Oxford Health NHS

NHS Foundation Trust

Strategic Plan Document for 2013-14

Oxford Health NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	31st May 2013

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accuratelyreflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Planis an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views ofthe Council of Governors;**
- **The Strategic Planhas been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The StrategicPlan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directorsby:

Name *(Chair)*	Martin Howell

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Stuart Bell

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Mike McEnaney

Signature

Executive Summary

Everything Oxford Health NHS FT (OHFT) plans to do in the coming 12-months is designed to enhance patient care.'Driving Quality Improvement' is at the heart of our strategy and will improve patient safety, clinical outcomes and patient and carer experience. OHFTprovides community services and mental health across Oxfordshire, Buckinghamshire, Wiltshire, Bath and North East Somerset. Across the main populations we serve there have been steady population growth and health improvementswith an increase in life expectancy. The demographic changes combined with improved access to services has resulted in a continued growth in demand for health and social care services, particularly inpatient, emergency and intermediate care to support elderly frail populations or people living with long-term multiple illnesses.

The Trust, like the rest of the NHS, is facing an extremely challenging financial environment. We already know that the NHS will receive limited growth funding, small increases in inflation funding and be faced with national efficiency targets of 4% year-on-year. The result of this will be a net real term reduction in income year-on-year. Overall, the Trust has continued its strong track record of delivering against financial targets, and has met its key financial targets for the 2012/13 financial year.

Our plan is focussed on delivering patient centred collaborative care; being at the forefront of a healthcare system that is fit for meeting the health and social care needs of 21st century.We will achieve this by working in partnership with health and social care partners across the system, advancing adoption of innovative treatments through closer working relationships with academic institutions and industry and providing transparent and accessible information for patients and carers.

1.0 Strategic Context and Direction

Oxford Health NHS FT (OHFT) provides mental health and community services across Oxfordshire, Buckinghamshire, Wiltshire, Bath and North East Somerset. Our income of £282m is generated primarily by four clinical divisions from seven main primary care commissioners and three lead county council commissioners.

The following table and map shows other NHS and private health providers in the surrounding counties:

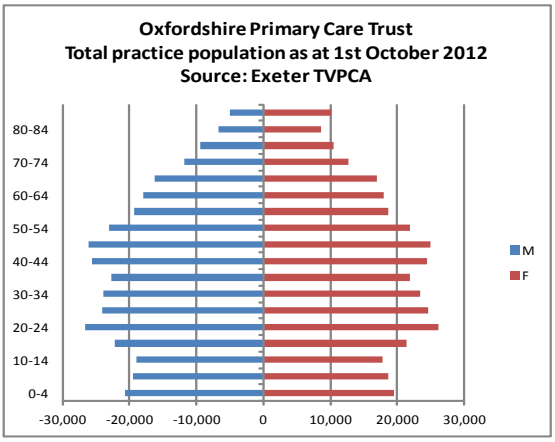
NHS Providers	Acute NHS Providers	Private Providers
Avon & Wiltshire MH Partnership	Oxford University Hospitals NHS Trust	Nuffield Health
Berkshire Healthcare NHS Trust	Buckinghamshire Healthcare NHS Trust	The Park Hospital (BMI)
Coventry & Warwickshire Partnership	Royal Berkshire NHS FT	The Horton Treatment Centre
Northamptonshire Healthcare NHS FT	Milton Keynes Hospitals NHS FT	Amber Healthcare
Southern Health NHS FT	Heatherwood & Wexham Park NHS FT	The Practice PLC
2gether NHS FT		Care UK

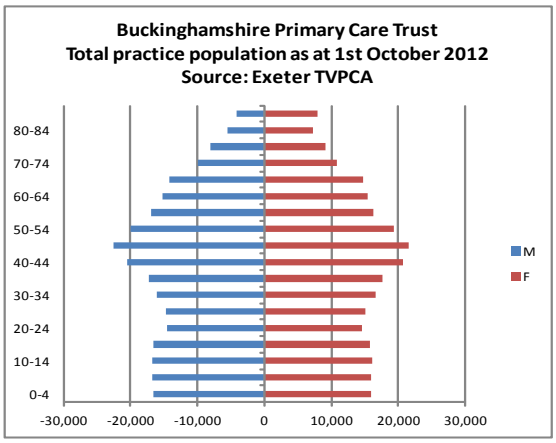
During 2012/13 The Trust was awarded the following three contracts under the any qualified provider system:

- Adult Assessment Service for Autistic Spectrum conditions
- Podiatry Services NHS Oxfordshire
- Podiatry Services NHS Berkshire

Demographics

The population size for our two core areas of service, Oxfordshire and Buckinghamshire together, is currently around 1.2million (based on PCT Practice population sizes). A breakdown by age and gender gives the following profile picture.





