

Central & North West London NHS Foundation Trust

CENTRAL & NORTH WEST LONDON NHS FOUNDATION TRUST

APR STRATEGY DOCUMENT

Template 1: Vision and key priorities

<p>The Trust's current position is summarised as:</p>			
<p>During 2009/10, the Board of Directors led a review of the Trust's 'brand strategy'. Understanding the perceptions, opinions, expectations and aspirations of all our key stakeholders was critical to this work and the review was undertaken very much in consultation with the Council of Members and other key stakeholder groups. Our vision and values were formulated following in-depth research and consultation with all of these audiences. Together they describe at the highest level our organisational purpose and how we wish to be viewed by our service users and carers, our staff and our partners.</p>			
<p>[See Appendix, Table 1 – Trust Vision and Values]</p>			
<p>2. Our Strategic Objectives</p>			
<p>The Trust has seven strategic objectives intended to help us to achieve our vision:</p>			
<ul style="list-style-type: none"> • Provision of integrated, high quality, timely services based on the needs of the individual. • Engaging meaningfully with service users, carers and the local community to improve and align our services to meet needs, and to ensure effective local accountability to the populations we serve. • Improving and maintaining to a high standard the physical environments in which we provide services. • Recruiting, retaining and developing a skilled and motivated workforce that is proud to work for the Trust and that the Trust is proud to employ. • Providing a financial base that is robust for the future development of the Trust and to provide economic and efficient services. • Improving Trust information systems to support improvement in patient care and performance management. • Seeking and developing new business opportunities and partnerships consistent with our vision. 			
<p>In the section below, our current position in relation to each of these objectives is described with reference to some of our key achievements during 2009/10.</p>			
<p>3. Our Current Position</p>			
<p>(i) High quality services</p>			
<p>Quality Improvement Programme</p>			
<p>In our 2009/10 Quality Report, we committed to quality improvements in three key areas and have made progress across all of these:</p>			
<ul style="list-style-type: none"> • The safety of our service users – Our priority was to increase the percentage of inpatient and community service users with risk assessments completed and linked to their inpatient or CPA care plans respectively; this percentage has increased throughout the year. • The effectiveness of our clinical treatments – Our aim was to increase the measurement of clinical outcomes for service users, using the Health of the Nation Outcome Score (HoNOS) tool. This was challenging as we had to quickly embed the routine use of HoNOS in clinical practice, something that has taken other Trusts some years to achieve. We also set ourselves some of the highest targets for recording HoNOS in the country. In all areas across the Trust we have significantly increased the use of these measures to record outcomes and achieved our challenging CQUIN targets in this area. • The experience of our users – We wanted to ensure that our service users on CPA are given a 12 month review as appropriate. The Trust made good 			

progress in this area but we fell short of the target we had set ourselves for community service users. We have been able to identify that this was mainly due to recording problems and have identified how our clinical data systems can be developed to support further improvement.

Service Developments:

A number of new services were launched during 2009/10, many of which were developed in partnership with other agencies and providers. Some of the most significant were:

Westminster IAPT Service - Westminster was successful in securing central funding to improve access to psychological therapies (IAPT) for people suffering from depression and anxiety disorders. The service was launched in October 09 with 29 new staff offering a range of support options, including cognitive behavioural therapy via GP practices and self-referral. The service will be further developed in 2010-11 with the introduction of 2 'shop front' premises, increasing both its visibility and accessibility.

New Forensic Community Team - Launched in the Summer of 2009, the new Westminster Forensic Community Service (FoCuS) is a dedicated forensic service specifically designed to meet the needs of service users who, as a result of long-term mental health problems, have committed offences or are at the risk of offending in the future. The new service is a joint initiative between CNWL, West London Mental Health Trust and Westminster City Council.

Westminster Memory Service - This new assessment service was set up in partnership with NHS Westminster, Westminster City Council and Housing 21.

Early Intervention Services – Following additional PCT investment, specialist services for early intervention in psychosis were established in Brent, Harrow and Hillingdon during the year. All of the new services were successful in delivering their new cases target for 09/10.

Reports from Regulators:

Annual Health Check – In this year's CQC Annual Health Check we were awarded 'excellent' for use of resources and 'good' for quality of services. During the past 6 months we focused intense work in the four areas where our performance fell short of the CQC's target requirements - Delayed Transfers of Care, Completeness of the Mental Health Minimum Data Set, the [Learning Disabilities] Green Light Toolkit and Experience of Patients. Our performance on the first three is now in line with or exceeding target requirements and we are confident of achieving improved scores in the next National Inpatient Survey.

Inpatient Survey - The national survey of acute inpatient mental health inpatient services by the Care Quality Commission placed all mental health trusts in London in the bottom 20% nationally. The key areas of concern for CNWL were poor ward signage and the poor quality and variety of food on offer. We have already begun implementing an action plan with ward signs being more visible and welcoming for service users and cares and food tasting is now a regular occurrence to improve the menus and increase the variety of the dishes. The survey was repeated three times over a three month period to assess the progress of the action plan and this demonstrated that service users were benefitting from the changes being made.

Recognising effective risk management - After an extremely rigorous two-day assessment process, where our risk management processes were scrutinised and tested, we were pleased to achieve Level 2 NHS Litigation Authority (NHSLA) standard.

Care Quality Commission registration - From 1st April 2010, the Trust was successfully registered with the CQC without any conditions.

(ii) Engaging with service users, carers and the local community

Improving service user / carer feedback systems

This remains a key priority for the Trust. In September, a mystery shopper initiative was launched to find out what impression the Trust really makes on service users and carers. A mixture of staff, service users and carers visited various sites across CNWL to assess service quality and highlight areas for improvement. Future mystery shopping projects will be identified by the new User Experience Forum. This group will engage with local service user forums to tap into feedback systems and identify key issues. Membership of the group primarily comprises service user governors and representatives of each specialist service. This is to ensure that service users' needs and concerns are kept at the heart of the group and action is taken. The UEF will be officially launched in May 2010 and will report to the Board of Directors on a quarterly basis.

Engaging with local communities

CNWL was a national pilot 'Focused Implementation Site' to demonstrate best practice in delivering race equality and improving access to services for Black and Minority Ethnic (BME) groups. This involved active engagement with many seldom-heard communities and, as a result, CNWL established relationships with 33 BME community groups who had previously had no contact with the NHS and supported 12 community groups in pursuing funding for new projects. Several local partnerships have been developed with voluntary organisations. Notable examples have been in Harrow, where the local service won the national HSJ / Local Government Award for Community Partnerships, and in Brent, where the Trailblazer project has continued to develop community links for socially isolated people.

(iii) Improving physical environments of care

Single-Sex Accommodation

There has been a considerable amount of work undertaken to improve inpatient environments by creating more single rooms with en-suite facilities. Increased single-room accommodation is already available at Park Royal and inpatients at Northwick Park will have access to a number of single rooms with en suites by the end of 2011. The Trust has declared compliance with delivering same sex accommodation and an action plan is in place to deliver further improvements during 2010/11.

Horton Haven Refurbishment

September 2009 saw the official opening of the two villas, Ascot and Birch, at our Horton Haven site in Epsom. The site provides specialist rehabilitative care for people with long-term complex mental health problems and, following the refurbishment, the villas can now accommodate a further 30 service users in en-suite bedrooms.

Patient Environment Action Team (PEAT)

Every year the National Patient Safety Agency requires us to undertake a self assessment of the physical environment on our sites. CNWL's PEAT assessment team included representatives from Local Involvement Networks and Table 2 in the Appendix summarises the team's very positive findings.

Building Better Healthcare Award

The Estates and Facilities Department were proud to win an award for 'Best Facilities Management Service' at the Building Better Healthcare Awards 2009. This was in recognition of their work in reviewing all of the Trust's services contracts and changing the ways in which services such as laundry, catering and

portering are delivered.

(iv) Skilled and motivated workforce

Staff Survey

The 2009 Staff Survey was carried out in October 2009 with 56% of our staff responding. Overall the results of the survey were encouraging and we were particularly pleased that our scores in relation to patient care, communication between senior managers and staff, staff job satisfaction and appraisals were in the top 20%.

However, there were a few key areas where we felt our results were not good enough and we are working to ensure an improvement in next year's results:

- Percentage of staff receiving Health and Safety Training
- Percentage of staff experiencing discrimination
- Equal opportunities for career progression
- Availability of hand washing materials
- Equality and diversity training

There were two further areas where, although our scores were good in comparison to other Trusts, we are working to drive further improvement:

- The number of staff reporting that they had an appraisal is currently at 77% and our aim is 90% in 2010/11;
- Currently 85% of staff report that they receive relevant training and our target is 95% in 2010/11.

Organisational Development Programme

Our three-year Organisational Development (OD) Programme was conceived in light of 'A High Quality Workforce: NHS Next Stage Review.' There are three key areas that underpin the OD Programme and highlighted below are some of our key achievements over the past year:

Infrastructure: a new learning management system is now in place to administer courses, check staff compliance with mandatory training and undertake follow-up action where necessary. A system is also in place to record and monitor the uptake of appraisals.

Ensuring the basics are in place: The staff charter, setting out the expected behaviours, values and vision for the organisation was developed and will be rolled out across the Trust in 2010/11. A customer care training package has also been rolled out across all inpatient services and it will continue to be delivered to all sites throughout the next financial year.

Leadership: October 2009 saw the launch of a number of initiatives relating to leadership and management development: the new in-house Diploma in Leadership and Management, a Clinical Leadership Programme for senior clinicians and a Coaching Programme for senior staff.

(v) Robust financial base

In our third year as a Foundation Trust, we successfully built upon our strong track record of financial performance. We again achieved our target financial risk rating, as well as delivering most of the efficiencies set out in the third year of our cost improvement programme.

The Trust has reported a surplus for investment of £4.7m, of which £5.7m is the underlying surplus. This result is due to a combination of factors, including the delivery of the Trust's efficiency targets, higher than planned income, and good financial discipline and cost control.

Financial overview

The Trust's Earnings before Interest Tax Dividends and Amortisation (EBITDA) for the year ending 31 March 2010 was £14.2m (6.0% of income), with total capital and reserves standing at £162.6m.

The Trust delivered a full year surplus of £4.7m, £6.9m lower than set out in the 09/10 Annual Plan, the majority of which is explained by the following factors:

- The Trust carried out a revaluation of its estate which resulted in a £5.9m impairment, due to falling land values and lower construction costs across London. This was charged to the Income and Expenditure account
- Whilst the Trust delivered £5.4m of recurrent cost improvements, it fell £1.4m short of its target. This was the main factor behind the £0.9m lower than planned EBITDA.

If the major non-recurrent items in the Trust's result (the fixed asset impairment and the planned profit from the sale of one of its properties) were excluded, the Trust would have recorded a surplus of £5.7m.

[See Appendix, Table 3 – Analysis of the 09/10 Surplus]

This result represents a healthy underlying performance, which is borne out by Monitor's financial risk rating.

At the year end, the Trust had cash of £37.6m. The Trust's strong cash position is demonstrated by our consistently scoring of 4 from Monitor on our liquidity ratio. Much of this cash is committed to meet existing financial commitments and funding future service developments.

Income

The Trust recorded income of £245.1m. This is analysed in the Appendix in Chart 1.

Expenditure

Total expenditure was £240.4m. This is analysed in the Appendix in Chart 2.

Monitor Risk Rating

The Trust has consistently maintained a financial risk rating of 4 (where 5 is the best and 1 the worst) throughout the year. Table 4 in the Appendix sets out the Trust's performance against each of Monitor's financial indicators.

Cost Improvement Programme

CNWL is committed to a challenging efficiency programme that will ensure our continuing financial good health. Over £20m of recurrent efficiencies have already been delivered in the first three years of operation as an NHS Foundation Trust and we are working to deliver a further £8.4m of recurrent savings over the course of the next year.

(vi) Improving Trust information systems

Becoming 'Paper-Light'

CNWL has invested significantly in expanding and improving the Trust's informatics service to support the strategic necessity of becoming an information-driven organisation. We continued throughout the year to roll out JADE, our new electronic clinical record system across each directorate and hope to complete the programme by March 2011.

