

**Operational Plan Document for 2014-16**

**Central and North West London NHS Foundation Trust**

**Operational Plan for Years Ending 31 March 2015 and 2016**

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## Operational Plan

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## 1. Executive Summary

The two year Operational Plan sets out five key challenges to CNWL over the next 2 years and the environment in which we are working. It then describes how CNWL will meet these challenges and prepare itself to be a resilient organisation looking into the future. These future programmes will be further developed in our Strategic Plan to be published later in the year.

The next two years, covered by this Operational Plan, will be amongst the most challenging for CNWL. The Board is committed to maintaining **quality, safety, effective governance and financial stability**. Yet the last year has been the hardest in several ways. We have quality issues identified by the Care Quality Commission (CQC) around two of our sites, and we have stretching work programmes to address these. In addition, we have savings of £33m to find in 2014-15, and £23-24m each year thereafter, while maintaining good quality services. This equates to 7.6% of our income in year 1, followed by 5.2% each year thereafter, assuming delivery of our Cost Improvement Programmes (CIPs). There is particular pressure in the first two quarters of next year as we transfer to a new ICT structure and the new savings plans begin to deliver. The financial plan delivers a surplus of £5.71m in 2014-15 and £2.86m in 2015-16. This is reliant on achievement of a Cost Improvement Programme (CIP) of £32.7m in 2014-15, of which 74% has been identified. At the same time as this financial and affordability challenge, we are seeing significant growth in population in all but one of our principle boroughs, and plans to radically redesign the local health and social care economies.

Meeting these challenges requires radical and urgent action, as set out in the Operational Plan.

To summarise, the five key challenges for CNWL will be:

- Driving Quality and Innovation in a Challenging Environment
- The Affordability Challenge
- Working within the Changing Commissioning Environment
- Effective Information and Communication Technology (ICT):
- Demographic Change

A **Strategic Framework** is in place within the organisation. This has six strategic workstreams, reviewed and refreshed each year with our Governors and Board from analysis of internal and external factors, and to meet our strategic objectives (Tables 5 and 6).

This framework is complemented by a robust **Change Programme** to support the organisation in radical change and savings delivery over the next 3 years. There will be eight operational change programmes, each led by an Executive Director and reporting to a Committee of the Board. These are:

- Service Redesign
- Workforce
- ICT
- Controls
- Estates
- Growth
- Portfolio Analysis
- Structures and Governance (20 week programme to support the other 7)

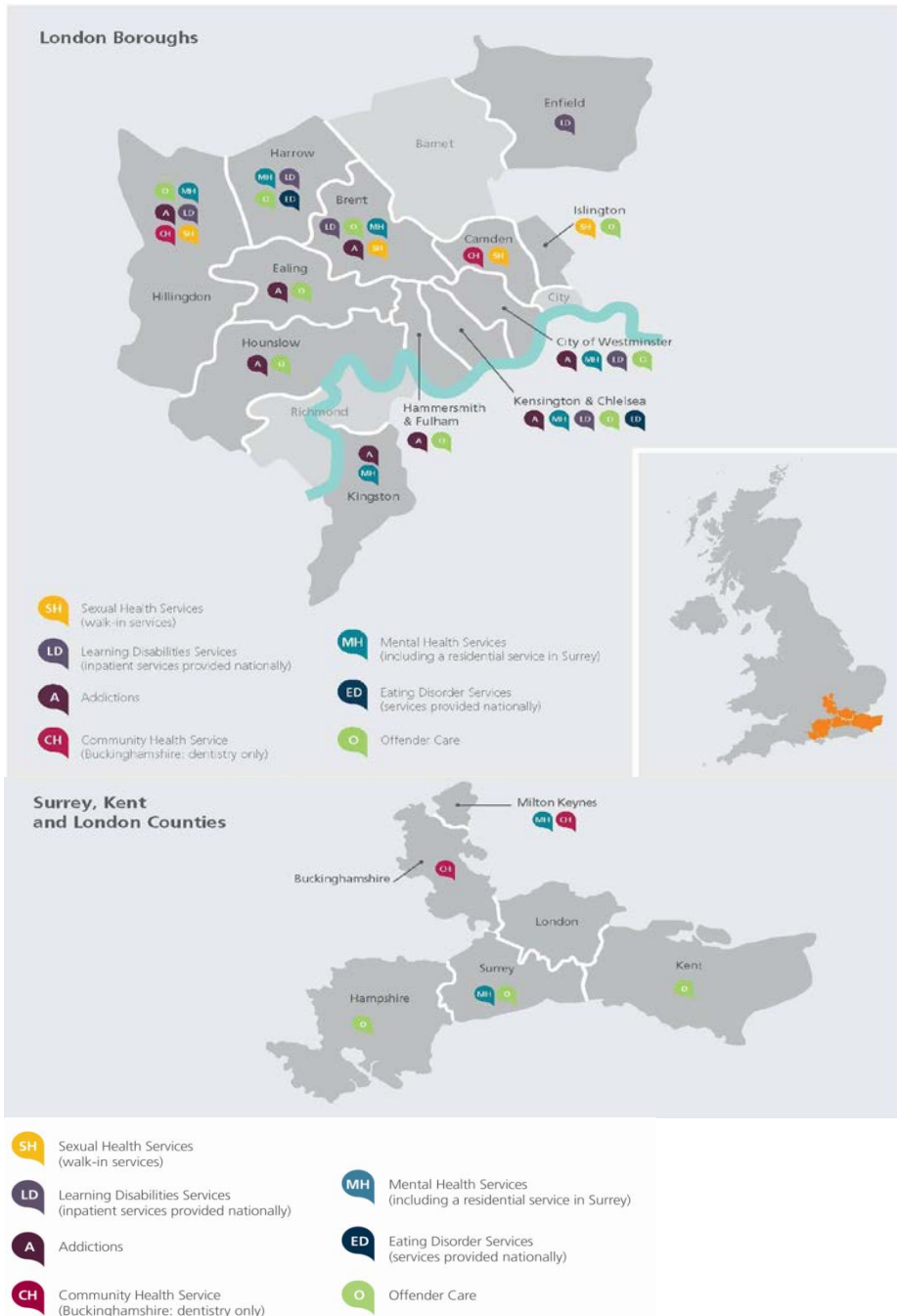
The Operational implementation plan over two years is presented around the Change Programme at Table 8. This is a high level summary of activity from the service lines and corporately. Each activity is associated with its CIP, productivity, efficiency or quality gain.

There is a section illustrating operational requirements and capacity pressures and a summary of the financial position as set out in the financial worksheets.

## Introduction

### CNWL – Who We Are:

CNWL is a large community facing trust, caring for people with a wide range of physical and mental health needs. We provide healthcare to a third of London, Milton Keynes and parts of Kent, Surrey and Hampshire



We employ approximately 6,600 staff who provide more than 300 different health and social care services across 150 sites and a number of other community settings. Our catchment area covers a range of vibrant and diverse communities, with over 100 first languages spoken. During 2014 we expect to provide care to around 300,000 people living in some of the wealthiest and the most deprived areas in England, with widely varying available investment in health and social care.

Our membership stands at approximately 15,500 of which public, patients and staff makes up 6,600, 2,400 and 6,500 respectively. The largest proportion of public members are aged 60-74 (28%). The largest patient group is aged 50-59 at 26%, closely followed by 65+ at 24%. Between public and patient members, 46% of each group are White British, with the second largest group being Asian making up 22% of the public and 19% of patient membership.

Our size and diversity offer opportunities to us and to those who are able to access a range of services. It gives us flexibility to develop our services to meet the challenge of improved linkage between physical and mental health. At the same time, we are aware of the risks of being large in this climate, where there is a focus on the local, and where organisations need to be able to respond swiftly to change. Our Operational Plan is based on our response to this environment.

We support the move to more NHS services shifting into the community, and believe that better links can be made between different providers of all kinds. Blocks between providers are not acceptable, and the transactional costs of duplication are not viable. We are supporting the **Whole Systems Pioneer Programme** in North West London (one of 14 national pioneers for whole systems) and integration programmes in Camden and in Milton Keynes.

A key part of our being able to manage this complexity is our **strong Board and Council of Governors**. Our new **Chair**, Professor Dorothy Griffiths joined us in January 2014, from her role as Dean of the Imperial College Business School and Professor of Human Resource Management. There are three new appointments to **Director** roles. Louise Norris joins as Executive Director for HR. Mark Large has been appointed to the substantive post of Director of ICT, a new role in CNWL. Mike Waddington is our new Communications Director.

Our **Council of Governors** is energetic and engaged in Trust governance, taking a leading role in selecting our new Chair last year, and having a sub-group to contribute to our Operational and Strategic Plans. The sub-group sent a copy of the Operational Plan to all Members with a request for feedback, which was considered before the final approval of the Plan. We have also discussed our detailed plans with our commissioners through the Transformation Board, made up of CCG, local authority, police, voluntary sector, and user and carer partners. A further set of processes will be held with them in relation to the Strategic Plan.

We have a committed **workforce**. Staff engagement is in the top 20% nationally and rising – with a score of 3.86 out of a possible 5 in the most recent staff survey. We have programmes to learn the lessons of Francis and Berwick, as well as what we learn from our own intelligence including **service user** feedback.

Our **governance processes** are strong throughout the organisation and are informed through robust organisational planning. It is based on the Monitor Quality Governance Framework.