Oxfordshire

Oxfordshire is a predominantly rural county in which approximately 679,000 people live. Indeed, the county is the most rural in the South East region and West Oxfordshire is one of the region's least densely populated districts. Over 50% of the population live in settlements of less than 10,000 people. There are also urban areas, such as Oxford and Banbury.

The county is best described as a mix of areas with distinctive characteristics as follows:

- Urban Oxfordshire – Oxford city;
- Major towns – Banbury, Bicester, Witney, Abingdon, Didcot;
- Market towns – 19 smaller towns serving rural communities;
- Rural settlements – villages, hamlets and isolated dwellings.

Future population growth in the county is expected to be concentrated around Banbury, Bicester, Didcot, Witney and Wantage, where several thousand new homes will be built over the next 15 to 20 years.

Health and well-being in Oxfordshire has been improving for many years. In general the population is healthy and compares well with the South East region and the rest of the country. The recent publication of Health Profiles for district areas highlighted the generally good health of the population. This message is reinforced by steadily increasing life expectancy which, on average, has gone from around 79.1 years (1998-2000) to 80.7 years (2004-06). The rate of improvement in longevity is in line with that across the country; average life expectancy in Oxfordshire is now 1 year 3 months longer than the rest of England.

Buckinghamshire

Buckinghamshire is a prosperous, largely rural county north of London with large areas of outstanding natural beauty and green belt. It is one of the least deprived counties in England based on government indices of deprivation. In common with other affluent counties there are pockets of urban and rural deprivation.

Buckinghamshire County has a population of 494,700 but as NHS Buckinghamshire includes residents in Thame, Chinnor and Aston Rowant in Oxfordshire, the CCG has a registered population of 515,000. Over a quarter of residents live in the two main towns of High Wycombe and Aylesbury. The population of Buckinghamshire is projected to increase by 5,900 from 2010 to 2026. Changes in the future level of housing growth will impact on these population projections and that the level of future housing growth is particularly uncertain in Aylesbury Vale district.

The population of Buckinghamshire is very healthy compared to the national average on most indicators. However within Buckinghamshire key groups have significantly worse health than the average for the area.
Life expectancy has been increasing steadily in Buckinghamshire and is significantly higher for both men and women than the national average. For men life expectancy is 80.4 and Buckinghamshire has the joint 3rd highest male life expectancy out of 152 PCTs putting it in the top 5% of PCTs. Female life expectancy is 83.6 and Buckinghamshire has the 10th highest female life expectancy out of 152 PCTs putting it in the top 10% of PCTs.

The main causes of death are cardiovascular disease e.g. heart disease and stroke accounting for 35% of all deaths, followed by cancers (28%) and respiratory disease (14%).

Overall health in Buckinghamshire is good. However certain groups have worse health than the average; People from the more deprived areas, people with learning disability, people with mental health problems and prisoners tend to have worse health than the general population. Some ethnic groups have higher incidences of certain diseases than the general population such as diabetes, heart disease and stroke.

1.1 Strengths and Weaknesses

Strengths

The following is an analysis of OHFT strengths:

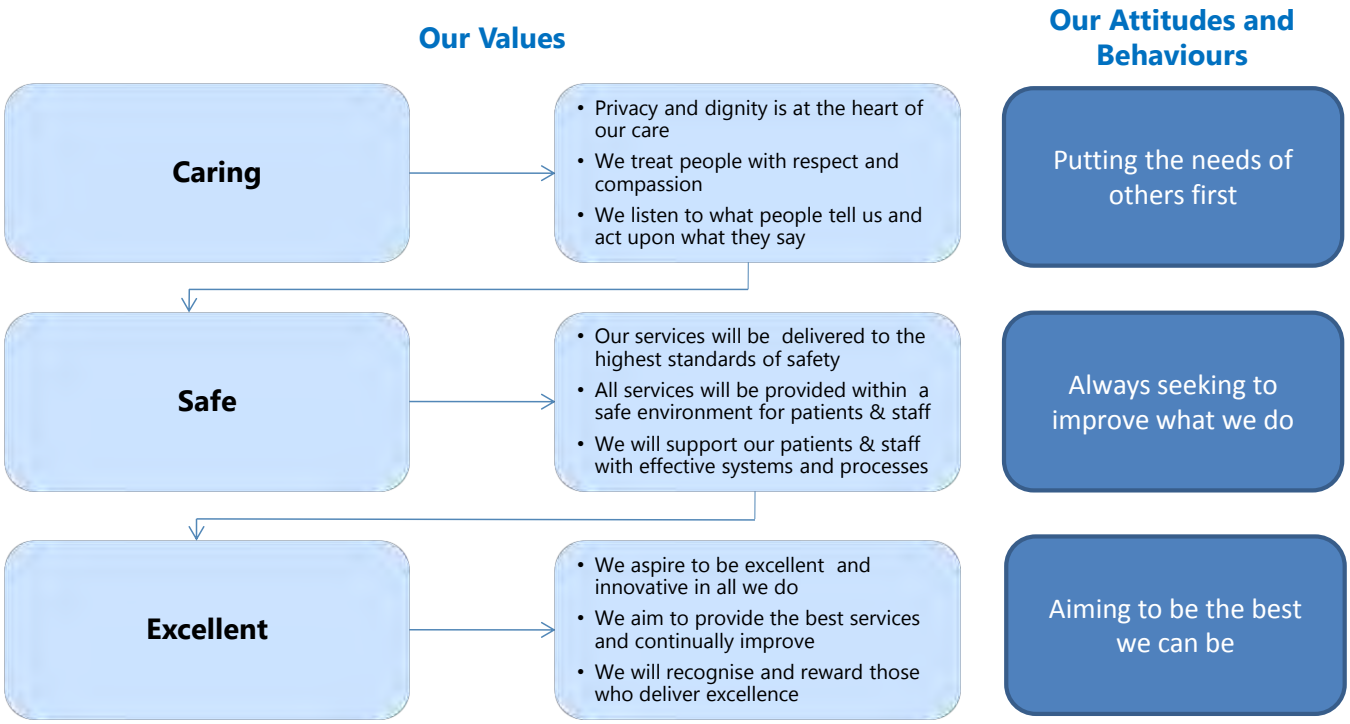
- Extensive experience and high proportion of care already delivered in the community both for patients with both physical and mental health needs.
- High level of involvement and participation of patients in care design & delivery in some services such as CAMHS (Child and Adolescent Mental Health services).
- Strong partnerships with academic institutions that support innovation and evidence-based practice, e.g. implementation of True Colours in collaboration with the Department of Psychiatry.
- Financially resilient.
- High level of recognised clinical expertise and specialist services and national leaders in some services such as eating disorders.
- Established track record of good performance against Monitor financial and quality ratings.
- Increasing delivery of "sub-acute" care in Oxfordshire through the Abingdon pilot in collaboration with the Oxford University Hospitals Trust (OUHT).
- Successful track record of acquiring organisations and managing safe and effective transitions of Buckinghamshire Mental Health Services and Oxfordshire Community Services.
- Established strong working relationships with commissioners across 5 counties that have led to successful delivery and continuation of service.
- Working partnerships with local authorities across the 5 counties are in-place and already supporting the delivery of social care with pooled budget and joint working arrangements in Oxfordshire and Buckinghamshire.
- Implemented care closer to home, movinga proportion of our mental health services into the community with experts mapping risks backed-up by inpatient services.
- Durable working relationships with primary care with primary care teams working together to deliver services.
- A burgeoning clinical and academic leadership across the Trust that has been integral to the development and delivery of Business Plans and leading service re-modelling.
- Continued and successful track record of identifying and delivering new models of care and innovation.

Weaknesses

Analysis of weaknesses identifies the following for consideration and plans to mitigate and improve:

- Under-performance in some measures of quality (e.g. CQC, patient satisfaction, staff survey)
- Areas of particular concern are some adult / older adult mental health services and some areas of community health services e.g. district nursing.
- Underdeveloped relationships with patients and carers as well as partner organisations.
- Slow to integrate mental health and community services.
- Emphasis on patient and carer centred care has not yet gone far enough in co-production and participation in care design and delivery.
- Lack of alignment of incentives between other health and social care providers that enable fully functioning working that crosses organisational boundaries.
- Lack of structured and systematic approaches to collecting and using patient, carer and staff feedback to improve patient care.
- Poor interoperability of systems and system interfaces makes using, sharing and analysing data challenging.
- A data quality and information system to convert information into knowledge that supports decision-making and provides strength of evidence for service changes and improvements requires significant development.
- A lack of fully articulated service models and performance frameworks, including local, national and international benchmarking is an area for further development.