Improving Access to Information

The Quality Information System (QIS) is a new business intelligence tool that will help us to improve service user care and team efficiency. It will enable clinicians and managers to access, manipulate and interrogate data from all of the Trust's systems so that we can plan, forecast and monitor services more effectively. The information system has been delivered and testing is currently in progress with a planned completion date of September 2010.

E-Rostering

The first phase of implementing electronic rostering (e-rostering) within all in-patient wards has commenced. The new system helps managers to roster staff more effectively to cover service needs and will be rolled out across all 52 inpatient wards over the next 12 months.

(vii) Developing new business opportunities and partnerships

Community Provider Services

During the past month, the Trust was delighted to receive confirmation that we were successful in our bid to become the preferred integration partner for Hillingdon and Camden Community Provider Services. This could lead to growth of circa 45% within the next 12 months. Our 2010/11 plan details the significant amount of preparatory work that will be undertaken to ensure successful integration of these new services from next April.

Section 75 Arrangements

A Section 75 agreement for the integrated provision of Westminster's mental health and social care services was agreed and went live on 1st April 2010. During the year ahead we will be working to agree and implement new S75 agreements in Brent and Hillingdon that will include older adult services and the current Harrow S75 agreement is also to be expanded to include older adults.

Enfield Learning Disability Service

CNWL took over Seacole Ward, the inpatient learning disabilities services in Enfield, from NHS Enfield in September 2009. A new model of service was developed to ensure that the team works more effectively with service users to assist recovery in care settings that are the least restrictive and promote optimum independence.

HMYOI Feltham and HMP Wormwood Scrubs

During the year CNWL was successfully appointed to provide all healthcare services to HMYOI Feltham. The service, delivered in partnership with West London Mental Health Trust, Confederation of Hounslow Practices and Terrence Higgins Trust, will cover primary care, mental health, substance misuse and sexual health provision.

The Trust was also successful in its joint bid with Central London Community Healthcare for the provision of healthcare services to HMP Wormwood Scrubs. Our current service provision will be expanded during 10/11 and we will take on responsibility for the delivery of all mental health and substance misuse services within the prison.

4. Operational Context Going Forward

We recognise that the three years ahead will be among the most challenging in the history of the NHS. In 2010/11 we will need to make efficiency savings of 3.5% simply to keep pace with the rate of inflation and a number of our commissioners have already expressed their intention to seek further reductions in funding in both the short and medium term. This is against a background of rising stakeholder expectations regarding service quality and increased demand for our services, due in part to the consequences of unemployment and economic uncertainty and, most significantly, to the impact of dementia in a population that is living longer.

However, whilst we fully acknowledge and are justly concerned by the scale of these future challenges, we also see within them a number of opportunities to develop, improve and expand our services and emerge from the economic downturn as a stronger and more innovative and exciting organisation. The PEST analysis in the Appendix (Table 5) provides a high-level summary of the key changes we anticipate to the context in which we operate and the linked opportunities and threats that we foresee.

We believe that the maintenance and development of strong partnerships will be absolutely critical in ensuring that services are protected and developed while efficiencies are delivered. As a Trust, we have an excellent track-record of partnership working and believe that this constitutes one of our greatest organisational strengths. In developing our strategy for the three years ahead, we have reflected upon both our strengths and our weaknesses, ensuring that we capitalise upon the former and address the latter comprehensively and sustainably. Table 6 in the Appendix below provides a high-level summary of our self-assessment.

5. Introducing our Strategy

Our strategy for the next three years reflects the Board of Directors' careful consideration of all of the analyses described above and it may be summarised under two key headings:

(i) Our Corporate Development Strategy – ensuring that our services offer the best possible value for money, our contracts with commissioners are robust and mitigate against the risks associated with economic uncertainty and our corporate infrastructure is lean, efficient and service-focused.

(ii) Our Growth Strategy – seeking new business opportunities and partnerships that will enhance service quality and financial efficiency and, in some instances, mitigate the threat of funding cuts (e.g. where we are able to develop services that deliver savings to other areas of our commissioners' spend).

The two strands are inextricably linked and both will be critical in delivering our challenging 2010-13 Cost Improvement Programme. We have identified a small number of Trustwide priority workstreams that will underpin the delivery of the objectives above. These are described in detail in the section that follows.

Template 1: Vision and key priorities

<p>The Trust's vision over the next three years is to:</p>			
<p>1. Corporate Development Strategy</p> <p>Over the next three years, the Trust will be undertaking a fundamental service restructuring, moving to a service line management framework whereby service lines will be mapped to the assessed and profiled needs of our service users. This approach is fully aligned with the developing Payment by Results framework for mental health services. Our management structures and supporting corporate infrastructure will no longer be based simply upon geographical location. Instead, each service line will comprise a 'family' of similar needs-based integrated care pathways and will be jointly led by a specialist operational and clinical director 'pair'. Each director pair will together be accountable for:</p> <ul style="list-style-type: none"> • Quality & performance • Productivity & efficiency • Effectiveness & outcomes • Growth & income generation <p>in relation to each of the service line care pathways. Service line leaders will be actively encouraged to innovate and will have access to the Trust's Innovation Fund to test out new approaches. They will also be expected to work closely with commissioners to effect the shift to cost-and-volume contracting based on the new PbR currencies and to explore opportunities to introduce new partnerships within care pathways that could improve quality and value for money.</p> <p>We believe that this approach to SLM implementation has the potential to deliver real quality and productivity gains and to encourage stronger clinical leadership and a culture of innovation. The approach also shows a good 'fit' with polysystem-commissioning (commissioning by care pathway) which will become increasingly important, particularly as CWNL integrates new community provider services.</p> <p>Delivery of the priority workstreams summarised in Table 7 of the Appendix will be critical to the successful and sustainable realisation of this organisational change programme.</p> <p>2. Growth Strategy</p> <p>In previous years the Trust's broad criteria for business development were that we would:</p> <ul style="list-style-type: none"> • Continue to provide familiar services in familiar geographic areas • Consider developing familiar services in unfamiliar geographic areas • Consider developing unfamiliar services in familiar geographic areas • Not usually seek to provide unfamiliar services in unfamiliar geographic areas unless there were compelling circumstances <p>However, in light of key changes to the environment – most notably PCTs' tendering of their community provider services and the economic downturn – the Board undertook a review of the Trust's business development objectives and our business development activity during the past year. The following key points were noted:</p>			

- Whilst we had expressed interest in relation to a number of service tenders / potential business development opportunities, our 'hit rate' averaged at 1 in 10.
- We had demonstrated minimal development / appetite for growth in unfamiliar geographic areas and a cautious approach to developing 'unfamiliar services'.
- If we had been successful in winning all of the new services being tendered for / scoped at that particular point in time, it would have resulted in only circa £9m growth; a successful bid for a community provider service would bring in upwards of circa £25m growth and far greater opportunities to deliver economies of scale.

The Board therefore agreed a revised business development focus for the next five years and a far more ambitious external growth strategy:

- A target for expansion was agreed, of up to 100% within the next five years.
- It was agreed that we will seek to expand geographically as the local geography will saturate.
- We will actively seek to diversify.
- However, we will also ensure that we retain the confidence of existing stakeholders as we grow and none of the above will be at the expense of service quality.

We are delighted that we have now been selected as the preferred integration partner for both Hillingdon and Camden Community Provider Services. This could lead to growth of circa 45% within the next 12 months.

The Board also agreed that our 'internal' growth strategy (development of existing services) would be focused in areas that had the potential to contribute either to our own savings targets (e.g. developing private patient services) or to the wider savings targets of our commissioners (e.g. in primary mental health care, specialist mental health placements or in acute trust services).

Table 8 in the Appendix summarises the specific external and internal service areas we have targeted for growth and the rationale for these decisions.

3. Priority Workstreams: Milestone Targets for the 3 Years Ahead

See the table in the section that follows.

Template 1: Vision and key priorities - Key priorities for the Trust which must be achieved in the three years of the annual plan to underpin the delivery of the Trust's vision

Key priority (and timescales)	How this priority underpins the strategic vision	Key milestones (2010/11)	Key milestones (2011/12)	Key milestones (2012/13)
<p>Improving information systems, data quality and the use of information (2010-2012)</p>	<p>Improving Trust information systems to support improvement in patient care and performance management.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p>	<p>10/11 - Q1:</p> <ol style="list-style-type: none"> 1. Reach and maintain >99% completeness on all key MHMDS indicators from the end of Q1 onwards. 2. Reach and maintain target % completeness on Monitor outcome indicators from the end of Q1 onwards. 3. Ensure robust delivery plans are in place in relation to CQUIN targets for completeness of outcome recording. 4. Reporting of key performance indicators to be fully reliant on electronic systems from the end of Q1 onwards. 5. Agree Data Quality Improvement Plan with PCT Commissioning Collaborative and establish robust monitoring systems to track progress. 6. Establish Paper-Light Project Group and launch projects in Harrow, Hillingdon and Westminster. 7. Update clinical policies as required to support use of JADE as the primary clinical record. 8. Develop 100-day paper-light-transition 'toolkit' for use in all future JADE roll-outs. 9. Launch new IM&T strategy / development structures. 10. Commence review of Clinical Systems function. <p>10/11 - Q2:</p> <ol style="list-style-type: none"> 1. Harrow, Hillingdon and Westminster services to achieve 'Paper-Light' status - JADE being used as the primary clinical record. 2. Project plans to be in place for paper-light transition in directorates going live on JADE during the quarter. 3. Complete review of Clinical Systems function and agree next steps. 4. Commence due diligence work on Hillingdon 	<ol style="list-style-type: none"> 1. JADE roll out across the Trust to be completed by the end of Q1. 2. All directorates to have achieved 'Paper-Light' status - JADE being used as the primary clinical record - by the end of Q2. 3. Full integration with social care information systems to be achieved by the end of Q4. 4. Service line reports integrating information from all systems (clinical, financial, HR, risks, bank & agency etc.) to be rolled out to all service lines by the end of the year. These will be structured in line with PbR-clusters for adult and older adult service lines. 5. Information and Management Accounts functions to be reviewed to consider whether any improvements in quality and efficiency could be realised through closer working / integration. 	<p>N/A - workstream objectives to be delivered by 31st March 2012.</p>

		<p>Community Provider Services' IM Systems.</p> <p>10/11 - Q3:</p> <ol style="list-style-type: none"> 1. K&C to achieve 'Paper-Light' status - JADE being used as the primary clinical record. 2. Project plans in place for paper-light transition in directorates going live on JADE during the quarter. 3. Implement recommendations of Clinical Systems function review. 4. Complete due diligence work on Hillingdon and Camden Community Provider Services' IM Systems and report to Integration Project Board. Agree integration plan. 5. New (redesigned) Service Analyst posts to be fully recruited to. 6. QIS training programme to be launched. 7. Balanced Scorecard and Quality Dashboard to be launched on QIS. <p>10/11 - Q4</p> <ol style="list-style-type: none"> 1. Brent and Older Adults to achieve 'Paper-Light' status - JADE being used as the primary clinical record. 2. Project plans in place for paper-light transition in directorates going live on JADE during the quarter. 3. Deliver requirements of Hillingdon and Camden Provider Services IM Systems integration plan. 4. New service (and commissioner) reports to be launched on QIS. 		
<p>Profiling the Trust's caseload using the national PbR clusters (and locally developed needs clusters for services outside the scope of the national PbR programme) (2010-2012)</p>	<p>Provide integrated, high quality, timely services based on the needs of the individual.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide</p>	<p>Objective: To provide clinicians with the tools to cluster patients and to cluster all adult and older adult patients across the Trust.</p> <p>End of May: completion of training. End of June: completion of clustering of all adult patients. End of October: completion of clustering of all older adult patients.</p>	<p>Objective: To provide clinicians with the tools to cluster patients and to cluster all CAMHS and LD patients across the Trust.</p> <p>End of May: completion of training. End of June: completion of clustering of all CAMHS patients. End of October: completion of</p>	<p>N/A - work programme to be completed by October 2011.</p>

