Central and North West London NHS
NHS Foundation Trust

CNWL Operational Plan for 2016/17

Public Version

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Glossary:

	Full name	Description where needed
ACO	Accountable Care Organisation	A body made up of a number of organisations coming together to deliver a service
ACP	Accountable Care Partnership	The process before the ACO is fully formed
B&F	Business and Finance Committee of the Board	Committee of CNWL's Board
CAMHS	Child and Adolescent Mental Health Services	
CCG	Clinical Commissioning Group	GP led commissioning body
CIP	Cost Improvement Plan/Programme	Savings made for CNWL (see QIPP)
CQC	Care Quality Commission	Regulatory body
CQUIN	Commissioning for Quality and Innovation	Quality improvement scheme with incentivised payment as part of contract
FFT	Friends and Family Test	
FYFV	Five Year Forward View	Main policy document for the next five years
GLA	Greater London Authority	
H&F	Hammersmith and Fulham	
HMP	Her Majesty's Prison	
IAPT	Improving Access to Psychological Therapies	Service model for treatment of depression and anxiety
ICT	Information and Communications Technology	
IST	Intensive Support Team	This is an NHS service to provide expert support around demand and capacity planning
K&C	Kensington and Chelsea	
Like Minded	Like Minded	North West London's five year mental health strategy which is under development
MOJ	Ministry of Justice	
NCL	North Central London	
NHSE	NHS England	
NICE	National Institute for Health and Care Excellence	
NWL	North West London	
PMO	Programme Management Office	Service to manage projects and programmes
QIPP	Quality, Innovation, Productivity and Prevention	Savings made for external bodies (see CIP)
STF	Sustainability and Transformation Fund	Government funds for the NHS developments – dependent on the quality of the STP (below)
STP	Sustainability and Transformation Plan	Five year place-based plans to be rolled out across 44 localities
SystmOne	SystmOne	A new clinical record system for CNWL
TRAC	TRAC	Recruitment system for the NHS

CNWL Operational Plan 2016/17

Overview:

This year's operational plan is set within the context of significant challenge in 2016/17. The next year will be critical to the future affordability of the NHS. CNWL's Board are submitting this plan in full recognition of the severity and urgency of the challenge which must be addressed through our one- and five-year planning. This includes maintaining and improving quality and safety in an environment of financial pressure, availability of workforce, and the gaps identified in the Five Year Forward View (FYFV).

CNWL ended 2015/16 meeting our financial savings target, but this has included non-recurrent savings, and there is a great deal more to do to address underlying costs in the coming year. To tackle this, we have identified five demanding operational priorities for 2016/17. CNWL's operational priorities for 2016/17 are measured against our vision, values and strategic objectives which have been reviewed by our Board and Council of Governors and found to be a true expression of our strategic intentions.

Diagram 1 – Visual Summary of CNWL Vision, Values, Objectives and Priorities:

<table>
<tr><th colspan="3">Our Vision</th></tr>
<tr><td colspan="3">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 health and social care, and personal support</td></tr>
<tr><th colspan="3">Our Values</th></tr>
<tr><td colspan="2">Compassion: Our staff will be led by compassion and embody the values of our care outlined in our Staff Charter</td><td>Empowerment: We will involve, inform and empower our service users, carers and their families to take an active role in the management of their health. We will ensure our staff receive appropriate direction and support, to enable them to develop and grow</td></tr>
<tr><td colspan="2">Respect: We will respect and value the diversity of our service users and staff, to create a respectful, inclusive environment, free from discrimination</td><td>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</td></tr>
<tr><th colspan="3">Our Strategic Objectives</th></tr>
<tr><td>High Quality Care and Best Outcomes for Patients: To provide high quality care to people who use our services, and to their carers. These services to be safe, caring, effective, responsive and well-led</td><td>Operational Stability: To design our services for improved quality, efficiency and outcomes. Integrated care and reduced unnecessary admissions</td><td>Financial Sustainability: To make the necessary savings, ensure all contracts are viable and that we comply with standards to ensure organisational resilience and sustainability</td></tr>
<tr><th colspan="3">Our Operational Priorities for 2016/17</th></tr>
<tr><td colspan="3">Partnership and Communication: To create a clear vision of future organisational form with clear, easy to understand, impactful narrative and brand. To position the Trust as an important and valued partner across our broad and disparate landscape</td></tr>
<tr><td colspan="3">Transformation and redesign: To ensure that CNWL has a redesign process which assures modern, values-based, effective care at competitive cost</td></tr>
<tr><td colspan="3">Workforce: To ensure that the Trust has an able workforce who feel valued and are available in sufficient number</td></tr>
<tr><td colspan="3">ICT: A revised ICT strategy, an effective plan to meet the 20/20 vision and local aspirations for interoperability and access</td></tr>
<tr><td colspan="3">Finance: To drive clearer, more effective financial performance, ensuring clear lines of sight for the Board</td></tr>
</table>

From a financial perspective, CNWL's Board is approving the plan in the absence of agreement of a number of key contracts. While the environment remains financial unstable, CNWL is making plans for how to meet a savings target of £27.2m and a planned deficit of less than £1.1 for 2016/17. The next year will be critical for CNWL's finances, as for those of the NHS as a whole.

Pressures on funding in the NHS are compounded by reductions to local authority funding. For CNWL this will impact on availability of services for vulnerable groups – including children – which is putting further squeeze on available services.

Our operational plan is the first year of three five-year Sustainability and Transformation Plans (STPs) in which CNWL is a partner. These cover the footprints of North West London, North Central London and Milton Keynes, Bedfordshire and Luton.

1. Activity, demand and capacity

CNWL has a wide range of services with variation in how activity is planned, reported and funded. This has set a challenge for us and our commissioners in terms of accurate demand and capacity planning. CNWL's organisational response to this for 2016/17 is set out at 1.1. In addition to organisational factors driving change in demand and capacity, there are demographic and societal changes which are discussed at 1.2.

