Oxleas NHS Foundation Trust – operational plan 2016/17.

This document sets out our operational plan for 2016/17 and is consistent with our five year strategy, published in 2014. We remain committed to delivering high quality services, underpinned by robust governance and financial stability, in what continues to be a very challenging environment. Our performance over the last financial year continues to demonstrate our ability to deliver organisational growth and change, while delivering the highest standards of patient care and levels of staff engagement that are amongst the best in the country. In 16/17, we are finalising a robust plan that will allow us to continue this approach and provide a stable platform for meeting our control total and delivering the transformation required through the Five Year Forward View.

Oxleas approach to activity planning

As in previous years we have worked collaboratively with our commissioners to align our services with their priorities. During 2015/16 we saw increased investment in dementia and children's services, and higher numbers of intermediate care beds being opened in our community health services to enhance systems resilience. As we move into 2016/17, the 3 year allocations provided to our commissioners will allow us jointly to develop initiatives that will transform our services, in a way that is affordable within the future financial envelope. In relation to the continuation of parity of esteem and increases in funding for mental health provision (e.g. perinatal services and child and adolescent mental health services (CAMHS)), our commissioners used the increase in 2015/16 to provide a pool of funds to enhance the delivery of their priority areas - we anticipate that a similar approach will be taken in 2016/17, although these plans have not formally been presented at this time.

NHS planning guidance establishes the 9 'must dos' for local health systems for 2016/17. Although a number of the requirements do not apply directly to our services we have highlighted below those that do and the actions we will be taking to ensure we achieve the next steps in relation to implementing the forward view.

<u>Aggregate financial balance</u>

The financial plan contained within this submission presents a surplus position in line with our agreed control total for 2016/17. We are actively ensuring compliance with the cap on agency rates of pay, but are mindful of the fact that we may continue to experience financial pressures where agencies are not prepared to supply staff at the new reduced rates, and will be implementing a number of strategies through 2016/17 that will deliver savings in line with Lord Carter's report.

<u>The two new mental health access standards</u>

Throughout 2015/16 we have been tracking our performance against these new standards in readiness for their introduction on the 1st April 2016. This upfront work has been key in helping to ensure we are compliant with the targets and able to capture and report robust data. We are pleased to report that we have been meeting these targets during this

implementation phase and are confident that we will be able to maintain this performance during 2016/17.

Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia

Although this is a standard we are not directly accountable against we are measured on how our services play a key role in this target being achieved by our primary care colleagues. During 2015/16 we have worked closely with commissioners and primary care to streamline pathways for assessment and diagnosis which have enabled our partners to meet this target in 2015/16. During the upcoming year we will continue to ensure we support colleagues in this work to ensure the dementia diagnosis rate is maintained.

Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity and rolling out care and treatment reviews in line with published policy

Transforming care for people with learning disabilities sets the context for improving services for people with learning disabilities and follows reports, such as that into Winterbourne view, where the appalling care and treatment provided to people with learning disabilities provoked a national scandal. We have kept abreast of national developments and explored opportunities to develop and improve our own services. We have recognised the requirement to reduce the need for those with a learning disability to be in hospital.

We have worked with Commissioners (CCGs and Local Authorities) to make sure anyone that may require admission has a care and treatment review and, through better multi agency working, are offered safe and appropriate treatments in a community setting with open access to the skills and experience of our community learning disability teams.

We have developed a proposal for an enhanced community crisis service which diverts resources from our bedded service and strengthens our community based crisis interventions. Early discharge planning (at the point of admission) has reduced the maximum length of stay to 9 months and an average length of stay of 230 days.

We have a strong culture of working collaboratively with families and carers and for bringing in other agencies, such as Mencap, to provide independent chairing of patient meetings in our services. A transforming care board has been established locally and we are working with CCG colleagues to ensure we are represented in the meetings and discussions.

Participation in the annual publication of avoidable mortality rate

We will be participating in this publication and have set up a Mortality Surveillance Group. The membership of this group comprises our Non-executive director, Medical Director, Director of Nursing, Head of Patient Safety, Information Department Representation, Patient Safety Systems Administrator and Co-opted Consultants as required. The operational function of this group is to work towards the elimination of all avoidable in-hospital and community caseload mortality.

The committee has identified key priorities

1. Ensure that we are capturing every death that occurs in community caseloads, in-patient units and prisons

2. Ensure that we are satisfied that the deaths have been carefully reviewed and accurately classified as expected or unexpected and where necessary, ensure that they are followed up for example, with the coroner and upon receipt of further information such as post mortem toxicology results and then reviewed or investigated

3. Ensure that we have an identified a group of key clinical reviewers in each directorate who will review each death as it occurs and report back to the mortality surveillance committee via a standard template which includes a summary of the treatment and judgement about the death

4. On a monthly, retrospective basis the surveillance committee will review all deaths by service area as follows: adult community health services, children's services, child and adolescent mental health services, adult mental health services, forensic mental health, prison health, adult learning disabilities, adult mental health and older peoples' mental health

5. Contribute to the establishment of standardised definitions and parameters across London in respect of the terminology used by the Mortality Surveillance committees and thematic review

6. Ensure that we have taken action to address any gaps in our self-assessment against the Southern Health NHS review.

Our approach

Our plan assumes relatively little change with regard to patient contacts and bed capacity from 2015/16, although we are in the process of discussing and finalising these levels with our commissioners.

Having expanded our contracts to provide healthcare within prisons in 2015/16, we now provide healthcare services to one in every eleven prisoners in England. We have instigated a number of initiatives to improve the wellbeing of prisoners. We are responsible for providing healthcare services to the three prisons within the Greenwich prison cluster, and do so in partnership with eight other providers, including the independent sector. We will look for further opportunities in 2016/17, to work in partnership with NHS, third sector and independent providers across trust services.

