern care that meets the changing needs of our populations are vast. In particular, we are working as a system to identify the best locations and ways to deliver care that achieve the best outcomes and experiences for patients, families and carers.

OHFT continues to be one of the most efficient NHS Foundation Trusts in the country as demonstrated by its reference cost index (RCI) of 94 (MFF adjusted) in 2016, compared to 87 in 2015. OHFT prides itself on the delivering outstanding care and involving patients and carers to achieve the best outcomes, safety and experiences. Benchmarking and the recent Good CQC rating is a testament to the high value care that OHFT continues to deliver. Our operational plan aims to find ways of reducing expensive out of area treatments and identifying new ways of working to reduce the costs of care and workforce pressures.

Along with our partners in the Oxford Academic Health Science Centre we are leading the way in research and development. Our successful application to be one of only two biomedical research centres in the UK dedicated to mental health; as well as the continuation of the Clinical Research Facility will enable us to further contribute to reducing the health inequalities for people suffering mental illnesses. We host the Collaboration in Leadership and Health Research and Care (CLAHRC) leading research in physical care and work with partners across a wide geography covered by the Academic Health Science Network (AHSN) to rapidly adopt innovation and share learning.

OHFT is pioneering new care models such as the outcomes-based contract with five voluntary sector partners in Oxfordshire. We are also in the process of developing a Thames Valley and Wessex Forensic Network for low and medium secure services. As lead provider responsible for commissioning whole pathways of care across a large geography the Network aims to reduce out-of-area treatments, reduce lengths of stay, reduce expenditure on beds and increase investment in out-of-hospital care.

We are committed to working as system to identify transformations that support delivering sustainable care in the future. In Oxfordshire, Stuart Bell leads the Transformation Board and we are active partners in the Healthy Buckinghamshire Leaders Group. We are also leading the Mental Health workstream for the BOB STP and key participants in several other workstreams to play a pivotal role in developing relationships throughout the health and social care system.

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.

The OHFT board's priorities for the next 2 years are:

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 Activity Planning**

Operational Directorate plans for FY18 are based on historic activity data trends and extrapolations taking into account demographic changes in the region, with forecasts being jointly discussed with commissioners in Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath & Northeast Somerset, as well as specialist commissioners (NHS England).

**2.1 Children and Young People**

Each of our CAMHS services are undergoing transformations based on the report Future in mind, and aims to ensure that the emotional and mental health needs of children and young people are appropriately met at the earliest opportunity through a schools in-reach service, with the aim of prevention and reducing the likelihood of long-term mental health problems. This re-modelling to our service and the provision of training to key workers in education and primary care will improve access for young people to CAMHS services as it focusses on earlier intervention and building resilience. The proposed pathway model is based on The Thrive Approach as indicated by the Future in Mind document. This is currently subject to a tender process with the CCG. There has been a year on year increase in referrals within our Oxon CAMHS service and an increasing case load (there has been a 5% increase in referrals and 7% increase in caseload in Oxon for Tier3 for Q1 & Q2 for during FY17 compared to same period in FY16).

We have forecast waiting times against our current capacity and have identified that without an increase in clinicians, the service will be unable to meet demand. The service currently depends on temporary staff, short term contracts, sessional workers and locum staff through agencies. To meet current demand and reduce this dependency on temporary staffing, we have made the assessment clinic process more efficient through reviewing work allocations, introducing more assessments and increasing the numbers of group interventions for mental health and wellbeing. However sustainable staffing still presents a challenge. We have subcontracted on a case by case basis 30 assessments (and follow ups) to an independent provider and are supporting a recruitment process being led by third sector partners with a view to expand during FY18.

Within the Children and Young People directorate, we also provide both community and in-patient services for adults with eating disorders. There are lengthy waiting times for CBT-E in Buckinghamshire and

Oxfordshire which is due to an increased numbers of referrals that have been historically under resourced and over performing (25% increase in referrals received for Month 8 FY17 compared to the same period in FY16). We are developing online referral processes, and are reviewing the model with our commissioners with an intention to achieve an increased through put of patients receiving treatment. For more information on Children and Young People plans, see appendices.

**2.2 Adults**

For Adult Mental Health Services in Buckinghamshire and Oxfordshire the overall referral rates for the Adult Mental Health Teams (AMHTs) for FY16 and FY17 show that there has been an 50% increase in referrals to the services (see appendices – trend charts), since the expansion of the age criteria for IAPT services. The prior two years indicated a 14% increase in referrals. 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 over the next two years. To support the increasing demand, and to ensure that the service delivered for patients (and carers) maintains a high quality of care, a number of service improvements are under development.

In response to pressures on AMHTs, we are trialling a new model in the South Oxon AMHT to better manage changes in capacity and demand. This will be reviewed in 2017 against pre-trial baseline measures (patient and staff satisfaction surveys, and mileage). In Buckinghamshire we are expanding an outcome based mental health contract based on its implementation in Oxfordshire during FY17. Access to psychological therapies will be improved by the plans to increase training in psychological interventions for staff in AMHTs. This will allow more staff to offer psychological interventions which will be supervised by psychologist who will be embedded into the teams. Access will be further improved by plans to integrate step 4 psychological services into the AMHTs who will provide expertise, supervision, training and interventions for those who require specialist psychological interventions.

Further adaptions to services are under-development or are being planned to support the current and anticipated activity. These programmes reflect the key priorities in the FYFV for Mental Health such as improving access to psychological therapies (IAPT) for people with long term conditions, providing more integrated physical and mental health services, improving outcomes in secure mental health units and preventing suicide, integrated health and social care pathways to support autism, improving timely access to inpatient mental health services for those who present at A&E, and helping to deliver Integrated Urgent Care to national standards. (See appendices for more information of response to national requirements).

The number of Out of Area Treatments (OATs) has increased compared to previous years during 2016/17 with a current cost of over £3m presenting a significant challenge to the trust, and an opportunity to reduce spend and improve patient experience. We know that much of the reason for OATs is that our wards are at fully capacity as we have people who no longer require acute beds, but need supported accommodation and further care. We are exploring ways to develop better patient flow, and deliver the required capacity, through consistent and standardised processes. During 2017 we will undertake the majority of the work to address the OATs challenge. This includes our Right Time, Right Place work programmes, targeted solutions for patients with short stays to remove the need for ward stays, and developing suitable supported housing.

**2.3 Older People**

The Older People Directorate's business plans outline their anticipated activity and required inputs for FY18 and FY19. Cross-system working will be crucial over the next two years to sustain the flow of patients through the health and social care system. Services will move away from a fragmented approach to development, often driven by specific cost pressures or condition-specific interventions, to a shared set of

priorities around pathway redesign. This will be based on OHFTs strategic principle of making care a joint endeavour with patients and carers, through a multidisciplinary approach.

The approach to activity planning in the Older People's directorate is based on the following areas: Rebasing activity on the Oxfordshire contract (contains majority of the demand & cost pressures); Implementing the next phases of the productivity and skill mix projects within Podiatry, CTS and Urgent Care services, based on demand and capacity modelling work; System-wide transformational change of the community therapies pathway, community nursing, bed-based pathway and the urgent care pathway.

Community health and social care services (including GP practices) will have a significant role to play in extending services closer to home, enabling more patients with more complex needs to be treated closer to home wherever this is clinically appropriate. Our services will be modernised to enable full integration at a locality level and inpatient setting, organised in to population-based multi-disciplinary teams (health, social care and the third sector). Rather than viewing our services in vertical silos we will consider which services should be located at a neighbourhood level (30-50 thousand population), a locality level and at a county level. Each locality will determine and deliver local integrated care across the physical and mental health spectrum within dedicated and block resources. For more information on specific plans, see appendices.

We will develop new initiatives to work with primary care in the development of our long term conditions and the frailty pathway. Further to the work of the Community Nursing Service Review and the findings of the Newton Europe Assessment, we will work closely with OCCG, OUH, OCC and GD Federations to agree principles of joint working and build the platform for OHFT and GP Federations to work together in partnership in primary and community care. Reducing dependency on bed-based care for patients who can be better supported in their own homes is a crucial aspect of the Directorate's strategy. Over the next two years OHFT will participate in a public consultation to determine the longer-term role of community hospitals. This consultation will be rooted in three key principles: achieving optimum clinical outputs for patients, ensuring deliverability regarding our workforce and estates in line with demographic changes, and offering the greatest financial efficiency across the health and social care system. Recruiting and retaining our workforce presents a significant challenge to the Older People's directorate, and will require the development of innovative approaches. For further information, see Workforce section.

## 3.0 Quality Planning

### 3.1 Approach to Quality Improvement

In September 2016 the trust board approved the establishment of the Oxford Centre for Quality and Safety. This will include an improvement faculty, which will utilise the resources from the Improvement and Innovation Team and Safer Care Team. The Centre for Quality and Safety Improvement will support teams to improve the safety and quality of care they provide and is being developed for FY18 and beyond. Partners of the Centre will include patients; Institute for Health Improvement; Oxford Universities Hospital NHS FT; NHS Elect; University of Oxford; Oxford Brookes University; Said Business School; and the South of England Mental Health Collaborative. The methodology adopted is rooted in the Institute for Health Improvement (IHI) Method for Improvement and the adoption of measurement for improvement techniques. Measurement will be at the heart of the work led by the Quality Centre to ensure a focus on impact and outcomes. New approaches are also being developed such as an innovative shadow board scheme, comprised of clinical staff, to develop new ways of approaching specific efficiency challenges, decisions making, and to develop leadership.

Since the publication of the independent report into the investigation of deaths at Southern Health Trust by Mazars, Oxford Health NHS Foundation Trust promptly undertook its own self-assessment of its mortality processes. This was with a view to understand: where it might need to improve arrangements for

investigating and learning from deaths; examine the setting up a Mortality Review Group and to identify priorities for future focus. The Trust is reviewing its priorities and processes in the context of the report's findings and recommendations.

**3.2 Capacity, Capability & Sustainability of Quality Improvement**

OHFT will continue to build quality improvement plans and monitor them through OHFT's detailed Quality Accounts. In our Quality Account 2016/17 we described four quality priorities for the year aligned to our overarching 7 strategic priorities, which were developed in previous years through discussion with our clinical Directorates, our Governors, commissioners, and Healthwatch. (Summary of quality improvement plans in the appendices).