1.1 Organisational response:

1.1.1 Managing demand and capacity looking forward:

CNWL has expressed an interest in taking part in the development programme of the Intensive Support Team (IST) methodology for both mental health and community services, which would be used for operational planning and for service redesign. This will help to overcome a situation where different approaches to analysing funding and activity have led to different conclusions on gap and action required.

1.1.2 Managing inpatient capacity:

Plans to reduce inpatient capacity in mental health have been re-aligned in North West London to fit with the development of Like Minded as a strategy for mental health across the patch. Programmes of bed rationalisation are well advanced in some boroughs where CNWL is operational, while others require further development of community and primary care services. This is part of the dialogue around redesign. Where additional beds are needed, capacity is increased through purchase of provision in other NHS trusts or in the private sector.

1.1.3 Benchmarking:

CNWL is part of the national mental health benchmarking club, which supports understanding existing practice in the context of other trusts and learning from that. Key intelligence from this includes:

- Inpatients: CNWL has high demand for beds
- CNWLs' Emergency readmission rate is in the lower quartile and is the 14th lowest in the country.
- Acuity on inpatient wards appears high with CNWL having the 4th highest number (75%) inpatients on clusters 10-16, which are the psychosis clusters while 61.6% of community contacts are by patients on clusters 10-16.
- CNWL has higher staff vacancy rates and turnover than the national average – although the lowest in London.

1.1.4 Development of tariff:

- The continuing use of block contracts in most mental health and community services means that payment for additional use beyond capacity has historically been subject to debate.

- Further to Monitor's response to the consultation, the timescale for move to tariff is now clear, by 2017/18.
- This is further supported by the Mental Health Taskforce determination that use of activity based on block contracts is no longer acceptable.
- CNWL is likely to move to a shadow mental health tariff in 2016/17, rather than a shift from block to tariff. The tariff will be based on activity in Q1. This will be supported by a national mental health CQUIN to develop outcomes based tariff in 2016/17 - work in which CNWL is engaged with NHSE.

1.1.5 Productivity:

- This is a workstream within CNWL's programme of service redesign, and is monitored through a range of indicators e.g. patient and staff feedback, sickness, turnover and agency costs. Productivity has been analysed and capacity rebased during 2015/16 for community mental health teams (CMHTs) as part of the redesign process. It is hoped that there will be opportunities to further develop this, within the STP programme and/or with NHS England's Intensive Support Team.
- During 2016/17 the efficiency review by **Lord Carter** will be finalised and will provide a framework around management costs and estates usage – with a focus on reducing variation. This is further discussed in the Finance section (4).
- Development of **STPs and ACOs** will further support productivity and efficiency through sharing of management costs. This is further discussed in the STP section (5).

1.2 External drivers for change in demand and capacity:

1.2.1 Policy and commissioning intentions:

The policy environment is framed by the FYFV, with guidance for different sectors being developed - for example through the national Mental Health Taskforce report. There are also local policies - the development of STPs and, in North West London, the mental health strategy, Like Minded. This is discussed at Section 5.

1.2.2 Demographics:

CNWL reviews population change and use of service to anticipate service demand each year. During 2016/17, these projections will be refreshed in partnership as part of development of STPs. Assumptions are shared with commissioners through consultation each time our strategic plan is refreshed and are discussed through care quality governance processes in each locality. Information on demand planning is publicly available on our website through the published plans[1].

a) **Population:** As set out in previous plans, population across CNWL is projected to rise by 8% between 2014/15 to 2020/21. This is slightly higher than the London average at 7% over that period. Distribution of growth across CNWL is, however, very varied both for whole populations and between groups. Hillingdon and Milton Keynes are CCGs and local authorities with significant financial challenge, and yet will grow by 10% in the analysed years. In inner London, Kensington and Chelsea remains the borough with least growth overall, 2%, as in previous years.
b) **Age:** In Milton Keynes, over 34% of the population is projected to be over 65 years of age by 2021, followed by Kensington and Chelsea at 23%. This older population will require increasing levels of resource and integrated services. The child population will grow by 15% in Hillingdon and by 13% in Harrow and Milton Keynes. Again, there are specific needs associated with young people, including the prevention agenda, which is highlighted in the FYFV as essential to the sustainability of the NHS and the national financial position.
c) **Deprivation and impact on health:** While deprivation with associated impact on children and longer-term health is much worse than the English average in the boroughs of Westminster,

[1] **Strategic Plan 2014/15-2018/19**. http://www.cnwl.nhs.uk/wp-content/uploads/CNWL_Strategic_Plan_2014-19.pdf

Kensington & Chelsea, Camden, and Brent, these boroughs have lower levels of smoking and associated disease in relation to national and North West London figures[2]. Deprivation in the outer London boroughs, particularly Harrow, is low, but morbidity associated with diabetes and cardiovascular disease is considerably higher than average for London. Milton Keynes shows a mixed picture – less deprivation and long term-unemployment, but more violent crime and homelessness.

1.2.3 Pressure on and from Acute Services:

Pressure on A&E and beds in acute hospitals, particularly in North West London, is felt elsewhere in the system. Difficulties in managing demand faced by acute trusts which are addressing critical levels of activity are passed on to mental and community health providers. This relates to all services, including children's services

2. Quality Planning:

CNWL started this operational year in receipt of the findings of a CQC inspection in February 2015. This provided independent data on where the organisation needed to focus quality improvement.

2.1 Quality Improvement – to provide safe, high quality care and to achieve a rating of outstanding from the CQC: The CQC carried out a comprehensive inspection of the Trust in February 2015. The CQC rated the Trust overall as 'requiring improvement' with 24 areas being deemed non-compliant. Across the five CQC domains, the Trust was rated overall as outstanding for 'caring', and good for 'effective' and 'well-led'. Sexual health services were rated as "outstanding", and district nursing, health visiting, podiatry, end of life care, community health inpatient and dentistry were rated "good".