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	<p>economic and efficient services.</p> <p>Improve Trust information systems to support improvement in patient care and performance management.</p>		clustering of all LD patients.	
<p>Develop standard best-practice care pathways linked to the national PbR clusters (and locally developed needs clusters for services outside the scope of the national PbR programme) and, based on these, implement SLM and service redesign programme across the Trust. [cf template 4 – service development strategy] (2010-2012)</p>	<p>Provide integrated, high quality, timely services based on the needs of the individual.</p> <p>Engage meaningfully with service users, carers and the local community to improve and align our services to meet needs and to ensure effective local accountability to the populations we serve.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p> <p>Improve Trust information systems to support improvement in patient care and</p>	<p>Q1-2</p> <p>Community: Clustering work to be completed. Clustering information to be used by service directorates to redesign CMHT, specialist NSF team and day service structures in line with planned future service lines. In Brent, Harrow and Hillingdon, this work will include the development of community forensic services. Draft change proposals to be prepared.</p> <p>Inpatients: Review of adult (K&C and Westminster directorates) acute & PICU and older adult inpatient services to commence, identifying care pathway / practice changes required in order to reduce reliance on inpatient capacity and ensure that as many inpatient service users as possible have access to our highest quality sites (in terms of ward environment). Draft change proposals to be prepared. Work to establish Pinn Ward as a dedicated inpatient unit for foreign nationals to commence. Business case to be prepared. Shadow inpatient service line to be established by the end of September.</p> <p>Rehabilitation: Shadow residential rehabilitation service line to be established by the end of September. This directorate will lead the placements repatriation work (see priority 2.2 below).</p>	<p>All Services Formal launch of all service lines from 1st April</p> <p>Adult and OA Inpatients & Community Shadow PbR currencies in 11/12 contract and commence tariff development work with a view to full implementation of PbR in 12/13 contract year.</p>	<p>N/A - work programme to be completed by the end of 11/12.</p>

	performance management.	<p>Q2-3 Community & Inpatient: Consultation to take place regarding change proposals.</p> <p>Q3-4 Community: New pan-Trust needs-based community service lines to be established in shadow form from the beginning of January. Joint work with commissioners and other stakeholders to commence to agree integrated care pathways and accompanying contract service specifications aligned to the PbR clusters. Inpatients: Pinn Ward to be opened as a specialist ward for foreign nationals, freeing up inpatient capacity within other areas of the Trust. Overall inpatient bed capacity to be rationalised by the end of December and the best possible use of capacity to be made at highest quality (in terms of ward environment) inpatient sites. Learning Disability Service line to be established in shadow form at the beginning of September. Liaison Services / Psychological Medicine: Service line to be established in shadow form by the beginning of January</p>		
Review of HQ services to ensure that they offer value for money (2010-2013)	<p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p> <p>Improve Trust information systems to support improvement in</p>	<p>Quarters 1 & 2: Feasibility studies to be undertaken. The feasibility studies will outline how the Trust's back-office, non-core functions could be alternatively managed to promote VfM - e.g. outsourcing, expansion (e.g. to another NHS organisation), reorganisation etc. Following completion of each feasibility study, function leads will present their findings, including change proposals, to an Executive panel ('Test Team') for review and challenge.</p> <p>Quarter 3: Collected findings of feasibility studies & change</p>	Tbc	Tbc

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	<p>patient care and performance management.</p> <p>Seek and develop new business opportunities and partnerships consistent with our vision</p>	<p>proposals to be presented to the Executive Board where next steps and future milestones will be agreed.</p>		
<p>Organisational development programme (2010-2013)</p>	<p>Recruit, retain and develop a skilled and motivated workforce that is proud to work for the Trust and that the Trust is proud to employ.</p> <p>Provide integrated, high quality, timely services based on the needs of the individual.</p> <p>Improve Trust information systems to support improvement in patient care and performance management.</p>	<p>By the end of Q1:</p> <p>(i) Performance management framework (inc. manager's handbook) is implemented</p> <p>(ii) OD programme to support Service Line Management is in place with key milestones and deliverables identified</p> <p>(iii) Scoping work undertaken to diagnose development needs of staff in senior leadership roles in support of SLM configuration</p> <p>By the end of Q2:</p> <p>(iv) Organisational change processes and methodologies in place to support future SLM implementation</p> <p>(v) Development packages (as per iii above) commissioned and in place</p> <p>(vi) OD initiatives to support HQ service review and restructuring identified</p> <p>Ongoing:</p> <p>Delivery /implementation of OD programme (as per ii and v above)</p>	<p>Ongoing:</p> <p>Delivery /implementation of OD programme (as per ii and v above)</p> <p>By the end of Q1:</p> <p>All staff are able to access a newly created learning zone area of the intranet</p> <p>The organisations has a range of staff in place who are formally trained in coaching</p> <p>By the end of Q3:</p> <p>Assessment and development processes are in place to support clinical staff in their transition to management roles</p>	<p>Tbc</p>

Key priority (and timescales)	How this priority underpins the strategic vision	Key milestones (2010/11)	Key milestones (2011/12)	Key milestones (2012/13)
<p>Actively pursuing opportunities to acquire community provider services and collaborate with neighbouring MH trusts [cf template 4 – service development strategy] (2010-2013)</p>	<p>Seeking and developing new business opportunities and partnerships consistent with our vision.</p> <p>Providing integrated, high quality, timely services based on the needs of the individual.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p>	<p>10/11 - Q1</p> <ol style="list-style-type: none"> 1. Establish Integration Project Board 2. Establish Integration Project Team, freeing up / investing in additional capacity / specialist expertise as required. 3. Commence due diligence work 4. Implement communications strategy including Hillingdon and Camden staff engagement events as a priority. <p>Other: Draft new Business Development Strategy aligned to expansion target of up to 100% within 5 years. This will encompass a review of current business planning, development and marketing capacity.</p> <p>10/11 - Q2</p> <ol style="list-style-type: none"> 1. Complete due diligence work and agree integration plans. 2. Launch integration projects. <p>Other: 1. Complete Business Development Strategy and present to the Board of Directors for approval. 2. Commence any recruitment / reconfiguration required to deliver strategy requirements.</p> <p>Throughout the year Other MHTs: Continue discussions with neighbouring MHTs that have not yet achieved FT status regarding opportunities for collaboration. If, by the start of Q3, there are neighbouring MHTs that are not on track to achieve FT status by the December 2012 deadline, commence more formal discussions regarding integration options.</p>	<p>11/12 - Q1 Hillingdon and Camden Community Provider Services integrated into CNWL from 1st April.</p> <p>Additional milestone targets to be identified during 10/11 in light of: 1. The success of other bids for community provider services. 2. Whether neighbouring trusts are on track to achieve FT status by the December 2012 deadline.</p>	<p>Tbc</p>
<p>Development of</p>	<p>Seeking and</p>	<p>The project objective for 2010/11 will be the delivery of</p>	<p>tbc following agreement of</p>	<p>tbc following agreement of</p>

<p>services enabling repatriation from high-cost out-of-area placements. [cf template 4 – service development strategy] (2010-2013)</p>	<p>developing new business opportunities and partnerships consistent with our vision.</p> <p>Encouraging recovery and social inclusion through high quality care.</p> <p>Integrated services based on the needs of the individual.</p> <p>Improving and aligning our services to meet local needs.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p>	<p>approximately £1.4m efficiency savings on CNWL commissioners' Adult MH continuing care budgets. This will be achieved primarily through a series of 'quick wins' such as renegotiation of placement contracts, reduced length of stay, achieving placement move-on etc.</p> <p>End of Quarter 1:</p> <ol style="list-style-type: none"> 1. Complete baseline scoping exercise and options appraisal. 2. Agree 2010/11 efficiency targets on Harrow and Hillingdon continuing care budgets 3. Identify efficiency targets on OA continuing care budgets. 4. Project governance and reporting structure set up completed - including project board 5. Completion of project strategy & governance documents 6. Completion of initial design of the placements review database 7. Meet Q1 placement savings-targets for Brent and K&C <p>End of Quarter 2:</p> <ol style="list-style-type: none"> 1. Completion of preliminary data and trend analysis 2. Meet Q2 placement savings-targets for Brent, K&C, Harrow and Hillingdon 3. Completion of 6 month progress reports <p>End of Quarter 3</p> <ol style="list-style-type: none"> 1. Completion of Residential Rehabilitation Service Line Business Case setting out service / care pathway development options to enable repatriations during 11/12 and 12/13. 2. Savings targets identified for 2011/12 for Harrow, Hillingdon, Brent, Westminster, K&C (adults and older adults) 3. Completion of database development 4. Meet Quarter 3 placement savings-targets for Brent, 	<p>Residential Rehabilitation Service Line Business Case (10/11 Q4)</p>	<p>Residential Rehabilitation Service Line Business Case (10/11 Q4)</p>
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		<p>K&C, Harrow and Hillingdon</p> <p>5. Preliminary Commissioning discussions to have begun regarding 11/12 plans.</p> <p>End of Quarter 4</p> <p>1. Completion and submission of year 1 progress end stage report to the project board</p> <p>2. Reviewed existing processes and workstreams to ascertain that they remain fit for purpose</p> <p>3. Business cases for service / care pathway development options to enable repatriations during 11/12 and 12/13 signed off by Trust Board</p> <p>4. 11/12 plans agreed with commissioners.</p>		
<p>Reducing PCTs' non-MH and primary care MH spend [cf template 4 – service development strategy] (2010-2013)</p>	<p>Integrated services based on the needs of the individual.</p> <p>Improving and aligning our services to meet local needs.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p> <p>Seeking and developing new business opportunities and partnerships consistent with our vision.</p>	<p>Work in 2010/11 will be focused in Harrow as this is the area most at risk of funding cuts unless savings can be found in other areas of PCT spend. Harrow will be treated as a pilot site; our intention is that similar projects should be rolled out across other service areas from the latter part of 10/11 onwards. This work will be led by the Liaison Service Line.</p> <p>10/11 Q1:</p> <p>1. Complete baseline scoping exercise identifying services that could be developed in Harrow to reduce MH-related spend in acute and primary care services (e.g. alcohol-related presentations in A&E, inappropriate prescribing of MH drugs by GPs, acute hospital delays / long stay-lengths linked to mental health problems etc.).</p> <p>2. Launch service development projects</p> <p>N.B. Future milestones will be identified following completion of 1 & 2 above.</p>	Tbc	Tbc
<p>Development of private patient services</p>	<p>Recruit, retain and develop a skilled and motivated workforce.</p>	<p>By the end of Q1: Complete scoping exercise</p> <p>By the end of Q2: Plans in place to delivery 0.75%</p>	<p>By the end of Q1: Assessment of the first year</p>	<p>Establish commercial links to deliver regular income through private patient</p>

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<p>[cf template 4 – service development strategy] (2010-2013)</p>	<p>Provide a financial base that is robust for the future development of the Trust.</p> <p>Seeking and developing new business opportunities and partnerships consistent with our vision.</p>	<p>income target in 2011/12</p> <p>By the end of Q4: Services up and running</p>	<p>By the end of Q2: Establish, depending on private patient cap, possible investment to generate plan</p> <p>By the end of Q4: Establish target for 2012/13 & establish commercial partnerships</p>	<p>company</p>
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Template 2: Key external impacts