## 2. The Short Term Challenge

This is a very challenging time for CNWL and the wider health economy, as we strive to meet high levels of ongoing change. We have identified 5 top challenges over the next two years:

### 2.1. Driving Quality and Innovation in a Challenging Environment:

- As set out in previous Plans, our Board has defined that **quality, safety, effective governance and financial stability** must lie at the heart of our strategic planning.
- At the same time, financial pressures pose an **affordability challenge** (discussed below) to the delivery of services, which meet our quality standards and priorities identified with service users and other stakeholders.
- Part of the quality challenge for CNWL over the immediate future, is compliance with Care Quality Commission (CQC) standards. For the first time, 2013-14 has seen the CQC raise concerns about CNWL services. Firstly The Campbell Centre, the mental health inpatient ward at Milton Keynes, which CNWL took over as part of a wider acquisition in April 2013. An 18 month improvement programme was put in place, with significant investment in staffing and estates, but the CQC is concerned that turnaround is not fast enough and a Warning Notice has been applied. The second is Beatrice Place, an older adult's inpatient unit, where issues of compliance had been identified, and the CQC felt improvements had not been made quickly enough. The Trust has also received a Warning Notice for this site. This is discussed further at Section 5.2 below.
- We understand that models of health delivery, and the organisations currently providing them, will look different in five years time. We need to deliver services which produce good outcomes at a reduced cost. CNWL's Medical Director is leading a **review of Models of Care** to help us meet this challenge. This is one of our Change Programmes set out at Table 7. It will require **internal redesign** supported by the development of three divisions with clinical and managerial leadership, to mirror the existing structure in Service Lines. As part of this, and discussed further below in the context of the affordability challenge, CNWL will no longer subsidise services which are not sufficiently funded.
- The Trust recognises the essential role of **service users and carers** at the heart of delivering quality services. There is more on service user involvement in section 6.2 below.
- As people are **living longer** and their conditions are more complex longer term, there is a challenge to meet their needs, and those who care for them. Much of the **integrated care** work, as well as ICT solutions such as Telehealth, are focussed around this group. However, CNWL is also very much focussed on the other end of the spectrum. Reductions to local authority funding has created pressure on **services for children** who are vulnerable, have learning disabilities, or mental health problems, in some boroughs, exacerbated by limited availability of **Child and Adolescent Mental Health Services (CAMHS) inpatient beds** nationally. The outcome is that there are children waiting for treatment, being treated far from home, or being accommodated on our adult wards, for several days. We will be looking to bring integrated care into discussion around children's services.
- In order for health and social care to be affordable and sustainable, there is a critical role for prevention **and health promotion** in managing quality of life. CNWL now has a pan-Trust smoking cessation programme. CNWL's sexual health and HIV services provide prevention services and information. CNWL's health visiting services provide a range of services to prevent disease and damaging lifestyles in early life. Preventing falls, urinary tract infections, and pressure ulcers are integral to all our services for older and vulnerable groups, and were

supported by a national CQUIN (Care Quality Innovation Scheme) in 2013-14. A CQUIN is designed to incentivise achievement of agreed quality innovations.

- A key element of our quality work is around our **workforce**. The Francis Report has sharply highlighted the risks of inadequate workforce management.

*What we will do:*

- CNWL has a series of plans to address the CQC findings, which are reviewed internally and externally with our commissioners, CQC and Monitor. These are subject to intense scrutiny by our Board and Executive Team.
- CNWL is working with the local health and social care providers through transformation processes, including the development of Whole Systems Pioneers, to develop a range of programmes of integration, internal redesign and transformational change. These are based around recovery – in secondary and primary care.
- Workforce is a Strategic Priority and a workstream within our Change Programme. This is discussed at 6.1 below.
- CNWL's quality priorities are identified each year and are based on feedback about services. This feedback is from those who use services, carers, staff, commissioners, and stakeholders who refer patients to CNWL and work with us. This is further discussed in Section 6 below.
- Where the available funding from commissioners means that we cannot maintain or improve the quality of care, or where the services are running at a deficit, then a commercial review will form the basis of decisions and consultations with the CCGs and other commissioners around closure of these services.
- CNWL continues to include growth as part of its strategy. We will continue to seek opportunities for major and minor acquisitions, where they meet the Trust's objectives and financial strategy. The Executive will examine any proposals and engagement in tendering processes will be agreed by the Business and Finance Committee. This policy will continue until a new direction is agreed by the Board.

## **2.2. The Affordability Challenge:**

- Over the next two years, CNWL faces a significant savings challenge. The organisation needs to find savings of £33m in year one, and £23-24m of our total income year on year after this. This equates to 7.6% of income, then 5.2% at current funding levels year on year after that. We were not able to meet our CIPs in 2013-14 which means that £8m now rolls over into the next year. There are particular challenges in the first two quarters - as we move to new ICT delivery systems and new savings plans are being implemented.
- Growth moneys – payment for demographic change - have not been passed on to CNWL – this is an issue as there is demographic pressure on the organisation and wider health and social care economy and increased complexity in demand (section 3.4 p 10)
- Reduced funds not only have implications for the statutory sector, but also impact on the third sector and community partners on whom our service users and carers depend, and who are critical to the philosophy of moving patients down the care system, out of specialist and acute services, and into community and primary care services.
- There will be competition as new providers come into the market and there is more tendering of services, with the opportunities and challenges of integrated care. The differential regulatory framework for NHS and non-NHS providers, and the fact that NHS providers must provide the full range of services, means that while a provider mix is positive, there are transactional costs for NHS providers which put us at a disadvantage. For example, response to Freedom of Information requests.

*What we will do:*



- A robust programme of CIPs identification and delivery is in place and will be sustained through the Change Programme at service line and corporate level. At this time and before the Change Programme is fully in place, we have identified 74% of our CIPs (£24.5m) of which £7m (21%) is rated as high risk,
- Decisions will be made around services which cannot be provided within commissioning budgets, at the level CNWL requires for quality, safety and efficiency. Where services run at a loss, or where commissioner investment is not to a level where a quality service can be delivered, then CNWL will no longer subsidise them.
- CNWL has a programme of work around Estates which will also be significant in terms of costs and as part of the Change Programme. Environmental improvement is a major area of investment, particularly where CNWL takes on services, as was the case in Milton Keynes
- We will be reinforcing timely payment by commissioners as late payment has negatively impacted our dividend
- We will continue to invest in the Drive productivity programme, and a further Lean programme management process.
- The priority workstream around controls will drive efficiencies including outsourcing, procurement, new business, and contract management, within a framework of accountability for control management throughout the Trust.
- Priority workstreams around estates and ICT will contribute to more efficient use of buildings including agile working.

### **2.3. Working within the changing commissioning environment**

Over the next two years we will continue to see radical changes in how we are commissioned:

- The move to tariff from block based contracts in mental health is complex. CNWL has been active in developing care pathways around patient need, and this will continue as the basis for organisational and care model redesign over the next 5 years. However, the allocation of costings to these pathways is not yet resolved nationally, and there is a risk of instability in the system as this happens.
- In addition, we are actively participating in work to develop and take part in services paid for through capitation – particularly as part of the move to Whole Systems Integrated Care in North West London, but this may well apply to other services and models. These ongoing changes to funding have the capacity to destabilise services.
- Linked to Whole Systems, the inception of the Better Care Fund (BCF) will move funds and potentially activity into local authorities. CNWL has not yet been invited to take part in discussions around the BCF – either through partnership boards or through Health and Wellbeing Boards on which we are represented in only some boroughs.
- There are issues around NHS England (NHSE) commissioning – for example beds for children using child and adolescents mental health services (CAMHS) – which are forcing children back into the adult mental health system at the most vulnerable time.
- Some services which have been open access have been impacted by a move of commissioning. Sexual Health is now commissioned by Public Health which sits within local authorities who, as local authorities, must deliver services to their population only.

*What we will do:*

- We will work actively within the new environment locally – Whole Systems, BCF, and the shift of commissioning into local authorities. We will be making clear representation that clinicians who have provided and developed expertise around specific groups should not be excluded from discussions around future models of care.

- We will provide clear feedback on our concerns about any consequences, often unintended, of changes to commissioning which have a negative impact on patient care – e.g. around access to sexual health services.
- Our new costing system will support accurate analysis of the true resource requirement of our services, which will be core to our negotiating position.
- Over the next two years, CNWL will move from predominantly block to tariff payment, including capitated budgets through Whole Systems programmes, offering opportunities to integrate care pathways with other partners, including the third sector, into joint ventures and single contracts. Finance and contracts to meet this challenge will be a significant focus
- We recognise that there will be potential for significant change to this organisation as we know it, and as it has evolved over the years. This is further change and we are clear that with our challenges in delivering our CIPs and the very large amount of change particularly in North West London, there is a risk to our stability. We will work within the system to provide the best outcomes for patients which for us means protecting and developing many of our services.
- As part of this, we will not agree to further funding reduction as part of the Quality, Improvement, Productivity and Prevention (QIPP) process, where these reductions are predicated on activity changes that have not been supported by commissioners. We will seek income growth against the real rise in demand for our services (Section 3.5 and 8).

#### **2.4. Effective Information and Communication Technology (ICT):**

- ICT systems have been one of the greatest obstacles to NHS integration. This needs to be overcome to provide the efficiencies needed from services and estates. It is also required to support essential efficiency at the front line – reducing transactional time spent on data entry and workarounds when the system is not intuitive or agile, all of which has a cost clinically and financially.
- Good information systems underpin our ability to gather the data for analysis, and use as clinical and commissioning tools, and to provide transparency. As in last year's plan, we have made significant gains such as our integrated scorecards where information from more than one source is brought together to provide a robust picture of performance and potential threats. However, this will not be able to progress at the same pace without effective ICT as a vehicle.
- ICT is an essential part of our being able to use estates more efficiently. Agile working for those in the community, and reliable access to ICT systems on every ward and in every location, are key to our success.