Our 24 non-compliant areas (our "Must-Dos") were predominantly around processes and escalation protocols to manage demand for mental health inpatient services in London. At January 2016 the Trust declared full compliance against the 24 Must-Do compliance actions. Monitoring continues into 2016/17, overseen by the Divisional Quality Boards.

2.2 CNWL Quality Inspection: In November 2015, CNWL undertook its own Trustwide quality inspection. All services were inspected by staff, commissioners, service users, carers, HealthWatch and other interested parties. The inspection tool was based on Key Lines of Enquiry (KLOEs) the five CQC domains of safe, effective, caring, responsive and well led. Bringing together CQC findings and those of the Quality Inspection, four key themes have emerged to be addressed in 2016/17 and reflected in our plan:

- Staffing
- Leadership
- Care Planning
- Physical Environment.

2.3 CNWL's Quality Priorities 2016/17

CNWL has an annual consultation process involving service users, carers, commissioners, HealthWatch and other stakeholders to identify our Quality Priorities for the forthcoming year. This process is underway and will conclude in May 2016.

[2] **Public Health overview – Health Indicators: 2015.** Summarised at **Appendix 1**

A consultation process is underway throughout April in all our localities around the priorities which have emerged from our first series of events to identify Quality Priorities for 2016/7. These are around relationships:

- Staff engagement
- Patient and Carer involvement

The goals for staff engagement on which we are consulting are:

- A workforce which feels **committed, motivated** and **valued**, to give of their best or go the extra mile for colleagues, patients and carers
- Thinks and acts in a **positive way** about their work, the people they work with and serve
- Adopts a **supportive, inclusive leadership** style
- **Demonstrates the Trust's values**

For patient and carer involvement, goals are likely to include:

- Patients and their families are **actively included and consulted** in relation to the plan of care or treatment, including medication decisions, which **matter to the patient**.
- Patients and their family are **treated with respect and dignity** at all times, and are provided with supportive information about the condition and services available, and where appropriate access to support out of hours.

An initiative identified to support achieving our quality priorities is '**Hello my name is…**' – a campaign around engagement between staff and patients led by Dr Kate Granger.

2.4 CNWL's Sign up to Safety Plan:

As part of the sign up to safety initiative, the Trust has identified the following areas where we will be undertaking specific work to support harm reduction during 2016/17:

- Pressure ulcers
- Medicines management
- Violence reduction
- Falls
- Suicide and self-harm

The Trust is working with both the Imperial and Thames Valley Academic Health Science Networks to support delivery throughout 2016/17. The product will be a range of projects utilising quality improvement methodology.

2.5 Implementing 7 Day Services:

CNWL delivers 7 days services and these will be further developed during 2016/17:

- We are working with partners to develop a range of integrated services – through Whole Systems Pioneers; as a partner in hospital avoidance programmes in Camden, Hillingdon, Milton Keynes and Ealing (with West London Mental Health Trust); through developing ACPs such as that in Hillingdon where we are one of four partners developing an early ACO for delivery in April 2017. All will provide integrated, 7-day care
- The achievement of 7 day and crisis access for mental illness is a driver for CNWL's redesign programme, including the mental health Single Point of Access (SPA)
- The Single Point of Access – is available 24/7/365 as a phone and booking line. It is complemented by a Home Treatment and Rapid Response Team (HTRRT) in North West London. Development of CNWL's crisis response is a key part of our STPs in North West London, North Central London and Milton Keynes, Bedfordshire and Luton. CNWL provides 24/7 liaison psychiatry in hospitals. Liaison nursing is available in the Eating Disorders Service with access to medical support

2.7 Delivery of priorities identified by the Mental Health Taskforce:

The Taskforce will deliver the FYFV in Mental Health. It sets out a programme which will be fully reflected in CNWL's five year plan. It sets out plans which are necessary to manage NHS finances, while considering the issues which are specific to treatment and prevention of mental ill health. We particularly welcome the focus on young people, and on quick access form part of CNWL's prevention strategy with partners. Similarly, using and adapting new care approaches which have been found to be beneficial – such as Open Dialogue which CNWL has used in our HTRRT models. Through such means we aim to reduce unnecessary use of medication which has individual physical benefits, as well as system-wide efficiency gains.

2.8 Triangulation and risk management of quality and performance:

CNWL has developed scorecards and an integrated dashboard which brings together information on quality performance (external and internal standards), finance, workforce and safety as measured through a suite of indicators.

3. Workforce Planning:

CNWL's aim in 2016/17 is to develop an organisation where people deliver excellence and feel involved, inspired, appreciated, fulfilled and healthier at work. We must simultaneously meet the recommendations of reviews, such as that of Lord Carter, to reduce waste such as unnecessary use of agency staff, and increase productivity in the NHS. These aims are compatible:

- Effective leadership is essential to managing quality of care and wellbeing of staff, including impact on recruitment and use of agency. It was identified as a priority in Lord Carter's review and in CNWL's quality inspection
- Agency use and its reduction is part of the workforce strategy to meet the national ceiling value . It is also an action plan for immediate implementation which started in 2015/16 and will continue into 2016/17.
- Our workforce planning framework is supported and informed by education, leadership, engagement and health and wellbeing strategies
- CNWL's workforce strategy is internally influenced by a number of factors including Service Redesign and externally by growing partnership opportunities such as ACOs.
- A review of the ratio of frontline staff in relation to back office provision, is being undertaken and benchmarked with other trusts and organisations to identify where there are potential savings.