OHFT's vision is that patients and carers feel that they experience **outstanding care delivered by outstanding people** and the values that underpin everything that we do and the expectations that we all have are to be **caring, safe and excellent**.



Patients and carers tell us that health and social care provision is fragmented and we know in Oxfordshire 80% of health funding is spent on approximately 20% of population, the majority of whom are frail elderly or have long-term conditions and complex co-morbidities.

We want to deliver the best value patient-centred coordinated care possible and we know that we can only do this by working with other health and social care providers, voluntary organisations, local authorities, academic institutions, industry partners and patient and carer groups. We must provide modern treatments that support patients and carers to remain as healthy as possible and to manage their own long-term conditions; when necessary we must provide expertise and interventions to manage acute phases of care.

We are leading the creation of a new healthcare system by re-designing care pathways that improve patient experiences and outcomes and increaseour productivity. At the heart of the new system involves:

- **Managing care closer to home** where possible and supporting the development of emergency multi-disciplinary assessment units attached to community hospitals.
- Keeping people healthier through **early intervention, recovery** and **rehabilitation**
- **Integrating** physical and mental health, primary and secondary care, social and community care and involving patients and carers in the management of their care.
- **Engaging with people** to better understand their needs and expectations and to co-produce how health and social care is delivered.
- Delivering essential trust wide improvement programmes such as the **Productives Programme** and **Safer CareInitiative**that further enhance the quality of clinical services we provide.

Our service models will have clearly **defined care pathways**with locally based multi-disciplinary teams and services. Care will be managed across entire pathways in **partnerships** with other NHS and non-NHS providers as well as social care and voluntary sector organisations and we will have clear **clinical, managerial and academic leadership** to coordinate the care delivered.

Transparency is essential and we will achieve the best quality of care by providing information that enables better patient and carer involvement in their care and by improvinghow we measure outcomes and manageperformance. Providing and measuring accurate data and means that we can **publish our performance** at all levels of the

organisation and can compare the patient experiences and outcomesfrom our services with the best performers locally, nationally and internationally.

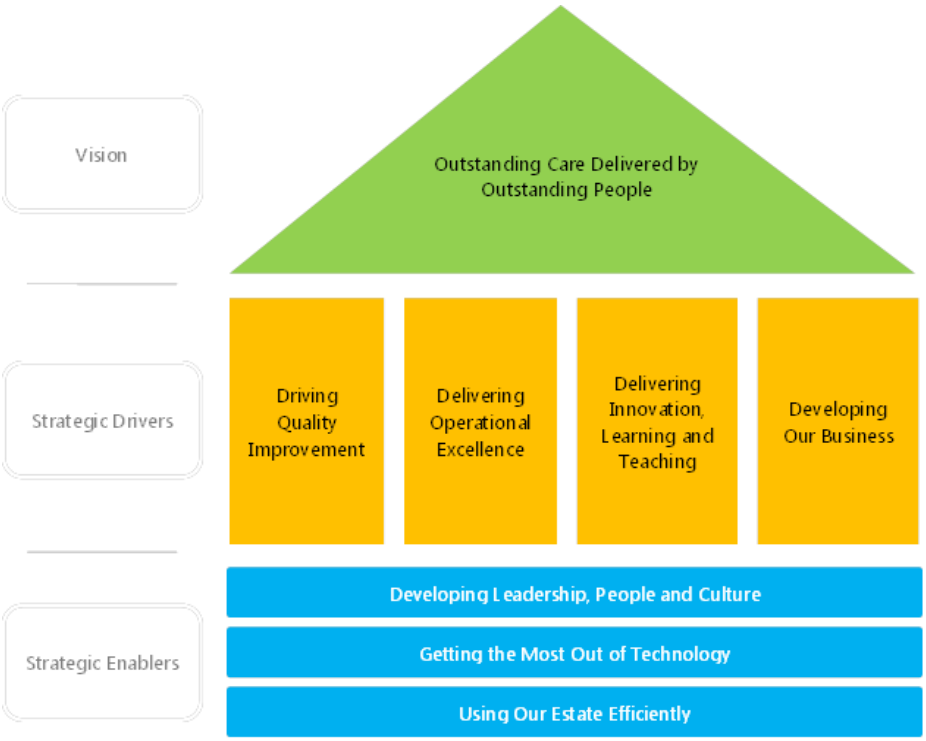
An integral part of our drive to meet the information needs of everyone involved with our organisation is the development and design of a new **Healthcare Management System** (Electronic Patient Record) that supports the effective and efficient delivery of patient care. Linked with this is the development of our **business intelligencesystem** that provides everyone with opportunities to analyse and use the information we have to inform our decisions. Engagement with clinical and nursing teams as well as patient and carer groups is an important element in the production of these systems so that we are all able to maximise the benefits they offer.