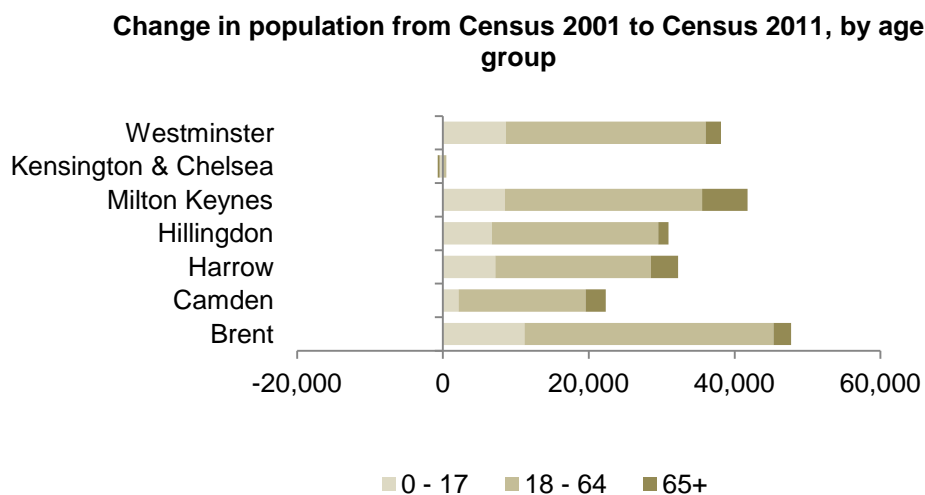
#### *What we will do:*

- Estates and ICT are a priority workstream, as set out above.
- We have appointed a substantive Director of ICT, Mark Large, as above.
- CNWL is in the second year of a five year ICT delivery plan. This has seven programmes of which three are the focus of the next two years. These are: organisational design, infrastructure changes, and clinical systems procurement, which go into year 3. The focus of the subsequent three years will include roll out of the new clinical system. There is further information on this at Table 8.
- The first major workstream is being implemented from April 2014 and that is the transfer of all the Trust's ICT infrastructure and support over to CGI in order to give increased robustness and technological support for the Trust to deliver value for money services going forward.
- We will work with commissioners and partners to develop mutual access, patient access, and interoperability across all systems over the next 5 years.

## 2.5. Demographic Change:

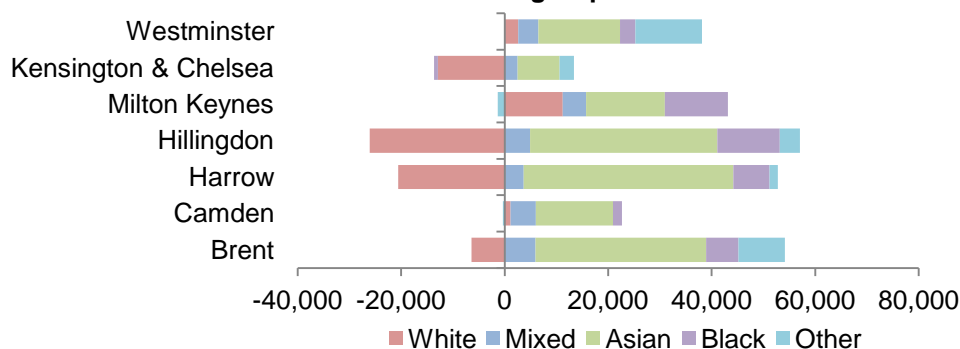
- Another key challenge for CNWL and for the local health and social care environment is the growth and changes in socio-economic status in our populations. The impact of this on CNWL is that these are groups who have high needs in terms of physical and mental health care. These are also people who need local authority provision, at a time when many local authorities are seeing reductions in funding.
- A number of plans emerging through commissioning intentions, the Health and Wellbeing Boards and for BCF funding, relate to these groups – frail elderly people as people live longer and the incidence of dementia rises; deprived adults with poor job prospects who may also have, or develop, depression or substance misuse issues; children living with multiple disadvantages, living in deprived families, with adults with complex needs and perhaps facing obesity – all contributing to a difficult start in life. It is therefore important for CNWL and our commissioners to have a joint understanding of these statistics and their impact on our planning. Two of the main pressures will be around population growth and deprivation, and this data is set out in the tables below:

**Table 1:** Population has grown in all but one borough and in all age groups. It is particularly high in Brent where there is also the highest deprivation. The population in Milton Keynes is traditionally young, but is now starting to grow in the over 65s and projections are that the increase in Milton Keynes will be three times greater than the national average between 2011 and 2021.



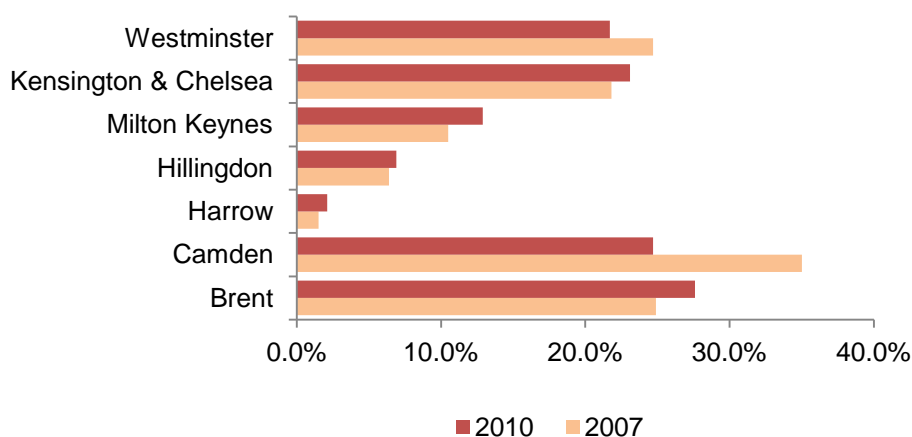
**Table 2:** Ethnicity has also changed considerably in our boroughs, bringing with it changing demands in services as we see a significant reduction in White populations, and a growth in Asian and Black populations with different health and service needs.

### Change in population from Census 2001 to Census 2011, by ethnic group



**Table 3:** There has been a rise in deprivation in Milton Keynes, Kensington and Chelsea, Hillingdon, Harrow and Brent. This is an indicator for greater use of services.

### % of people in the CNWL area who are living in the 20% most deprived areas in England



## 4. National and Local Commissioning Environment

In this section, there is a brief examination of the key drivers in national and local commissioning which will shape CNWL’s operational direction over the next two years:

### 4.1. National Commissioning Priorities:

**4.1.1. The Francis and Berwick Reports:** CNWL’s Board has considered the key areas covered by these reports, and has identified a number of areas of development for the Trust, against the 290 recommendations and the Government’s response in November 2013. It has agreed five major workstreams, all of which are relevant to CNWL, and are subject to work programmes and regular reports to our Board and Commissioners. They cover: Complaints; Patient safety including incidents; Governance; Staffing; and Informatics and information sharing. These inform our five strategic workstreams and Quality Priorities.

**4.1.2. The Care Bill** introduced in 2013, and which will become an Act in 2014, brings into law some of the findings around Francis and seeks to bring together strands from disparate legislation around care. It will make safeguarding a statutory duty. It is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. It also requires the promotion of integration of care and support with local authorities, health and housing services, and other service providers. CNWL is in the process of identifying

where we will need to change practice, and an action plan will be integral to our strategic plan and work with partners. It brings into place the requirement for trusts to be instructed to take on essential services from failing trusts. CNWL's experience in Milton Keynes where we have willingly taken on a huge piece of investment to improve patient care, we know that the impact of such a change is considerable in terms of resource and regulation.

**4.1.3. The Winterbourne Report** – is also subject to an action plan, regularly reported to the Board and Commissioners. CNWL's Learning Disabilities Service received a positive report after a CQC in 2013.

**4.1.4. Closing the Gap** (January 2014) is a refresh of the 2011 mental health strategy No Health Without Mental Health, with a set of pragmatic steps for achievement over the next two years. Central to this is the aim to improve the quality of life for people with mental health problems and prevent these problems occurring. Its recommendations inform our strategic and operational planning, for example through the programme around waiting times, integrated care around mental and physical health, and the Recovery College which promotes co-production and prevention. As with the reports around safety and care above, this is a document where the recommendations will be further explored in our Strategic Plan.

**4.1.5. Crisis response and urgent care** is also high on the agenda. Sir Bruce Keogh's report (December 2013) and recommendations, are based around Acute care but are relevant to mental health and community trusts. Identifying that there is higher mortality out of hours and at weekends, the report recommends that a move to services open 24 hours a day, 7 days a week, beginning with urgent care and diagnostics. More recently, the Crisis Concordat has been published around crisis access for those specifically with mental health needs.

- CNWL's community services have a range of models of **rapid response**. Services in Milton Keynes provide an established round-the-clock service working with the acute hospital.
- In terms of mental health, urgent access and improved crisis response are the key priorities for North West London. This is the focus for a CQUIN - and for a major service redesign. This was started in 2013 and is due to be implemented at pace, to match CCG readiness and funding availability over the next years. We will begin with our better resourced boroughs of Westminster and Kensington & Chelsea where enhanced primary care models are in place. The matching work to increase GP availability to all hours and every day, will be critical to the overall flow of patients, and to reduce crisis presentations to mental health and Accident and Emergency Departments, because of critical issues elsewhere – for example around carer support or housing issues. CNWL will be a party to achieving the goals of the **Crisis Concordat** (February 2014). At the same time, we are discussing with our commissioners the need for resources to meet the ambitious vision and major transformation programme.

**4.1.6. Parity of Esteem** between mental and physical health needs, is a government strategy, and is now headed up by Lord Adebowale. This is long overdue – for individuals and for organisations. The twenty year mortality gap between those with mental health issues and the rest of the population remains virtually unchanged. CNWL is responding through, for example, a programme of smoking cessation, and participation in whole systems pilots and programmes in North West London, Milton Keynes and Camden to bring together physical and mental health care.

**4.1.7. The Friends and Family Test (FFT)** for staff and for patients will be rolled out across CNWL during 2014-15. Our most recent staff survey indicates that 66% of our staff would recommend CNWL to their family and friends against an average of 59% in London. For service users, we are looking at using real time feedback processes (Optimum Meridian) to support the FFT and to integrate the FFT to all surveys by the third quarter 2014.

**4.1.8. Whole Systems Pioneer Programmes** have been referred to above and their local application is discussed in the next section.

## 4.2. Local Commissioning Priorities:

The picture set out at 3.5 is of a growing population with complex needs. The commissioning environment needs to respond to this.

### 4.2.1. The North West London Commissioning Priorities:

North West London (NWL) is undergoing two sector-wide transformation programmes with significant implications and impact on CNWL.