3.1 Clinical engagement and governance of workforce planning:

Clinicians are represented in workforce planning centrally and through Divisions:

- A central education team engages with and consults with Divisions on workforce development and plans: an annual learning needs analysis takes place in every division
- Workforce plans are developed and agreed with service and divisional managers, clinicians and directors and are subject to quality impact assessment processes (QIA)
- Divisional and Borough management teams monitor vacancy rates closely and the divisional recruitment project which includes a programme to reduce agency use

3.2 Managing Agency use:

CNWL's Director of Nursing is leading a programme of review and management of agency - to meet the cap and maintain safety. Agency remains a significant challenge and addressing it is a major programme of work from 2015/16 which continues into 2016/17

Key drivers for agency use are: recruitment challenges particularly in some areas such as Offender Care; short-term contracts; further work to be done around e-rostering.

There are a number of workstreams flowing from the agency reduction programme:

- A short term programme of agency management:
- Recruitment and Retention Plan:
- E-rostering: .
- Training and development

4. Financial Planning:

4.1 Forecast Revenue, Expenditure and the Financial Gap

4.1.1 Forecast Income

- Income modeling assumptions are derived from Planning Guidance, finance department estimates, contract negotiations and contractual clauses.

- In overall terms **the Trust has a total gross initial income forecast for 2016/17 of £ 439.8m**

4.2.2 Expenditure Plan

- The Trust's budget setting process has identified a number of local cost pressures that are unable to be accommodated within existing resources.
- Built in to this financial plan is an unachieved CIP's of £ 5.4 million for all divisions from 2015/16.
- In overall terms **the Trust has a total gross initial forecast expenditure plan for 2016/17 of £467.0 million** (net of brought forward CIP this is £461.6 million). The Trust has been set a control total of a deficit of £1.1m.

4.3 Potential Planning Shortfall

- **Planning Shortfall for 2016/17:** At this stage of the process, the Trust's forecast expenditure of £ 467.0 million exceeds the forecast income of £ 439.8 million by £ 27.2 million for 2016/17..

The current potential shortfall, factoring in the planned deficit can also be categorized as follows:

Table 6 – Efficiency Requirement by Category

	£ m's
NHS Efficiency Requirement	6.4
Local Authority/Non-NHS Efficiency Requirement	4.1
Loss of Contribution	3.2
Brought Forward deficit from 15/16	8.1
Unmet CIP from 15/16	5.4
Sub-Total:	27.2
Planned Deficit	(3.8)
TOTAL EFFICIENCY REQUIREMENT	**23.4**

- **Agency spend:**

The narrative on CNWL's use of agency is set out in the Workforce at section 3.

- **Service Redesign:**

There is a programme of service redesign to drive efficiency and productivity across the Trust, to transform services, improve quality and efficiency and improve patient outcomes. This is discussed elsewhere.

- **Recommendation of Carter Review:**

These are touched on elsewhere in the document and the final recommendations will be integrated to existing workstreams around estates (section 4.5.1), workforce (section 3) medicines management, procurement and data management during 2016/17.

- **Medicines management:**

  CNWL has taken part in benchmarking against the Carter criteria for medicines management and where applicable to a non-acute setting, there Trust was not an outlier. Further work will be undertaken next year and the Trust would like to be part of the development of the model, including staffing levels, for mental health and community settings.

- **Procurement:**

  The Trust is working collaboratively with the London Procurement Partnership to identify areas were savings through joint procurement can be made.
  In terms of medicines management and the Carter Review, all procurement is via regional or national processes where possible which is overseen by the Department of Health for outliers. Local agreements around medicines management are in place with GPs to manage quality and cost between providers.

- **Data management:**

  The current ATI metric recommended by Lord Carter is an imperfect fit with services which are more than 90% outside of hospital. CNWL has put itself forward to be one of those involved in adapting the measure for mental health and community services. As set out elsewhere, CNWL is keen to also work with IST to develop demand and capacity models to support our productivity and efficiency in mental health and community services

4.4.1 Estates:

During 2015/16 regular strategic workshops have been established with each Division including clinical staff, to align the property strategy and investments with clinical strategies. Also to optimise use of Estates and management of associated cost such as energy use, in line with the Carter Review (4.4.1d). This work will underpin overall Trust strategy and to deliver ongoing savings. These workshops feed into the Estates Strategy Group which reports to Business and Finance Committee.

This process has identified Estates-led opportunities for cost reduction which acted as a catalyst for Divisions to consider how they might maximise each opportunity.

A prioritised register of actions, with quick wins for 2016/17, has been identified. Planned roll-out of new technology during 2016/17 will facilitate the full introduction of agile working which will mean that we will require less office type space due to the ability of some staff to work remotely; whilst building-based staff can share accommodation in many cases.

In conjunction with this we are pursuing partnering with other service providers to share accommodation, such as the NWL Strategic Partnering Group where we are looking at integrated hubs and partnership with other service providers and Local Authorities so that our joint estate is fully utilised.

4.4.2 ICT:
This is essential to facilitate plans to improve staff and patient satisfaction and treatment outcomes in the context of a 5 year forward vision and digital vision for 2020.

The new clinical system – SystmOne – has been rolled out to community services in Milton Keynes, Hillingdon and Camden. The process of migrating mental health data to SystmOne has been initiated and as part of this programme of work, the transformation and standardisation of processes across both mental health and community is being undertaken. Rollout will be completed in October of 2016.

The Trust is simultaneously undertaking a data quality improvement programme, and is consulting widely with other providers and CCGs across London to develop common coding structures that will allow consistent data and processes across different settings of care. Common practices will be applied to messaging, correspondence and clinical records in line with national standards and recommendations on data quality. The trust will have a specific focus on improving the quality of information exchanged for direct patient care, social care, and in particular information that is shared with or accessible to patients and carers either through correspondence or access to online records.

Work continues on developing the Trust's mobile working solution and the development of a Trust Integration Engine, with them aim of allowing a more extensive view of patient records to be shared with GPs and other healthcare providers. The Trust is also leading on a cross-provider, cross-CCG joint project with 2 major clinical systems providers, EMIS and TPP, to push for the development of more extensive 2-way real time data exchange between their systems.