Patients, communities and economies will benefit from the strong relationships that we are developing with academic institutions through our involvement and leadership in the **Oxford Academic Health Science Network (AHSN),Oxford Academic Health Consortium (OAHC)** and**Collaboration for Leadership in Applied Health Research and Care (CLAHRC)**. These aim to speed up the adoption of evidence-based innovations, reduce unwarranted variations in clinical practice and increase the implementation of best practices across clinical networks.

Everyone that works for OHFT plays a pivotal role in making sure that patients and carers receive the best possible servicewith the best outcomes and experiences. We are designing ways of **recruiting, retaining and developing high calibre staff** to deliver our plansand to nurture a culture of being caring, safe and excellent.

It is essential that **staff are motivated and high performing** and work in supportive teams with **shared objectives** that are aligned to the Trust's plans as we enhance our planning and performance management processes. Everyone that works in the organisation will feel **listened to, involved andempowered** to own and lead the drive to improve their own performance and the performance of their teams and we will begin to create a**flexible workforce** that is agile and able to respond to the changing needs of the people we work with.

It is necessary to **upgrade** some of the clinical and non-clinical facilities that we use and as we move care closer to home we will consolidate our estate to create a **community service hub in each locality** that we work in.



We are continuing to use our strategic framework (illustrated here)to provide structure in the development and alignment ofour plans and objectives throughout the entire Trust to provide "outstanding care delivered by outstanding people".

1.2 Threats and opportunities from changes in local commissioning intentions

Change in Commissioning Arrangements

In April 2013 Clinical Commissioning Groups (CCGs) replaced Primary Care Trusts (PCTs) with responsible for commissioning health services, with the exception of certain services commissioned directly by the

NHS Commissioning Board; health improvement services commissioned by local authorities and health protection and promotion services provided by Public Health. OHFT is working closely with the new commissioners to ensure that appropriate contractual arrangements are in place for all services and to develop relationships that build on our existing collaborative approaches.

At the heart of the Joint Health and Wellbeing strategies in Oxfordshire, Buckinghamshire, Bath and Somerset is the drive to support people to live long, healthy independent lives as well as prioritising the most vulnerable populations – the young, the disabled, those people with long-term illnesses and elderly frail people.

With a focus on developing patient-centred coordinated care pathways we are working with other health and social care providers as well as the commissioners as well as using patient and carer input to identify appropriate clinical and patient outcomes. It will be these outcomes that are used to manage our system-wide performances and payment systems are likely to be developed in-line with this. Commissioners are also driving to move care delivery from hospitals to localities and homes and OHFT are working with commissioners and other health and social care providers in the areas we work in to improve entire care pathways. The recent £1m investment for sub-acute interface medicine is a good example of a recent service development for Elderly Frail Pathways that will reduce admissions to hospitals in Oxfordshire by 6%.

Financial Challenges

Contract values will be subject to the national deflator of 1.3%, which includes an efficiency saving of 4%. To meet his requirement, the Trust is facing a significant reduction in its cost base whilst maintaining and improving the quality of care for patients. The track record of the Trust in CIP delivery and financial performance in recent years has been robust, however, it is recognised that cost improvement increasingly relies on strategically re-designing services and system-wide changes than transactional savings possible in previous years.

Reflecting the expectation of close to zero growth in central funding and increasing demand for services, especially for people with complex needs and within an ageing population, significant transformations, innovations and service developments are required across the organisation in order for us to continue to provide high quality services within this constrained financial climate and increasingly competitive environment. The Trust is well placed to increase its community and mental health service provision to meet local commissioning intentions which are aligned with the national priorities of providing care as close to home as possible and meeting the needs of the population with long term conditions.