Our plans contain a small financial contingency for winter, or other unexpected pressures and we are confident we can flex resources and bed availability to meet spikes in demand. We have proved resilient to increased demand in previous years and, although not complacent, feel we have sufficient financial and operation plans in place to meet unplanned changes in demand.

Overall, we are confident that this plan is aligned with our commissioner expectations regarding activity levels and performance, contract negotiations to date have been based primarily on 2015/16 activity levels and for most commissioners we believe that we are sufficiently resourced to meet these demands in 2016/17. For those contracts that remain in negotiation at this stage we are concerned that activity requirements will not be sufficiently resourced.

Oxleas approach to quality planning

Our purpose at Oxleas is *improving lives* and we do so by providing the best quality health and social care for users of our services and their carers. Our trust core values and our promise to users of services and their carers articulated in our *4 'must do'* priorities are fundamental to achieving this goal.

Our values are:

Having a user focus – we view things through the eyes of our users and carers
Excellence – We are never content with a service that is second best
Learning – We constantly review and improve how we do things
Being responsive – We avoid unnecessary delays for treatment and care
Partnership – we work with others to ensure people get the help they need
Safety – We seek to protect you from harm

Our 4 Must Do priorities are:

1. Increase support for families and carers
2. Provide better information for our service users and carers
3. Enhance care planning
4. Improve the way we relate to both our service users and carers by treating them with dignity and respect

We discuss and agree our quality priorities at a number of meetings with stakeholders. These include commissioners of our services, Council of Governors, and our annual borough focus groups. The Quality Committee and the Trust Board of Directors also review and approve our quality priorities.

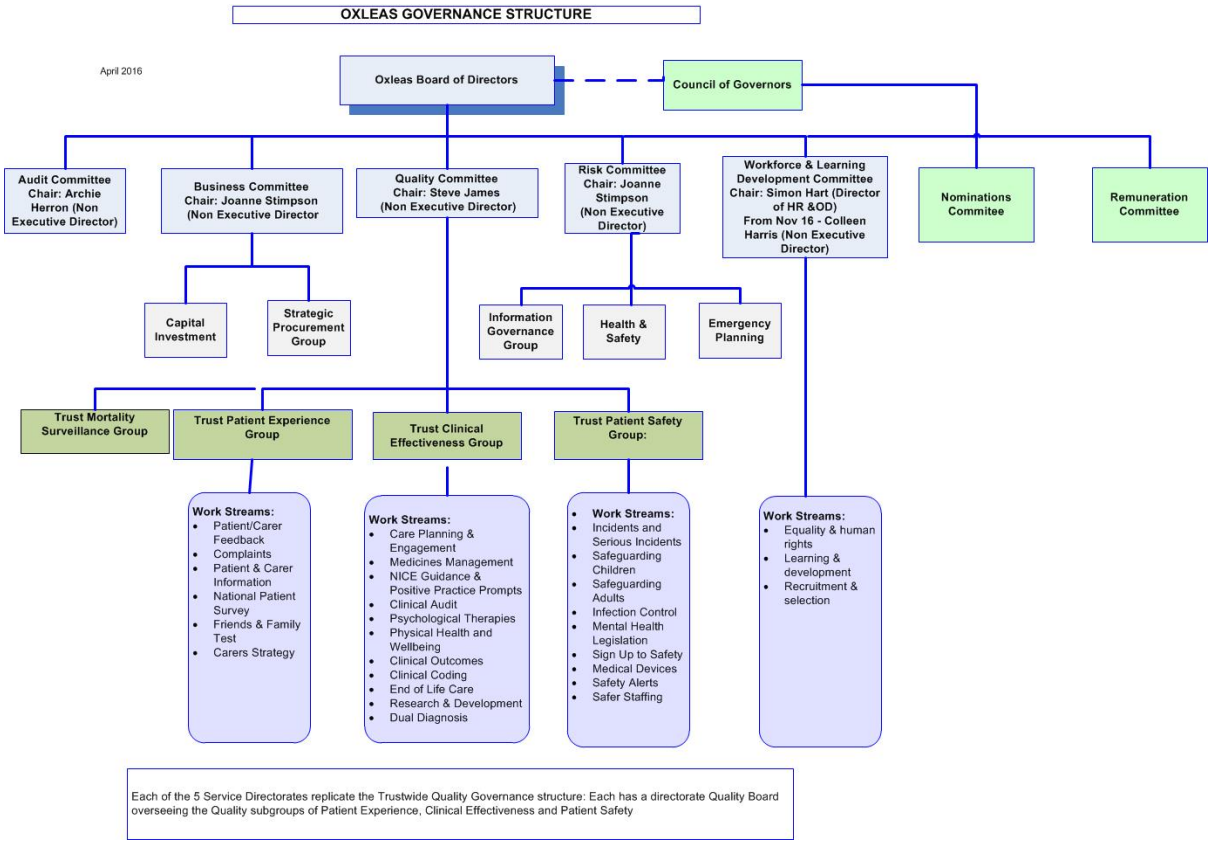
In Oxleas, we define quality as

- the effectiveness of the intervention and care provided (Clinical Effectiveness);
- the safety of that intervention and care (Patient Safety);
- and ensuring a positive experience of the care by the patient or service user (Patient Experience).

Our Quality Governance Framework
We have an established quality governance framework which underpins the following quality performance processes of:

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care

The Trust Quality Committee reports to the Trust Board and has a key role in monitoring performance across the three quality domains of patient safety, patient experience and clinical effectiveness. The Quality Committee is chaired by the Medical Director and membership includes clinical directors and quality leads from all Oxleas directorates. Each service directorate within Oxleas has a quality structure which replicates the Trustwide Quality Management structure, i.e. a local Quality Board overseeing the constituent Patient Safety, Patient Experience and Clinical Effectiveness Groups.



The Trust named executive Lead for Quality is Dr Ify Okocha, Medical Director.