The Trust's ICT strategy is revisited annually, informed by the National Information Board priorities, and local agendas, though active participation in collaborative initiatives and strategic planning groups, and through the development of its Digital Maturity Roadmap.

5 Looking forward - the next 1-5 years:

In planning for 2016/17 and anticipating key points of STPs we have considered the following elements:
- Analysis summarised above
- Commissioning intentions

CNWL's objectives for 2016/17 (Table 8) are based on assumption as to what will be in the STPs.

5.1 Developing Sustainability and Transformation Plans

Guidance around sustainability and transformation planning is clear that all plans must deliver on the triple promise of the FYFV while meeting a number of criteria from the NHS Mandate and Constitution. These can only be achieved jointly, in partnership across localities. CNWL is a partner in developing place-based STPs in North West London, North Central London and in Milton Keynes, Bedfordshire and Luton.

Considerations include:
- Ensuring that the plans are fit for purpose in meeting key metrics, for example in relation to cancer, waiting times and the new mental health standards;
- Establishing shared assumptions from which to work, including baselines of population need and provider readiness;
- Together, these are part of discussions to produce plans which will meet emerging requirements for funding via the Sustainability and Transformation Fund (STF).

Realising the FYFV and Dalton Review will require the establishment of new partnership forms. Together with the development of ACOs as provider vehicles, effective Sustainability and Transformation Plans will move towards addressing the imbalance of demand and resource in our localities. These imbalances are negatively affecting care. They also demand unacceptably high levels of transactional resource through repeated contracting. Integrated planning and delivery will challenge organisational boundaries, and support the Efficiency Opportunity set out in the Carter Review to reduce inefficiency and duplication. CNWL is therefore fully engaged in the planning process.

As part of delivering the STPs, CNWL is engaged with **development of ACOs** across our geography – including as one of four partners in Hillingdon. These are discussed under each area's commissioning intentions.

5.2 Developing Accountable Care Organisations

- ACOs will be developed across the CNWL geography during 2016/7 and will be reflected further in CNWL's five year plan. They are further discussed under each geography
- CNWL is involved in work to develop methodology for ACOs – legal form and work around tariff. In Hillingdon, there is an accelerated programme to develop a full Accountable Care Partnership (ACP) or ACO by April 2017. CNWL is a partner in this innovation, alongside Hillingdon Hospitals NHS Foundation Trust, the GP Federation (Metrohealth) and consortium of third sector providers, (Hillingdon4All). We are working with the CCG to establish an ACP initially for older people with long term conditions but with a view to this being extended from this venture will inform future other developments

5.3 Redesign:

Planned activity for Service Redesign for year 2 (2016/17) includes implementation of:

- NWL Child and Adolescent Mental Health Services Single Point of Access (SPA)
- Physical health checks (for mental health patients) in NWL
- Embedding the new models in our NWL Adult Community Mental Health Teams (Phase 2)
- Sexual Health Transformation
- Bed rationalisation of community beds in Milton Keynes (MK)
- Bed rationalisation of adult mental health beds in MK
- Single Point of Referral into adult mental health services in MK
- Transformation of the adult mental health urgent care pathway in MK
- Redesign of the adult mental health pathways in MK.

Additional programmes may come online during the course of the year. Details of these programmes are integrated to our activity plan (Table 8).

5.3.1 Engagement around Service Redesign:

A large element of our service redesign programme involves engagement with stakeholders. This typically takes the form of co-production where staff, patients, carers and commissioners work together to redesign services, putting the patient at the centre of that process.

5.4 Tariff to support integration:

- CNWL is one of the providers working with NHS England to define the relative benefits of capitation and year of care funding for people with mental health needs
- We recognise that tariff is not a stand-alone issue – effective use of resource also requires underlying good partnership, effective governance, reliable data, firm contracting and evaluation.

5.5 Commissioning intentions:

5.5.1 Borough-based commissioning intentions:

- These are set out under each geographic area below

5.5.2 Specialised Commissioning Intentions:

- Redesign and tender of **Sexual Health services across London** has been brought forward to 2016/17 from the anticipated date of 2017/18. The programme will tackle rising demand and cost, through a programme to increase internet access and self-diagnostic packs, and decrease the number of centres from which these services are provided. A similar exercise in relation to HIV will take place in 2016/17 or the year after
- **Addictions and Offender Care services** are regularly tendered. During 2015, the announcement was made to close Holloway Prison and move to a new provider which will impact on CNWL staff working there during 2016/17
- **Eating Disorders:** With the move to local commissioning, there is growing trend for reluctance to admit people with complex and severe eating disorders locally. This has a poor impact on quality of care and use of Acute beds. CNWL will seek to address this with commissioners for 2016/17.

5.5.3 Learning disabilities across CNWL:

- CNWL's response to the national move to reduce bedded service for people with a learning disability continues. CNWL's service for people with a learning disability has some beds for intensive care but primarily focuses on community solutions in partnership with local authorities and the third sector. This work includes a model of intensive support to keep people living at home with more support over a short or longer term period.
- An audit of polypharmacy for people with a learning disability will be undertaken in 2016/17.

5.6.1 NWL Commissioning Intentions:

a) North West London STP

The approach in NWL is for each CCG to identify issues for a local STP and these will then be brought together centrally. A gap analysis has been completed by CCGs. The mental health part of the STP is being framed by the Like Minded strategy which is under development. CNWL's planning is based around our understanding of key issues.

5.6.2

b) **Development of ACOs** (see c)

c) Like Minded

The programme to improve health and wellbeing across North West London, discussed in last year's plans, is progressing under the banner of Like Minded

The aim of Like Minded is to establish excellent, integrated mental health services to improve mental and physical health across NWL. It is being developed on the principles of co-production – involving those who use services as equal partners.