A major programme of Service Remodelling work is underway. The programme aims to maximise the opportunities and benefits of integrated care 24 hours, seven days per week. Care Pathways are being developed for the three care groups - children and young people, adults and older adults. These pathways cross traditional age boundaries, and 'managing transitions' is one element of work across the pathways. The aim is to deliver a coordinated locality based model of care, as part of the whole system working with partners from health and social care and the third sector. The service remodelling programme focuses on improving safety and patient experience and outcomes.

Competition

OHFT remains focussed on retaining the services that it currently provides within our current geographical areas by continuing to provide high quality patient care and striving for continuous improvements, greater integration and better patient experiences and outcomes. Increasing its market share will only focus on areas where we have expertise and where we can bring benefit to patient care. The Trust's existing commissioners have not given notice of any significant changes in commissioning patterns or demand for activity for FY14.

1.3 Strengthening our Academic Linkages

OHFT is committed to strengthening our linkages with academic institutions in order to benefit the health and wealth of our local populations.

Oxford Academic Health Science Network (OAHSN)

The OAHSN is a partnership between healthcare research, clinical care delivery, education and the life science industry with commissioning bodies, patients and the public to deliver innovation and improved outcomes through a series of clinical networks that cover a population of approximately 3 million from Thames valley and Bedfordshire. It is anticipated that the AHSN will officially launch in the first half of 2013 with oversight from the National Commissioning Board. For more information about our AHSN please visit the website http://www.oxfordahsn.org/

Collaboration & Leadership in Applied Health Research and Care (CLAHRC)

Aside from establishing the regional AHSN OHFT has begun to lead the application to the National Institute for Health Research (NIHR) to establish CLAHRC. This will be a nationally funded collaborative research programme that focuses on patient outcomes through the conduct and application of applied health research with particular focus on chronic disease and public health interventions, the term of authorisation is normally 5-years with up to £2m per year research funding. OHFT is the lead NHS Trust for the CLARHC and Professor Richard Hobbs from the Department of Primary Care at the University of Oxford has been appointed as the CLARHC Director.

The CLAHRC consists of Oxford's main health and social care providers including Oxford University Hospital Trust, General Practice and Social Care and will draw on internationally renowned research and teaching expertise from the University of Oxford Medical Sciences Division, Oxford Brookes University and the Said Business School and with input from the NHS Commissioning Board Local Area Team, the Local Education and Training Board, Oxford and Buckinghamshire Health and Wellbeing Board and Oxford and Buckinghamshire Clinical Commissioning Groups.

The themes for the Oxfordshire CLAHRC application are:

- Early Intervention and Service Redesign
- Health Behaviours and Behavioural Interventions
- Patient Experience and Patient Reported Outcomes
- Better Management of Medical-Psychiatric Comorbidity
- Patient Self-Management of Chronic Disease

If this application is successful it would be a very major academic development for this Trust and would significantly strengthen our clinical and academic work in physical health as well as mental health.

Oxford Academic Health Consortium (OAHC)

Finally, on 17th September 2012 health and social care partners[1] from across Oxfordshire came together to launch the OAHC. The main aims of this collaboration between commissioning, service delivery, research, education and training organisations are:

- To establish a strong partnership that develops and implements strategies to strengthen the existing Oxford academic and clinical partnerships, ensuring improvements in healthcare, effective translational research, and strengthened multi-professional education and teaching.
- To provide strong links and support for the Oxford Academic Health Science Network (AHSN)
- To provide the platform for a successful Academic Health Science Centre (AHSC) application in 2013