<u>Quality Standards & Monitoring</u>

Each year we agree with our commissioners a Quality and Safety Improvement Plan (QSIP) and CQUIN priorities that we are monitored against. The QSIP priorities are across the three main Quality domains of Patient Safety, Patient Experience and Clinical Effectiveness. We also agree our Quality Priorities as part of our annual Quality Accounts.

All quality indicators are assessed and reviewed by the Quality Committee and the quality of our performance with clear accountability on our progress is reported back to the Trust Board. The Quality Committee ensures the indicators/standards present a balanced view of the quality of the services provided. Our local clinical directorates also review local clinical quality measures and provide assurance to the Trust Quality Committee. This review encompasses agreement of action plans and ensures implementation of recommendations across the trust's various services.

There is comprehensive guidance for staff on implementing quality, translating the corporate commitment into practice; these are available as policies or guidance or operational procedures, covering data collection, recording, analysis and reporting and are available to staff on the trust intranet. Where new guidance is required such as meeting our CQUIN targets (Commissioning for Quality & Innovation) or other identified quality goals, the trust Quality and Governance team provide implementation guidance and process pathways to ensure all staff are aware of the accurate process for recording and reporting.

Risk management is well embedded into the activities of the organisation. The trust's Risk Management Strategy sets out the process for how risk and change in risk is identified, evaluated and controlled. It sets out the responsibilities for individuals and key sub-committees in terms of how risks are reported and escalated through the governance structure. The trust openly encourages incident reporting and continues to achieve an increase in reporting low level incidents, whilst reducing more serious incidents; this is a widely recognised indicator of a positive safety culture. For example, the Trust Patient Safety Group reviews all serious incidents, monitors progress against actions plans and ensures that learning takes place through regular trustwide embedded learning events.

<u>Agreeing our Quality Priorities for 2016/17</u>

In our service development strategy, enhancing quality by ensuring excellence for every patient is our first priority and our quality goals are outlined in our Quality Account and the Quality & Safety Improvement Plan.

<u>Oxleas Quality Account Priorities</u>

Our quality account indicators are split into the 3 quality domains of patient experience, patient safety and clinical effectiveness. These have not yet been finalised for 2016/17 however they broadly cover the following areas:

- Our 4 'Must dos' – that form the foundation of our patient experience priorities
- Monitor key quality indicators
- Current priorities where trend data is available to measure improvement year on year.
- Areas of quality agreed with our stakeholders

The proposed quality priorities for 2016/17 are provided in the table below. These will be confirmed following consultation with our Borough public focus groups and sign off by the Quality Committee and Trust Board in March 2016.

Patient Experience Quality Priorities	**Patient Safety Quality Priorities**	**Clinical Effectiveness Quality Priorities**
85% of patients reporting that their carer/family have been supported	95% of patients on CPA discharged from hospital followed up	Ensure 95% of our patients have a recorded care plan on RiO

	within 7 days	
85% of patients reporting they have been provided with enough information about care and treatment	100% of patients admitted to hospital following self-harm followed up within 48 hours of discharge	95% of our patients on CPA to have received a review in the last 6 months
85% of patients reporting that they been involved in decisions about their care and treatment	Maintain no incidences of MRSA infections	To ensure that 80% of patients have a goal based measure in place as part of their care and treatment plans (CAMHS Clinical Outcomes)
85% of patients reporting that staff have treated them with dignity and respect	Maintain no more than 6 incidents of CDiff infections	Ensure each Oxleas Directorate have agreed clinical outcome measures so we know our services are effective
85% of patients reporting that they would recommend our service to friends and family if they need similar care or treatment	80% of staff are trained in level 1 safeguarding children	
85% of patients reporting that their quality of life has improved as a result of the care and treatment that they have received	80% staff are trained in level 2 safeguarding children	
85% of patients reporting that their quality of life has improved as a result of the care and treatment that they have received A quality goal that reflects Oxleas new carers & support network strategy **(to be agreed)**	80% of staff are trained in level 3 safeguarding children	
	80% of staff are trained in safeguarding adults	

<u>Top Risks to Quality</u>

We have identified the following high risks to quality which can be summarised in the following broad headings. The full detail and mitigation plan is enclosed.

- High bed occupancy
- Embedded learning from incidents and complaints
- Vacancies, recruitment and local induction
- Care Planning – risk assessments and involvement of patients in their care plans

Being a Well-led Organisation

Oxleas has maintained a focus on being a well-led organisation. In 2014/15 we commissioned Deloitte to independently review our governance arrangements against Monitor's well-led governance framework. The results of the review show that our governance, leadership and management arrangements were the best that Deloitte had reviewed in comparison to other trusts. Oxleas achieved green compliance in 7 of the 10 identified themed areas and amber/green in 3 areas. Deloitte's report benchmarked our scores on each of the questions in the Framework against other trusts they had reviewed under the Well Led Framework at the time.

Since the publication of the Deloitte review, we have put in place an action plan to further improve the areas that had been rated amber/green linked to Strategy and Planning and Measurement. This action plan was approved by the Board of Directors and recommendations have been reviewed and implemented in 2015/16.

We will continue to focus on the well-led elements of the framework in 2016/17 to ensure we meet the requirements stipulated as part of the Care Quality Commissions well-led domain.