There are five **workstreams:**

- Serious and long-term mental health needs
- Children and young people
- Wellbeing and prevention
- Common mental health needs
- Additional workstreams are underway and will contribute to Like Minded: the Crisis Care Concordat including redesign of urgent care services; perinatal; learning disabilities; out of hospital; eating disorders

The Like Minded **pathway** has four key elements:

- Living a Full and Health Life in the Community
- Coordinated Community, Primary and Social Care linked to higher intensity community-based support
- Urgent/crisis care in the community, and avoidance of admission to inpatient settings
- Acute inpatient admissions

Amongst the principles of Like Minded is that this is a system where people can access what they need when they need it. Therefore, the approach is not a tiered system of steps through which people progress sequentially. This also caters for people having more than one health need and requiring more than one element of the pathway at any given time. This contributes to the central principle of all mental health services - that care and support should be safely provided in the least intensive setting necessary to address the person's needs.

Like Minded is one of the pillars of CNWL's forward planning, and will provide a significant part of the mental health element of the NWL STP, along with the national Mental Health Taskforce.

d) ACOs in NWL:

- A Director has been appointed to drive delivery of ACOs across NWL by April 2018.
- The existing **early adopters** within the Pioneer programme are likely to progress to shadow ACO status in 2017/18 with anticipated establishment of the ACO in April 2018. The plan in NWL is to understand the scope, options and procurement regulation changes by mid-April, 2016, with a view to all milestones for development of ACPs to be in place in June 2016, and to go to market in-year. Shadow capitation should be in place during 2017/18 and full transition for April 2018.
- As above, there is early work including CNWL to develop an ACO in Hillingdon by April 2017

- CNWL will look to further develop our role as a partner with GP Federations in th**e Community Independence Service (CIS)** in the Triborough area during 2016/17.

e) **Psychiatric liaison:** funding changes may reduce viability

- Rising demand for **paediatric psychiatric liaison** in London due to changes in access through SaHF
- **Crisis response** –24/7 access including a Single Point of Access and a Home Treatment and Rapid Response Team (HTRRT) – which are core to CNWL's redesign 2015/16 and 2016/17
- Growing demand for **post-traumatic stress disorder** services to meet needs of forced migration population
- IAPT will be tendered in the outer boroughs (BHH) in 2016/17 and there will be a pathway review by West London CCG following the TUPE of IAPT staff from CLCH to CNWL to take place early 2016/17.
- Other consistent items in commissioning intentions for mental health are **Memory Assessmen**t by GPs **IAPT,** development of **primary care** and **homelessness**.

f) **Services for young people and perinatal:** Additional resource will be sought from announced funding. This includes:

- **CAMHS** and associated **Parental Mental Health**. These are services under pressure, with reduction in local authority funding for tier 2 – non urgent patients. There is a n issue of lack of equity of access to CAMHS services – NSPCC has called this "a national time bomb"
- **Perinatal** services through NHS England – changes to guidance on admission (full final trimester), length of stay has risen
- The upper age limit (35) for **Early Intervention in Psychosis (EIP**) is removed from April 2016 (currently 14-35) with considerable organisational and financial implications.

g) SaHF:

- Another key strand for London is addressing the impact of closure of A&E under Shaping a Healthier Future – resolving outstanding issues about flow of demand is anticipated to be an aspect of the STP in North West London.

5.7 Camden within NCL STP Commissioning Intentions

a) STP development

- An engagement process to develop the STP has led to a draft case for change at the time of this report being submitted to the Board.
- The key areas are consistent with commissioning intentions for Camden – although with a greater focus on the role of Social Care and the Third Sector in delivering the FYFV, in particular the prevention programmes

b) Commissioning intentions in Camden:

- Camden Commissioning intentions set out a linked set of goals - review of Acute Care, transformation of the primary care pathway, a focus on mental health inpatient services and review of estates. It is currently anticipated that these will feature in an STP
- Commissioning intentions outlined under NWL will apply to NCL in relation to services for children and specialised services including perinatal.

c) ACO development in Camden:

- Camden was not a Pioneer, but has been at the forefront of developing integrated services and outcomes based commissioning. Camden in NCL has established a number of efficient and effective partnerships which could translate to ACOs. CNWL is involved in a number of these, for example, Mosaic for vulnerable people. We will be looking to work in partnership to take forward ACO opportunities during 2016/17
- Camden will be taking forward integration work through the **London Partners**, specifically modelling estates integration for efficiency – supporting one of the objectives of the Carter Review.

5.8 Milton Keynes Commissioning Intentions

a) STP Development:

- A process is underway with providers and commissioners to identify the priorities to address local gaps in addressing the FYFV

b) Commissioning intentions in Milton Keynes:

- Milton Keynes launched a number of new developments in 2015/16 and have a further ambitious set of plans for 2016/17 including **24/7 crisis liaison services**; new **eating disorder** and memory **assessment** services; review of pathways for **respiratory disease** and **diabetes**.
- CNWL's role in an STP for Milton Keynes, Bedfordshire and Luton will need to address the challenge of rebalancing the budget across the locality and managing demand so that the high levels of secondary care use are managed. A positive contract round forms a good basis for progress in 2016/17.
- Commissioning intentions outlined under NWL will apply to Milton Keynes in relation to services for children and specialised services including perinatal
- lTariff work with NHS England as set out under NWL will apply to Milton Keynes.

c) ACO Development in Milton Keynes:

- Conditions in Milton Keynes are appropriate to the development of an ACO – including the history of Milton Keynes as an early adopter of integrated care models. CNWL is involved in active discussions around the potential for an ACO in Milton Keynes

6. Members and Elections

The Trust currently has over 15,500 members across 13 broad constituencies. . An independent study has found that the Trust was one of the most successful in encouraging people to vote on line with 58% of votes cast this way.