**3.3 CQC**

Since the Care Quality Commission (CQC) inspection in September 2015, the CQC revisited OHFT. The outcome of the CQC re-inspection of our three core mental health services, resulted in the trust being awarded an overall 'good' rating with two core services rated as 'outstanding', twelve are rated as 'good', and one 'requires improvement' which was not re-inspected. Internal progress with the improvement plans are monitored through an action plan review group. A peer review programme reviews the outcomes of the actions. For specific plans around community hospitals, see appendices.

**3.4 Quality Improvement Governance**

OHFT has 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). A core part of our plan is to make care a joint endeavour with patients, families, and carers. In April 2016 a new Patient & Carer Involvement Strategy was approved by the trust board. The aims of the new three year strategy are to:

**i)** Develop a culture which encourages, supports and develops effective partnerships between people who use OHFT services and their carers/ families and professionals,

**ii)** Improve the experiences of people who use services and their carers/ families, and

**iii)** Improve the opportunities of how people are involved to identify issues and actions to improve services.

**3.5 Quality Measurement**

Measuring quality at OHFT is achieved through developing and monitoring relevant performance measures in combination with qualitative narrative reporting impact within services. OHFT is adopting statistical

process control methodologies described in the NHS Quality Improvement Toolkit to ensure effective monitoring or quality over time, exploring trends, and a detailed understanding of how quality is impacted by our internal and external operating environment. Measures include local and national data returns include those in the Five Year Forward View for Mental Health Dashboard. In the last two quarters of FY17 and at the time of this report, OHFT is undergoing a review of its approach to performance measurement across directorates. A reorganised and centralised performance team will be in place for FY18 onwards to monitor service delivery, and contracts.

**3.6 Summary of quality impact assessment process**

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. The Programme Management Office (PMO) with a dedicated Cost Improvement Programme Manager coordinates the process and oversees the development and delivery of plans including assessment for strategic fit, ease of implementation, risk exposure, clinical and quality assurance and financial value. The Trust has a clear monthly process for reporting CIP development and delivery into the monthly Board of Directors through a framework that sets out key roles and responsibilities, terms of references and reporting timescales.

Each project is required to develop and submit a project brief that outlines 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. Successful delivery of transformations requires a high level of support, leadership and engagement across the Trust. 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 relatively high efficiency and the challenges it has experienced in delivering high levels of CIP the Board of Directors chose to set a challenging target of £6.5m in FY17. The trust expects the FY18 & FY19 targets to be exceptionally challenging at **£7.4m in FY18** and **£6m in FY19**.

During 2017, Operational Directorates' support functions will be restructured and centralised (to include Service Change, Contracting, and Performance and Information functions). This will enable refinement and consistent reporting from front line services at team level through to the Board of Directors and Council of Governors. We will streamline processes between directorates for the initiation, management and benefits realisation work, to ensure work across the organisation is appropriately prioritised, resourced, delivered and measured.

### 3.7 Triangulation of Quality with Workforce and Finance

OHFT has set out 7 strategic priorities, to which our business plans can be aligned:

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

These priorities enable progress of business plans to be reported to the Board of Directors quarterly against each of these strategic priorities and provide an indication of what we are doing to deliver them through a narrative and KPIs aggregated at directorate and service level performance. We are proactively seeking ways to improve reporting of information throughout the organisation and are looking to build a framework that is scalable, concise and enables clear demonstration of how workforce, activity, and finance collectively impact performance. The further development of service line reporting will be embedded in services in FY18 supporting this work. Monthly performance reports have been redesigned and trialled with the Adults directorate with the intention to refine the detail and content further, expanding to our Children and Young People, and Older People's directorate for FY18.

We develop our business plans through a 'top down' and 'bottom up' approach. The strategic priorities representing the 'top down' element. The planning process is 'bottom-up' to support the development of team and individual objectives designed to deliver the Trust's strategy. Each Directorate is required to complete a business plan template and submit it to the PMO. These typically feed into our operational plans submitted to external regulators. From FY17, due to altered timeframes, we are reviewing the timeline for developing business plans.

### 4.0 Workforce Planning

Oxford health faces a growing workforce challenge, facing a high number of vacancies; increasing turnover and growing agency spend like many other trusts. There is a risk that services may become unsafe and financially unsustainable. Among our directorates Older People, is the most challenged with the highest number of vacancies, and then the Adults directorate. There are very significant vacancies in Nursing (Bands 5 & 6) as well as in Bands 1-4.

### 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 had been successful in a bid for support to develop this analysis for a period of time and employed additional resource to develop workforce plans but this funding ended in

September 2016. The senior HR team will continue to link with key strategies developed in the trust such as the System Workforce Group and its associated work streams.

The HR Directorate is 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. A new HR Director has now been appointed and commenced work within the trust.

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) and includes programmes to develop Values Based Recruitment through defining the values of specific groups of staff and a revised and renewed Performance & Development Review which also makes more use of exit interview data to develop a better understanding of the staff retention challenge. The strategy document details internal and external forces on workforce associated with national skills shortages and national and local economics. The Trust Board has sharpened its focus on these issues that have created risk around recruitment and retention of staff and will use this information to drive leadership across the trust to address this challenge.

The Recruitment Team proactively work with managers to develop local plans to fill "hard to fill" vacancies. Examples include open days for district nursing and targeted advertising. There will be further developments to address the workforce challenges over the next two years, balancing the need to develop OHFT's workforce while meeting the ever constant need for efficiency and transforming services in preparedness for the future and delivering the trust's strategic priority 5: *"To ensure Oxford Health NHS FT is high performing and financially viable"*. See Quality and Finance sections for how this risk is managed.

**4.2 Local Workforce Transformation Programmes and Productivity schemes**

In November 2015 the Health Education England Thames Valley (HEE TV) 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 capacity and capability planning. The transformation programme steering groups are developing workforce transformations that reflect the wider transformations 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 and delivery of STPs.

**4.3 E-rostering and Agency Staffing**

Rollout of the Workforce Management System (WFMS) has continued in 2016/17 and in April 2016 the Trust disengaged from NHSp (NHS professionals) and implemented a centralised bank for areas on WFMS. As rollout continues, more areas will move onto the centralised bank (Wave 4 commences March 2017 with 1700 staff). By the end of FY17 it is anticipated that approximately 70% of the Trust will be on the WFMS, with the remaining units going live in 2017/18. This has provided the Trust with increased control over temporary staffing as all requests are managed through the centralised bank which ensures appropriate authorisation and cascade of shifts to agencies in line with procedure if necessary. The use of temporary staffing is monitored on a weekly basis by the Executive team; use has increased over the previous year due to higher vacancy levels and labour turnover (see appendix). With improved reporting and engagement with managers we will drive more efficient rostering. Temporary staffing is highest in the Nursing and midwifery staff group. New Trust agency supplier lists have been developed using the Collaborative Procurement Partnership National Framework. We have driven improvements in rostering practice (Top quartile for comparator Trusts), with a focus on Lead time rosters released to staff; Unfilled Shifts & Hours counts. Consideration is also being given to developing a wider second tier bank across STP.

**4.4 Triangulation of Quality and Safety Metrics with Workforce Indicators**

A range of workforce metrics are reviewed on a regular basis including: staff turnover, sickness absence levels, agency and flexible staffing use, vacancy rate and safe staffing reports as well as Health & Wellbeing issues. The "Business Area Review" process involves the HR team reviewing each metric for every service in its Directorate and developing specific 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 also reviewed regularly at senior management team meetings where they are reviewed in consideration of quality and finance measures. 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 to demonstrate whether line managers are taking appropriate actions to address staffing issues. An in-house recruitment system is being rolled out during the latter part of 2016 and this will improve the efficiency by automating some processes and allow greater ability to identify delays.

Triangulation of data is undertaken weekly, which addresses safety related incidents and complaints with HR 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 2016 a proposal was made for the Trust to consider an Employee Assistance Programme to address stress related conditions and hopefully reduce sickness absence.

**4.5 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. A new agency supplier list is being established for all medical and clinical staffing groups using the CPP National Framework. 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. The maturation of the e-rostering system and the introduction of the centralised bank where implemented has strengthened the Trust's ability to manage staff effectively and provided additional controls regarding agency use. This implementation is continuing with the whole Trust anticipated to be live by the end of 2017/18.

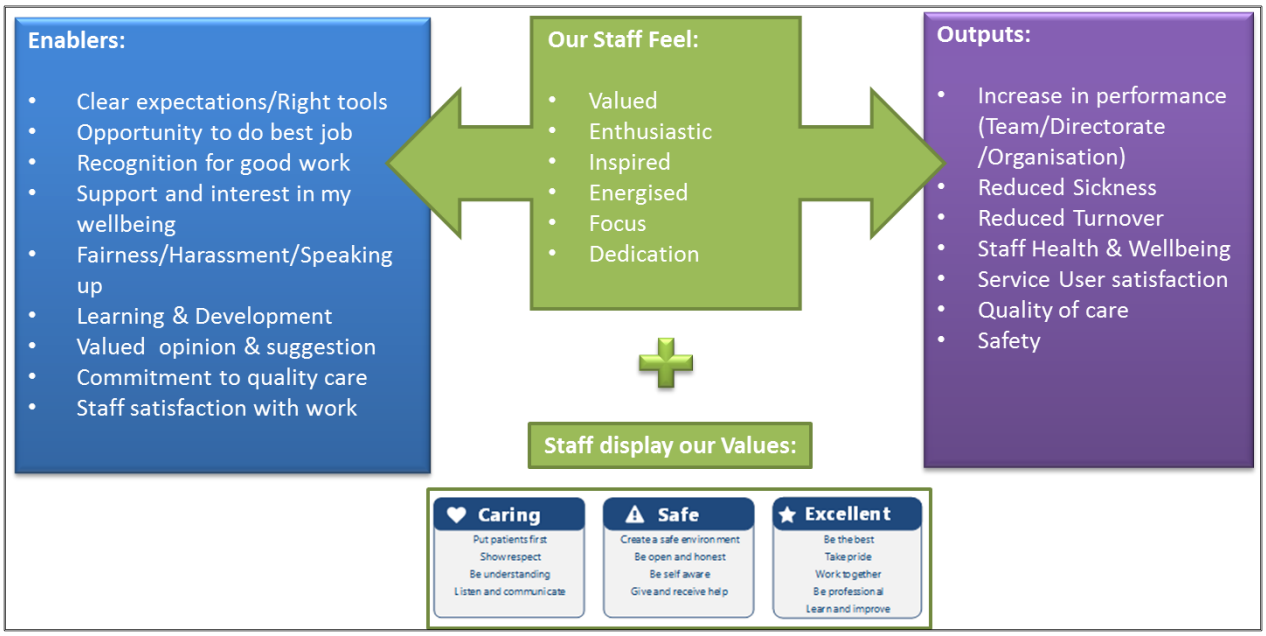
**4.6 Systems to Regularly Review and Address Workforce Risk Areas**

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.