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
<p>0% uplift to 2010/11 contract income and consequent CIP requirement to meet inflation.</p> <p>Increase in demand expected due to rising unemployment, predicted population growth and increasing life expectancy.</p>	<p>Trust has to absorb all inflationary pressures. This is estimated at £8.4m ie 3.5%. Failure to achieve this will impact on the Trust's financial performance to the extent that the variance is not matched by other savings or increased income.</p> <p>Risk is that service demand increases with no additional increase in funding from commissioners.</p>	<p>Cost improvement plan of £8.4m being implemented and contingency plan also developed.</p> <p>Service plans and contracts developed to reduce potential impact, increasing clarity regarding levels of service commissioned and mechanisms to manage potential service risks arising from increased demand. Residual risk high due to lower funding availability. Mitigation via prioritisation of patients to be treated at primary and secondary care levels.</p>	<p>Trust to achieve plan with 1% in reserve to cover potential shortfall.</p> <p>Some risk absorbed through improved efficiency that is not cash releasing. Thereafter, agreed changes to referral routes/ treatment regimes. PCTs increase payments due to over performance.</p>	<p>Lead Directors: TS, RD, AM Reported to Exec Board, Business & Finance Committee and through to Board of Directors on a monthly basis.</p> <p>Lead Directors: TS, JV Monitored through contracts and through Contract Management Group with control through Business and Finance Committee.</p>
<p>Notice from commissioners of efficiency saving requirements / disinvestment plans.</p>	<p>NHS Brent require £655k savings from the Trust's contract. Failure to deliver these as well as a £500k saving on the NHS Brent out-of-area placements spend would adversely impact on the Trust's financial performance.</p> <p>Current proposals are to agree a savings package to support NHS Harrow's financial plan. Failure to deliver could impact on future years' funding. Current proposals would lead to £1,100k full year effect) reduction on contract.</p>	<p>1. Project established to identify and manage out of area expenditure on behalf of the PCTs.</p> <p>2. Local managers have either agreed service reductions or obtained agreement to be non-PIG compliant in delivering PCT targets regarding EI new cases (exceeding PIG recommendations regarding maximum caseload per individual caseload holder)</p> <p>3. Harrow project group being established to look at</p>	<p>Low risk 2010/11, concern about 2011/12 in relation to Trust vs PCT efficiency requirements</p> <p>Increased cost in the medium term, partly offset by better use of facilities thereby reducing the total sites</p>	<p>Lead Directors: TS, RD, AM Regular updates to Executive Board and through normal monthly financial reporting to Business & Finance Committee.</p> <p>Lead Director: IM Estates & Facilities Group reporting quarterly to Business & Finance Committee.</p>

	<p>NHS Hillingdon require savings through a reduced investment in the EIS team. The risk is that the Trust would not then deliver the new cases target</p> <p>NHS K&C require the Trust to bear the risk on delivering £600k of savings in the PCT's out-of-area placements expenditure and a further £200k saving on general MH services</p> <p>NHS Westminster: no savings required</p> <p>Other Contracts: There is a total of £636k reductions in other contract values, the largest of these are NHS Barnet (£200k), NHS Hertfordshire (£193k) and NHS Hammersmith & Fulham (£86k). A range of savings totalling £855k are required on the Addictions contracts.</p>	<p>potential savings in-year from the PCT's wider mental health spend [cf templates 1&4] .</p> <p>4. Savings in other contracts are matched by reduction in activity plans and risk share arrangements which require PCTs to fund activity above the reduced activity plan.</p> <p>5. Addictions savings are being managed through the directorate's major service redesign programme [cf template 4].</p>		
<p>Wider political / economic agenda</p> <p>Impact of rising fuel costs and general price inflation</p> <p>The level of funding to both NHS Westminster and NHS Kensington & Chelsea is more than 20% above target.</p>	<p>Uncertainty, due both to the recent Coalition document and concerns as to how the remaining shortfall in public sector finances shortfall will be met, is at an all-time high – even given political promises of protection for NHS funding increases. Structural changes may cause further disruption with a loss of corporate knowledge and the lack of a mental health currency.</p> <p>Specific inflationary pressure will reduce the Trust's overall financial efficiency.</p>	<p>Develop long-term financial plans that can be adapted including dis-investment options</p> <p>Have a shared understanding with PCTs on likely scenarios</p> <p>Build case for new services funded from acute spend</p> <p>Further develop environmental strategy to reduce fuel usage.</p> <p>Improved use of contracts to manage down risk.</p>	<p>Greater levels of disinvestment in MH & community services</p> <p>New out of hospital services at lower cost</p> <p>Overall financial position worsens</p> <p>There will be some reduction, the extent of which is unclear at this stage.</p>	<p>Lead Director: TS</p> <p>Updates provided to Board of Directors</p> <p>Lead Directors: TS, RD</p> <p>Executive Board and Business & Finance Committee.</p>

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	<p>Increase in VAT will add to general inflationary pressures.</p> <p>The extent to which funding reductions might impact on local PCTs - the level of notional over-funding may well mean a greater reduction of funding to and from these two PCTs.</p>	<p>Work with PCTs to identify services that may be considered for reduction or discontinuation.</p>		
<p>Reductions to local authority funding and launch of significant redundancy programmes.</p>	<p>The Trust has formal S75 Provider Agreements with LBs Harrow & Westminster and is negotiating one with LBs Brent and Hillingdon [cf template 4]. These contracts could be adversely affected by a reduction in funding and there may be a requirement to reduce staff. Where no such agreements are in place, the impact is that existing CNWL staff may have to pick up additional level of work to meet demand.</p>	<p>A clear agreement on funding and levels of activity will reduce the potential for breaches of contract whilst risk pooling arrangements will mean that risk is shared between Borough and Trust.</p>	<p>Minimised adverse impact on other Trust services and overall Trust position.</p>	<p>Lead Directors: TS, RD, AM Monitored by Business & Finance Committee on a monthly basis as part of normal business processes</p>
<p>Expected changes to PCT commissioning arrangements.</p>	<p>Risk that the new arrangements will serve to lessen engagement with the Trust and local authorities. The development of GPs as the commissioners will be fast-tracked in London. The impact of this is at present unknown.</p>	<p>Work with commissioners and local authority partners to mitigate risk ensuring full contractual audit trail supporting the Trust's contracts. The Trust has existing three year contracts with all but one of its major commissioners and the majority of the other commissioners.</p>	<p>Ensure services are protected from unnecessary risks arising from any reform of arrangements</p>	<p>Lead Directors: TS, RD, AM Through monthly Contract Monitoring Group reporting through to Business and Finance Committee</p>

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Implementation of World Class Commissioning agenda	The increased use of tendering for service lines may have an impact on the Trust as already seen in the Addictions service.	Further develop commissioner relationships, improve data and ensure actual delivery of services, whilst jointly working on understanding the future requirements of the communities served.	There may be increased tendering of services as part of PCTs' requirements to deliver cost reductions	Lead Directors: TS, RD, AM Regular monitoring of relationships at Contracts Monitoring Group and through that at Executive Board
Introduction of PbR for mental health services.	Information system inadequacies and lack of clinical engagement invalidates initial data collection	Established project structure within SLM / Service Redesign Project to ensure delivery and link with other work-streams	Adult and Older Adult service users clustered by the end of the year	Lead Directors: TS Project timetable established and reporting through to Project Board who are accountable to Executive
Requirements of new 3-year contract, including: (i) CQUIN framework for 2010/11 (ii) Data quality improvement plan	(i) Failure to meet some or all of the CQUIN framework will have financial impact of up to £2.7m, as well as a reputational risk (ii) Failure to implement the data quality improvement plan will undermine the validity of the Trust's information and could lead to with-holding of contract income as well as lack of confidence from commissioners.	(i) Regular monitoring of CQUIN delivery against agreed trajectories [cf template 3]. Residual risk is part-implementation which may be due to external factors. Incentive scheme for services to be introduced based on achievement of financial and quality measures. (ii) Data Quality Group established reporting through to the Performance Management Committee. Residual risk will be present as DQ improvement will be an on-going process.	(i) Plans set on achieving at least 1/3rd of CQUIN income. However, further CQUIN funding released in- year based on CQUIN performance. (ii) Enhanced quality and level of recording of clinical activity to agreed definitions enabling quality and performance data to be produced and used to manage service and meet commissioners' requirements	Lead Directors: JV, RD, AM (i) CQUIN information to be reported to the Performance Mgt Committee and, through PMC, reported by exception to both Business & Finance and Quality Committees who in turn report to the Board (ii) Data quality forms part of reporting to the Performance Management Committee as well as PCTs
Integration of PCT provider arms	Management and other resources are expended on externalisation at the expense of the other Trust business.	Additional resource identified to support process in a proportionate way. Residual risk that insufficient resource	Merger by 1st April 2011 of at least Hillingdon Community Services with CNWL.	Lead Director: JV Staged process with initial stage of due diligence then

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		available when required and/or scale of diversion not fully recognised. Process to be managed by dedicated project board reporting to Executive Board and through this to Board of Directors.		integration project. Joint Integration Project Board reporting to PCT and CNWL Boards.
2012 Olympics	The diversion of workforce (for free) to engage on Olympic work may undermine the delivery of services and the financial viability of the Trust.	Engage jointly with other NHS organisations to minimise possible loss of staffing especially in high risk areas. Residual risk around commitment made to release staff for the Olympics	Some additional agency cover required to be negotiated with commissioners	Lead Directors: TS, RD, AM Immaterial impact on contract and service delivery.

Template 3: Clinical quality

Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11 2011/12 2012/13
Access to services when in crisis	<p>This was identified as a clinical priority through user feedback and organisational learning (among other sources). It links directly to the following elements of our strategic vision: Provide integrated, high quality, timely services based on the needs of the individual Engage meaningfully with service users, carers and the local population to improve and align our services to meet needs.</p>	<p>This workstream will be coordinated by a dedicated project team led by a Lead Clinician. Progress will be monitored by the Clinical Safety Group reporting to the Quality Committee (a sub-committee of the Trust Board).</p> <p>Key Actions 1. Establish the Emergency Care Project Team. 2. Scope the project using a 3 year trajectory – informing the quality priorities for future years. 3. Plan, communicate and monitor the key actions required to achieve the targets. 4. Work with the CPA Steering Group to direct the development of organisational capacity and capability.</p> <p>Delivery Risk & Mitigation Plan</p> <p>Risk: Quality priorities are not perceived as being as important as CQUIN targets and therefore do not receive sufficient priority. Mitigation: Progress will be reported to the Board of Directors in the Quality Dashboard alongside the CQUIN targets and other quality priorities.</p> <p>Risk: Targets B and C are patient reported measures and therefore subjective. Mitigation: The Project Team will reinforce the good practice measures required by CPA through the CPA Steering Group. The quarterly compliance audits (against Target A) will provide helpful triangulation of findings.</p>	<p>CRT gate keeping: Quality Report target of 90% has been consistently exceeded</p>	<p>The 2010/11 Quality Account targets will be as follows: A. 90% of community service users on the Care Programme Approach (CPA) have a completed crisis/contingency plan as part of their care plan B. 75% of community service users on the CPA report that they have a phone number to call in a crisis C. 60% of community service users on the CPA feel that they got the help they wanted</p> <p>Performance will be monitored using the Quality Dashboard, reported to the Board of Directors on a quarterly basis.</p>
Respect &	Encourage recovery, well	This workstream will be coordinated by a dedicated	Customer care	The 2010/11 Quality Account targets will be as