We are currently planning elections for May 2016. We will, as in previous years, adopt a hybrid approach enabling people to vote either electronically or by post to ensure the maximum levels of participation so as to boost member voting in elections:

We must balance regular turnover of governors, with highly beneficial new and diverse perspectives, with the need to ensure they are equipped to carry out their statutory duties. All new governors receive a comprehensive induction concentrating specifically on their role and responsibilities, an introduction to the services provided by the trust including the standards they are expected to meet and an explanation of the financial position of the trust and the wider health economy. All governors are encouraged to visit trust services with a full programme of visits being provided each year.

There is an ongoing programme of education for governors:

- CQC standards
- Learning from mistakes and complaints
- How services are commissioned and the potential future of commissioning
- The role of the Auditor
- Understanding performance and financial information
- Asking powerful questions
- Partnerships in healthcare.

Our Trust website is regularly updated and is the primary source of information about the Trust. The public can join the Trust online, and access board papers and minutes as well as papers and minutes for the Council of Governors.

The Trust is committed to involvement and engagement and uses a range of opportunities

- Service users on all senior interview panels
- Each service required to have a specific mechanism for collecting service user feedback
- Extensive engagement in development of Trust quality priorities and strategic planning
- Member engagement events
- Embedding experts by experience in the regular workforce
- The Recovery and Wellbeing College - an extensive programme of co-produced courses facilitated by peer trainers and practitioners.
- Open consultation on service change.

Table 8: Summary of CNWL Operational Plan for 2016/17 as first year of STPs

Reviewing the environment as set out above, including commissioning intentions, the following areas have been identified as the focus for 2016/7 as the first year of the STP:

Priority area	Objective	Jameson	Goodall	Diggory	Risk and *mitigation (Trust Risk Register)*
• **Partnership and Communication** • **To create a clear vision of future organisational form with clear, easy to understand, impactful narrative and brand. To position the Trust as an important and valued partner across our broad and disparate landscape** • **Executive Lead: John Vaughan, Director of Strategy and Performance**	• **Partnership:** • In the 2016/17 Plan, clarify CNWL's role as a system enabler, values and business model. • Clarify CNWL's offer – different in each locality • Develop ACOs, ACPs and place-based models of care, new and existing partnerships in UK and overseas • Move to formal partnership and analysis of capability and capacity to support more integrated working – HR, Finance, ICT	• Q1: • NWL STP development. • Like Minded as MH component of STP • Progress CIS if bid successful • Q1/2: • Potential implementation of Community Independence Services • LD revision of IP provision to AOT/respite/community settings • ACP development programme • Q2/3 • Early intervention RTT 14/35 yr old. Phase 2 – all age	• Q1: • NCL STP development • Progress CIS if bid successful • Q1/2: • Implementation Hillingdon ACP • Camden pathway development – dementia, psychosis and urgent care • Integrated practice unit (IPU) using Value Based Commissioning.	• Q1: • MK, Beds and Luton STP development • Q1/2 • Preparation for pan-London tenders – sexual health, addictions • Q2/3 • MK ACP development	• Impact on service delivery and patient experience of organisational change • Internal capacity to change • Financial stability • *Mitigation:* • *ACO development led by Director of Strategy and linked to service redesign, financial strategy and QIA process*

Priority area	Objective	Jameson	Goodall	Diggory	Risk and *mitigation (Trust Risk Register)*
• **Transformation and redesign** • **To ensure that CNWL has a redesign process which assures modern, values-based, effective care at competitive cost** • **Executive Leads: Dr Alex Lewis, Medical Director (redesign)** • **Hardev Virdee, Director of Finance (Tariff)**	• In cooperation with patients, public and commissioners, ensure that CNWL has clear plans for service redesign which assures modern values-based, effective care at competitive cost. • Ensure approaches to tariff and payment support delivery of cost effective integrated care	• Q1: • NWL CAMHS SPA • Revised CPA approach • Standards for physical health checks • Phase 2 community MH team redesign • Q2: • Realignment Jade to new models • EIS workforce development completed for over 35 model	• Q1: • NWL CAMHS SPA • Revised CPA approach • Redesign, agree and implement standards for physical health checks • Older Adults	• Q1: • Sexual health transformation • Community bed rationalisation • Community paediatric review • Q2: • MH bed rationalisation • MH SPA • Q3: • CAMHS review • MH pathway redesign • 24/7 urgent access pathway • Transformation programme – Sexual Health and HIV Service - for whole trust.	• Redesign programme insufficient to deliver level of change required – inc cost, quality • *Mitigation:* • *Redesign process clinically led.* • *subject to formal programme management* • *QIAs required for all changes*
		• Agreement of tariff options for MH and other services – year of care/capitation options to underpin integrated care models and the STP			• Viability and quality of services • *Mitigation:* • *Jointly led by clinical and financial heads*
		• Addressing dependency with workforce, ICT and Estates			• Dependencies not managed • *Mitigation:*