- **Shaping a Healthier Future** or the **Out of Hospital Strategy** is redesigning Acute Hospital provision, including Accident and Emergency. The growing population of frail elderly people with a range of conditions, including dementia, are significant users of A&E and Acute Care. There are those who may access mental health services in a crisis via A&E, or whose unplanned use may be related to mental health needs.
- NWL is a **Pioneer Programme** for the Government's **Whole Systems Integrated Care programme**. As part of this, invitations were made for early adopter proposals to pilot integrated care locally. CNWL is participating in a number of **Whole Systems Early Adopters programmes**. Three have been chosen here to demonstrate how they will address national and local priorities:
  - **Integrated Care in Hillingdon:** A pilot around 2 GP networks with GP led Multidisciplinary Teams (MDTs) providing care, funded through capitation.
  - **Physical Healthcare for People with Severe and Enduring Mental Illness (SMI) in NWL.** This is key to the achievement of parity of esteem and patient experience. The programme is about ensuring that people with mental illness – those in contact with services or not – are supported in accessing physical health care. This is being run through the Mental Health Programme Board (MHPB) – the lead mental health GPs, local authority representatives, and the Chief Executives of the mental health trusts in NWL – CNWL and West London Mental Health Trust.
  - **Integrated Physical and Mental Health for People with Long Term Conditions:** This programme will also be run through the MHPB.

**4.2.2. The Better Care Fund in NWL.** Integrated care programmes identified through the NWL Whole Systems Integrated Care Pioneer programme, will be a significant recipient of BCF funds while there are additional local plans which are summarised below. Involvement of CNWL in BCF plans or discussion has been limited, which is a risk to the organisation, as we are not present to take part in discussion around opportunities. This is a development area for our new Divisional Directors in our operational plan (Table 8).

- Mental Health features in the draft BCF plans seen by CNWL in Brent, although detail has not yet emerged from Harrow who held a BCF discussion which included mental and physical health. Both CCGs include frail elderly but also a focus on improved coordination and coherence – part of the Whole Systems vision.
- The Triborough – the joint body representing Hammersmith & Fulham, Westminster and Kensington & Chelsea – has stated in their BCF that 'We recognise that there is no such thing as integrated care without mental health'. These are all platforms for CNWL to be able to aim for greater involvement in discussions around the BCF.

**4.2.3. Health and Wellbeing Boards (HWB) in NWL:** CNWL is not represented on Health and Wellbeing Boards in North West London, except in Hillingdon where CNWL provides the community services as well as mental health. As with the BCF, and closely linked, there is a need for CNWL to be better linked to the HWBs where both our partners and competitors have open

dialogue. The key themes that we have seen emerging in HWB plans are physical and mental health care, personal budgets and self care, addressing inequality, vulnerable families, frail elderly care including dementia, and a healthy start for children including addressing obesity. The Triborough has also produced a specific mental health strategy within the HWB with 8 points of vision for mental health, picking up on the issues above, and which will be integrated into our strategic plan.

**4.2.4.CCG priorities:** Key intentions arising in the commissioning round for mental health services include shifting settings of care from secondary to primary care; liaison psychiatry; prescribing; older people's beds and dementia pathways, and; unspecified contract efficiencies.

- Shifting settings of care covers a broad range of activity but comes down to shifting activity and resources into primary care. Agreement has been reached with some CCGs, that where savings were made in these areas last year and have not delivered the capacity for secondary care to transfer activity, although resource has gone, then this will be recognised in this contracting round. This is not yet finalised.
- At the time of submission, there is a funding gap between commissioners and the trust of £10m in NWL mental health services, and an additional risk around CQUINs worth £4m. A proposal has been made for £5m to be reinvested as transformation funds over one year – that is, associated with programmes which will provide services for the patient groups for which services are being decommissioned in CNWL. Contract discussions are continuing.
- For Hillingdon community services, key intentions include tissue viability and wound care, resources for a new cardiology pathway; community matrons to respond to activity identified by care navigators, the physiotherapy pathway which has been oversubscribed, and reconfiguration to respond to wider system change.

There remain significant risks around proposed QIPPs and agreement around CQUINs.

### **4.3. The North Central London Commissioning Environment:**

Camden's Shadow Health and Wellbeing Board identified two key areas of focus in 2012. These were to deliver a reduction in health inequalities, strong partnerships and prevention within the Borough's commitment to shared services, and providing both physical and mental health to adults and children so that people can reach their full potential.

**4.2.1** Camden also has a number of **integrated care** programmes.

- **Frail Elderly Care for people in Camden** is based around a Complex Case Management (Frailty) pathway
- **Camden MOSAIC** is an integrated service for disabled children. The service brings together 80 healthcare professionals from 17 disciplines and currently cares for more than 650 disabled children. CNWL delivers the service in partnership with four other organisations: Camden Council, Whittington Health NHS Trust, Tavistock and Portman NHS Foundation Trust, and Royal Free London NHS Foundation Trust, while of course working closely with individual GPs.
- Associated with these integrated models, the CCG has indicated it will move away from annual contracts to ones straddling multiple years, in order to drive innovation and integration in service delivery. Savings are to be built around this model, in partnership. From an efficiency perspective, there is an intention to seek improvements by benchmarking with peer organisations. CQUINs will then align with these aspirations of integration, efficiency and positive experience.
- Key services agreed in the service level agreement, focus on continuing care, heart disease, neurology, stroke and respiratory services, rapid response and rehabilitation, palliative care, podiatry, and wheelchairs.

#### 4.4. The Milton Keynes Commissioning Environment:

The Milton Keynes commissioning environment is complex, with significant demographic change as above, which needs to be met by service change. Reductions in acute care are causing activity to flow back into primary care and, where primary care is not yet equipped to deal with it, into community services which are also not resourced to the level to meet ongoing need. A programme of work, commissioned by Monitor, is being conducted by McKinsey, to build sustainability across Milton Keynes and Bedfordshire health systems. CNWL must work with Milton Keynes Commissioners to identify £2m of QIPP proposals.

**4.4.1. Whole Systems integrated care in Milton Keynes** includes well developed teams to address **Rapid Response** and **Frail Elderly**. The frail elderly strategy includes a pathway developed with Milton Keynes Hospital and Council. The Rapid Response team operates in partnership with the hospital and Council to provide round-the-clock admission avoidance and fast discharge.

**4.4.2. Health and Wellbeing Board in Milton Keynes:** CNWL has a seat at the HWB and is therefore working with partners around the use of the **Better Care Fund** for local people. Key emerging themes to improve wellbeing include:

- To reduce early deaths and tackle major diseases
- To reduce health inequalities

**4.4.3.** As with North Central London, the priorities for our services in Milton Keynes are a good fit with those identified by CCGs and HWBs in other parts of CNWL. This will facilitate development of better integrated services, providing a better and safer patient experience.

## 5. Quality Plans

**Quality, safety, effective governance and financial stability** lie at the heart of our strategic planning. Quality governance is based in the Monitor Quality Governance Framework. Governance around quality is embedded throughout the organisation. Care quality groups are in place at every layer of the organisation, providing organisational learning.

- The Quality and Performance Committee (QPC) receives assurance around quality on behalf of the Board, on a monthly basis. The QPC receives a range of reports including the integrated dashboard, exceptions reports, CQC Quality and Risk Profiles, and CQUINs on a monthly basis. There are quarterly or bi-annual reports on quality governance, organisational learning and summaries of the Quarterly Review meetings. The main aim is to triangulate information so that areas of risk and opportunity are identified and actions can be taken in a timely way.
- A key repository for quality plans to meet the three goals of patient experience, safety and clinical effectiveness is the **Quality Account**. CNWL's draft Quality Account for 2014-15 has three quality priorities. These priorities have been identified from a range of information including: our performance against current quality priorities and other quality indicators; our organisational learning themes – identified through a clinically-led process; our feedback from stakeholder consultation, and CQC feedback. They are co-produced on an annual basis through a consultation process involving service users and carers, our Council of Governors, Board and other partners. The reasons and process for agreeing these are set out in our quality account. The proposed Quality Account Priorities (QAP) for 2014/15 were discussed at a public consultation at an "all-stakeholder event" (6<sup>th</sup> March), which included Healthwatch, CCGs, councillors, patients, carers, staff, commissioners and others. These are out for consultation from 4 April - 5 May 2014. The proposed QAPs are shown in the table below:



**Table 4: Quality Priorities – 2014-15**

<p><b>Overarching measure of quality:</b></p> <p><b>IMPROVED PATIENT EXPERIENCE</b></p> <p>Patients would recommend services to their family/friends OR How patients would rate the services they received.</p>			
QAP Proposed Area	1. INVOLVEMENT IN CARE/TREATMENT PLANNING	2. SUPPORTING CARERS	3. COMPETENT AND COMPASSIONATE WORKFORCE
AIM	To actively involve patients in the creation of their care and treatment plan, and ensure the plan is effectively implemented.	<p><i>'Carers are CNWL's allies/ partners in healthcare provision'.</i></p> <p>To ensure carers are routinely identified and recorded, and provided with the support they need to enable them to keep their loved one <i>safe and well</i></p>	To ensure patients are cared and treated by staff who are engaged, motivated, up-to-date in their professional training and care for patients with compassion and respect.

**5.1 Quality governance:**

- The Board regularly reviews its systems and processes for reporting and acting on quality concerns in line with Monitor's Quality Governance framework. The management of the Trust's service lines consists of joint clinical and managerial leads ensuring absolute and transparent clinical ownership of all significant decisions. The Board and its committees have championed an increased use of benchmarking and all business cases are required to include internal and external benchmarking of service outcomes.
- As well as the robust system of reporting on performance against agreed quality objectives, the Board receives feedback from service users at each of its meetings and Non-Executive and Executive Directors undertake regular 'Board to Ward' visits where they informally visit services to talk to front-line staff and service users. Any issues or themes arising from these visits feed into the Trust's organisational learning. These processes are constantly reviewed, with projects to improve our ability to hear and act on patient experience, including mechanisms to support real-time feedback.
- Staff have a number of ways of raising concerns, culminating in a formal whistle blowing procedure. However it is anticipated that concerns would have been aired and addressed before this is necessary. Each service line has its own embedded systems of quality governance which enable problems and issues to be considered. Clinical and Service Directors have a corporate forum where they can raise any issues which cannot be addressed at a local level and the Quality and Performance Committee will direct action to address any issues escalated to it. In addition, each of our priority workstreams has an identified lead Executive Director to whom concerns can be escalated if needed.