<p>Involvement</p>	<p>being and social inclusion, individual choice and independent living through high quality care.</p>	<p>project team led by a Lead Clinician. Progress will be monitored by the User & Carer Experience Group reporting to the Quality Committee (a sub-committee of the Trust Board).</p> <p>Performance against the CQUIN targets will be monitored by the Performance Management Group reporting to the Performance Management Committee (a sub-committee of the Trust Board).</p> <p>Key Actions 1 Establish the Respect & Involvement Project Team 2 Scope the project using a 3 year trajectory – informing the quality priorities for future years 3 Plan, communicate and monitor the key actions required to achieve the targets 4 Work with the CPA Steering Group to direct the development of organisational capacity and capability</p> <p>Delivery Risk & Mitigation Plan</p> <p>Risk: Delivery of Target A is predicated on the capacity to deliver the required training. Mitigation: Various e-training options are being pursued.</p> <p>Risk: Targets B&C and all of the CQUIN targets are based on service users’ self-reported experience. Analysis of previous survey findings has shown that the term ‘care plan’ has not always been recognised by service users and this has had an adverse impact on survey scores. Mitigation: All care coordinators to ensure not only that service users are involved in, understand and are offered a copy of their care plans (as per best practice) but also that the term ‘care plan’ is properly explained and used consistently and that care plan documents are clearly labeled as such.</p>	<p>training: 09/10 Quality Report target of 65% of staff working with service users and carers having attended customer care training has been met.</p>	<p>follows: A. 80% of staff working with service users and carers have attended customer care training B. 60% of service users on CPA report definitely understanding what is in their care plan C. 50% of service users on the CPA report they have definitely had enough say in decisions about their care.</p> <p>QA targets for 2011/12 and 2012/13 will be identified during the year.</p> <p>The following are CQUIN targets for 2010/11. By 31st March, 2011: (i) 60% service users on CPA to report that they were given or offered a written copy of their care plan. (ii) 60% of services users on CPA to report definitely understanding what is in their care plan. (iii) 50% of service users on CPA to report that they have definitely had enough say in decisions about their care.</p>
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<p>Physical Healthcare</p>	<p>Provide integrated, high quality, timely services based on the needs of the individual</p>	<p>This workstream will be coordinated by a dedicated project team led by a Lead Clinician. Progress will be monitored by the Clinical Effectiveness Group reporting to the Quality Committee (a sub-committee of the Trust Board).</p> <p>Performance against the CQUIN targets will be monitored by the Performance Management Group reporting to the Performance Management Committee (a sub-committee of the Trust Board).</p> <p>Key Actions 1 Establish the Physical Healthcare Project Team 2 Scope the project using a 3 year trajectory – informing the quality priorities for future years 3 Plan, communicate and monitor the key actions required to achieve the targets 4 Work with the appropriate fora e.g. the Acute Care Forum to direct the development of organisational capacity and capability</p> <p>Delivery Risk & Mitigation Plan</p> <p>Risk: Quality priorities are not perceived as being as important as CQUIN targets and therefore do not receive sufficient priority. Mitigation: The Physical Healthcare Steering Group will oversee the implementation of both the quality priorities and the relevant CQUIN targets. Progress against both will be reported to the Board of Directors as part of the Quality Dashboard.</p> <p>Risk: For the first CQUIN target (encounter records) - the Trust has more than 5000 service users on CPA and will be starting from a zero-baseline. Receipt of encounter records cannot be logged using the Trust's electronic care record systems and local data collection systems will have to be set up quickly and maintained effectively.</p>	<p>These targets were not reported against during 09/10.</p>	<p>The 2010/11 Quality Account targets will be as follows: A. 95% of inpatient service users have had a physical health assessment after admission B. 55% of inpatient service users felt that they got enough care for their physical health C. Establish a baseline for community service users (% of service users who felt that mental health services gave them enough support in getting help for any physical health needs they had)</p> <p>QA targets for 2011/12 and 2012/13 will be identified during the year.</p> <p>The following are CQUIN targets for 2010/11 relating to physical healthcare: 1. GP encounter records are to be obtained for 80% of service users on CPA by the end of Q4 [20% by the end of Q1, 40% by the end of Q2, 60% by the end of Q3, 80% by the end of Q4] 2. By the end of Q3, a 30% increase (against a Q1 baseline) in the number of patients on CPA with diagnosis of Diabetes, Coronary Heart Disease or COPD on QOF registers who have received primary health care checks within the last 15 months</p>
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<p>Improving communication with GPs</p>	<p>Work in partnership to provide responsive and dependable services. Provide integrated, high quality, timely services based on the needs of the individual</p>	<p>This workstream will be coordinated by a dedicated project team led by a Lead Clinician. Progress will be monitored by the Clinical Safety Group reporting to the Quality Committee (a sub-committee of the Trust Board).</p> <p>Performance against the CQUIN targets will be monitored by the Performance Management Group reporting to the Performance Management Committee (a sub-committee of the Trust Board).</p> <p>Delivery Risk & Mitigation Plan</p> <p>Risk: Delivery of the first target relies upon the active engagement of the acute trust pharmacies who check and provide a final summary of prescribed medication on discharge.</p> <p>Mitigation: Senior Trust Pharmacy Leads to engage with the relevant acute trust teams to agree clear protocols.</p> <p>Risk: Junior doctors are responsible for writing the</p>	<p>These targets were not reported against during 09/10.</p>	<p>The following are 2010/11 CQUIN targets:</p> <ul style="list-style-type: none"> • By 1st July 2010, the discharge notification should be being sent to the patient's GP within 24 hours of discharge for 85% of discharged patients. • By 1st July 2010, the discharge summary should be being sent to patient's the GP within 20 operational days of discharge for 85% of discharged patients.

		<p>majority of discharge summaries and there may be increased risk of hitting the 20-day deadline during new-rotation periods.</p> <p>Mitigation: Lead Clinicians to ensure that Consultants have mechanisms in place to confirm that all outstanding discharge summaries have been completed prior to new-rotation periods.</p>		
Embedding the use of outcome tools in clinical practice	Provide integrated, high quality, timely services based on the needs of the individual	<p>This workstream will be led by the Trust's Clinical Effectiveness Lead via the Outcomes Steering Group.</p> <p>Performance against the CQUIN targets will be monitored by the Performance Management Group reporting to the Performance Management Committee (a sub-committee of the Trust Board).</p> <p>Delivery Risk & Mitigation Plan</p> <p>Risk: The new CQUIN targets represent a significant 'stretch' in some areas.</p> <p>Mitigation: Clinical leads to continue to stress the importance of the use of outcome tools at key stages in the care pathway. New dedicated 'Outcomes Analyst' to provide clinician-tailored feedback of paired outcome scores to increase engagement in and the clinical utility of this work programme.</p>	<p>The Trust met or exceeded all of the CQUIN targets for completeness of outcome recording set by commissioners:</p> <p>Adult IP: 50% OA IP: 80% CAMHS IP: 100% Adult Community: 15% OA Community: 40% CAMHS Community: 80%</p>	<p>The following are 2010/11 CQUIN targets:</p> <p>By 31st March 2011</p> <ul style="list-style-type: none"> • 80% Adults and Older Adults (combined) admitted to in-patient units will be assessed using HoNOS / HoNOS 65+ upon admission and discharge • 60% Adults and Older Adults (combined) will be receiving a HoNOS assessment upon acceptance to and discharge from community caseload. • 60% Adults and Older Adults on CPA (combined) will be receiving a HoNOS assessment at CPA review. • 100% of CAMHS inpatients will be assessed using HoNOSCA upon admission and discharge (maintenance target) • 80% of CAMHS service users will be receiving a HoNOSCA assessment upon acceptance to and discharge from community caseload (maintenance target) • An improvement in HoNOSCA scores to be demonstrated for > 60% of CAMHS inpatient cases over a six month period. • 100% of eating disorder service users to receive an EDE-Q assessment on admission / acceptance into treatment and on discharge (or other more appropriate point in the care pathway). • By 1st October, paired EQE-Q outcome data from Quarters 1 & 2 will be used as a baseline to agree, by diagnostic group, a target for improvement (as yet not quantified) between paired assessments for the rest of the year.

Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11 2011/12 2012/13
Preparing for the implementation of PbR for mental health	Provide integrated, high quality, timely services based on the needs of the individual Improve and align our services to meet needs.	<p>This workstream will be led by the Trust's Clinical Effectiveness Lead and will report to the SLM / Service Redesign Programme Board, jointly chaired by the Medical Director and Director of Operations.</p> <p>Performance against the CQUIN targets will be monitored by the Performance Management Group reporting to the Performance Management Committee (a sub-committee of the Trust Board).</p> <p>Key Actions, See template 1.</p> <p>Delivery Risk & Mitigation Plan</p> <p>Risk: It is not currently possible to record HoNOS-PbR and clustering information on the Trust's electronic care record systems Mitigation: Development work is underway and is on track to be completed by the end of Q2 at the latest.</p>	Not applicable.	<p>The following is a 2010/11 CQUIN target.</p> <p>By end of Q2:</p> <ul style="list-style-type: none"> • All staff who will need to implement HoNOS-PbR have been trained; • A robust project plan with trajectory is in place; • The Trust is ready to implement data collection. <p>By the end of Q4:</p> <ul style="list-style-type: none"> • 80% of adults and older adults on CPA have been assessed using HoNOS PbR and assigned to a cluster.
Ensuring appropriate prescribing for patients with dementia	Provide integrated, high quality, timely services based on the needs of the individual	<p>This workstream will be coordinated by a dedicated project team led by a Lead Clinician. Progress will be monitored by the Clinical Safety Group reporting to the Quality Committee (a sub-committee of the Trust Board).</p> <p>Performance against the CQUIN target will be monitored by the Performance Management Group reporting to the Performance Management Committee (a sub-committee of the Trust Board).</p> <p>Delivery Risk & Mitigation Plan</p>	Not applicable.	<p>The following is a 2010/11 CQUIN target:</p> <p>Annual internal audit of antipsychotic prescribing to be completed and reported to commissioners no later than the end of Q3.</p>

		<p>Risk: Failure to complete audit report by the end of Q3 Mitigation: Audit project to be robustly managed by the Clinical Audit and Pharmacy teams to ensure completion to timescale.</p> <p>Risk: Audit does not report on the data required for the CQUIN target Mitigation: Data collection tool to be reviewed by Clinical Audit Manager and Deputy Chief Pharmacist to ensure it measures the information required by the CQUIN target.</p>		
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Template 4: Service development strategy

Service development priorities	Contribution to the overall vision	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
Organic / innovation:				
<p>Trustwide: Develop standard best-practice care pathways linked to the national PbR clusters (and locally developed needs clusters for services outside the scope of the national PbR programme) and, based on these, implement SLM and service redesign programme across the Trust. [cf template 1 – key priorities]</p>	<p>Provide integrated, high quality, timely services based on the needs of the individual.</p> <p>Engage meaningfully with service users, carers and the local community to improve and align our services to meet needs and to ensure effective local accountability to the populations we serve.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p> <p>Improve Trust information systems to support improvement in patient care and performance management.</p>	<p>See template 1 for milestone targets.</p> <p>Delivery Risks (and mitigation)</p> <p>(i) Failure to deliver within timeframe Reprioritise and run additional service lines live sooner than planned</p> <p>(ii) Failure to achieve financial savings Additional support to be provided to service line directors. If this fails, the Executive Board will override local SL decisions and possibly replace SL directors.</p> <p>(iii) Failure to achieve qualitative gains As for (ii)</p> <p>(iv) Staff unhappy / discontented. Review and amend communication plan if required.</p> <p>(v) Risk to LA and PCT relationships. Slow down disengagement of Service Directors from local areas and reconsider approach to local</p>	<p>Investment in the following areas: Programme Management – director, support, external assurance and communication Service Line Transition – double running costs, selection process, development support Plus - dedicated support from all Corporate Directorates</p>	<p>See template 1 for milestone targets.</p> <p>KPIs: Progress against project milestones. % of care pathways designed. % of care pathways operationalised. % of care pathways costed % of care pathways priced % of care pathways used as currencies in PCT contracts £ savings delivered through redesign</p>

		relationships (vi) Loss of contracts Focus on improved communication with CEOs and DoFs.		
Trustwide: Development of services enabling repatriation from high-cost out-of-area placements and significant savings to commissioners' placement budgets [cf template 1 – key priorities]	<p>Working in partnership to provide responsive and dependable services in a range of settings for the communities we serve.</p> <p>Encouraging recovery and social inclusion through high quality care.</p> <p>Integrated services based on the needs of the individual.</p> <p>Improving and aligning our services to meet local needs.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p> <p>Seeking and developing new business opportunities and partnerships consistent with our vision.</p>	<p>See template 1 for milestone targets.</p> <p>Delivery Risks (and mitigation)</p> <p>(i) A lack of PCT commissioner buy-in and engagement in the process will lead to delays and project not achieving target savings Early engagement and involvement. Commissioners to be represented on project board.</p> <p>(ii) Breakdown in commissioning relationships (e.g. between PCT and LAs) would impact on the ability to deliver the project and potentially impact other service areas. Ensure effective panel processes are in place.</p> <p>(iii) Project fails to deliver savings within required timescales Robust project governance structure</p> <p>(iv) Project may result in increased pressure on social care budgets. CNWL manages this budget in Harrow. Ensure effective panel processes are in place.</p> <p>(v) Savings made fail to mitigate risk of income reduction</p>	<p>The following dedicated roles to be identified within existing resources: Project Director Project Manager Business Lead Lead Clinician</p> <p>Additional investment required for the life of the project: 2 x Band 7s - to lead the work to review current placements 1 x Band 5 - full time administrator</p> <p>Plus support from the following Directorates: Operations Finance Estates Strategic Planning & Information</p>	<p>See template 1 for milestone targets.</p> <p>KPIs: Progress against project milestones Progress against savings targets</p>