Priority area	Objective	Jameson	Goodall	Diggory	Risk and *mitigation (Trust Risk Register)*
					• *Integrated planning approach via PMO*
• **Workforce** • **To ensure that the Trust has an able workforce who feel valued and are available in sufficient numbers** • **Executive Leads: Jane McVey, Director of HR** • **Dr Con Kelly, Medical Director (medical);** • **Andy Mattin, Director of Nursing and Quality (leadership)**	• Ensure the Trust has an able, motivated, productive workforce who feel valued and are available in sufficient numbers. • Review medical workforce in line with new models of care • Review leadership and management for all non-medical groups	• Implementation of workforce priorities: • Agency use reduction programme – led by Director of Nursing and Director of HR • Leadership development strategy and development programmes • Training and development programmes • Recruitment Plan: Further pay rebalancing with bank, incentivisation schemes, apprentice pathway (band 2-4); use of TRAC recruitment processes; staff wellbeing strategy • E-rostering – fully rolled out • AHP leadership structure revised and in place, particularly in community services and Milton Keynes community and • Support for an open culture in the organisation, where staff can influence change and hold accountability at the right level			• Risk to service quality and cost if unable to recruit and retain engaged high quality staff • Use of agency over cap and off-framework • Poor quality of care • *Mitigation:* • *Action plan around agency use* • *Recruitment and Retention Strategy* • *Engagement strategy* • *Controls in place to ensure only quality assured agencies used to provide temporary staff* • *Quarterly friends and family test*
• **ICT** • **A revised ICT strategy, an effective plan to meet the 20/20 vision**	• Linked to opportunities to improve staff and patient satisfaction and treatment outcomes in the context of a 5 year forward vision and digital vision for 2020. • Key programmes for 2016/17: • Full rollout out of SystmOne • Ongoing programme lead by CIO to embed and adapt				• Lack of alignment service redesign/ clinical system programme. • Loss or corruption of

Priority area	Objective	Jameson	Goodall	Diggory	Risk and *mitigation (Trust Risk Register)*
and local aspirations for interoperability and access • **Executive Leads:** • **Hardev Virdee** • **Mark Large, ICT Director**	• The digital road map (how we will achieve digital maturity and paper free at the point of care). • Launch of Knowledge and Information module • Review of CPA and SystmOne				patient records could be a major incident. • *Mitigation:* • *CIO in post. Tight governance including services, CFO and COO*
• **Finance** • **To drive clearer, more effective financial performance, ensuring clear lines of sight for the Board** • **Executive Lead Hardev Virdee**	• Finance - To drive clear, effective financial planning within CNWL and as part of localities. • Restore and maintain financial balance across sectors	• Strategy as set out at section 4 • **Demand and Capacity** – proposed engagement with IST to support development of non-acute methodology. If no IST support, then by Q4 to have agreed, Trustwide D&C management process • **Capital** – Q4 – refreshed Estates strategy based on roadmap established through clinical engagement around estates use. • **Contracts:** Ongoing contract renewal and renegotiation including new partnerships and ACPs Tenders - programme of defense and growth for 2016/17 tenders including IAPT, primary care in prisons, addictions, sexual health • Move to shadow tariff in mental health from April 2016 • Programme to identify and address variation in cost and against reference costs across CNWL			• Financial balance not achieved due to failure to deliver to plan; • failure to plan for demand and capacity and cost in 2016/17 • lack of resource in local health and care economy; • *Mitigation* • *Approach as set out* • *Monthly reporting to Board via B&F and to Monitor inc CIPs*

Appendix 1: Public Health overview – Health Indicators: 2015

Significantly worse than English average	Significantly better than English average
• Brent: Deprivation, Children in poverty (under 16s), Statutory homelessness, Violent crime (violence offences), Long term unemployment, Obese Children (Year 6), Recorded diabetes, Incidence of TB, Acute sexually transmitted infections, and Under 75 mortality rate: cardiovascular	• Smoking and smoking related deaths; admissions to hospital related to alcohol (under 18) obesity in adults; under 18 conception; life expectancy, under 75 mortality rate for cancer, hospital stays for self-harm
• Harrow: Recorded diabetes, Incidence of TB, obesity in children and physical activity in adults. • However, infant mortality has moved from being significantly worse than the English average in 2014, to about the same	• Deprivation, Children in poverty (under 16s), Statutory homelessness; violent crime, smoking, self-harm, alcohol related admissions, drug misuse, acute sexually-transmitted infections, drug misuse, life expectancy, under 75 mortality rate: Cardiovascular and cancer, hospital stays for self-harm
• Hillingdon: Children in poverty (under 16s), homelessness, violent crime (violence offences), Recorded diabetes, Incidence of TB, Acute sexually transmitted infections.	• Deprivation, , homelessness, unemployment, breastfeeding, self-harm, hospital stays related to alcohol, drug misuse, life expectancy, hospital stays for self-harm • However, obesity in children has moved from significantly to about the same as the English average
• Kensington and Chelsea: Deprivation, Children in poverty (under 16s), statutory homelessness, violent crime, Drug misuse, Incidence of TB, obese children, sexually transmitted infections, Killed and seriously injured on roads.	• Long-term unemployed, breastfeeding, obese children (year 6), smoking, obesity in adults, hospital stays related to alcohol, recorded diabetes, life expectancy, under 75 mortality rate: Cardiovascular and cancer, hospital stays for self-harm
• Westminster: Deprivation, Children in poverty (under 16s), Statutory homelessness, Violent crime (very high), Obese children (Year 6), Drug misuse, Incidence of TB, sexually transmitted infections, Killed and seriously injured on roads.	• Long-term unemployed, smoking, breastfeeding, obese children (year 6), self-harm, hospital stays related to alcohol, life expectancy, under 75 mortality rate for cancer, hospital stays for self-harm
• Milton Keynes: Statutory homelessness, violent crime (violence offences), Breastfeeding initiation, Excess weight in adults, Life expectancy at birth (Female). • However, life expectancy at birth (Males) has moved from much worse to the English average)	• Deprivation, , long term unemployment, drug misuse, hospital stays for sell-harm and sexually transmitted disease • However, children living in poverty and recorded diabetes have moved from much better to about the English average
• Camden: Deprivation, Children in poverty (under 16s), violent crime (violence offences), Drug misuse, Incidence of TB, Acute sexually transmitted infections, Killed and seriously injured on roads.	• Homelessness, long term unemployment, alcohol related admissions, breastfeeding, hospital stays for self-harm, diabetes, life expectancy • However, obesity in children has moved from being significantly better than the English average in 2014, to about the same

- *SOURCE: Public Health of England - Health Profile (2015). http://www.apho.org.uk/default.aspx?QN=HP_FINDSEARCH2012*