## 5.2 Existing quality concerns:

- The key areas of concern around CQC Warning Notices are in two of our mental health units – Beatrice Place for Older Adults and Milton Keynes inpatient provision, the Campbell Centre. Detail of CNWL’s approach to this is set out in the appendices.
- There is also the issue set out above around maintaining quality and innovation at a time of reduced funding, and through a period of such dramatic change in services, both nationally and, with two major transformation programmes set out above. In NWL we have Shaping a Healthier Future and Whole Systems, while in Milton Keynes a change programme is being overseen by McKinsey. We need to be able to respond to this at every level – from how the organisation is managed and governed by its Board, to how staff cope and respond at the front line. Leadership is key to our response.

## 6. What the Quality Plans Mean For:

### 6.1. The Trust workforce:

In order to meet the challenges ahead, we need a flexible workforce which can deliver on quality while under pressure and throughout change. As our largest cost, we also need to look to workforce for part of our CIPs.

Workforce is a Strategic and Change Programme priority, reflected in Table 8. In addition, the more recent set of efficiency workstreams also features workforce.

Changes in pay costs have been factored into our forward planning, covering both agency use and the impact of the decision around the proposed pay awards

Some of the highlights of our workforce plans are set out below:

- **Holding to Account:** we will be rolling out a 100% appraisal system with clear expectations of performance, where people are supported to achieve performance but held to account if they fail to deliver.
- **Remuneration:** CNWL is failing to win a number of tenders, because our staff costs compare poorly with our competitors in the third or private sector. While we have always made the case for what we feel is the staffing to provide the best quality of care, we need to review this if we are to remain a contender in this competitive environment. In order to do this, there is to be an analysis of pay, associated benefits and team structures to service teams operating in a competitive environment so that the skills mix and other costs can be reviewed for these services.
- **Review of size and shape of non-clinical workforce:** CNWL’s management and support roles across the Trust have developed historically. A review and redesign is to be undertaken to provide a more equitable, efficient provision of these support staff.
- **Analyzing duplication in corporate functions and development of new structures to support divisions:** CNWL has grown over the years, with the addition of new London and now out of London areas. We now need to review these functions to move them into the new divisions to support local flexibility and responsiveness.
- **Looking at skills versus demand:** This is a programme **initially** focussed in acute wards. First there will be a piece of internal benchmarking, examining skills mix, bed numbers and mix, Health of the Nation Outcome Scores ( HoNOS ) which report on clinical outcomes, complaints and incidents. This work will also incorporate the capacity and demand evidence set out at Section 8. If there is no variation between different staffing levels and these outcomes, this points towards more standardised staffing across each ward. We will drill

down to what clinical services should be delivered on each ward and who is needed to provide them.

These workforce programmes are part of the workstreams on **Workforce** and **Models of Care** efficiency workstream with a focus on integrating physical and mental health care and what the workforce implications of that are. This will be further examined in the Strategic Plan.

It is also linked to **'Working without walls'** – a programme of agile working. The challenge will be to ensure that there is a collegiate workforce, with people feeling part of a team and supervised.

### **6.1.1 Nursing Workforce:**

These are specific actions led by the Director of Nursing – as this is our largest element of the workforce and there are significant challenges for nurse recruitment and retention. Nurse workforce issues are subject to the general programme above as well as this specific focus:

- The Director of Nursing is leading a formal retender exercise for pre-registration of mental health nursing programmes across the North West London.
- There will be a roll out of e-rostering across the whole trust to monitor staffing and drive more effective roster management.
- There will be testing and assessment of staff in core medicines administration competency.
- **Recruitment:** The Trust is making continued use of the Assessment Centre process. Potential recruits are assessed before their interview for numeracy, literacy and empathy. Only nurses who pass these tests may proceed to interview. Once successfully appointed, nurses are subject to a programme of mentoring and preceptorship to ensure that standards are maintained. The assessment centres now run twice per month.
- Work is underway to recruit from non traditional groups of staff e.g. targeting new graduates from appropriate programmes for health care assistant and other non registered posts.
- CNWL is offering educational incentives to newly qualified staff to target recruitment hotspots.
- We are using a "Head-hunter" model for Band 6 and 7.

### **6.2 Patients/ Service Users and Carers:**

6.2.1 CNWL depends on our patients, service and users and carers for **critical feedback** around our services and to be part of plans around service development, through participation or co-production. A few examples of this include:

- Community Services have well established user and carer fora involved in service planning.
- Acute mental health services and Community Recovery have a service user forum looking at service issues and development.
- Addictions Services have service users groups in each borough engaged in service co-design and future contracts.
- Older People and Healthy Ageing (OPHA) have two service user groups across the 5 boroughs (MH);
- Learning Disabilities have a user and carer forum involved in co-design and who took part in a CQC inspection.
- Service users and Carers take part in recruitment of staff (nursing assessment centre).
- Service Users and Carers are part of CNWL Mental Health Transformation Board for North West London, where partners come together to drive forward and implement strategy.
- In taking part in audit around patient experience.
- In developing the Quality Priorities.

- Involvement in subsequent action planning around improvement areas. An example is our user-led care planning processes which were co-produced through the Recovery College.
- The development of the cohort of Peer Workers on the wards is now in its second year and is providing valuable support as well as data on how to improve our processes.
- The Recovery College is based around co-production with service users and staff developing and running courses together.
- A new development for 2014 is that Service Users and Carers are now engaging in developing a forum to take part in research and development. The Forum will be chaired by a User Governor.

## 7. Responding to the Challenges 2014-16

7.1. CNWL's operational plan 2014-16 brings together our identified clinical developments around service safety, quality and access, with associated enabling programmes.

- CNWL has a **vision, values and associated Strategic Objectives** for the organisation. These are reviewed with our Council of Governors and Board each year (**Table 5**).
- These are reflected in six **Strategic Priorities** which are refreshed each year in response to the external and internal environment. (**Table 6**).
- For 2014-17 the Strategic Priorities are underpinned by an additional set of Change **Programme workstreams led** by a Challenge Board to drive delivery of CIPs and quality (**Table 7**). The Change Programme is the framework around which the Operational Plan is written.
- Detailed schemes and measures of success have been agreed by the Service Lines, Board and Council of Governors against each Change Programme workstream (**Table 8**). CNWL's Board looks for evidence of quality, safety, effective governance and financial stability in these detailed plans.
- We have discussed our detailed plans with our commissioners through our individual meetings and through the Mental Transformation Board made up of CCG, local authority, police, voluntary sector and user and carer partners.
- Our plans and progress against them are reviewed each quarter with each service line through a Quarterly Review process. An area for improvement for CNWL is how we summarise and feedback the outcome of these reviews for organisational learning – as recommended by Price Waterhouse Cooper in their review for Monitor of Foundation Trust planning processes. This will be further explored in our Strategic Plan, to be submitted at the end of June.

**Table 5: CNWL's vision, values and objectives**

Our vision	
Wellbeing for life	We work in partnership with local people to improve their health and wellbeing. Together we look at ways of improving an individual's quality of life, through high quality healthcare and personal support.
Our values	
Compassion	Our staff will be led by compassion and embody the values of care outlined in our Staff Charter.
Respect	We will respect and value the diversity of our service users and staff, to create a respectful and inclusive environment, free from discrimination.

Empowerment	We will involve, inform and empower our service users, carers and their families to take an active role in the management of their illness. We will ensure our staff receives appropriate direction and support, to enable them to develop and grow.
Partnership	We will work closely with our partners to ensure that our combined efforts are focussed on achieving the best possible outcomes for the people we serve
<b>Our strategic objectives</b>	
<p>We will provide integrated, high-quality, timely services based on the needs of the individual.</p> <p>We will involve, inform and empower the people we serve.</p> <p>We will ensure our healthcare facilities are well maintained and fit for purpose.</p> <p>We will recruit, retain and develop skilled and compassionate people who embody our values of care.</p> <p>We will spend every penny wisely, to support the delivery of patient care.</p> <p>We will invest in technology to deliver better patient care and provide the information we need to support our business.</p> <p>We will develop new relationships, business and partnership opportunities, consistent with our vision.</p>	

In order to help us deliver these Strategic Objectives, we update our Strategic Priorities for the organisation each year with a three year plan against each:

**Table 6: Strategic Priorities 2014-2019:**

No	Strategic Priority
1	High quality services which achieve best outcomes for patients which are delivered efficiently using resources productively
2	Achieving financial stability and delivering savings through better control mechanisms, productivity and efficiency
3	Contributing to a stable local health and social care economy through partnership in NWL, NCL and Milton Keynes
4	Information technology which meets CNWL's needs and those of our partners over 2 and 5 years
5	A workforce plan which is aligned to transformation and which is flexible to meet new demand
6	A strategy of building resilience through consolidation and growth

As above, these priorities are underpinned by a 3 year Change Programme to deliver the savings and change needed in the short term:

**Table 7: Change Programme Workstreams 2014-16:**

	Workstream	Lead Executive	Reporting to Committee of the Board
1	Service Redesign	Dr Alex Lewis – Medical Director	Quality and Performance Committee
2	Workforce	Louise Norris – Director of HR	Executive Board
3	ICT	Trevor Shipman – Director of Finance	Informatics-Committee
4	Controls	Trevor Shipman	Business and Finance Committee
5	Estates	Ian McIntyre – Director of Commercial Developments	Business and Finance Committee
6	Growth	John Vaughan – Director of Strategic Planning and Partnerships	Investment Committee
7	Portfolio Analysis	Ian McIntyre	Business and Finance Committee
8	Management and Governance Review	Robyn Doran – Director of Operations	Short term 20-week programme reporting to the Executive Board. Not part of Operational Plan

These workstreams break out into a number of activities at service line and corporate level. A high level version of our operational plan in relation to the Change Programme is set out at **Table 8**. Each activity aligns to a strategic priority for the Trust. The table includes our planned **productivity, efficiency and CIPs** against these key activities. CIPs are shown as **Transformational or Traditional**. Traditional is a CIP which is a reduction in cost or increase in productivity, whereas a Transformational CIP is one which is part of creating new services and care models within CNWL and with partners.