**4.7 Retaining and Engaging with our Workforce**

Within the Trust Workforce Strategy there is a focus on Retaining and Engaging our staff. We describe our engagement goals as creating an emotional attachment with OHFT, by supporting our employees, giving

them the development and tools they need to do their job, being clear and empowering our employees to be the best they can be. We have identified nine enablers that focus on areas where practical action(s) can be taken to influence how our employees feel, that have an effect on performance, quality and safety. The model below shows the link between the nine enablers, how our employees feel and recognised outputs:




The national NHS Staff Survey provides a wealth of data which we use to help shape our approach to people management. We use the data alongside the Staff Friends and Family Test (Staff FFT), a locally designed survey (pulse check) and workforce information such as Turnover, Absence Figures, Vacancies and Temporary staffing usage.

Alongside this, we also have in place a Health & Wellbeing Action Group sponsored by a Board Executive with membership from across the organisation. This group have created an action plan based upon feedback from staff via various sources and workforce information which focuses on Physical, Psychological and Organisational wellbeing. There is a dedicated Health & Wellbeing Co-Ordinator and we have a network of over forty Wellbeing Champions who run local initiatives and support the work of the group.

### 4.8 Workforce & Service Development Plans

As a general rule we do not increase staffing for activity growth, as it is assumed this will be dealt with through productivity improvements. Only significant service developments are typically captured in our workforce returns. One such development is the development of our plans to potential provide Oxfordshire Learning Disabilities services from FY18. From October 2016 to March 2017, we have been devising a new model which includes additional staff. The basis for the staff costs is the current team establishment as provided by SHFT. Additional staff have been included to mitigate risks identified during the quality due diligence process and increase capacity to reduce waiting times & meet demand (see appendices for staffing detail). An additional manager will be required to manage the bed based fund (6 beds) as this was previously managed under the assessment and treatment in Ridgeway, to manage step down and to oversee the forensic pathway development in Oxfordshire as this is the likely most transformational component of the contract.

## 5.0 Approach to Financial Planning

OHFT is facing a challenging financial future. We know that the NHS will continue to be faced with a national efficiency target of 2% per annum leading directly to reductions in income for existing contracts

each year. With the majority of our services under block contracts, there is no allowance for increasing income for the expected continued increases in activity which consequently puts 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 disproportionately by the non-acute service providers who do not benefit from PbR at the national rate

It is recognised in the Mental Health 5 Year Forward View published by NHS England that there has been underinvestment in mental health services for a number of years: with 70% of our revenue derived from mental health services the impact of underinvestment on maintaining financial sustainability is material. Even when there has been an increase to the CCG allocations the block contracts struggle to attract a proportionate increase. In the year 2016/17 Oxfordshire Clinical Commissioning Group (CCG) received an increase in year on year allocations at £49.7m (7.3% increase). OHFT, although the contract has yet to be signed, has been offered an increase of less than 2%. This exacerbates an already challenging situation.

For 2017/18 Oxfordshire Clinical Commissioning Group (CCG) will receive an increase in year on year allocations of 2.0% increase compared to 2016/17. The two CCGs in Buckinghamshire, our other major CCGs, also received an increase in year on year allocations; Aylesbury Vale a 2.37% increase and Chiltern CCG a 2.21% increase compared to 2016/17.

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 increasingly difficult. The relatively high level of efficiency already achieved by OHFT (national reference cost of 94 in 20156, 6% more efficient than the average Trust) makes the delivery of CIPs to the level required to offset the national efficiency target extremely challenging and, when combined with the low levels of income received, results in the benefit not being realised in the bottom line.

Improving efficiency and productivity whilst maintaining high standards of quality continues to be a priority for OHFT. In recent years, we invested our own money in remodelling our services to improve integration, local access to high quality care and 7-day working, however, any 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 (STPs) 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**

The development of the FY17 Financial plan looked beyond FY17 and into later years in order to develop a financially sustainable plan. The plan set out how OHFT would, in the overall context of low funding for our services, achieve financial sustainability in the longer term and with the immediate aim of maintaining cash balances to remain a viable going concern and the longer term aim of returning to breakeven and a Financial Use of Resources Rating of 2.

This approach has been extended in FY18 and the Trust's FY18-19 two year financial plan forms an integral part of the OHFT's overall planning process, including development of the OHFT Business plan. It has also been developed in the wider context of the development of the Buckinghamshire-Oxfordshire-Berkshire Sustainability and Transformation Plan (BOB STP) which looks beyond FY18 to FY21 in order to develop a financially sustainable health system. The BOB STP identifies an annual financial gap of £479m by the year 2020/21 for the footprint if no action is taken; this gap can be largely accounted for by growth in demand and complexity. The usual approach to efficiency and cost improvement will not be sufficient to close the whole gap; something more transformational and system-wide will be required in addition. OHFT is fully

engaged with the collaborative initiatives being developed within the BOB STP and with the appropriate funding is confident that it can contribute significantly to delivering the required improvements in productivity necessary to close the financial gap.

**5.2 FY17 Financial Forecast**

The OHFT plan for FY17 is a deficit of £0.6m, after receipt of £2.0m of Strategic Transformation funding. This is against the Trust's Control Total of £1.5m deficit. At month 8 the reported position is a £0.6m surplus. The Trust is experiencing a number of significant operational pressures and is forecasting a £1.6m shortfall against its CIP target, partly offset by underspends in non-clinical and trading areas. The Trust started the year with £4.3m of contingency reserves; £2.0m of this has been released to support the half year position and it is expected the remaining £2.3m of contingency will be required to cover pressures for the remainder of the year. Recovery plans have been implemented to address key operational pressures and a detailed mid-year financial review has been undertaken which has identified further actions. Progress against these actions and recovery plans is being monitored at monthly financial review meetings with Service Directorates. Based on the mid-year review and actions being taken, the year-end forecast remains in line with the planned deficit of £0.6m.

| | Plan | Forecast |
|---|---|---|
| EBITDA | | 11.7 |
| I&E Surplus/(Deficit) | (0.6m) | (£0.6m) |
| CIP | £6.5m | £5.0m |
| Cash Balance (year-end) | £11.5m | £11.5m |
| Capital Expenditure | £6.7m | £6.7m |
| FSRR | 3 | 3 |
| UoR | 2 | 3 |

**5.3 Original Plan FY18-FY19**

OHFT's original draft financial plan for FY18-FY19 was developed as part of the FY17 planning round, in the context of the Trust's Financial Sustainability Plan with the aim of returning the Trust to break-even in FY19. This plan was reviewed by Monitor following investigation into the deficit financial position of OHFT in 2015. A summary of the key financial metrics is shown in this table, and showed an anticipated return to a break-even position in FY19.

| | Original Plan FY18 | Original Plan FY19 |
|---|---|---|
| EBITDA | £11.5m | £12.5m |
| I&E Surplus/(Deficit) | (1.0m) | - |
| CIP | £6.8m | £7.0m |
| Cash Balance (year-end) | £12.3m | £13.2m |
| Capital Expenditure | £5.0m | £5.0m |

**5.4 Changes 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 updated to reflect the following key changes:

- FY17 forecast outturn position including the recurrent CIP peformance;
- National planning metrics for inflation and efficiency;
- Notified Control Totals and Strategic Transformation funding;
- Known significant contract changes;
- Significant service developments;
- Anticipated capital investment and capital receipts.

**5.5 Key financial plan assumptions**

The FY18-FY19 draft plan was submitted to NHS Improvements on 24 November 2016. The final plan is unchanged from the submitted draft plan and includes the following assumptions:

*Control Totals (see section below)*

- The OHFT Control Total is accepted for FY18 and set and accepted within the NHSI rules for FY19;
- Strategic Transformation funding of £1.9m is assumed in FY18 and FY19;

*Income*

- Clinical income increases by £52m in FY18 mainly due to the transfer of Learning Disability services from Southern Health (£7.8m) and Forensic services, New Models of Care (£42.3m) and
- An additional revenue contribution of £2.5m in FY18 from additional income secured through contract negotiations with commissioners and that the new Oxfordshire Rapid Access Care Unit (RACU) service will be fully funded (£1.4m) by the CCG. No additional revenue benefit is assumed in FY19;
- Contract changes reflected include the full year effect of loss of reablement contract in FY17 and the anticipated loss of dental contracts in FY18 £0.2m contribution. It is assumed that any other potential contracts lost are replaced with new contracts won at same level of contribution;

*Expenditure*

- Inflation uplifts applied as follows:

| | **FY18** | **FY19** | |
|---|---|---|---|
| Pay | 1.5% | 1.2% | to cover national pay awards assumed at 1% and annual increments |
| Drugs | 4.5% | 4.5% | initially taken to contingency reserves |
| Non-pay (other) | 1.2% | 1.9% | this represents the balance of the total 2.1% uplift, this is not allocated to budgets but is taken to contingency reserves |

- The Apprentice levy will be applied to the Trust in accordance with national rules (0.5% gross pay costs) at an annual cost of £0.9m in FY18;
- The agency ceiling notified by NHS Improvements is £9.1m for FY18 and FY19 (in line with OHFT's FY17 ceiling). The Trust is taking a number of actions to reduce agency spend (see below) but is forecasting to exceed its agency ceiling in FY17 and FY18;

*Cost Improvement Programme*

- CIP target of £7.4m in FY18 and £6.0m in FY19;
- The plan reflects the impact of a recurrent CIP shortfall of £3.1m against the FY17 target;

*Service Developments*

- No significant self-investments in service developments;
- Learning Disability services: will transfer to OHFT from Southern Health in FY18, increasing income by c. £7.8m with an assumed revenue contribution of £0.6m;
- New Models of Care: funding for forensic services, which will transfer to OHFT from NHS England in FY18, increasing income by £42.3m; assumed nil revenue contribution (pass-through) on transfer to OHFT in FY18;

*Contingency Reserve*

- Contingency reserve of £3.5m, in accordance with the Trust's Budgetary Control Policy which requires a 1% contingency to be held at the start of the year;

*Capital and Cash*

- Capital investment of £5.0m in FY18 and £9.0m in FY19;
- Capital receipts of £0.4m in FY18 in relation to asset disposals, nil receipt sin FY19;
- No significant changes to working capital.