		<p>Obtain agreement from commissioners that savings delivered will offset income reductions that were initially proposed.</p> <p>(vi) Placement review process may result in increases to placement costs</p> <p>Agree savings targets only after initial review of placement details.</p>		
<p>Trustwide: Development of services to help PCTs to reduce their spend on non-MH and primary care MH services [cf template 1 – key priorities]</p>	<p>Working in partnership to provide responsive and dependable services in a range of settings for the communities we serve.</p> <p>Integrated services based on the needs of the individual.</p> <p>Improving and aligning our services to meet local needs.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p> <p>Seeking and developing new business opportunities and partnerships consistent with our vision.</p>	<p>See template 1 for milestone targets.</p> <p>Delivery Risks (and mitigation)</p> <p>(i) Failure to deliver savings in NHS Harrow’s wider commissioning spend will result in cuts to frontline mental health services. Maintain ongoing exec-level communication with NHS Harrow. Ensure robust project governance structure.</p> <p>Undertake work to benchmark NHS Harrow spend on secondary MH services to demonstrate that any further reduction in funding would further reduce the PCT’s relative level of investment against comparator areas.</p> <p>(ii) Until we have been given access to relevant acute hospital coding data and GP prescribing data, CNWL’s ability to scope and realise savings opportunities will be limited. Harrow Service Director and Chief Pharmacist to work with staff at NHS</p>	<p>tbc following baseline scoping exercise</p>	<p>See template 1 for milestone targets.</p> <p>KPIs: Progress against project milestones (once agreed) £savings delivered against spend in targeted areas</p>

		Harrow to obtain the data required to identify savings opportunities.		
Trustwide: Development of private patient services [cf template 1 – key priorities]	<p>Recruit, retain and develop a skilled and motivated workforce.</p> <p>Provide a financial base that is robust for the future development of the Trust.</p> <p>Seeking and developing new business opportunities and partnerships consistent with our vision.</p> <p>Improving and aligning our services to meet local needs</p>	<p>See template 1 for milestone targets.</p> <p>Delivery Risks (and mitigation)</p> <p>(i) Clinicians start to undertake private work prior to the establishment of regulations</p> <p>Trustwide communication to alert all clinicians of requirement to undertake work within a proper framework. Reinforcement via lead clinicians and service directors.</p> <p>(ii) Local systems are inadequate for the collection of correct information to identify PPs and allow for income recovery.</p> <p>Develop framework and put data collection processes in place at points where PP work will be allowed.</p> <p>(iii) Failure to recover PP income when work undertaken</p> <p>Establish local systems requiring prior payment and standard contracts for corporate work.</p>	<p>£50k – legal work in year one</p> <p>£15k – tax consultancy</p> <p>Each operational directorate to identify a clinician to lead on this workstream and contribute to a Trustwide Working Group.</p> <p>Lead Business Manager to be identified to provide project management support.</p>	<p>See template 1 for milestone targets.</p> <p>KPIs:</p> <p>Progress against milestone targets</p> <p>% of income raised through private patient services</p>
<p>Brent & Hillingdon: Develop Section 75 partnership arrangements for the integrated provision of adult and older adult mental health services with CNWL as the lead provider organisation.</p> <p>Harrow: Extend the current Section 75 arrangements to include the</p>	<p>Working in partnership to provide responsive and dependable services in a range of settings for the communities we serve.</p> <p>Integrated services based on the needs of the individual.</p>	<p>Key actions:</p> <p>Brent: Continue joint project with LB Brent working to implementation deadline of September 2010 (3-month tolerance built in given election hiatus)</p> <p>Hillingdon: Appoint project manager</p>	<p>8a Project Managers x 2 for the life of the Brent & Hillingdon S75 projects.</p> <p>Support from the following Corporate Directorates:</p> <ul style="list-style-type: none"> • Finance 	<p>Progress against project milestone targets.</p>

<p>integrated provision of older adult mental health services with CNWL as the lead provider organisation.</p>		<p>and establish project governance structure during Q1. Agree joint project plan with LB Hillingdon working to deadline for implementation of April 2011.</p> <p>Harrow (OA): Establish project governance structure during Q1 and agree joint project plan with LB Harrow working to deadline for implementation of Jan 2011.</p> <p>Delivery Risks (and mitigation)</p> <p>(i) Competing demands on time of senior staff involved may present risk to timely completion Robust project management structures established with dedicated senior staff input.</p> <p>(ii) Differences between CNWL and local authority payscales may present financial and recruitment risks. A 'generic' mitigation plan is being developed by CNWL HR and Finance Teams in collaboration with local authority senior leads. This will be presented to the Trust's Business & Finance Committee for approval.</p>	<ul style="list-style-type: none"> • HR • Operations • Contracts • Information 	
<p>Additions: Complete the restructure and redesign programme to ensure that the service offers the best possible value for money.</p>	<p>Provide integrated, high quality, timely services based on the needs of the individual.</p> <p>Engage meaningfully with service users, carers and the local community to improve and align our services to meet</p>	<p>Key actions:</p> <p>1. Increasing front line key-working capacity and competence by ensuring each team has a greater capacity for key work, delivered by a multi-disciplinary team all trained in a core package of treatment and recovery interventions.</p>	<p>To be delivered within available resources within the directorate.</p> <p>Dedicated support will continue to be required from the</p>	<p>This programme began during 09/10 and the restructuring work is due to be completed by the end of Q2.</p>

	<p>needs and to ensure effective local accountability to the populations we serve.</p> <p>Provide a financial base that is robust for the future development of the Trust and to provide economic and efficient services.</p> <p>Working in partnership to provide responsive and dependable services in a range of settings for the communities we serve.</p> <p>Integrated services based on the needs of the individual.</p>	<p>2. Enhancing psycho-social interventions to tackle addiction and mental health issues.</p> <p>3. Increasing evidence-based stabilisation, detoxification, opioid maintenance and ameliorative prescribing options. An increased number of prescribing pathways options will be offered, non-medical prescribing will be increased and our interface or 'shared care' services with primary care will be improved.</p> <p>4. Improving physical healthcare interventions. The healthcare of substance misusers in CNWL treatment will be improved and our nurses will champion a range of best practice healthcare interventions.</p> <p>5. Management: The senior management team will be streamlined to create an improved focus on performance and financial management, based on high quality monthly data. Service line management will be implemented with sector managers and lead clinicians jointly responsible for local performance, quality and budgets. Each service will also have a service user group with representatives who contribute to service management and feed directly into the SMT.</p> <p>Delivery Risks (and mitigation)</p> <p>(i) Project is not completed by the end of Q2</p> <p>Robust project management arrangements with stage progress</p>	<p>Finance and HR & OD directorates.</p>	
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		<p>reports to the AOCD SMT and phase completion reports to the Trust Board.</p> <p>(ii) Trade unions objections Continue process of open communication with union representatives throughout the project via planned meetings.</p> <p>(iii) Inadequate training and development plan to support staff in their post-restructure roles Audit of skills required to deliver services against evidence-based best practice to be undertaken. T&D plan will be tailored in line with audit findings.</p> <p>(iv) Cost of redesigned service will exceed income Directorate will continue to work closely with the Finance Dept to ensure that service models can be delivered within available resources (whilst delivering planned efficiency savings).</p>		
Acquisition etc:				
<p>Actively pursuing opportunities to acquire community provider services and collaborate with neighbouring MH trusts [cf template 1 – key priorities]</p>	<p>Seeking and developing new business opportunities and partnerships consistent with our vision.</p> <p>Providing integrated, high quality, timely services based on the needs of the individual.</p> <p>Provide a financial base that is robust for the future</p>	<p>See template 1 for milestone targets.</p> <p>Delivery Risks (and mitigation)</p> <p>(i) Community Provider Services: Insufficient funding transfers with the acquired service to deliver contractual commitments to an appropriate level of quality Senior representatives from CPS to</p>	<p>Executive Director lead (Director of Strategic Planning & Partnerships)</p> <p>Dedicated support from all of the Corporate Directorates.</p> <p>Investment in Senior</p>	<p>See template 1 for milestone targets.</p> <p>KPIs: £new income opportunities identified as a percentage of 09/10 turnover £new income gained as a percentage of 09/10 turnover</p>

	<p>development of the Trust and to provide economic and efficient services.</p>	<p>be included in the membership of the Integration Project Board. Invest in expert advice if this is deemed necessary to mitigate risk.</p> <p>(ii) Community Provider Services: Insufficient senior management capacity at CNWL to manage the due diligence / integration process and deliver the Trust's other strategic and operational priorities. Establish Integration Project Team, investing in additional capacity (e.g. project management) if this is deemed necessary.</p> <p>(iii) Community Provider Services: CNWL's Board and Senior Management Team do not currently include specialists in the provision of community physical healthcare. Risk to robust due diligence. Establish Integration Project Team, including clinical due diligence workstream. Bring in specialist clinical experts to undertake or review this work if it is deemed necessary.</p> <p>(iv) Any expansion: Acquisition of poorer performing services could risk a breach of the Trust's CQC registration requirements or FT terms of authorisation. This risk will be addressed through the due diligence process. Any 'unacceptable' risks to the Trust's registration status or terms of</p>	<p>Project Manager to lead integration projects</p> <p>Investment in specialist expertise may be required as part of the due diligence process.</p>	
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		<p>authorisation would have to be addressed prior to integration.</p> <p>(v) Any expansion: Existing stakeholders (staff, service users, carers, commissioners etc.) are likely to be anxious regarding the impact of expansion on the Trust's focus and capacity to deliver existing services and planned developments. This could impact on patient and staff satisfaction (evidenced in the national surveys) and on commissioner confidence in CNWL as a provider of its current service portfolio. Establish Integration Project Team and implement agreed communications strategy.</p> <p>(vi) General: The Trust may not yet have the capacity and expertise required to deliver its expansion target of up to 100% within 5 years Draft new Business Development Strategy aligned to expansion target of up to 100% within 5 years. This will encompass a review of current business planning, development and marketing capacity.</p>		
<p>Offender Care: Following successful bid with Central London Community Healthcare for the provision of healthcare services to HMP Wormwood Scrubs, expand service provision to take on responsibility for the delivery of all mental health and substance misuse services within the</p>	<p>Seeking and developing new business opportunities and partnerships consistent with our vision.</p>	<p>Key Actions:</p> <p>Q1:</p> <ul style="list-style-type: none"> • Commence TUPE process • Agree contract and performance monitoring requirements • Review, amend and agree joint policies, procedures and clinical 	<p>To be delivered within available resources within the directorate.</p> <p>Dedicated support will continue to be required from the</p>	<p>Progress against project milestones.</p>

<p>prison.</p>		<p>governance arrangements.</p> <p>Q2:</p> <ul style="list-style-type: none"> • Complete TUPE process • Commence new contract from 1st July/mid August. • Implement new joint training and development strategy. <p>Delivery Risks (and mitigation)</p> <p>(i) Agreement of satisfactory funding arrangements with service commissioner. Involvement of senior Finance and HR representatives in negotiations with commissioner.</p> <p>(ii) Staff retention Development of shared recruitment, retention and staff development plan with CLCH. Also exploring rotation of CNWL community staff.</p> <p>(iii) Successful completion of TUPE transfer and recruitment to key positions Preparation work by CNWL HR team.</p> <p>(iv) Implementation of improved clinical governance and risk management within the mental health service Development of shared clinical governance system applying learning from HMP Holloway.</p>	<p>Finance and HR directorates.</p>	
<p><i>Transferred / discontinued activity:</i></p>				