Our 'sign up to safety' priorities

In June 2014, we joined the 'sign up to safety' national campaign and its five campaign pledges:

- Put Patient Safety First
- Continually Learn
- Share
- Collaborate
- Be Supportive

We have identified five key areas of patient safety as priorities for the Trust where further improvements can be made. Our sign up to safety priorities are:

1. Falls
2. Pressure ulcers
3. Prevent the physical deterioration of people with enduring mental illness
4. Reduce risk and harm of violence in mental health settings (safer wards)
5. Support an open and honest culture throughout the Trust (duty of candour)

Further Assurances

- The guidance on the Association of Medical Royal Colleges on the responsible consultant/clinician for patients who stay on our inpatient units is adhered to in Oxleas.
- Oxleas has a mortality surveillance committee which meets monthly. The group acts as the strategic mortality overview group with senior leadership and support to ensure the alignment of the departments for the purpose of reducing all avoidable

deaths in inpatients and community caseloads. It reviews the benchmarked mortality rates of the Trust and reviews all deaths reported - expected deaths and unexpected (natural causes, care of another trust, other reasons, 72 hour reports, critical level 4 RCAs and any not requiring investigation and why). We have also submitted our mortality assessment data to NHS England as required.

Oxleas approach to workforce planning

For each profession we have a clearly articulated strategy which includes

- Workforce plans which are overseen by the Workforce and Learning development committee. They also ensure that these are fully incorporated into the trust's Annual Planning process.
- Links in to broader recruitment and workforce development initiatives.

<u>The governance process for board approval of workforce plans</u>
Workforce plans are developed at a senior management team level within directorates and reviewed at Directorate Quality Boards. This process ensures that senior clinicians in the directorate have input into and are sighted on plans. This process ensures that the impact on the quality of our services has been carefully considered and any potential impact on clinical risk is mitigated. All plans are monitored for the impact that they may have on quality of services, during and post implementation.

Plans are further reviewed at quarterly CRE quality meetings which are attended by the Medical Director, Director of Nursing, Director of Therapies, Service and Clinical Directors, the Deputy Chief Executive and the Finance Director. This is a key quality approval meeting and provides a further opportunity to ensure:-

- any negative impact on quality is fully challenged and understood,
- mitigation actions are robust;
- quality improvements are recognised;
- staffing changes (numbers and skill mix) are appropriate and take into account all professional groups;
- staffing structures allow sufficient capacity to maximise productivity levels; and
- staff are supported.

Workforce plans are also formally signed off at the quarterly annual planning meeting. These meetings are attended by all corporate directors and the Directorate's senior team. A strategic input is provided by the trust's Business Committee and the Board of Directors who receive in depth reviews of major projects as appropriate.

In addition each profession has a clear structure and mechanism for developing its own professional workforce plan to ensure that the increasingly complex needs of patients are met through a more versatile and trained workforce. Through our Strategic Planning process, we are well engaged with Local Authorities and Clinical Commissioning Groups to

support plans for initiatives like the Better Care Fund and the service developments related to the implementation of the Five Year Forward View.

Integration of services and out of hospital care is central to the sustainability of local healthcare. We understand that this is our core business and lead new service models with primary and secondary care and develop new financial models with commissioners. Our aim continues to be ensuring that all patients will benefit from being treated by a truly integrated mental and community health trust.

Local workforce transformation programmes and productivity schemes

At Oxleas, we have a consistent focus on recruiting to our vacancies across all professions, and currently are paying particular attention to Band 5 Nursing vacancies. These efforts have resulted in a good range of applicants and currently recruitment is underway for 433 wte vacancies. A significant number of these posts have been offered to candidates and their recruitment checks either underway or start dates agreed. We manage our vacancies through the use of the E Roster system and effective deployment of temporary workers - Bank and Agency staff are deployed as required via the E Roster system. Bank workers are used wherever possible in preference to agency workers and we are largely compliant with the Agency worker "stand firm" price cap. In addition to vacancy cover, temporary workers may also be used to cover acuity or additional demand where this is required to exceed the established workforce.

Our Nursing Strategy is providing a focus on recruitment and has work streams in place to address the following:

- Standardised recruitment processes and competencies
- Guaranteed employment for final year students from University of Greenwich student nurses
- Focused work on attracting local students (16-24) and residents into cadets and apprenticeships
- Recruitment and retention initiatives (plus personalised career plans and job swaps internally)
- Task force programmes to support wards experiencing high agency usage.
- Development of new roles – Band 4 nursing associate / new models of care (5yFV)
- Exploration of dual registration roles i.e. RGN & RMN
- Career pathways e.g. Criminal justice system, end of life care (in partnership with Lewisham and Greenwich NHS Trust and GBCH)
- Increasing the number of M level qualified advanced practice nurses
- Establishing an apprenticeship pathway into nursing and healthcare
- Career development and greater opportunities for BME groups & nurses from our local communities
- Career development and greater opportunities for nurses with lived experiences of ill health
- Greater emphasis on research practice

- Joint posts with University of Greenwich
- Focus on prevention & well-being & coordination & personalisation
- Exploration of developing nurses in the Accountable Clinician role.

The Therapies Workforce strategy is providing a focus on productivity and has work streams in place to address the following:

- Job Planning across all therapy professional groups to maximise productivity and develop capacity.
- To develop the Approved Clinician role for eligible therapists.
- Implementation of refreshed family and carers and support network strategy ensuring that embedded learning in response to patient feedback remains a central focus.

Adult mental health services have and continue to be subject to major organisational change. The Adult Mental Health Services redesign completed in 2015 delivered:

- This large scale service redesign and transformation includes improved liaison and treatment interface with primary care for new patients and increased service user and carer focus, promoting self-management, recovery and relapse prevention. This cultural shift has created a move towards shared care and joining up of services.
- The service redesign led to £1.2m of savings, primarily pay costs, staffing productivity, changes in structures, and skill mix and the types of professionals needed.

The workforce implications for the 16/ 17 CIP are focused on the reduction of approximately 84 wte. These reductions are being made from the Management, Nursing (Qualified and Unqualified) workforce, with the majority of the reductions occurring in the forthcoming reorganisation of Adult Mental health rehabilitation services. Opportunities to redeploy into vacancies across the trust will be taken and affected staff will be appropriately supported. It is also anticipated that some elements of the existing workforce will be subject to TUPE as services migrate to third sector providers.