**5.6 Control Totals and STF**

OHFT has been notified of the following Control Totals and associated Strategic Transformation funding:

| £m | FY17 | FY18 | FY19 |
|---|---|---|---|
| Control Total | 1.5 deficit | 1.9 surplus | 5.0 surplus |
| SFT | 2.0 | 1.9 | 1.9 |

Since the original control totals were notified, NHSI has changed the control total for FY19 such that OHFT can set it subject to it being at least a breakeven position before receipt of £1.9m STF funding. OHFT will accept the Control Total of £1.9m surplus for FY18 and we are forecasting the Trust will achieve its Control Total of £1.5m deficit in FY17. On this basis OHFT has set its FY19 control total at £1.9m surplus, as FY18, and Strategic Transformation funding of £1.9m has been included in each of the years FY18 and FY19.

**5.7 Agency costs**

OHFT has been notified of the following ceilings for agency spend:

| £m | FY17 | FY18 | FY19 |
|---|---|---|---|
| Agency ceiling | £9.1 | £9.1 | £9.1 |

Temporary Staffing spend within the Trust continues to be a challenge as recruitment is a particularly difficult due to the Trust's close proximity to London. Forecast spend in FY17 is £15.0m and actions being taken are expected to reduce spend in FY18 to £11.6m with the aim of reducing spend within the ceiling of £9.1m in FY19. In summary, actions being taken include:

- Understand and reduce labour turnover;
- Improve the recruitment process and attraction of Oxford Health recruitment;
- Improve rostering and minimise the use of temporary staffing;
- Implementation of a new Workforce Management System and centralised Bank;
- Implementation of improved pay rates for Substantive Flexible Workers;
- Review of Pure Flexible Worker pay rates;
- Renegotiation of Trust agency framework based on CPP National Framework;

**5.8 Capital Programme**

Capital investment is assumed at £5m in FY18 and £5m in FY19, funded through internally generated cash from operations and £0.4m of capital receipts from asset disposals in FY18.

To ensure that the Trust invests its capital appropriately, and to ensure the effective management of risks associated with the built environment, planned capital expenditure is allocated based upon an assessment of risk. Risks resulting from the condition/functionality of the built environment are identified and graded using the 5 x 5 risk rating system. All graded risks are added to the Trust's Risk Assessed Work Plan. This plan is used to allocate capital expenditure based upon the risk scores identified. In order to ensure that the risk scores assigned are robust and reasonable the risks on the Risk assessed Work Plan and reviewed by the Risk assessed work plan group, which is a multi- disciplinary group, including clinical, estates, and health and safety professionals.

IT related investment is considered by the IT Strategy Group who review ongoing and ad hoc investment requirements annually and at periodic stages throughout the year. This will include the routine replacement and upgrade of infrastructure, such as laptops and servers, as well as licensing requirements and strategic system replacements.

The draft capital outlining the proposed investment that the group consider should be funded is produced for consideration by the Capital Programme Sub-Committee (CPSC) for approval. The capital programme is then submitted to the Finance and Investment Committee and the Trust Board for approval.

It is recognised that during the year additional risks and issues will be identified, and all new risks are reviewed by the risk assessed work plan group. The group considers all new risks and assesses if the risks should be addressed in year. All new risks together with the risk assessed work plans recommendations/next steps are shared with the Service Directors so they are aware of issues that may impact upon their services. Should the rawp group feel that risks need mitigating in year reports requesting additional funding /or reallocation of funding are issued to CPSC.

**5.9 Financial Plan metrics**

Based on the above assumptions, the key financial metrics for the FY18 and FY19 financial plan are as follows:

| | **Plan FY18** | **Plan FY19** |
|---|---|---|
| **EBITDA** | **£14.3m** | **£14.3m** |
| *EBITDA margin* | *4.0%* | *4.0%* |
| **I&E Surplus/(Deficit)** | **£1.8m** | **£1.8m** |
| *I&E Surplus margin* | 0.5% | *0.5%* |
| **CIP** | **£7.4m** | **£6.0m** |
| Cash Balance at year-end | £14.2m | £13.5m |
| **Capital Expenditure** | **£5.0m** | **£9.0m** |
| Use of Resources rating | 2 | 2 |

*Note: OHFT is projecting a bottom line surplus of £1.8m in both FY18 and FY19; the adjusted financial performance after removing depreciation on capital donations (£72k FY18 and £79k FY19) would be £1.9m in each year, in line with the control totals.*

The FY18 plan is fundamentally determined by the following two key elements:

- CIP of £7.4m (2.5% of cost).
- Additional revenue contribution of £2.5m.

In summary, the plan is highly challenging and requires a total benefit of £9.9m to be achieved through a combination of efficiency improvements and contribution from additional revenue. OHFT's Budgetary Control Policy sets a minimum contingency reserve requirement of 1%, which equates to approximately £3.5m, and the plan is set to allow for this required level of contingency. The level of CIP is challenging and the risks attached to achieving additional revenue contribution may result in having to achieve a higher level.

The Trust's relatively low RCI, combined with the historically low revenue allocation to OHFT contracts, increasing activity, and the increasing complexity of conditions supports the Trust's argument to secure additional revenue contribution from commissioners. 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. Experience suggests the risk of not achieving this level of increased revenue is high; hence any shortfall on additional revenue contribution is an added burden to the CIP requirement with a worst case of £10m.

**5.10 Efficiency savings for 2017/18 to 2018/19**

### 5.10.1 Efficiency Savings Development and Delivery

The main focus for CIP development for FY18 so far has been within the operational directorates. A series of confirm and challenge workshops with each directorate has been held to review and scrutinise CIP opportunities for FY18. Each confirm and challenge session has had an executive panel consisting of Director of Nursing, Medical Director, Chief Operating Officer and Director of Finance as well as PMO representation. We will be holding further sessions with corporate colleagues in January; this coupled with our recent corporate benchmarking returns will help to shape the FY17 programme. Following on from these workshops, we are launching our annual Business Planning process in January. This will give us a bottom up opportunity to capture CIP initiatives for next year, each project that will form part of the cost improvement programme will require a project brief which includes critical milestones, phased savings and a quality impact assessment (QIA). CIP schemes are currently under further development and have been scrutinised by the CIP delivery group and an executive panel in December 2016. Significant schemes include:

Proposals for OHFT to become lead provider of Forensic Low and Medium secure services in Thames Valley and Wessex have been developed. Work is progressing well with NHSE and principles have been agreed for our New Model of Care arrangement. Savings will be realised through repatriating out of area placements where possible, better gatekeeping and in year 2 by partnering with a voluntary sector organisation to setup a supported living facility and in the short term these savings will be re-invested in further improvement of the new models and improving quality. We are currently exploring other opportunities regarding New Models of Care and will be hoping to replicate this piece of work in out Tier 4 CAMHS and/or Eating Disorders services.

During the summer of 2017, there is a consultation planned in Oxfordshire regarding the sustainable development of services for people with long term conditions, and frail and elderly. This includes considering what local community services integrated with primary care and social care and what community hospitals are required. Subject to this there is an opportunity to consolidate and rationalise beds resulting not only in a reduced footprint also brings with it some economies of scale in areas such as staffing.

Work has commenced to centralise project, performance and contracting functions, the majority of this resource currently sits within directorates but through centralising we hope to achieve consistency in processes, shared learning and a reduction in WTE.

OHFT will continue to review and rationalise the estate that it operates in and we have identified a significant move that will realise savings in FY18, however we now feel that we are close to critical mass regarding our current portfolio of estate.

### 5.10.2 Efficiency Savings Arising from STP processes

The STP plan remains unpublished and providers within the BOB footprint are working together to find opportunities for collaboration or consolidation that deliver further efficiencies. These include identifying opportunities in administrative or corporate functions. There are also opportunities to develop region wide services e.g. perinatal mental health or veteran services.

Opportunities across the entire footprint to work more closely with General Practice and the acute trusts to improve out of hospital care for people with long term conditions urgent care needs and frail & elderly people are under development. Finally, new care models for low and medium secure forensic service for the Thames valley and Wessex area are under development working with NHS provider partners, providers from the voluntary sector, providers from the independent sector and NHS England specialised commissioning. If

successful OHFT in collaboration with others will consider developing new care models for T4 child and adolescent mental health and eating disorders.

**5.11 Capital Investment and cash**

Planned investment is mainly limited to compliance of estate to ensure that clinical services are provided in a safe and appropriate environment, as well as some investment required to rationalise the estate as part of the Trust's cost improvement programme. Investment will be prioritised according assessed risk of the relative service areas. There is no planned investment in new estate to replace part any older parts of the estate, 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;
- 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.

Capital receipts of £0.4m are planned in FY18 in relation to the disposal of a property at Hill Top Road. No capital receipts are anticipated in FY19.

Cash continues to remain relatively strong and cash balances are forecast to be £14.2m at the end of FY18 and £13.5m at the end of FY19. This includes the final stage payment of £1.6m in relation to the disposal of surplus land at the former Manor site in FY17. There are no anticipated significant movements in working capital.

**5.12 Risks and Opportunities**

Apart from the challenging economic environment within which the Trust continues to operate, the main risks facing the Trust during FY18 include:

- FY17 outturn is worse than the current forecast;
- FY17 recurrent CIP delivery is lower than currently forecast;
- the requirement for the continued delivery of significant efficiency savings;
- development and delivery of the required level of CIPs, especially delays due to system-wide working;
- securing additional revenue contribution of £2.5m from our commissioners in FY18;
- ongoing cost pressures in relation to agency staff, out of area treatments and drugs costs;
- the inability to flex resource to demand in a timely manner for cost & volume contracts;
- achieving the planned level of contribution from Learning Disability services transferred to the Trust in FY18.

Key opportunities include:

- FY17 outturn (recurrent position) is better than the current forecast;
- Actual inflationary pressures may be lower than the uplift assumed in the draft plan;
- CIP achievement above target;
- Revenue contribution negotiated with commissioners may exceed the planned £2.5m;
- Improved performance of cost per case activity;
- The achievement of revenue contribution from the forensics services transferred to the Trust in relation to New Models of Care developed.