Template 5: Workforce strategy

Key workforce priorities	Contribution to the plan	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11, 2011/12, 2012/13
<p>Maintain robust HR management procedures, with leaner working practices during period of organisational change and associated uncertainty.</p>	<p>This will particularly support the following priority workstreams: - Cost Improvement Programme - Service Line Management & Service Redesign Programme - Review of HQ services</p>	<ol style="list-style-type: none"> 1. Quickly realign HR department to new service lines to provide identifiable and consistent support through the change programme. Delays in doing this will lead to inconsistent support for new Service and Clinical Directors and may jeopardise the success of the venture. 2. Establish sickness-absence task force across service and corporate groups to maintain drive to reduce sickness absence and realise associated savings. 3. Continue with the e-rostering roll out project to support improvements in rostering processes/outcomes and deliver cost savings in relation to bank and agency spend. 4. Establish a leaner, centralised employee relations team within HR department, to increase productivity and timeliness of response and improve consistency/quality of service. 	<p>We anticipate this stream of work will be achieved within the directorate's current resource base. However, in order to achieve a successful outcome effective engagement with clinical services will be crucial.</p> <p>Some transitional funding to ensure appropriate capacity is in place to support the change programme may be needed. This will be separately negotiated.</p>	<p>2010/11 Q1: HR team reconfigured 2010/11 Q2: Taskforce established and work programme agreed 2010/11 Q3: Initial roll out of e-rostering complete for all inpatient areas. Decision taken regarding scope of future implementation</p>
<p>The success of the organisation is inextricably linked to the quality of the workforce. A key priority is therefore to retain our best staff, drive improvements in performance (where needed) and to ensure we recruit only the best. Without such an approach we are likely to reduce our competitive edge and the quality of care we</p>	<p>This will be essential to ensuring successful delivery of the Trust's overall strategy for the 3 years ahead.</p>	<p>1. The implementation of service line management provides an opportunity to rethink the ways in which our services are provided, utilising best practice at national and international levels and introducing more productive working practices. Without this our services may be prone to stagnation. A key part of the programme will be the production a workforce development strategy that considers career pathways, skill mix and that links to the organisation's learning and development strategy and informs future approaches to training and development. Without this in place, there is a risk</p>	<p>As above</p>	<p>2010/11 Q2: Assessment centre review complete and implementation plan agreed 2010/11 Q4: Workforce development strategy produced, for implementation in 2011 – 2013. 2010/11 Q2: Success of assessment centres measured and plans for future use on new recruits and existing staff in place</p>

offer.		<p>that productivity improvements will not be achieved, quality of care will be reduced and our best staff will leave the organisation.</p> <p>2. Our current portfolio of assessment centres will be reviewed and changes made, as appropriate. We are however generally committed to the approach and will be seeking to extend the range of assessments that we can internally provide. In addition, consideration will be given to the use of assessments for staff currently in post to determine whether it is a pragmatic and fair approach to reducing headcount.</p> <p>3. The current configuration of the recruitment service will be reviewed and the introduction of an internal recruitment agency offering a broader recruitment service considered, if the need and cost benefit can be demonstrated.</p> <p>4. Ensuring robust performance management systems in place to manage those staff who do not deliver the quality we expect is a key action [c.f. Leadership and Governance section]</p> <p>5. Continue to deliver and expand where necessary leadership development opportunities as defined in the OD programme.</p>		<p>2011/12 Q2: Development pathway to validate new managers in place 2011/12: Executive Board approve plans for recruitment bureau</p>
Ensuring effective change management support during transition to service line management and broader organisational reconfiguration / expansion.	<p>This will particularly support the following priority workstreams:</p> <ul style="list-style-type: none"> - Cost Improvement Programme - Service Line Management & Service Redesign Programme - Review of HQ services - Actively pursuing opportunities to acquire community provider services and collaborate with neighbouring MH trusts. 	<p>1. Building on the good relationships with staff side and trade unions we will seek to put in place fair and effective change management processes. Ratification of the change management procedure is the first stage in this process.</p> <p>2. See Leadership and Governance section for further information.</p> <p>3. Ensure appropriate, senior HR input to due diligence processes following service acquisitions, to ensure high quality workforce baseline information and associated action plans.</p>	See template 4 for resource requirements.	<p>2010/11 Q1: Trust Joint Consultative Committee approve Change Management policy 2010/11: Director of HR leads on workforce elements of due diligence processes and is satisfied with methodologies. 2010/12: Executive Board due diligence sign off and recommendations addressed.</p>

Template 6: Capital programmes (including estates strategy)

Key capital expenditure priorities	Amounts and timing	Contribution to the plan (including service delivery)	Key actions and delivery risk
Development:			
Developments (various)	Financial year 2010/11 £6,259k	Major scheme includes Northwick Park Hospital refurbishment improving quality of environment and single sex provision.	Ongoing as part of project spanning three years. Project Board meets monthly to review progress and risk allocation
Maintenance:			
Maintenance or replacement capex	Financial year 2010/11 £400k replacement boiler. £693k backlog maintenance.	Various schemes to improve access and maintain building in condition B.	Planned and urgent maintenance taking place on existing Trust facilities. Risks monitored and managed via Estates and Facilities Group reporting to Business & Finance Committee
Other capital expenditure:			
Other capital expenditure	Financial year 2010/11 £3,287k	Mostly related to various IT spend approved via the IT investment strategy	Regular procurement of equipment and technology including facilities dedicated to IT. Risks monitored and managed as above.
Other estates strategy:			
Other estates strategy	Financial year 2010/11 £83k	Expenditure related to disabled access and improving energy efficiency.	Programme of estates reorganisation and energy management schemes. Risks monitored and managed as above.

Template 7: Operational / financial effectiveness

Key operating efficiency programmes	Amounts and timing	Contribution to the plan	Key actions and delivery risk	Resource requirements	Milestones 2010/11 2011/12 2012/13
Introduction of e-financials	£149,000 2010/11 £70,000 (ongoing from 2011/12)	The programme will lead to savings within the Finance Department and increased accuracy and timing of invoice payment.	Key Actions: Trial the process in Westminster services then roll-out across the Trust. Delivery Risk & Mitigation Plan (i) The supplier fails to deliver the product. This is in part mitigated by the checks with existing clients and testing the processes. (ii) The failure to have sufficient codes on original documents still leaves a level of dependency on finance staff to allocate. This is mitigated by focused work with managers who consistently do not comply. (iii) Managers fail to authorise electronic copies. This is mitigated by having available the information required to follow this up and escalate as necessary.	Finance staff time and system development: £114,000 (one-off cost)	May 10 - go live with scanning June 10 - commence pilots in Westminster August 10 - onward roll out across the Trust
Introduction of e-procurement	2011/12: £85K	Roll-out of e-procurement to whole Trust during 2010/11.	Key Actions: Local staff to be trained in use of system. Master catalogue being established. Delivery Risk & Mitigation Plan Slippage in project – this is mitigated by the appointment of an experienced project manager on an interim basis.	Expert staff to train procurement team and local staff, and to provide system support: £30K (one-off cost)	Training Plan to be complete – July 2010 Supplier catalogues to be complete: Oct 2010 Direct ordering to supplier: Jan 2011
Review of transport costs	Car user allowance scheme review: £50,000 Lease car scheme	Regular car user allowance to be stopped for those not entitled to it from 1st June 2010. Lease car regime either to be revised or stopped.	Key Actions: Management reviewing historic claims and confirming entitlement. New lease car regime to be agreed on revised terms. Delivery Risk & Mitigation Plan (i) Managers fail to confirm regular car user	Management time for review	Lists of staff involved circulated in April to be actioned by June Policy to be agreed by Executive Board in April/May 2010.

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	review: £70,000		entitlements Assume confirmation. (ii) Delay in implementation Drive forward to minimise delay. (iii) Failure to implement an acceptable lease car scheme Clear project programme to implement to be put in place as soon as scheme agreed		
London Procurement Programme	Waste management (Aug 2010): £40Kpa Agency nursing: TBC Computer hardware (June 2010): reduced price per item	Services/Products currently under consideration include agency nursing, waste management and computer hardware.	Key Actions: Engagement with London-wide mental health procurement group Delivery Risk and mitigation plan: LPP focus is on acute trusts / PCTs rather than MH. This has been mitigated by MH Heads of Procurement establishing a working group with LPP.	£50,000 (LPP membership fee)	Review of progress/savings – Oct 2010
Integration of community provider services	2010/11: zero contribution 2011/12: 4% EBITDA 2012/13: 5% EBITDA	CNWL has been identified as the preferred integration partner for Hillingdon and Camden Community Provider Services subject to due diligence process. Other provider services are being tendered for. Integration and delivery of new care models will deliver savings particularly in relation to hospital avoidance and early-discharge as well as back-office functions.	See template 4.	See template 4.	See template 1.

Key operating efficiency programmes	Amounts and timing	Contribution to the plan	Key actions and delivery risk	Resource requirements	Milestones 2010/11 2011/12 2012/13
Management of agency costs	A minimum reduction of 10% ie £400,000 (net of savings already accounted for through e-rostering)	Increased control over the use and therefore cost of agency staff.	<p>Key Actions:</p> <p>Three work-streams (led by three directors) in place to establish clear protocols and monitor usage.</p> <p>Monitoring of agency staffing costs forms part of existing management controls</p> <p>Introduction of web-based reporting system for monitoring</p> <p>Delivery Risk & Mitigation Plan</p> <p>(i) Local Management still over-use agency staff</p> <p>Rights to book staff withdrawn and passed to more senior team.</p> <p>Clear unambiguous protocols on appropriate booking of staff based on safety.</p>	£40,000 - monitoring and reporting costs	2011/12: a further similar reduction

Template 8: Leadership and governance

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2010/11 2011/12 2012/13
<p>Implementation of SLM and service redesign programme across the Trust: Ensuring excellent clinical and business leadership skills to take forward the implementation and ongoing operational management of service lines, within a sound governance framework.</p>	<p>The realisation of future productivity and quality of care improvements within the organisation is predicated on the successful implementation of our service line management and redesign programme. Without excellent clinical and business leadership in place across each of the service lines the programme's success will be limited.</p> <p>Times of organisational change often lead to uncertainty; we need therefore to ensure that our ability to retain our best staff is not compromised.</p> <p>Implementing a significant change management programme whilst continuing to deliver effective care service requires a solid governance approach, to assure the quality and safety of care and associated service performance targets are achieved.</p>	<ol style="list-style-type: none"> 1. Recruitment to the clinical and service director posts will follow a rigorous assessment process, with a number of gateways. Executive Board sign-off to the appointments will only happen once a full service line business case has been produced and agreed. We anticipate that, to a lesser extent, this model will be used to recruit to all the key leadership positions in the service line. 2. Following the assessment process, each director will agree a personal development plan that takes account of their strengths and weaknesses. Coaching will be provided as will exposure to broader business productivity techniques and tools and ways of working (e.g. LEAN, John Lewis). Such an approach will be mirrored more broadly across the organisation. 3. Establish SLM programme using PRINCE2 framework. Ensure appropriate links to recently restructured Care Quality framework. Both structures are well represented by executive level personnel. 4. The drive to greater productivity and quality will be supported by a robust organisational performance management framework that clearly sets out expectations of staff and provides a streamlined process for managers to follow in dealing with those individuals who fail to deliver 5. An associated issue is whether our current reward system sufficiently motivates all our staff to deliver excellence. We will evaluate this during the period and consider alternative approaches to incentivisation. 6. We will continue to extend our range of management and leadership development opportunities across all levels, ensuring continuous skill development in this area, to support succession planning at all levels across the organisation. 	<p>2010/11 Q1: Launch performance management framework 2010/11 Q1: Communications strategy to support SLM programme is in place 2010/11 Q2: Final recruitment gateway for two service line Clinical and Service Director roles 2010/11 Q3: Final recruitment gateway for remaining service line Clinical and Service Director roles 2010/11 Q4: Evaluate governance frameworks to assure fitness for purpose, restructure as appropriate 2010 – 2012: Individual Director and supporting Corporate Directorate development plans in place and delivered 2011/12 Q4: Formal succession planning processes in place within competency/development pathways – linked through to workforce development strategy 2011/12 Q4: Evaluate performance management framework and consider future options/explore flexibilities within the pay and reward system 2011 – 2013: Deliver to OD programme milestones</p>