<u>Alignment with Local Education and Training Board (LETB) plans to ensure workforce supply needs are met</u>

Our workforce plans reference the wider LETB plans. Oxleas plans are shared with the LETB and are discussed in detail on submission. Broader supply issues are discussed with key Higher Education Institute (HEI) partners. We work closely with local HEIs to ensure that the necessary skills and training is incorporated into relevant courses. We participate in both the London clinical senate and the London workforce senate.

<u>Triangulation of quality and safety metrics with workforce indicators to identify and address workforce risk areas.</u>

The Formal Executive and Board receive a monthly integrated performance dashboard which trust performance is reviewed against Monitor financial and governance standards. In

addition: we monitor clinical effectiveness, patient experience, access and waiting times, patient safety, workforce and development and financial performance. All indicators are assessed through a RAG rating process and exception reports provided. Exception reports highlight key workforce indicators, track the KPI and assess the effectiveness of actions taken to date and any future actions and monitoring processes with an estimated time to resolve.

This approach facilitates strategic oversight by the board and executive of areas of concern. Areas of concern indicated here would also be triangulated on the trust's risk register and reviewed at both directorate and workforce governance structures.

Balancing of agency rules with the achievement of appropriate staffing levels

We are virtually compliant with the Monitor Agency Cap regulation and consistently only report a low number of exceptions. These are found within specialist children's care packages and prison services. Intensive efforts to recruit to these hard to fill posts are underway and progress is monitored by taskforce groups led by the Deputy Chief Executive to successfully control and reduce agency spend. Effective use of E Rostering is also supporting the creation of efficient rosters and ensuring that appropriate and safe staffing levels are in place.

Oxleas approach to financial planning

The table below sets out our planned SOCI for 2016/17. We are forecasting our NHS clinical income to grow in line with the national inflator.

£m	2015/16 *Forecast Outturn*	2016/17 *plan*
NHS Clinical Income	201.1	201.6
Non-NHS Clinical Income	17.3	17.5
Education, Training, Research & Other	25.1	24.2
Operating Income	**243.5**	**243.2**
Pay	-172.7	-168.8
Non Pay	-64.5	-75.1
CRE Target		8.0
Operating Expenditure	**-237.2**	**-235.9**
EBTIDA	**6.3**	**7.3**
EBTIDA %	*2.6%*	*0.0*
Depreciation	-2.8	-2.8
Interest Income	0.3	0.3
Dividends	-3.7	-3.6
Surplus (before one off items)	**0.1**	**1.1**
Surplus %	*0.0%*	*0.40%*

During the planning round for 2015/16 our Board took the decision to reduce the planned level of underlying surplus to £1m (0.4%) for 2015/16, in order ensure that as much resource as possible was maintained in front line services. We are on track to recurrently deliver our target of £6.8m for 15/16; this has included the implementation of two major service reconfigurations in our Older People and Adult Mental Health services.

Our operational plan sets out our ambition to maintain a continuity of service risk rating of 3 over the coming financial year.

Our Board considered the 'Control Total' issued to our Trust and has agreed that this is an achievable level of surplus, and represents approximately 0.4% of our 2016/17 turnover. Our financial plan is underpinned by a recurrent savings target of £8m, which although broadly in line with our 5 year plan submission reflects a higher than anticipated national cost inflation.

Since our draft submission we have significantly revised our savings target as a consequence of financial pressures within Greenwich CCG. We are now reflecting additional savings of £3m to £4m and are working with colleagues within Greenwich CCG to identify areas to meet this challenging efficiency requirement (over and above the national 2%). If this process results in further material impacts on our income levels we will address our forecast surplus position accordingly.

The forecast financial outturn for 2015/16 deteriorated from our operational plan submission in May 2015 and we have acknowledged a £1.0m surplus is unachievable. Our latest forecast outturn remains a break-even position or a marginal surplus of £0.1m. We have been unable to deliver our surplus due to the high level of in year overspending in Service Directorates (related mainly to the level of agency usage) and it is imperative we balance this position at the earliest to ensure we are in a good position to achieve our financial plan for 2016/17.

Finance will work the services to develop a plan of action linked to an agreed forecast spend for the directorate. Directorate's actual expenditure run rate each month will be monitored against this "control total" at the monthly directorate Financial Recovery Meetings (formerly finance meetings).

We continue to maintain a strong balance sheet position with a healthy cash holding. We anticipate starting 2016/17 with cash balances of c£85m, and with capital investment for 2016/17 planned at £36.6, there is no internal requirement to deliver high surpluses, or to carry a lending facility.

Income

Our income relates to the commissioning of mental health, community and specialist services by Greenwich CCG, Bexley CCG, Bromley CCG and NHS England. Planning assumptions are based on the 2016/17 inflator of 1.1%.

Expenditure

For 2015/16 pay costs, representing around 75% of our operating expenditure budget, have been calculated using individual staff banding, scale point, increment date, superannuation costs and additional allowances received. Our pay inflation assumptions include the introduction of Class A National Insurance contributions for all employees in the NHS Pension scheme and assumes a 1% pay award and incremental progression for all AfC bands and Medical staff. We believe in total this represents c£2.5m of increased costs for the trust.

Non-pay inflation for 2016/17 has been applied on a line by line basis against all material non-pay contracts.

Our planning assumes some use of agency staff but we are conscious that keeping a tight control on the use of agency staff is a key 'must do' in us delivering our financial plan for 2016/17. Our plan allows for some contingency in respect of this element.

CRE plan

We successfully delivered a number of transformational projects in 2015/16 and these were pivotal to us delivering our CRE programme for 2015/16 in full. The overall focus of our savings programme will remain broadly unchanged. As in previous years we will continue to prioritise change projects with a particular focus on:

- supporting the workforce;
- implementing our IT and estates strategy; and
- maintaining financial strength.