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 local sustainability and transformation plan**

OHFT is part of a number of STPs but the majority of this plan is relevant for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP. The BOB footprint consists of 3 distinct local health and care economies with a total population of 1.8m and a total place-based allocation for 2016/17 of £2.55bn. BOB is 1 of 44 STPs that are intended to address the following 3 gaps:

1. **Health and Wellbeing** due to:
   - Increasing demand for services, particularly for over 75s and people with complex conditions.
   - Pockets of deprivation which are difficult to overcome.
   - Population growth faster than expected because of significant increased new housing.

2. **Care and Quality** due to:
   - Community hospital buildings which require repair and are not fit to meet the needs of now and future populations.
   - Variable access to specialised services including cancer and interventional cardiology treatments.
   - Difficulty in recruiting and retaining staff due to the high cost of living, leading to unsustainable services and poor performance.
   - Fragmented and poorly coordinated specialist mental health services resulting in high levels of out of area treatments.

3. **Financial**
   - If we carry on as we are without significant transformation there will be a financial gap of £479m by 2021.

It is led by David Smith (Accountable Officer for Oxfordshire CCG) and within each county there are established system leadership groups to lead and coordinate the transformation work:

- Buckinghamshire Health Leaders.
- Oxfordshire Transformation Board.
- Berkshire West Integration Board.

The key partners of the BOB STP include 7 CCGs, NHS England, Buckinghamshire Healthcare Trust, Oxford Health NHS FT, Oxford University Hospitals NHS FT, Royal Berkshire FT, South Central Ambulances FT, GP Federations and 14 local authorities. Other interested and involved parties include the Oxford AHSN, Health Education Thames Valley, Thames Valley Clinical Senate, Strategic Clinical Networks, Thames Valley Urgent and Emergency Care Network, Thames Valley and Wessex Leadership Academy and the Oxford CLAHRC.

BOB has established 7 Priorities (with 8 workstreams and projects beneath them designed to deliver):

1. **Prevent ill health**, with a particular focus on obesity to reduce demand for services over the medium to long term.
2. **Standardise access to urgent care** so a range of well-informed clinicians can safely diagnose and prescribe treatment while minimising the number of duplicated consultations a patient receives. This will release GP time so they can work together at scale, become more integrated with community services operating out of community hubs and focus on people with more complex conditions. GPs will also be able to call on an increased number of home carers to enable more people to be cared for in their own homes rather than being sent to hospital.

3. **Improve our workforce offer and increase staff retention** by working with Trusts and Health Education England to improve recruitment, standardise terms and conditions and offer employees interesting rotational opportunities.
4. **Provide digital solutions for self-care**, virtual consultations and interoperability to increase patients' access to information and reduce duplication and travel.
5. **Increase efficiency by commissioning, where appropriate, at scale** across the BOB geography. For example, by co-commissioning specialised services with NHS England to identify alternative pathways of care.
6. **Centralise back office functions to deliver savings** by procuring at scale for example using the Shelford Group framework.
7. **Undertake meaningful engagement and consultation** activity on services, such as those at the Horton Hospital in Banbury to help inform decisions on the commissioning of future services.

The financial challenge is significant and by 2020/21 £2.87bn funding allocation across Buckinghamshire, Oxfordshire and Berkshire West represents a 12% increase ***but*** expenditure is growing at a faster rate than the increase in our funding.

If we do nothing different, rising costs, inflation and demand on the NHS will lead to a **gap of £479m** by the end of 2020/21. But we expect our plans to create a relatively small surplus of £11m, as follows:

| | | |
|---|---|---|
| **Efficiency savings** | Asking organisations providing NHS services to become 2% more efficient each year | £213m |
| **Delivering services in different and more cost effective ways** | Local transformational changes and finding better ways to reduce growth in the need for services | £88m |
| **Maximising the benefits of working at scale** | Working at scale across the BOB area to transform services | £83m |
| **National Sustainability and Transformation Funding** | Using additional national transformational funding, which has been allocated for use in our area in 2020/21. | £106m |

Within the STP, and BOB footprint, OHFT is developing several key strategic transformational programmes for delivery over the next two years. (These are outlined in appendices.)

**7.0 Membership and Elections**

The Trust recognises through experience that there is significant organisational gain to be had from seeking people's insights on healthcare, and it is through our membership alongside a Community Involvement Framework that we will aim to supplement our understanding of 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 set out to maintain an accurate and informative membership database to support effective communications and engagement to enable smarter working and analytical capability such that segmentation of member interests can be developed to meaningfully drive and target activity going forwards.

The Trust website continues to be enhanced to develop a people focussed orientation, with user-friendly navigation and accessibility on mobile devices such as smartphones and tablets. Its ongoing development now involves a wider range of stakeholders. Trust social media channels including Facebook, Twitter,

YouTube and LinkedIn have proved successful with a substantial increase in the use of interactive communications, video and partnership working on campaigns and initiatives attracting greater audiences supporting our aim to listen, learn, respond & improve. Events to support wider engagement have included support from the Oxfordshire Mental Health Partnership and other partners, Health Matters talks on key health issues which we intend to increase in FY18, as well as our AGM and Staff Recognition Awards. Successful governor elections have been run across constituencies, using innovative online election material and voting. All vacant seats were appointed to and a good number of seats were contested. For the staff constituency, regular Linking Leaders conferences continued across all counties to support delivery of effective patient care, organisational learning and improvement. A campaign to recruit governors was launched in February 2016 in preparation for the governor elections, driven by a campaign to raise awareness of the elections and included aspirant governor evenings which were well attended. The election process was administered by the Electoral Reform Services (ERS). A governor development day was held on completion of the elections to provide for induction of new governors. Building on the successes of the last elections, we will adopt the same process for impending elections for FY18 developing the induction process to accord with the ever changing environment within which the Trust operates.

Training to new and existing governors has been delivered in FY17 through a newly launched Training and Development programme with the opportunity to also attend targeted training offered by NHS providers. All sessions delivered have positive appraisal by our attending governors and we will continue to develop this ongoing programme to meet the needs of our Council. Our plans for FY18 will enhance opportunities to deliver engagement between governors and membership to enable our Governors to meaningfully get closer to the needs of their constituents and to the realities of the patients' and service users' experiences of care at the Trust.

Over the next 12 months, following the appointment in October 16 of a new lead for membership involvement and engagement, 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 including a program of Health Matters membership events throughout the year and increased collaboration with Oxford Health directorates and the third sector. Through implementation of our Community Involvement Framework and through alignment of priorities for both patient involvement/participation and membership engagement, we will involve all stakeholders locally and regionally in a positive and rewarding – mutually beneficial - relationship with the Trust's charity and a new volunteer services function.

With strategies for Patient Involvement and Experience, 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.

## Appendix

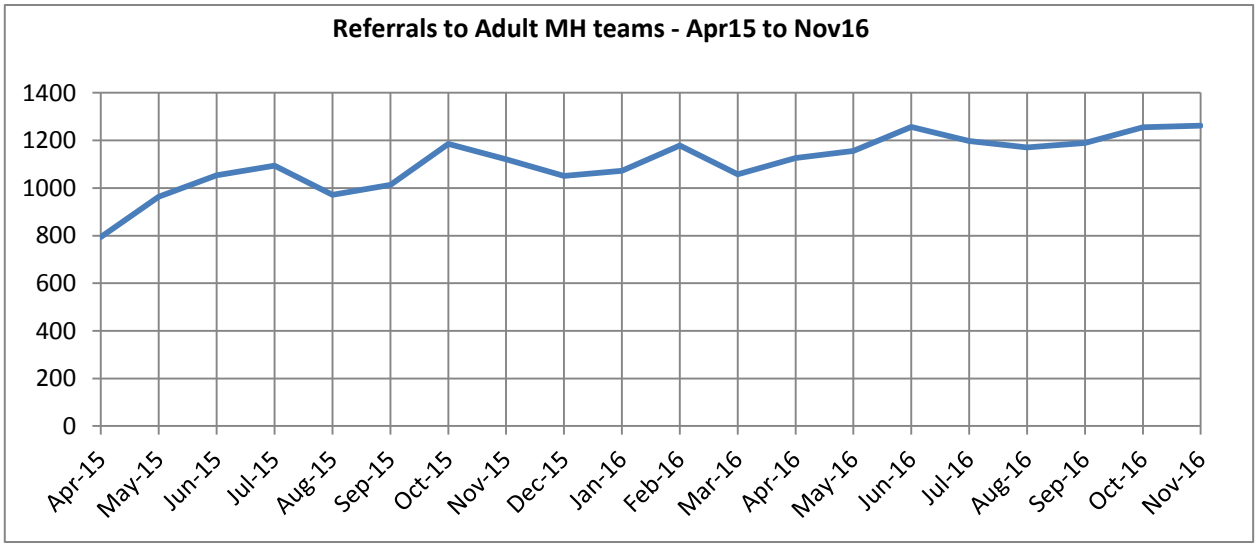
### A. Activity Planning – Children and Young People Activity Plans

We have developed a young-person friendly website for Buckinghamshire CAMHS with new content being developed for FY18. In collaboration with the CCG, we have also identified need within the neurodevelopmental pathway (ASD & ADHD).

We currently deliver Speech and language therapy, this contract will cease at the end of the financial year. In Buckinghamshire we have observed 16% increase of referrals from FY16 (Oct to Nov) to FY17 (Oct to Nov). The aim is to replace the service with an integrated model, providing Physiotherapy, occupational therapy and speech and language therapy from one single service. This will increase our activity in that we will be seeing all children with a therapy need across Buckinghamshire.

### B. Activity Planning - Adults Mental Health Activity trends

OHFTs Adult Mental Health Team referrals are monitored over time, to support forecasting of anticipated trends, incorporating local and regional forces on the local demography.




### C. Activity Planning - Adults

We have aligned teams working across 24/7 timeframe to assure a shared response. E.g mobile night team, staffing available 24hrs a day including our psychiatric liaison services.