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<p>Ensuring both external growth and organisational development strategies are successfully delivered, without either being compromised.</p>	<p>Corporate capacity needs to be sufficiently flexible to accommodate demands of both programmes. If it is insufficient there is scope for either or both to be overstretched, potentially leading to failure.</p> <p>Radical change in the wider external environment (e.g. at PCT and SHA level) could cause a loss of key relationships, resulting in a negative impact on the quality of commissioning decisions and understanding of financial agreements.</p>	<ol style="list-style-type: none"> 1. Stability at Executive Board level is crucial. We have a broad range of skills and expertise at this level and indications are that this group will remain stable in the medium term. The recent appointment to the Director of Nursing/Operations post has filled the only vacancy. 2. Ensure robust planning mechanisms in place for integrating new business opportunities, highlighting additional demands, governance issues etc., linking through to due diligence processes. 3. Ensure timely configuration of corporate services to support SLM, using principles of LEAN and an improved customer service focus. 4. Current economic conditions may prove advantageous in supporting a reduced staff turnover rate. Organisationally though we need to identify those key members of staff who hold much of the “organisational memory” and work hard to retain them. 5. Maintain robust audit trails: continue to utilise internal audit programme to assure and support robust financial and commissioning audit trails. 	<p>2010/11 Q1: Director of Nursing/Operations commences employment</p> <p>2010/11 Q3: The Corporate AD Group to have developed a draft proposal setting out how corporate functions might be restructured so as to best support the implementation of Service Line Management.</p> <p>2010/11 Q3: Revised OD programme agreed by Board of Directors</p>
<p>Achieve planned cost improvement programmes without safety or quality compromise</p>	<p>Patient safety and or quality of service is compromised</p>	<p>New care quality governance structures in place to be reviewed for effectiveness.</p> <p>All CIP plans and progress to be reported through the care quality governance structure with continued oversight by Business and Finance Committee.</p> <p>Equality, human rights and privacy impact assessments to be undertaken for all CIPs that impact on clinical services</p>	<p>Ongoing governance process.</p>

Template 9: Regulatory

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2010/11 2011/12 2012/13
<p>Failure to comply with the revisions to the Monitor Compliance Framework (proposed in December 09 consultation) in relation to service performance measures for MH FTs:</p> <ul style="list-style-type: none"> • 95% target for service users on CPA having a formal review once a year • Early intervention teams meeting contractual commitments in relation to new cases of psychosis • 99% target for completeness of identifier data (NHS number, DoB, postcode, gender, marital status, GP, PCT) • tbc% target for completeness of outcomes data (for patients on CPA – employment status, settled accommodation, HoNOS in past 12 months, diagnosis on discharge from inpatient care) • Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability 	<p>CPA Reviews: The risk here is related to reporting rather than service performance. It is not currently possible to produce a report of performance against Monitor’s definition of a CPA review (as per the 10/11 Compliance Framework) from our JADE system. This system is used in Harrow and Hillingdon and is to be rolled out across the rest of the Trust during 2010/11. The required links between data tables in the data warehouse (contact activity and care coordinator) have not yet been developed.</p> <p>EI New Cases: The Trust fully achieved the new cases targets for 09/10 and does not anticipate any difficulties in delivering 10/11 contractual commitments.</p> <p>Completeness of Identifier Information: The Trust is now achieving 99% completeness of these data items after considerable data clean-up work by the service directorates. The risk now is around ongoing compliance with these data quality requirements.</p> <p>Completeness of Outcome Information: Monitor has not yet published the target levels of completeness required. The Trust is therefore assuming a required threshold of 99%. This will demand some further work during Q1 to improve completeness of recording. However, significant progress has been made against all of these indicators during 09/10 and services are confident of achieving 99% completeness by the end of Q1.</p>	<p>CPA Reviews: The Trust’s Information Team is working to update our data warehouse to ensure that we are able to report performance against this indicator in our JADE directorates from month 1 onwards. In the meantime, we will continue to monitor performance using the CPA review ‘event’ activity type. Executive Lead: Director of Strategic Planning & Partnerships</p> <p>EI New Cases: Performance is and will continue to be monitored on a monthly basis at team, directorate and Trust level with exception reporting to the Performance Management Group and Performance Management Committee (see right). Executive Lead: Director of Operations</p> <p>Completeness of Identifier Information: As above. Executive Leads: Director of Operations and Director of Nursing & Operations</p> <p>Completeness of Outcome Information: As above. Executive Lead: Director of Operations and Medical Director</p> <p>Access to Healthcare for People with a LD: As above. Executive Lead: Director of Operations and Director of Nursing & Operations</p>	<p>Performance against all targets will be monitored on a monthly basis at team, directorate and Trust level.</p> <p>Responsible service and executive directors will be required to develop and implement action plans as an immediate response to any actual or anticipated exceptions. Progress against these will be monitored by the Performance Management Group (a sub-committee of the Executive Board) and reported to the Performance Management Committee (a sub-committee of the Trust Board).</p>

	Access to Healthcare for People with a LD: The Trust is already compliant with these requirements.		
Change in CQC registration status	<p>1. An unannounced inspection by the CQC that could result in enforcement action being taken</p> <p>2. Wrongly identified or unregistered 'location' and / or the provision of a regulatory activity that is not covered by the terms of our registration</p> <p>3. Inadequate control over the submission of national data may result in performance being reflected poorly on the Quality and Risk Profile(QRP)</p>	<p>1. Strong project management with the development of an action plan for improvement, key milestones overseen by project board, regular reporting to the Quality Committee and Board</p> <p>2. Nominated Individual and key internal contact for CQC to take responsibility for ensuring that the additional location / regulated activity is added to the registration immediately.</p> <p>3. Maintain robust internal quality control mechanisms over the submission of any data externally.</p>	Ongoing monitoring of registration requirements under the New Regulations and with quarterly updates to the Quality Committee on developments against the 16 essential standards for quality and safety.
Non-delivery of the Quality Account priorities.	<p>Lack of involvement from the key stakeholders in the development of quality priorities</p> <p>Lack of assurance from external auditors</p>	Strong project management to develop improvement action plans. Key milestones to be overseen by specific project groups, with regular reporting to the Quality Committee and Board of Directors.	Performance against Quality Account priorities [cf template 3] will be monitored by the Quality Committee and reported to the Trust Board on a quarterly basis. Progress against action plans will be monitored on a monthly basis by individual directorates and the Trustwide Care Quality Management Group. Responsible service / clinical and executive directors will be required to develop and implement mitigation plans as an immediate response to any actual or anticipated exceptions identified.
Medical Practitioner revalidation	Breakdown in internal processes resulting in medical staff not being licensed to practice	Responsible officer to be appointed by October 2010 followed by identification of appropriate management and administrative resource to oversee the process of revalidation. Appropriate policies & training for medical staff will be developed and implemented.	Progress against project plan to be monitored by the Care Quality Management Group (reporting to the Quality Committee, a sub-committee of the Board of Directors).

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<p>Financial Stability, Profitability, Liquidity Risks:</p> <ul style="list-style-type: none"> • Current economic situation will lead to increasing reduction of funding by PCTs and Local Authorities resulting in funding pressures • The extent of management change in the organisation leads to reduced financial control • Delivery of an ever-increasing CIP programme becomes more difficult and margins are cut 	<p>Reduction of Funding: The reductions in funding and costs of service closures result in lower EBITDA and overheads cannot be reduced to match.</p> <p>Management Change: Expenditure increases are not managed.</p> <p>CIP Programme: Failure to deliver CIPs and hence reduce margins will reduce liquidity, make future investment more difficult and lead to greater likelihood of failure to meet financial plans.</p>	<p>Reduction of Funding: Maintaining regular contact with PCTs through joint working with them on what level and spend of reductions are reasonable and can be managed.</p> <p>Management Change: Closer involvement with service managers, faster acceleration of concerns and more structured procedure for failing managers as well as rewards for good managers.</p> <p>CIP Programme:</p> <ul style="list-style-type: none"> • Clear project management of agreed CIPs • Alternative plans to meet shortfall • Budget for contingency 	<p>Monitoring by Contracts Management Group, Business & Finance Committee, Executive Board and Board of Directors</p> <p>Monthly reports to managers and Operations Directors with reports to Director of Finance</p>
<p>Private Patient Cap The Trust has a private patient cap of 1.5% of its turnover. Exceeding this would be a major breach of authorisation</p>	<p>Trust would have breached terms of its authorisation.</p>	<p>Establish rules and processes for approving private patient work then monitor income.</p>	<p>Reports will go to the Executive Board.</p>
<p>Non-compliance or poor compliance with key parts of the Mental Health Act 1983 as amended 2007</p>	<p>Section 58: Consent and Capacity recording by Responsible Clinicians (RCs) is an area of on-going concern raised at local level CQC visits. Section 132: The recording of patients' rights at required intervals - not routinely recorded by nursing staff and Trust documentation completed as required.</p>	<p>Corporate Training: programme to continue covering both areas and flagging concern at every opportunity.</p> <p>Audit: Section 58 and S132 audit commencing in April/May Trustwide undertaken by Clinical Audit Department with results presented to Mental Health Act Group and Clinical Management Group.</p> <p>Local Monitoring: Site-based Mental Health Act Offices monitoring non-compliance via local S132 and S58</p>	<p>Performance will be monitored at bi-monthly Mental Health Act Group meetings and relevant corrective action taken.</p>

		monitoring and checks including regular reminder letters.	
Non compliance with Hygiene Code of Practice and Health & Social Care Regulations Outcome 8	Failure to identify and rectify gaps in compliance	The HCAI Framework 2009-2010 (now replaced by the Gap Analysis) was presented at the April 2010 quarterly ICG. Gap Analysis against Hygiene Code of Practice being drawn up by Infection Control Team (ICT). Accompanying Infection Prevention and Control Programme 2010-2011 is being prepared by the ICT to deliver identified actions.	<p>The 2009-2010 Annual DIPC Report and Gap Analysis will be presented to the Board of Directors in May 2010.</p> <p>Infection Prevention and Control Programme 2010-2011 to be approved by Infection Control Group on 22/07/2010.</p> <p>The updated Gap Analysis and progress against the 10/11 IC Programme will be monitored by the Infection Control group on a quarterly basis and reported to the Board of Directors every quarter along with the DIPC Report</p>

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Financial Summary £m		2009-10	2010-11	2011-12	2012-13
		Actuals	Plan	Plan	Plan
Revenue (Total)		240.1	251.0	365.7	366.0
Employee Expenses		(177.5)	(186.9)	(276.1)	(278.1)
Drugs		(6.5)	(6.3)	(9.4)	(9.7)
PFI operating expenses		0.0	0.0	0.0	0.0
Other costs		(41.7)	(42.8)	(61.6)	(59.5)
EBITDA		14.4	15.0	18.6	18.8
Depreciation and amortisation		(3.9)	(3.4)	(3.4)	(3.4)
Net interest		(0.1)	(0.0)	(0.0)	(0.0)
Other		(5.6)	(5.7)	(6.1)	(5.6)
Net Surplus / (Deficit)		4.7	6.0	9.1	9.8
<i>EBITDA % Income</i>	%	6.0%	6.0%	5.1%	5.1%
<i>CIP % of costs</i>	%		3.1%	3.3%	1.8%
Net Surplus / (Deficit)		4.7	6.0	9.1	9.8
Change in working capital		(1.8)	(6.6)	(0.8)	(0.8)
Non cash I&E items		9.6	7.9	7.9	7.9
Cashflow from operations		12.5	7.3	16.2	16.9
Cashflow from investing activities		(1.3)	(10.9)	(9.6)	(9.6)
Cashflow before financing		11.1	(3.7)	6.6	7.3
Cashflow from financing activities		(2.2)	(4.3)	(4.2)	(4.2)
Net increase/(decrease) in cash		9.0	(7.9)	2.3	3.0
Cash at period end		37.6	29.7	32.0	35.0
Cash and Cash equivalents at PE		37.6	29.7	32.0	35.0