The delivery of financial plans and savings are the responsibility of the Board of Directors. Processes are in place to give the Board assurance with regards to the delivery of such schemes. Our challenge is to ensure that we continue to improve the quality of our services and also examine how improving quality can contribute to delivering an element of cost improvements. Our Quality Board, which includes our Directors of Medicine, Nursing and Therapies, provides assurance to our Board of Directors on the quality of services. It assesses the impact of all CIP plans to ensure they do not impact negatively on quality outcomes and promotes a culture of continuous improvement and innovation. It has clear lines of responsibility for the three domains of Quality across the Trust: patient safety, patient experience and clinical effectiveness.

CRE sign off and monitoring map

We have categorised our savings plans across the following themes:

- Integration
  Where it can achieve better outcomes and save money – for example, working more closely with social care to see how we integrate health and social care further and take on a systems leadership role
- Estates
  More flexible use, greater utilisation, rationalisation, income generation – making more of our estate multi-functional to increase utilisation of space leading to rationalisation and ultimately reduction the size of the estate
- Sub-contract delivery
  Where this improves quality and value for money. For example, the use of sub-contracting/partnerships within our prison contracts to increase expertise and service provision, as well as reducing costs
- Service re-design
  Re-design pathways and services to best meet the ever-evolving needs of our patients; and the requirements of partners. For example, reducing the reliance on

in-patient bedded services as the key enabler in delivering care; continuing to move to community based provision where ever possible and engaging further with third sector organisations in our pathways

- Procurement
  The implementation of a new computer based purchasing system has provided better management of price and volume of purchases. Through a number of direct initiatives to reduce variability in the specification of routine consumable items and the re-negotiation of telephony and print contracts we have saved over £500k in 2015/16. By using the themes emerging from Lord Carter's review we expect to target and deliver significant savings again in 2016/17.
- Reduce spend on agency staff
  Board led strategy to offer a more competitive package to staff and build on the high level of job and organisation satisfaction our current employees report; which should increase recruitment, retention in key areas, and make bank work more attractive. We have been improving rostering practice across the trust, aimed at ensuring we maximise our available substantive resource and that our demand for agency staff is as low as possible. We have also negotiated a number of local Service Level Agreements with our main agency staff providers which coupled with the introduction of new maximum rates in April 2016 should also bear down on our Agency costs.
- IT/ new ways of working.
  Building on the successful rollout of iPads across our District Nursing services we plan to expand mobile working out to all community teams across the trust over the next 2 years.
- Income generation
  Winning contracts for new services at a higher price than it costs us to deliver the services. Any recurrent surpluses on these contracts will be used to offset an element of our savings target

We have identified a requirement to deliver CIP savings in the region of £8.0m for the 2016/17 financial year and this has been allocated across both operational and corporate directorates.

All savings planned for 2016/17 are expected to be recurring in future financial years. To date we have schemes worth £9m which is £1m above of our current identified CRE target. A number of our current plans are classified as high risk (red) and these plans are not yet developed sufficiently enough to be certain of delivering the values assigned. The deterioration of the financial position at Greenwich CCG has, as stated above, been the primary driver in the significant increase in our CRE target and we have highlighted these requirements in the table above. We are currently engaged with Greenwich CCG and our service leads to discuss how these further savings can be made across services commissioned by Greenwich CCG.

Should we experience difficulty in delivering the planned savings there would be scope to make some small non-recurrent savings or use non-recurrent resources to aid delivery of

the financial plan. We have not previously needed to make non-recurrent savings to meet plans.

Although it is inevitable that our operational areas will deliver the bulk of efficiencies it should be noted that in percentage terms our corporate services have been set higher targets than our clinical services (previously 4.7% vs. 3.7%). This is part of our continued aim to have as lean an HQ function as possible, and keep as much resource invested in front line services as possible and this approach will continue into 2016/17.

IT and new ways of working

We continue to look to ways where IT can enhance our service delivery and improve the efficiency and effectiveness of our employees. During 2015/16, we rolled out mobile working solutions across our operational directorates which will now underpin a number of the efficiency gains anticipated in our 2016/17 CIP plans.

We will build on our internal dashboard system, iFox, which will increase the accuracy and timeliness of clinical data to decision makers. We continue to iteratively improve our data collection and analysis function to reduce the reporting burden on operational staff and enhance the information we use to manage our operations, share with our commissioners and other partners. The demand for information is large and ever changing and we continue to deploy significant resource amending and maintain reporting systems to meet the needs of our partners.

Delivering our estates strategy

Our estates strategy was refreshed and approved by our Board in 2014. As the financial pressures on the health economy have increased the reasonable expectation is that estates services contribute significantly to cost savings. At present, the annual cost of our estate is approximately £34 million, which generates an income of approximately £8.5 million. Opportunities still remain to reduce property use and costs, though these will require significant cultural change. We are confident that we can achieve this, and have active plans to reduce our estate. The future development of the estate will aim to deliver the following objectives:

- Provision of flexible estate through the development of clinical facilities on a multi-functional flexible basis that creates generic spaces that meet the needs of all services.

- Increased utilisation of estate by making provision for out of hours services whilst also ensuring that all clinical space is utilised fully during normal working hours would increase efficiency and support extended service delivery.

- Optimise estate costs by developing an accurate and shared understanding of estates costs to assist strategic decision making. Ensuring that our estate costs are recovered in full when leasing properties to other organisations.

- Enhancing patient experience through the provision of high quality estate that meets patient needs.

- Using the estate to generate income ensuring that surplus properties and land are disposed of or redeveloped to produce a capital receipt or income stream unless there is a clear benefit to retaining the sites.

Whilst the provision of services that are local to our patients is highly desirable it is acknowledged that the provision of high quality, appropriate, and efficient facilities may require a focus on a smaller number of larger more flexible facilities.