We have won a bid to increase capacity around 136 and calm suite, bid won for both counties, working on the implementation projects now (See place of safety app form). Continued investment in supporting and investing in health based places of safety (HBPOS) for vulnerable individuals remains a key priority for our organisation in partnership with all agencies signed up to our Crisis Concordat. We know that when people are in crisis they are at their most vulnerable. This project is part of the system redesign of the acute mental health pathway and supports the existing structure and resources that is in place to provide a HBPOS for patients of all ages that require this service. This proposal will support the improved access to services for people in crisis through the addition of a further HBPOS, therefore patients will be able to be placed in a HBPOS rather than custody (when currently the HBPOS are full). The proposal also allows for a more family friendly environment which will be age appropriate for anyone who is on S136 and requires a POS.

We are leading a bid in partnership with acute general hospitals and CCG for Core 24 bid A&E liaison services. In the process of bidding, all services to work towards 1hr response, 4 hr assessment for ward referrals, designated rooms for mental health assessments, getting people out of A&E in 4 hrs into a psychiatric bed.

LD bids and IAPT bids for more staff for one year.

### D. Activity Planning – Older People

The **District Nursing** service is implementing the recommendations from the work undertaken by 'Newton Europe' to try and improve efficiency and therefore capacity. Standardising handovers potentially will release 10 minutes per nurse per day across the service. Monthly caseload reviews ensure patients are not kept on the caseload without being reviewed, reduces inappropriate visiting and facilitates timely discharge. Standardising pathways in both venous and mixed aetiology leg ulcers care provides a reduction in spending on dressings and less nursing time spent on wound management.

The District Nursing service is working to increase the numbers of nurses with the specialist practitioner course in district nursing. This will lead to direct specialist clinical care in the service which evidence shows improved safety and quality of patient care. This will improve quality but not capacity.

District nurses are "expert generalists", the community nursing equivalent to general practitioners, and provide a wide range of care to older people and those with long term conditions. Meeting the challenge of shifting care closer to home will also require an increase in community specialist nurses for long term conditions, such as respiratory, diabetes and heart failure to provide an alternative to outpatient and inpatient care by acute hospital. This is a key element of the Oxfordshire Transformation Plan.

The Older People's Directorate has introduced centralised duty desks to manage patient calls to reduce the amount of time clinical teams need to spend responding to messages and referrals. Patients, their families and professionals can speak directly to a clinician reducing the amount of time in following up calls and being able to get all the correct information in one call

A shared duty desk is being piloted between the **Integrated Locality Teams, Community Therapy Service and District Nursing** to promote internal integration and reduce the number of visits by multi professional groups as the care could be met by the best person for the patient on that day

The **urgent care services** have reviewed activity and demand for the past 3 years and developed rotas to support anticipated demand going forward. It is anticipated that demand and activity will be mapped going forward to identify any further changes.

It has been identified that GP cover is challenging for the OOHs service, to mitigate this the service has reviewed the patients clinical needs that use the service and is skill mixing and developing different staffing groups to safely manage patient's needs. An example of this is the band 7 advanced practitioner which has been introduced to the OOHs service from January.

In order to meet the level of demand and ensure sufficient capacity, **Community Hospitals** have modelled the activity based on proposed bed numbers of 140 average across the year, a targeted reduction in length of stay and DTOC to agree an objective number of episodes of care similar to 2016/17 activity levels. Beds will be provided in different, lower level settings better matched to need e.g. ICB, HUB beds and there will be an increased development of ambulatory care and community/ domiciliary based rehab

**Older People's Mental Health** services are reviewing skill mix in CMHT to reduce vacancies, ensure better use of resources and to 'grow their own'. Joint duty desks with the Integrated Locality Teams are in place in collocated sites to promote internal integration and reduce the number of visits by multi professional groups as the care could be met by the best person for the patient on that day

The service is reviewing age of transitions and is working closely with the Adults of Working Age Directorate to utilise and maximise resource and functions

## E. Quality Planning - Quality Priorities

**Summary of the quality improvement plan (including compliance with national quality priorities)**

| Quality Priority | Link to Trusts business priorities for 2016/17 | Link to national quality domains |
|---|---|---|
| 1. Enable our workforce to deliver services which are caring, safe and excellent | - To support teams to improve the safety and quality of care they provide<br>- To support leaders to maintain a positive culture for teams. | Well led |
| 2. Improve patients and carers experiences through involving people in their own care and how services develop | To make care a joint endeavour with patients, families and carers | Caring and Responsive |
| 3. Improve quality through service pathway remodelling and innovation | - To improve the quality of care by transforming services<br>- To lead research and adopt evidence that improves the quality of care<br>- To embed and enhance the electronic health record. | Effective and Responsive |
| 4. Increase harm-free care | To support teams to improve the safety and quality of care they provide | Safety |

These priorities continue to be at the core of our quality improvement plans and the projects detailed within them continue 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). 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.

## F. Quality Planning - Specific Quality Plans

**Sepsis:**

The Older Adults directorate is working towards the implementation of NICE guideline NG51 relating to the recognition, diagnosis and early management of sepsis, which was published in July 2016. There are various work streams underway which can be summarised as follow:

1. The Out of Hours Service are developing care pathways including planned reviews of moderate to high risk patients as per the stratification criteria outlined by NICE. The service will also be developing targeted information for parents and patients relating to early recognition and appropriate timely intervention.

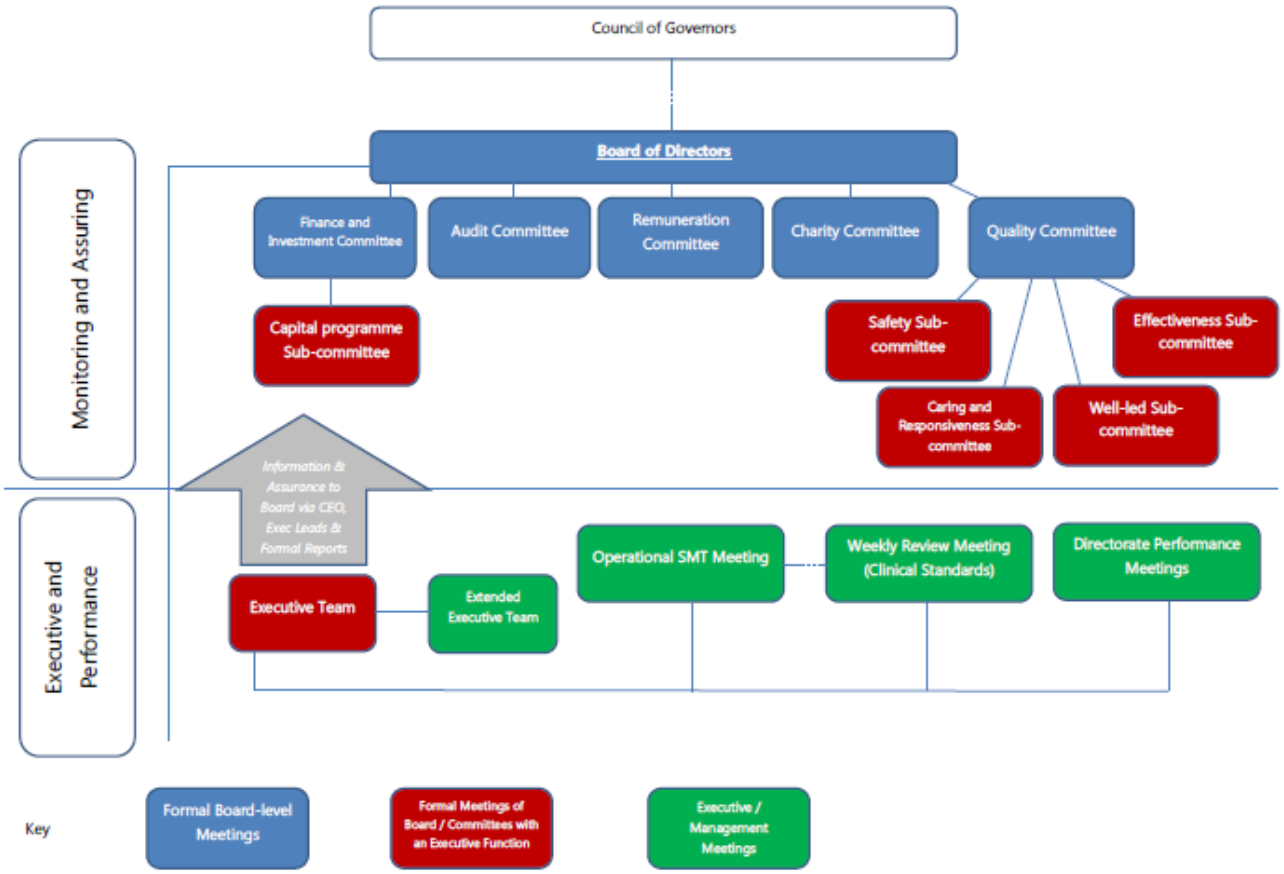
2. Community services, care home support and mental health services will be focusing on further developing initiatives to support early recognition of risks of sepsis and taking responsibility for onward referrals to specialist services.
3. Community hospitals will continue to audit the effective use of the National Early Warning Sore (NEWS) tool which was adopted this earlier year; further plans are underway to develop and improve clinical skills in the recognition of risk and deterioration via simulation training.

**Pressure Ulcers:**
The Older Adults directorate has made significant progress with the implementation of the pressure damage prevention project plan which encompasses various work streams, and the roll out will continue. The top 3 areas of focus are:

1. The roll out of Quick Time Learning (QTL) initiative across all of the localities following the pilot in 2016/17. QTL involves arranging a learning and feedback session within 3 working days from when an acquired pressure ulcer is reported followed by agreed actions for the district nursing teams. The process is currently led by the Tissue Viability team and the roll out will involve transferring this responsibility to the Clinical Development Leads (CDL's) with expert support from Tissue Viability.
2. A Braden Assessment Review- Incident review identified an issue with how the current Braden tool is used by some staff; the Tissue viability team applied some modifications to the format of the tool to ensure patients with existing and previous pressure damage are identified as high risk. The modified tool will be trialled with a few DN teams to provide assurance that the Braden assessments are being completed accurately and the modified tool will be rolled out further across all DN teams.
3. The Safer Care team is working with 6 DN pilot sites to identify improvement plans relating to pressure ulcer prevention using the safer care methodology. Each team started collecting data using safety crosses, with the majority of them measuring if Braden was completed on the first visit. The recommendations and learning from this will inform the pressure ulcers prevention work plan.