**Table 8: Implementation of the Operational Plan - 2014-2016**

Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
<p><b>1. Service Redesign and Quality.</b> High quality services which achieve best outcomes for patients which are delivered efficiently</p> <p>5-year Strategic Workstream: 1,5,6,7</p> <p>Strategic Objective: 1,2,3</p>	<p>Completion of care pathway review and associated redesign of the organisation</p>	<p><b>Q1:</b> two Divisional Directors in place  <b>Q2:</b> third Divisional Director in place  <b>Q3:</b> Care pathway review complete in selected areas  <b>Q4:</b> contracting round</p>	<p>Ongoing programme of change management and of opening new design areas</p>	<p>Quality Gain: Reduction in incidents/complaints relating to interface issues</p>	<p>Underpins delivery of QIPP programme and new commissioning direction</p> <ul style="list-style-type: none"> <li>(Trans)</li> </ul>	<p>Risk that focus on change diverts attention from service delivery</p> <p><i>Mitigation: The PMO will support effective planning and risk management</i></p>
	<p>Mechanisms to be in place to identify and respond to experience of those who use services</p> <p>Portfolio of models with delivery processes in place</p>	<p><b>Q1:</b> User engagement strategy refreshed</p> <ul style="list-style-type: none"> <li>Research User Forum to be established with implementation group</li> <li>Negotiation for Family and Friends test to be managed via real time system and integrated to all surveys from Q3</li> </ul> <p><b>Q2:</b> Service users and carers involved in research projects</p> <p><b>Q3:</b> Develop patient identified outcome measures</p> <ul style="list-style-type: none"> <li>Surveys to address patient identified quality outcome measures</li> </ul>	<p><b>Q2:</b> Consolidation of real-time feedback software packages to have just one across whole Trust to allow for comparability between service lines.</p>	<ul style="list-style-type: none"> <li>Improved efficiency</li> <li>Survey user surveys</li> <li>Friends and Family score</li> </ul>	<p>Quality gains:</p> <ul style="list-style-type: none"> <li>Increased levels of patient satisfaction reported</li> <li>outcomes over time</li> <li>Access to FFT in real time</li> </ul>	<ul style="list-style-type: none"> <li>Risk of raising expectations which cannot be delivered within the envelope</li> <li>Risk of not responding to patient feedback</li> <li>Risk of survey fatigue among patients and lack of engagement</li> </ul> <p><i>Mitigation: IT based feedback mechanisms and response which are swift. Demonstrate response to feedback through planning and action locally</i></p>
	<p>Integration</p>	<p><b>Q1:</b>Role in 2-3 Whole Systems</p>	<p><b>Q1-4:</b> Integrated</p>	<p>Quality gain:</p>	<p>CIP:</p>	<p>Staff capacity</p>

Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
	Programmes to be in place, internally and with external partners. This will include bringing together physical and mental health for identified groups.	<p>Early Adopter</p> <ul style="list-style-type: none"> <li>Design of capitated budgets around Early Adopter (EA) pilots</li> <li>Redesign of care pathways around need, CIPs and EA commenced</li> <li>Pilot high impact team for nursing homes (Milton Keynes (MK)West London CCG (WLCCG)</li> </ul> <p><b>Q2:</b>Deliver business case as Early Adopter with partners</p> <ul style="list-style-type: none"> <li>Pilot care plan integrating mental and physical health</li> <li>Modelling of IAPT for Long Term Conditions with WLCCG, and separate linked Liaison Psychiatry/IAPT model</li> <li>Pilot of intermediate care pilot (MK, Harrow)</li> </ul> <p><b>Q4:</b>Contract round including whole systems and tariff</p>	<p>services with capitated budgets will be in place for some groups/areas</p> <ul style="list-style-type: none"> <li>Redesign of pathways will continue in line with intentions and new policy directions.</li> <li>Ongoing negotiation for new services including procurement (inc IAPT)</li> </ul>	<p>improved patient and carer experience around interface issues</p> <p>CIPs: not yet allocated to programme – within service redesign (Trans)</p>	<p>Restructuring - £300k</p> <p>Quality Gain:</p> <ul style="list-style-type: none"> <li>Reduction of unplanned admissions to Acute hospitals</li> <li>Improved response rate in patient survey</li> </ul>	<p>insufficient to meet need and management of stress (feedback from survey).</p> <p><i>Mitigation: Wider training and development programme.</i></p> <p>Further changes to the commissioning environment (BCF, shift of commissioning to local authorities)</p> <p><i>Mitigation: PMO to support flexible response to external and internal challenges</i></p>



Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
	Consolidation / development of Primary Care Plus Services (PCP+)	<p><b>Q1:</b> Identification of where PCP+ to be developed via contracts and supported by Transformation Board</p> <ul style="list-style-type: none"> <li>• Identification of funding source via contracts (Outer Boroughs)</li> <li>• Programmes rolled out for managed discharge and easy re-entry</li> </ul> <p><b>Q2:</b> Transformation plan in place identifying each step down goal</p> <ul style="list-style-type: none"> <li>• Ongoing integration of Assessment and Brief Treatment (ABT) into primary care services as each CCG plan progresses</li> </ul> <p><b>Q4:</b> new models in place for contract round 2015-16</p>	<ul style="list-style-type: none"> <li>• Commissioning of new models of care. Potential PCP+ models in Harrow, Hillingdon and Brent</li> <li>• Managed discharge rolled out across CNWL</li> <li>• Reduced Length of stay in Older Adult wards, outer boroughs</li> </ul>	<ul style="list-style-type: none"> <li>• Patient survey</li> <li>• Reduction in incidents/complaints relating to interface issues</li> </ul>	<p>Step down of: 188 patients/ annum (West London CCG - WLCCG) 207 patients/ annum (Central London CCG - CLCCG) Agreement on model of primary care plus for Harrow, Hillingdon and Brent (Transformational) CIPs: under negotiation further allocation to programme within service redesign (Trans)</p>	<p>Primary care services not set up with capacity to receive patients. <i>Mitigation: Individual work with CCGS and via the Transformation Board to replicate effective models.</i></p>

Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
	Improved access in crisis and discharge	<p><b>Q1:</b> Launch of process to develop Single point of access for Mental Health Urgent Access Programme (MHUAP) in each borough where this is commissioned</p> <p><b>Q4:</b> Revised Home Treatment Team model agreed (Acute)</p> <ul style="list-style-type: none"> <li>• Development of Older Adults Home Treatment Teams using inpatient resource.</li> <li>• Integration of urgent access programme for mental health to contracting round</li> </ul>	<p><b>Q1:</b> Urgent Access Programme operational.</p> <ul style="list-style-type: none"> <li>• Further redesign ongoing to free up capacity in system to manage urgent access.</li> <li>• Monitoring processes agreed for new Home Treatment Teams</li> </ul>	Breaches against criteria for waiting times for urgent access	<p>Quality: Criteria in place:</p> <p>Emergency – 4 hrs</p> <p>Urgent – 24 hrs</p> <p>Routine Plus – 7 days</p> <p>Routine – 4 weeks</p>	<p>Unfunded service having impact on quality and safety in other areas</p> <p><i>Mitigation: Contract negotiation and ongoing dialogue with CCGs</i></p>
<p><b>2. Workforce: A workforce plan which is aligned to transformation and which is flexible to meet new demand</b></p> <p>Strategic Workstream: 1, 5</p>	Establishment of productivity management across the organisation - with transparent, measurable outcomes	<p><b>Q1:</b> Develop project plans and organisational development strategy for the 5 workforce review work streams; Remuneration options, Skill mix to meet capacity demands, performance management and corporate services review.</p> <ul style="list-style-type: none"> <li>• Restructure the HR service to support the new divisional structure</li> <li>• Savings project sickness and agency starts</li> </ul>	<p>2014-15 continued:</p> <p><b>Q2:</b> Monitor implementation of performance management system</p> <p><b>Q3:</b> commence new staffing models in community services</p> <ul style="list-style-type: none"> <li>• Recruitment cost saving project starts</li> </ul> <p>Q 4: 100% of staff have appraisals in place</p>	<p>Quality Gain:</p> <ul style="list-style-type: none"> <li>• Staff Survey</li> <li>• Family and Friends Test (once established)</li> <li>• Sickness and disciplinary levels reduced</li> <li>• maintenance of low levels of C-Diff and MRSA infection</li> </ul>	<p>CIPs:</p> <p>Pay Review: £7,632k</p> <p>Recruitment: 2,500k</p> <p>Outsourcing: £950k</p> <p>Sickness management: £500k</p> <p>(Trad) – check with figures</p>	<p>Sickness and other absence in response to stress of change</p> <p><i>Mitigation: Programme of Occupational Health support.</i></p> <p>Increased use of agency during periods of uncertainty</p> <p><i>Mitigation: Specific work stream allocated</i></p>

Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
Strategic Objective: 1, 4		<b>Q2:</b> Implement new remuneration options for new tenders Start to implement new staffing models on Acute impatient wards <ul style="list-style-type: none"> <li>Implement new HR structure</li> </ul>			Quality Gain: Increased capacity or reduction in staffing cost Effective and efficient transactional HR services	to agency reduction.
<b>3. Information technology which meets CNWL's needs and those of our partners over 2 and 5 years</b>  Strategic Workstream: 4  Strategic Objective: 6	Programmes in place to address requirements in relation to: <ul style="list-style-type: none"> <li>Infrastructure</li> <li>Clinical System, Integration and Collaboration</li> <li>Information and Knowledge Management</li> <li>Service User Access</li> </ul>	<b>Q1:</b> Clinical Systems Programme commences extensive requirements gathering. <b>Q2:</b> Specialist technology provider selected to manage and transform Infrastructure <ul style="list-style-type: none"> <li>Information and Knowledge Management Programme launched</li> </ul> <b>Q3:</b> Transition CNWL's Infrastructure to a high performing service and recognised provider of ICT <b>Q4 :</b> Commence transformation of Infrastructure <ul style="list-style-type: none"> <li>Roadmap defined.</li> <li>Information and</li> </ul>	<b>Q1:</b> Integration and Collaboration Programme launched <b>Q2:</b> Selection of Information and Knowledge Management platforms <ul style="list-style-type: none"> <li>Infrastructure transformed: Staff and partners can access at any time/ location</li> <li>Commence transition to new Clinical Systems</li> </ul>	CIPs: Agile working in place to support Drive  Quality gain: Improved record keeping	Quality gain: <ul style="list-style-type: none"> <li>Improved clinical management information</li> <li>Agile working</li> </ul> Financial gain: <ul style="list-style-type: none"> <li>The ICT programme is key to delivery of Drive QIPP and whole systems</li> </ul>	Access to capital for continuation of development programme <i>Mitigation: Linked to Controls Workstream including ensuring payment for commissioned activity</i>

Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
		Knowledge Management Strategy agreed	<b>Q3</b> :Selection of platform <b>Q4</b> : Service User access strategy defined allowing digital access for users to their records			
<b>4. Controls: Achieving financial stability and delivering savings through better control mechanisms, productivity and efficiency</b>  Strategic Workstream: 1,3,6  Strategic Objective: 5	Controls programme in place	<b>Q1</b> : A range of controls identified for which there is clear accountability and structure for delivery. Across all areas  <b>Q2</b> : delivery commences	Ongoing controls programme	Delivery of control measures Overseen by PMO	Impacts on all areas of savings in all 8 Change Programmes	Delivery <i>Mitigation: Accountability campaign and programme</i>
	Ability to manage internal efficiencies to the required level and to meet all CIPs	<ul style="list-style-type: none"> <li>Achieving financial stability through delivering savings of £33m in year one and</li> </ul> Key areas: <ul style="list-style-type: none"> <li>Contracts, procurement, tendering</li> <li>Workforce, recruitment, agency, sickness, pay reviews</li> <li>Estates</li> <li>Productivity</li> <li>Income</li> </ul>	£23/24m savings delivered. Key CIPs programmes as in 2014-15 with further efficiencies identified through workstreams	Introduction of performance indicators to be agreed against each workstream	Contract efficiencies:£3 25k (Trad/Trans Procurement: £1,570k Pathology (sexual health) £270k Medication move to generic drugs (HIV): £2,010	The environment is unpredictable and volatile and there are undelivered CIPs <i>Mitigation: A tough programme of CIPs delivery which will see reduced staffing</i>

Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
	Delivery of a Productivity programme /Drive	<p>There is an identified list of DRIVE programmes managed through a Programme Management Office (PMO). 3 key programmes for 2014-15:</p> <ul style="list-style-type: none"> <li>• Inner Boroughs efficiency drive</li> <li>• Hillingdon District Nursing</li> <li>• Corporate support</li> </ul>	<p>Future programmes to be confirmed in light of Whole Systems planning To include continued work on care pathways</p>	<p>Delivery of CIPs (Trad/Trans) Delivery of quality measures Overseen by PMO</p>	<p>Quality Gain: Lean services – agreed with commissioners where it will involve service change CIPs: £1,428k (Trans/Trad)</p>	<p>Service change not agreed by commissioners, savings not made, Trust unsustainable <i>Mitigation: Drive is evidence based and uses clinical and service user input to efficiency planning</i></p>
	Transition to Mental Health Tariff or other tariff system – including capitation – to be made with commissioners and partners, while retaining financial stability	<p><b>Q1:</b> Shadow year for Mental Health Tariff.</p> <ul style="list-style-type: none"> <li>• Integrated Care Early Adopters in place - Design of capitated budgets around EA pilots underway</li> <li>• Currently this is fluid</li> <li>• Establishment of process to align PbR care package with new care pathways</li> <li>• Linked to establishment of outcomes frameworks</li> </ul> <p><b>Q3-4:</b> Establishment of financial tariff and inclusion in contracts</p>	<p><b>Q1:</b> Likely to be a range of contractual arrangements for 2015-16 included some capitation and some tariff based on care pathways</p> <ul style="list-style-type: none"> <li>• Anticipated role out date for Mental Health Tariff as payment mechanism</li> </ul>	<ul style="list-style-type: none"> <li>• Improved performance against validity</li> <li>• Meeting CQUIN targets 2014-15</li> </ul>	<p>Quality gain of Nice-compliant care pathways. These will form the basis of all provision and commissioned services within the MH tariff. (Trans)</p>	<p>Services based on inaccurate costing so that Trust is unsustainable/impact is too high on LHE <i>Mitigation: CNWL is ensuring we are part of a range of pilots to have exposure to different funding models and to take part in debate around them</i></p>

Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
<b>5. Estates</b>  Strategic Workstream: 1,2,3,4 Strategic Objective: 1,3	Provision of appropriate, accessible, well-maintained accommodation	<b>Q1:</b> Estates Workstream with efficiency drive established <ul style="list-style-type: none"> <li>• Redefining clinical processes to minimise estates portfolio.</li> <li>• Property disposal strategy of high cost sites.</li> <li>• Use of IT &amp; mobile services</li> <li>• Shared space</li> </ul>	<b>Q1</b> <ul style="list-style-type: none"> <li>• Property disposal strategy</li> <li>• Specialist sites for 24/7 care</li> </ul>	Monitoring of controls workstream  Achievement of CIPs	Estates CIPs to be established through efficiency workstream (Trad/Trans)	Availability of capital to improve buildings <i>Mitigation: Integral to overall finance strategy</i>
<b>6. Portfolio Analysis</b>  Strategic Workstream: 1,2,5,6  Strategic Objective: 1,2,3,5	Ensure current and new business activities cover corporate overheads and an average 5.5% margin is achieved across our services.	<b>Q1:</b> Commercial reviews of all services kicks off, to identify consolidation, growth and divestment options. <b>Q1:</b> 30% of reviews completed. <b>Q2:</b> 50% completed. <b>Q3:</b> 80% completed. <b>Q4:</b> 100% completed and appropriate plans in place. <ul style="list-style-type: none"> <li>• 80% of existing contracts retained where desirable to do so. 100% of new business achieves corporate overhead and 5.5% margin.</li> </ul>	Business & marketing strategy in place for 2015/18. 90% of existing contracts retained where desirable to do so. 100% of business achieves corporate overhead and 5.5% margin.	Reviews completed each quarter Business tracker on schedule	Trust overhead and 5.5% margin achieved across all services	Business model may not be viable. May not meet commissioner requirements <i>Mitigation: Use pilot and engage with commissioners throughout development</i>

Change Programme Workstream 2014-16	Measure of success/how we will know we have succeeded	Schemes and Milestones		Assurance	CIP (Trans/Trad), Income, Quality Gain	Risks to Delivery and Mitigation
		2014-15	2015-16			
<b>7.Growth: A strategy of building resilience through consolidation and growth</b>  Strategic Workstream: 1,2,5,6  Strategic Objective: 1,2,3,5	Ensure the Trust sets and achieves growth targets	<ul style="list-style-type: none"> <li>• % increase in turnover (to be confirmed) based on 2013/14 turnover.</li> <li>• % increase in turnover target identified for 2015/16</li> <li>• To be in accordance with the agreed Business Development Strategy</li> </ul>	<ul style="list-style-type: none"> <li>• 100% of services have sales targets in place.</li> <li>• % increase in turnover based on 2014/15 achieved.</li> <li>• 100% of new business achieves corporate overhead and 5.5% margin</li> </ul>	Achievement against growth target reported quarterly	Trust overhead and 5.5% margin achieved across all services	Growth targets may not be achievable and may need in year review in light of market changes
	Income generation	Inpatient income generation programmes across wards Other income streams  Placement Efficiency Project in Rehabilitation Service Line. Projected income for 2014-15	Inpatient income generation programmes across wards  Placement Efficiency Programme – expected to be reducing	Achievement against income targets reviewed in Quarterly Reviews and Business and Finance	Income gen: Income from <i>Inpatient beds</i> per quarter: £2,487k <i>Small individual misc</i> income: £1,168 <i>Other</i> income/tenders: £1,489 Placement Efficiency: £100k)	Competitive market <i>Mitigation: Rise in demand</i>

## 8.Operational requirements and capacity

There are significant operational challenges to CNWL in the light of demand and capacity issues. Analysis of our population shows considerable growth in population and deprivation. This is matched in some boroughs by growth in bed use and community care. The snapshots below are for illustration and are not intended to show all areas of Trust pressure, but some key and consistent areas in two areas; NWL mental health and Milton Keynes Community Services. We have also added some data from the NHS Benchmarking Network for Mental Health 2013

### 8.2 NHS Benchmarking Network – Mental Health 2013:



The 2013 benchmarking exercise took place in July and August 2013. The project received contributions from 57 NHS Mental Health providers across England and Wales.

The work showed that CNWL was not an outlier except in having long term rehabilitation beds. CNWL is just above the median for Adult Acute Mental Health beds, and for admissions, per 100,000 population.

However, CNWL's occupancy was the highest of all participating Trusts, demonstrating pressure on beds which have been reduced over the last two years to meet QIPP. We have checked whether this is because of long stay or readmission, but our Length of Stay in Acute and PICU beds, and our readmission rates are all just above the bottom percentile, so we are confident that this is not the case and that there is genuine bed pressure for the Trust. This is further explored at 8.2 below where we have compared the number of beds used by CCGs against the number commissioned – both before and after QIPP was made to the bed numbers.