Capital programme

We will be continuing with our planned capital investment strategy through 2016/17, expecting to spend £36.7m in total with significant investment in developing the Queen Mary's hospital. A summary of the areas is contained in the table below:

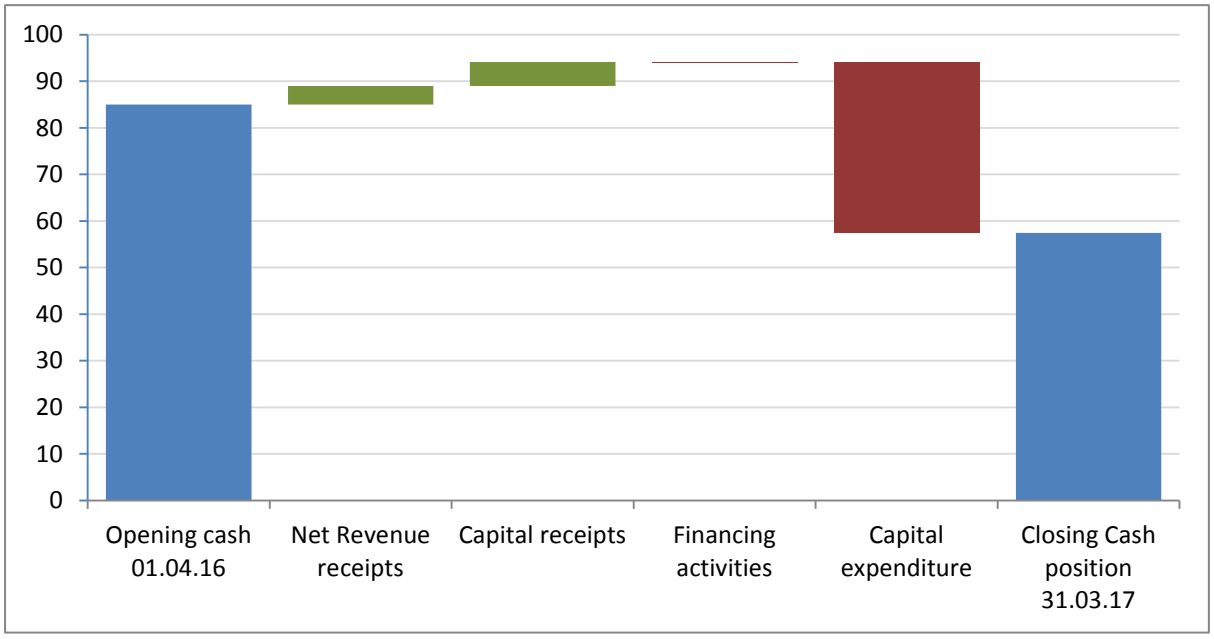
£m	**2015/16**	**2016/17**
Queen Mary's Hospital redevelopment	8.5	25.7
Other Estate development and maintenance	4.1	8.5
IT projects	2.7	2.8
Gross capital investments	**15.3**	**37.0**

In support of our productivity and efficiency programme our Capital programme is primarily focussed on these areas:

- £3.6m of capital expenditure is directly related to the delivery of CIP efficiencies through Estates reconfiguration, £0.5m of which are sustainability projects
- £23.9 relates to redevelopment of QMH providing more efficient use of space and reductions in running costs
- A further £2.8m in IT which relates primarily to delivering efficiencies through mobile working and data collection and reporting

Cash

We will finance the bulk of this investment from asset disposals from previous years and our own cash reserves.



We are forecasting cash balances as at 31 March 2017 of £57.4m. As part of our overarching 5 year capital programme we identified that the Trust will maintain a minimum cash buffer of £24m to ensure we are able to maintain liquidity throughout the coming years. Specifically for 2016/17 we will maintain a significant cash surplus throughout the year and maintain our existing tight controls in relation to accounts receivable and payable in order to mitigate any liquidity risks. Our capital programme is reviewed on a monthly basis and will be flexed to ensure cash reserves do not fall below the £24m cash buffer.

Link to emerging Sustainability and Transformation plan

Our approach to planning and adapting to future activity levels is being undertaken at a number of levels:

- At the macro level, we are part of the "Our Healthier South East London" group which draws together all providers and commissioners within the South East London health economy. This group forms the basis for our sustainability and transformation planning and is expanded upon below.
- We are working more closely with other local mental health providers to develop an innovative proposal for NHS England regarding the provision of forensic services, we expect this to deliver a more coherent approach to the supply of secure services as well as deliver financial efficiencies for the commissioner.
- We are working locally with our three main commissioners on a number of transformation projects, for example:
  - We are working with Greenwich CCG on their "Ageing Well" programme, which seeks to reduce the number of acute admissions for the over 65s and provide a wider range of community and home treatment services;
  - In Bexley we are working with the CCG and local authority to integrate a number of existing services;
  - With Bromley CCG we are working on a system redesign of services

The South East London (SEL) sector contains two £1bn a year Shelford Group Acute trusts within its membership. Collectively it has developed a 'place-based' sustainability and transformation plan for the whole sector and we have been fully involved with this work.

The strategy has identified the following key issues across all health services in SEL that need to be addressed:

1. Too many people live with preventable ill health or die too early
2. The outcomes from care in our health services vary significantly and high quality care is not available all the time
3. We don't always treat people early enough to have the best results
4. People's experience of care is very variable and can be much better
5. Patients tell us that their care is not joined up between different services
6. The social care system is under increasing pressure

The collective vision for the future of health and care services laid out in the STP is to achieve better outcomes over the next five years by:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Making sure primary care services are consistently excellent and have an increased focus on prevention

- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste.

Oxleas are fully engaged in this process, primarily through the delivery of Local Care Networks which are the centrepiece of the strategy. For people with long term conditions, community based care will take a rehabilitative/ re-ablement approach, supporting people to manage their own health positively, prevent deterioration wherever possible and reduce risk of exacerbation/admission. For those with complex long term conditions or who are in the last year of life, support will enable them to continue to lead as full and active life as possible.