**End of Life (EoL) Care:**
1. The directorate will proceed with further implementation of the EoL Work Plan addressing recommendations outlined in the 'One Chance to get it Right' report which was issued by the Leadership Alliance for the care of dying people. This will involve working with various care providers and healthcare organisations within our region to standardise care plans.
2. Further develop and roll out the delivery of EoL care training utilising the EoL Link Nurse Network.
3. The directorate will carry on working with Oxfordshire Clinical Reference Group for EoL Care on the implementation of palliative care records.

## G. Quality Planning – Governance




## H. Quality Planning – Quality Impact Assessment - 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<br>Non-Executive<br>Trust Secretary<br>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)<br>Service Directors<br>Clinical Directors<br>Project Leads |
| **Directorate Governance** | Directorate Confirm and Challenge | **Monthly (2nd week)** | Overall update on all Directorate projects and challenge project managers on outliers.<br>Recovery plans to be completed. | Service Directors<br>Clinical Directors<br>Service leads<br>Project Managers<br>Finance<br>Performance<br>Information |
| **Project Governance** | Project Meetings | **Weekly** | Project progress, financial & performance trends, risks & mitigations.<br>Working with service leads to transform services inline with project objectives | Project Manager<br>Service Lead<br>Finance<br>Performance<br>Information |

**Information flow using standardised PMO templates**

**Confirm and challenge performance**

## I. Quality Planning – CQC – Community Hospitals

Following the full CQC inspection which was undertaken within Oxford Health NHS Foundation Trust during September, a number of areas for improvement in relation to Community Hospitals were raised These fell under the following seven categories: -

1. Emergency Equipment
2. Training in Basic Life Support
3. Record Keeping
4. Use of the 'track and trigger' physical healthcare checks
5. Assessment of pain
6. Deprivation of Liberty (DoLs)
7. Assessment of swallowing

In response the Trust adopted a Quality Improvement initiative across all services. This was under the umbrella of the Improving Care across the 5 domains (IC5) project. All areas of concern were highlighted and a multidisciplinary team agreed the actions requirement to ensure the required clinical outcomes. The actions were then implemented at service level, which were required to submit evidence of completion before the action was identified as completed. The Trust adopted a Red, amber and green (RAGR) rating in order to monitor progress against the required actions.

Progress against the action plans have been overseen corporately directly by the IC5 action group and progress has been formally reported to and monitored by the Executive Team, Quality Committee and the Trust Board. In total there were 24 separate actions identified which fell under the above 7 categories. To date 21 out of the 14 identified actions have now been completed and evidence of completion submitted and accepted at the IC5 group meeting.

There has been considerable progress in relation to three remaining areas are identified in table 1 below, together with current status.

**Progress to Date:**

| No. | Concern | Actions required | status |
|---|---|---|---|
| 1 | **Emergency equipment** is fit for purpose and available in all areas at all times. (Safe) | 1.1. SOP for daily checking of resuscitation trolleys to be reviewed to ensure that it is fully applicable to Community Hospitals. This will be reviewed annually. Reviewed checklist and SOP to be validated at Resuscitation Committee. | |
| | | 1.2. Resuscitation Link Nurse role description to be developed amended to incorporate responsibility for ensuring that correct version is in use .Review date to be on document. | |
| | | 1.3. Check by Matron on a monthly basis that the daily checks are happening (Matrons checking each other wards) and results reported to the monthly Unit Managers meeting. Once standard consistently achieved frequency of reporting would become less frequent. | |
| 2 | All staff are **trained in basic life support** to deal with emergency situations (City CH) (Safe) | 2.1. Review BLS training records to cleanse data and establish training gap and write to individual members of staff identifying the date for completion of training | |
| | | 2.2. Agree risk based training plan for basic life support at the Unit Managers meeting and monitor on a monthly basis. | |
| | | 2.3. At least 95% of staff to have received training in BLS across all community | |

| | | | |
|---|---|---|---|
| | | hospitals.<br>**Update: Training level now increased to 88%** | |
| **3** | **Comprehensive and contemporaneous notes** are maintained at all times for all patients (nursing staff and medics recording notes in different places). (Safe) | 3.1. Agree HR process for honorary contracts to enable medical staff to access and use care notes in community hospitals. | |
| | | 3.2. Agree expectations around completion of medical notes with medical staff as part of governance arrangements within contracted arrangements and ensure that this signed off by Service Director and Clinical Director.<br>**Update: The roll out of care notes in Geratology has now been agreed at the contact meeting.** | |
| | | 3.3. Revise and implement current audit tool to provide more assurance around quality of notes (replace CHAT tool). Results to be reported through Clinical Audit & Effectiveness Group. | |
| 4 | The **track and trigger system is used correctly** and that there is early escalation of concerns if a patient's condition deteriorates. (Safe) | 4.1. Complete pilot of National Early Warning Scoring system (NEWS) and assess effectiveness using safer care methodology. Monitor and report effective use of tool through Community Hospitals Performance Dashboard Process. | |
| | | 4.2. Agree comprehensive staff training plan that incorporates recognising the deteriorating patient and recognition of sepsis. Monitor progress towards achievement of that plan through the Unit Managers meeting. | |
| | | 4.3. Agree scope for clinical simulation training to be delivered as part of project with AHSN HETV.<br><br>Update: Simulation training is a 2 day course and the first day of the course will take place between 09.02 -02.03.2016 with 100 CH clinicians attending from all CH Wards. CH total staffing numbers are 220 (individuals). | |
| | | 4.4 Agree escalation actions roles and responsibilities and expectation with regard to NEWs/ Track and Tracker escalation with all clinical staff. Monitor progress through Unit Managers meeting. | |
| 5 | Systems and procedures for the recording and assessing of **patients' pain** are reviewed. (Effective) | 5.1. Decide on single assessment tool across the trust e.g. Abbey Pain Score, recommendation paper to be completed | |
| | | 5.2. Pain assessment tool to be introduced | |
| | | 5.3. Incorporating assessment of pain question into intentional rounding chart. | |
| | | 5.4. Amend and implement a revised records audit to review effective use of pain assessment tool and identify improvement actions reported through Clinical Audit and Effectiveness Group | |
| 6 | Due process is followed regarding **Deprivation of liberty** (monitoring while waiting for outcome of an application) (Effective) | 6.1. Validate Mental Capacity Act and Deprivation of Liberties SOP for inclusion within care planning and care records. | |
| | | 6.2. Agree content and delivery of bespoke training sessions for Community Hospitals with prioritisation of attendance of Band 6 and 7 staff | |
| | | 6.3. Adults safeguarding report will contain details of management of patients awaiting confirmation of DOLS status for oversight/ assurance | |
| | | 6.4. Introduce weekly reporting and monitoring within the Community Hospital Inpatient management meeting | |
| 7 | There is a clear system for the **management and assessment of patients with swallowing difficulties**. (Effective) | 7.1. Risk note sent out to all staff in Oct 2015. Completed. | |
| | | 7.2. SOP and risk based incremental training plan with clear milestones for community hospital staff on use of thickening agents. | |
| | | 7.4 Roll out of training for staff in community hospitals. | |

## J. Quality Planning – Quality Impact Assessment - CIP Delivery Terms of Reference

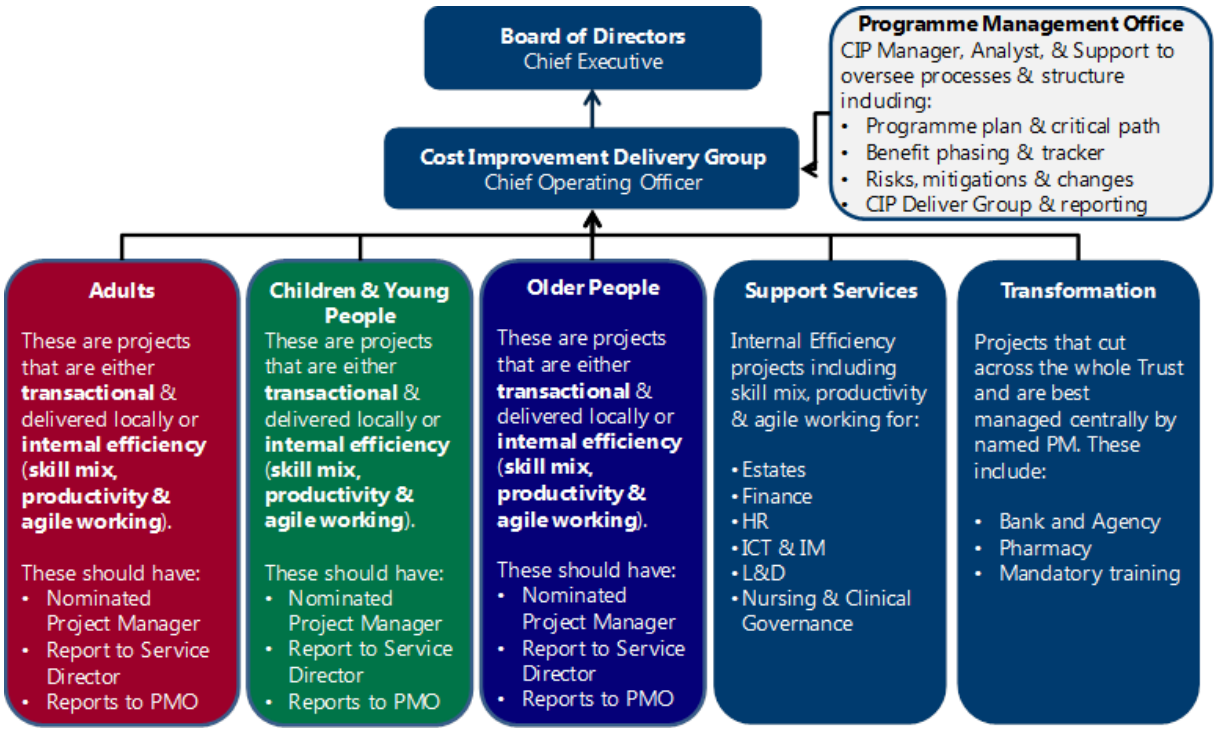
**Cost Improvement Programme (CIP)**
**Delivery Group: Terms of Reference**

**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. Purpose

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.