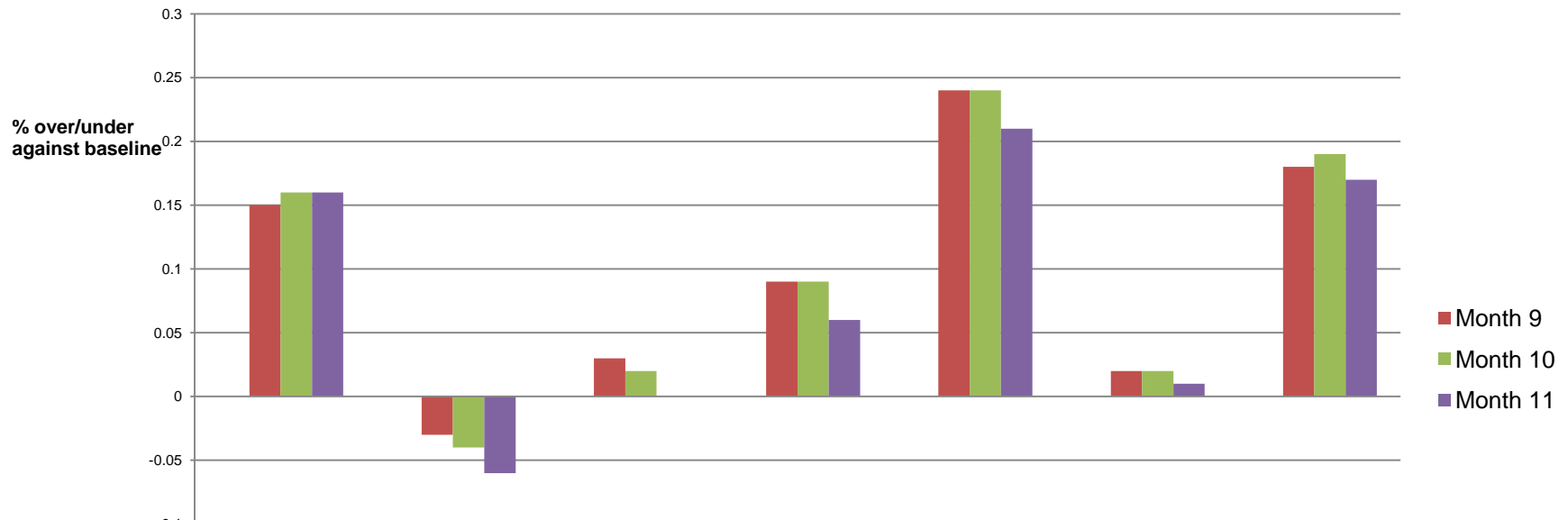
In community mental health services, CNWL's staffing is just above the mean, but our caseload is a little lower, indicating that there is further work to build on the Drive efficiency programme to increase productivity.

These are some snapshots of a larger document.

**8.3North West London Mental Health Services:** CNWL and commissioners are committed to reduce beds and replace them with more community and primary care based care. However, the current position is that we have seen a growth in demand. This may be addressed longer term as community and primary care services develop. CNWL has responded by remodelling bed use in Adult Acute, in particular with the development of triage wards which have reduced LoS without leading to a rise in readmission. However, pressure continues to grow in all acute wards except Harrow, where psychiatric intensive care bed use (PICU) has doubled to return to 2011-12 levels after a drop in 2012-13:



### Acute Mental Health OBDs NWL - Cumulative Variance Against Commissioned Capacity



	Brent CCG	Harrow CCG	Hillingdon CCG	K&C &QPP CCG exl QIPP	K&C &QPP CCG incl QIPP	Central London CCG exl QIPP	Central London CCG incl QIPP
OBDs Cumulative Variance							
Month 9	15%	-3%	3%	9%	24%	2%	18%
Month 10	16%	-4%	2%	9%	24%	2%	19%
Month 11	16%	-6%	0%	6%	21%	1%	17%

## 8.4 Community provision in Milton Keynes:

This is a model of raised demand against commissioned capacity in a community setting. The same pattern is seen in other areas due to demographic and QIPP pressures:

Specialist Podiatry in Milton Keynes				
<ul style="list-style-type: none"> <li>•The specialist podiatry service (SPS) covers both the community service and that provided to Milton Keynes Acute Foundation Trust</li> <li>•The SPS provides care for those with a medium to high risk foot problems. The service provided at the acute hospital are for the “at risk foot clinics” dealing with patients who have critically neuropathic/ischaemic limbs and are at risk of / or have had previous amputation.</li> <li>•Effective podiatry has been proven to reduce unnecessary amputations and prevent hospital admission.</li> </ul>	<b>Referral comparisons for 11/12 – 12/13- 13/14 to outline increases in referral patterns</b>			
		<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>
	<b>Number referrals</b>	1770	3172	4243 (to Feb 2014)
	<b>Summary of changes to staffing levels within the last 3 years /additional pressure on services</b> <ul style="list-style-type: none"> <li>•The investment has been reduced by 54% in the Any Qualified Provider (AQP) process.</li> <li>•The introduction of AQP podiatry created a two tier service. Specialist patients are in need of faster response times than AQP patients due to their specialised needs.</li> <li>•In order to meet the 18 week wait target for new patient assessments, existing patients are now waiting up to 12 weeks over their prescribed return times due to lack of capacity within the service.</li> <li>•The foot conditions now seen in the specialist clinics are more complex and therefore require more time to see them and treat them. As there is an increasing amount of time to wait to be seen between appointments when patients finally get their appointments then there is more to do or their foot condition has deteriorated. They then need to be prioritised for their next appointment and need a shorter return. We need to increase the amount of time that clinicians have to see and treat patients to ensure that we are clinically safe and that we are meeting fully the needs of the patients. Investment here will reduce further (more costly) complications.</li> </ul>			

## **9. Financial and Investment Strategy**

### **9.1CNWL's current financial position:**

The Trust did not achieve its financial plan in 2013/14.

At month 11, the Trust was forecasting a surplus of £0.5m, which is £8m behind plan. This has been caused by slippage on CIP and QIPP schemes together with the additional cost of meeting quality concerns in Milton Keynes and Beatrice Place (£2m combined) . This creates a combined savings target of £33m (7.6%) for 2013-14, dropping to £23m (5.2%)] in the next two years

The merger with Milton Keynes Community services from 1<sup>st</sup> April 2013 is part of our strategy for growth and to meet our savings targets. The financial impact was to increase the Trust's turnover by approximately £58m. However, unexpected cost pressures have been incurred in Milton Keynes arising from estates costs in the Campbell Centre. These cost pressures are expected to continue into 2014-15.

This has in part heightened the financial risk for a year that was already due to have many financial challenges. At the time of writing, Heads of Terms have been agreed in Camden. There is agreement in some specialised areas commissioned through NHSE. There are still areas where negotiations are not yet finalised. CQUINs are not signed off in any area and represent a significant risk to the Trust if not paid.

The backdrop is then one of uncertainty which the Trust has flagged with both commissioners and services. The Trust has, since becoming an FT planned running a surplus in excess of 5% and whilst the incorporation of Milton Keynes services from 1<sup>st</sup> April 2013 with a return of 0.9% brings down the overall Trust return, it is the additional QIPPs being required by commissioners of over 5% of income, in excess of the Monitor efficiency requirement which brings uncertainty around many income lines.

### **9.2CNWL's financial strategy going forward:**

The Trust has set out its intention through the Board of Directors to maintain an EBITDA of 5.5%. However there are considerations and risks in this. This year we have ended the year at 3.6% and have a recovery programme over next year. CNLW's Board and Executive understands the seriousness and scale of this task, and the requirement to find our full CIPs and meet our income targets in 2014-15. This will be supported by the Change Programme.

### **9.3Key priorities and investments:**

The first financial priority is the on-going identification and regular delivery of programmes of savings to first meet the Trust's own internal financial pressures and then to release savings to the local health economy. There are a number of actions contained in such an approach. First the identification of schemes, then the assessment of quality including clinical safety; engagement with users, carers and commissioners; where appropriate there is consultation; and finally there is delivery of the scheme itself. Each scheme has its own complexities and the Trust has identified that it needs to improve certain of these stages to meet the requirements going forward.

The Trust is not only looking forward to meet savings targets in the future, but recognizes that many of its areas of activity may/will be subject to commercial tendering over the next 1-5 years and as such the Trust will not only have to demonstrate the quality of its services but also that they are providing value for money and often that may well be weighted greater than quality by commissioners and so price will be significant. The Trust has a long track record in tendering both successfully and unsuccessfully for existing and new services and recognizes that the unit cost is a key element of evaluation. For this reason and the development of tariff and capitation for parts of mental health, the Trust has introduced a more sophisticated costing system, together with rigorous review of services and adjustment of the apportionment tables with management and clinicians.

#### 9.4 Key uncertainties and issues for resolution

- The decisions around the 1% pay award means that the full anticipated cost of £3m will not be required. However, we are currently budgeting for a large part of this money, given that the decision has only just been made and there may be further discussion before this is finally resolved.
- Contract negotiations have not concluded with commissioners, though first offers have been received at the time of writing. There is wide variety in the offers that have been received, further information is provided in the contracts update paper. As contracts are agreed the budgets will be adjusted accordingly and QIPP targets will be created specific to the agreed schemes;
- Agreement has not been reached on the likely level of funding required for special measures in Milton Keynes during 2014/15 or the amount of IT costs that would be included within restructuring costs.

#### Glossary:

<b>ABT</b>	Access and Brief Treatment Service Line	<b>CQUIN</b>	Care Quality Innovation Scheme
<b>CCG</b>	Care Commissioning Group – GP led commissioning unit	<b>CSU</b>	Commissioning Support Unit. Technical support to CCGs
<b>CLCCG</b>	Central London CCG		
<b>WLCCG</b>	West London CCG		
<b>CAMHS</b>	Child and Adolescent Mental Health Services	<b>MHUAP</b>	Mental Health Urgent Access Programme
<b>CQC</b>	Care Quality Commission	<b>OPHA</b>	Older People and Healthy Ageing Service Line
<b>CIPs</b>	Cost Improvement Programmes	<b>QIPP</b>	Quality, Improvement, Productivity and Prevention (QIPP)