Local care networks (LCNs) will provide a universal service covering the whole population, from 'cradle to grave', and will involve primary, community and social care colleagues working together and drawing on others from across the health, social care and the voluntary sector to provide proactive patient centred care. Services will be delivered in ways that respond to the varied needs and characteristics of the LCN community.

LCNs will include a leadership team to work with general practices at a locality basis (federated with single IT system). Community pharmacies, the voluntary sector, community services, including mental health and therapies, social care and community based diagnostics will be part of the LCNs.

These models will deliver improvements through:

- Support for patients to manage their own health (asset mapping, social prescribing, education, community champions etc.)
- Prevention – obesity, alcohol and smoking
- Improved access to core general practice services
- Improved call and recall systems for screening and early identification and management of long term conditions
- Reduction in gap between recorded and expected prevalence in long term conditions
- Support for vulnerable people in the community including those in care homes and domiciliary care
- Reduction in variation (level up) primary care management of long term conditions
- Reablement – admissions avoidance and effective discharge
- MDT approach to key long term conditions groups (incl. mental health) and frail elderly
- Better end of life care

The SEL strategy/STP has identified eight outcomes:

1. Preventing people from dying prematurely and enabling them to live longer and healthier lives
2. Reducing differences in life expectancy and healthy life expectancy between communities
3. People are independent, in control of their health, and able to access personalised care to suit their needs
4. Health and care services enable people to live a good quality of life with their long term condition
5. Treatment is effective and delivers the best results for patients and service users
6. Delivering the right care, at right place, at the right time along the whole cycle of care
7. Commitment to people having a positive experience of care
8. Caring for people in a safe environment and protecting them from avoidable harm

The Oxleas service development strategy (13/14 – 15/16) has four strategic priorities to ensure the trust continues to offer high quality care and remains financially strong; these priorities were taken forward in our Monitor five year strategic plan (14/15 – 18/19); they also incorporate the work of the SEL strategy. The table below identifies ways in which we are developing these strategic priorities in 16/17:

Strategic priority	**16/17 targets / plans**
Enhance quality: ensuring excellence for every patient	1. Learning from incidents and complaints is embedded through implementing the trust's *Embedding Learning* action plan.
	2. 80% of staff receive supervision as per trust policy.
	3. Each directorate has at least one set of outcomes measures in place.
Promote innovation: redesign services with patients, families and commissioners	4. Improve support for carers through implementing year 1 of the trust's *Carers strategy*.
	5. Improve support for GPs on mental health through implementation of Primary Care Plus.
Increase productivity: be resilient and resourceful to thrive in difficult times	6. Through recruitment, reduce the number of trust vacancies.
	7. Reduce use of agency staff.
Transformational change: in service delivery and use of estate – in line with STP.	8. Working as o-commissioner with Greenwich CCG for the over-65 programme budget (the Ageing Well Programme) to reduce hospital attendances and admissions through improved primary and community services, changed pathways and anticipatory management plans co-designed with patients.
	9. In Bexley, community services will be realigned to GP localities and the trust and local authority are exploring putting an integrated care provider model in place.

Strategic priority	16/17 targets / plans
	10. In Bromley, we are working with the whole system to co-design a new model of care, based on the LCN approach.

Oxleas membership and elections

1. *Governor elections in previous year and plans for coming 12 months*

- August 2015
  - Public Governors - 3 x Bexley, 1 x Bromley, 1 x Rest of England
  - Service User/Carer Governors - 1 x Learning Disability (no nominations received), 1 x Carers (elected unopposed and announced July 2015)
  - Staff Governors - 1 x Child and Adolescent Mental Health (elected unopposed and announced July 2015), 1 x Forensic (no nominations received), 1 x Bexley Community Health Services (elected unopposed and announced July 2015)
- January/February 2016 – by-election
  - Public Governors - 1 x Bromley, 1 x Greenwich
  - Service User/Carer Governors – 1 x Learning Disabilities
  - Staff Governors – 1 x Forensic Mental Health
  - Declaration of results 5 February 2016
- Summer 2016 – planned elections for those governors coming to end of term:
  - Public Governor (1 x Greenwich)
  - Service User/Carer Governors (1 x Working Age Adult Mental Health, 1 x Adult Community Health, 2 x Older People Mental Health, 1 x Children's)
  - Staff (1 x Older People Mental Health Services, 1 x Working Age Mental Health Services)

2. *Examples of governor recruitment, training and development, and activities to facilitate engagement between governors, members and the public*

- Information pack on governor role, governor induction and workshops internally; opportunities to attend GovernWell training
- Working with membership provider to develop online training needs/skills analysis toolkit for governors
- Governor information sessions (recent topics include patient experience, research on young people and mental health, IT strategy)
- Regular meetings between governors and non executive directors
- Members' Focus Groups in Bexley, Bromley and Greenwich in February 2015 attended by 150 members.
- Member health event focusing on long term conditions in December 2015 attended by 170 members
- Governors' Review and Council of Governors who's who and contact details
- Annual Members' Meeting attended by 450 in Sept 2015
- Participation in trust and community events

3. *Membership strategy and efforts to engage a diverse range of members from across the constituency over past years, and plans for the next 12 months*

- New strategy 2015-2018 with focus on increasing member engagement and building our service user/carer constituency.

- Annual Members' Focus Groups in Bexley, Bromley and Greenwich to gather feedback on trust priorities from members.
- Annual Members' Meeting – September 2016
- Member health events including 'meet our governors' stands
- Governor visits to services
- Raising profile of membership at trust and community events including those aimed at engaging with harder to reach groups such as people with a learning disability, younger people and people from ethnic minority backgrounds.