**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.

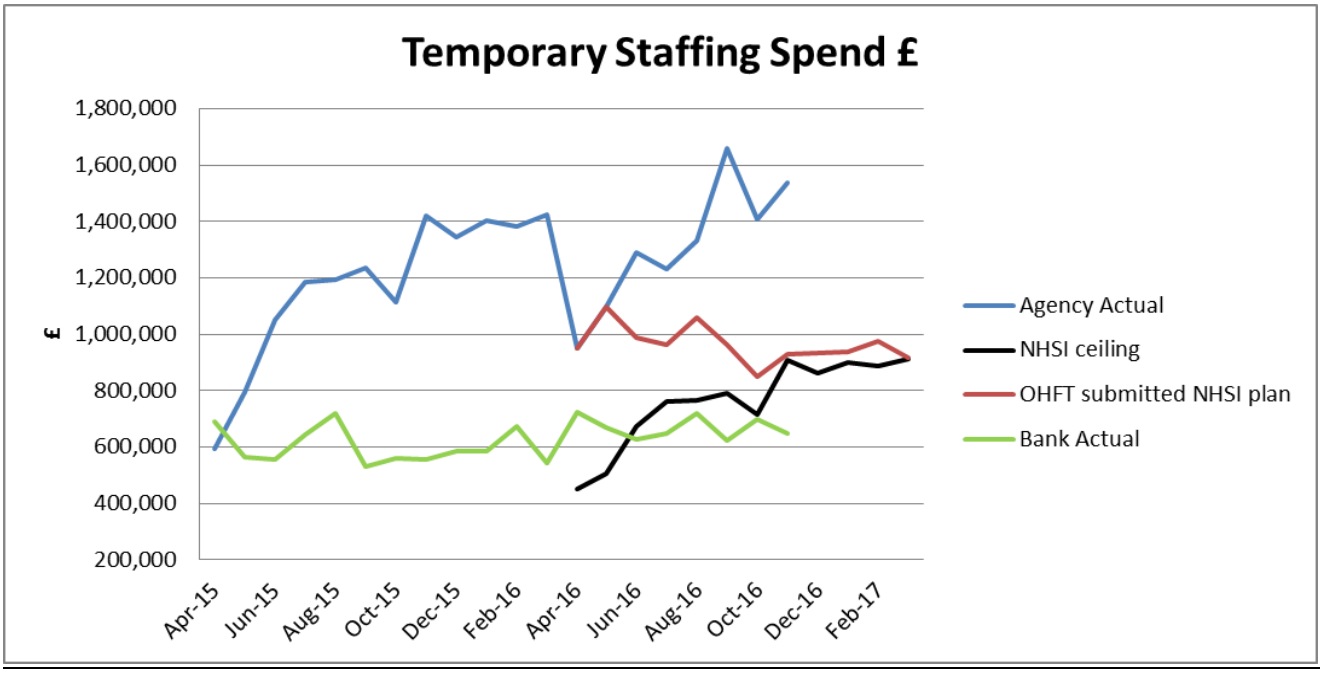
**10. Review**

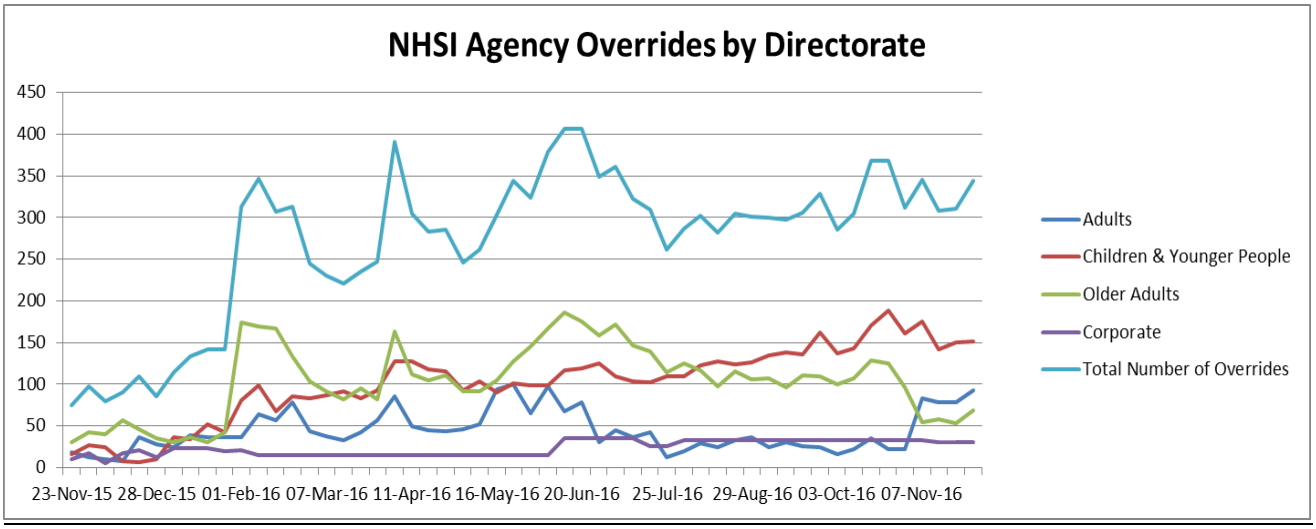
The CIP DG Terms of Reference will be reviewed in full on an annual basis by the CIP DG.

**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.

**K. Workforce – Agency Spend**






YTD agency spend is 89% above the NHSI ceiling. Agency Spend is 8% higher than November 2015 despite an estimated £1.5m per anum reduction in cost due to reduction in prices.

## L. Workforce: Specific Workforce & Service Development Plans

OCCG has approached OHFT to consider providing the Oxfordshire Learning Disabilities services currently provided by Southern Health NHS FT. OCCG commissioning intentions state that a new model of care will be co-produced in partnership with experts by experience and families / carers, the existing provider and Oxford Health NHS FT as the intended future provider. The staffing assumptions made in the new model are as follows:

Proposed Additional LD Staff costs

The basis for the staff costs is the current team establishment as provided by SHFT. Additional staff have been include to mitigate risks as identified during the quality due diligence process and some minor increase in capacity to reduce waiting times. The additional staff costs included are:

- Three social care senior practitioners to mitigate the risk identified by OCC of the model becoming too medical and not holistic. This approach to mitigating this risk is currently under discussion with OCC who have asked we consider approaches by other areas to mitigate the risk where the teams are no longer integrated and a locality based model exists.
- An additional manager to manage the bed based fund (6 beds) as this was previously managed under the assessment and treatment in Ridgeway, to manage step down and to oversee the forensic pathway development in Oxfordshire as this is the likely most transformational component of the contract.
- An additional 2 days of input from the Dietetics team as feedback from the service is that there is high demand for this.
- Additional nursing staff in Step Down (6 beds) to ensure that there is 24 hour nursing cover and help address the current quality concerns in this unit.
- 1 day a week of a Speech & Language Therapist in IST to help manage waiting times
- 1 day a week of a Consultant Psychologist in the community teams to help manager waiting times.

## M. Link to STPs: Key Programmes

**Integrated Locality Teams- GP improving access to out of hospital care**
OHFT is working to embed Integrated Community/Locality Teams across Oxfordshire, between Primary Care, Social Care and Community Healthcare for adults in partnership with voluntary organisations. Over the next two years, OHFT will work in partnership with city federation and OCC to deliver services in the city locality, developing a single (Crisis) care plan, standardise reporting across the integrated locality teams and referral pathway and develop a multidisciplinary approach to high need service users.

**Bed Based Care in Oxfordshire**
To improve services for older people, and ensure that patient flow is delivered throughout the system, work is underway to focus on Bed Based Care Assessment and treatment in community setting and appropriately allocate resources, through rationalisation and consolidation of bed based services (dependent on consultation outcome). We are working closely with partners to reduce delays, and manage increasing patient demand, particularly around delivery of delayed transfers of care (DTOC) and whole system winter resilience plans.

**Forensics**
The proposed new model of care and service delivery is predicated on a fundamental shift in thinking and organisational focus away from physical security-based service lines to a needs-driven, care pathway-based approach. This model would deliver treatment according to patients' needs, in the level of physical security commensurate with risk, and would support recovery and risk-reduction.

We will work together to develop a collaboration of providers of specialist mental health care across a larger footprint of STPs coordinating inpatient and community-based services to improve the overall value of care provided. Our organisations are effectively engaged with the development of the STPs: and the application is in line with the aspiration to focus on a relatively small number of priorities which lend themselves to a regional approach.

**CAMHS T4 Future in Mind**
This model aims to ensure that local children and young people presenting to the acute hospital with deliberate self-harm/crisis and/or at risk of admission to a Tier 4 unit are able to access rapid, longitudinal assessment and initiation of treatment within the acute setting with the aim of negating admission to Tier 4 where possible. We seek to enable an integrated approach initiating the right care, at the earliest time in the pathway to contain and manage the period of crisis and distress locally. We will approach delivery from the point of presentation and work with the child and family in the least restrictive environment possible drawing upon the full range of services available locally, whether that is Health, Social Care, Education or wider placement services.

We will work with leaders in each of the STP foot prints to ensure joined up plans for tier 4 services and to support the commissioning of comprehensive community outreach and crisis services for children and young people. The development of specialist community eating disorder services for children and young people will support a reduced call on tier 4 beds over time due to early intervention and ability to reduce length of stay because of comprehensive community treatment being available locally. Our model will be implemented by providers with proven extensive experience of managing both inpatient and community-based care for young people.

**Mental Health Partnerships - Outcomes Based Commissioning**

OHFT and our commissioners in Oxfordshire have developed an Outcomes Based Commissioning model for adult mental healthcare based on a capitated payment approach that is linked to outcome measures, co-developed with experts-by-experience and third party sector partners (Mind, Restore, Response, Elmore and ConnectionFS).

In its capitated contract with Oxford Health NHS FT, Oxfordshire CCG pays 80% of the total capitated contract value upfront, with the remaining 20% linked to the achievement of defined quality and outcome measures. Of this 20%, 0.5% is linked to national commissioning for quality and innovation (CQUIN) payments and 19.5% to the achievement of seven locally developed outcome measures:

- Outcome 1: people will live longer
- Outcome 2: people will improve their level of functioning
- Outcome 3: people will receive timely access to assessment and support
- Outcome 4: carers feel supported in their caring role
- Outcome 5: people will maintain a role that is meaningful to them
- Outcome 6: people will continue to live in stable accommodation
- Outcome 7: people will have fewer physical health problems related to their mental health.