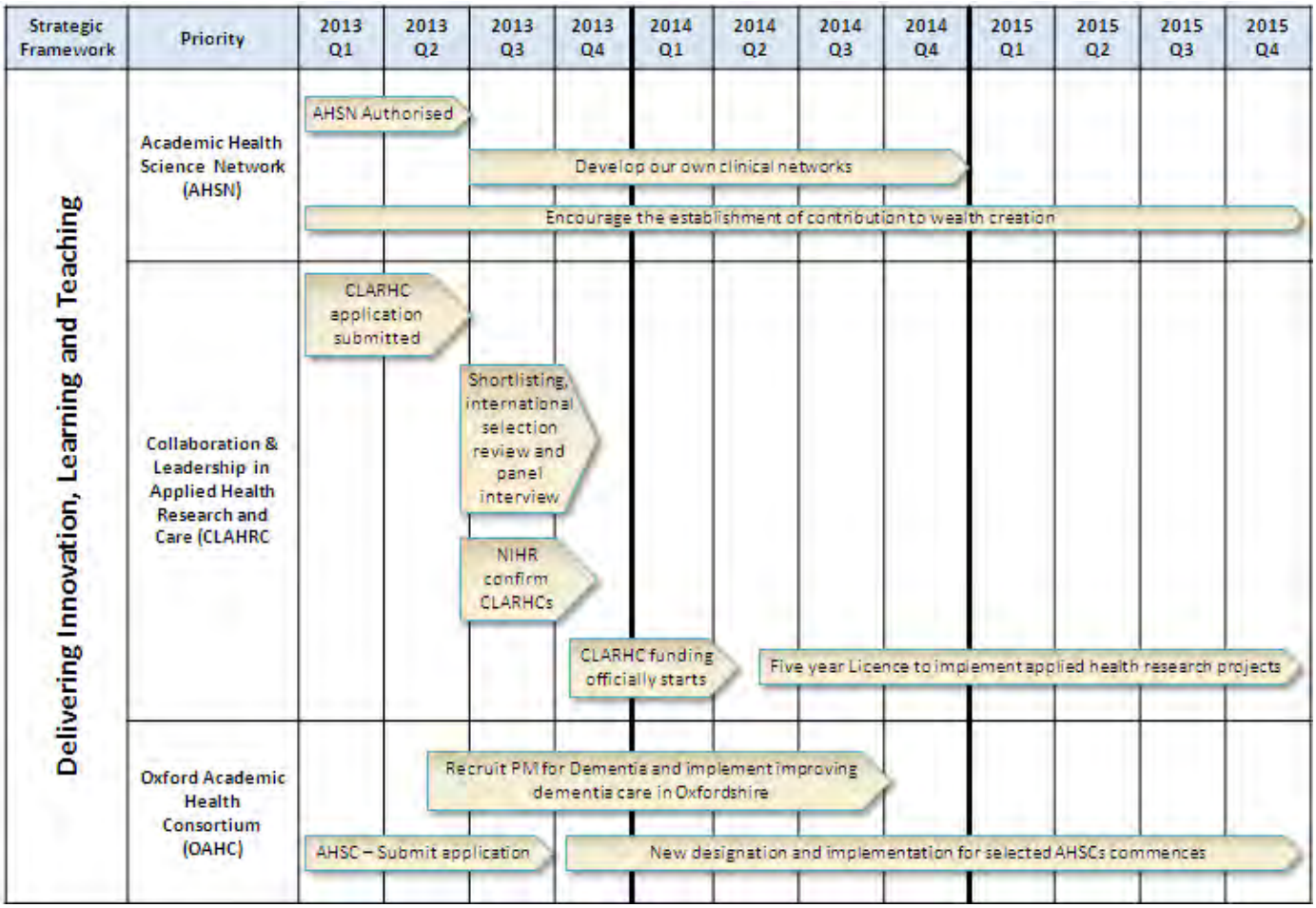
The OAHC unanimously agreed that improving dementia care in Oxfordshire would act as one of its first exemplars and involve all partners from the OAHC. Partners from the OAHC have agreed to jointly fund a management post to

[1]Oxford Brookes University (OBU), Oxford Health NHS FT (OHFT), Oxford University Hospitals NHS Trust (OUHT), Oxfordshire Clinical Commissioning Group (OCCG), Oxfordshire and Buckinghamshire PCT (OBPCT), Oxfordshire County Council (OCC), Oxfordshire Learning Disabilities NHS Trust (OLDT), University of Oxford (OU)

coordinate Improving Dementia Care Programme. It is intended that this post will work with patients and carers, social and health care providers (including from the voluntary sector and private sector), research and teaching institutions and clinical commissioners and Oxfordshire County Council to demonstrate how system-wide collaboration can improve care and experiences for dementia patients and their carers.

Delivering Innovation, Learning and Teaching

A summary of our 'Delivering Innovation, Learning and Teaching' Priorities can be found below:



1.4 Developing Commercial Services

OHFT is pursuing the development of non-NHS services to generate additional income that enables further investment in NHS services, contribute to cost improvement and drive innovation. The Trust Executive has approved funding for a formal structure and resource to progress this work by providing seed-funding to employ a Commercial Services Manager to work with existing corporate and operational teams to develop and implement commercial services in the following areas:

- Consultancy
- Specialist training
- Smallscale private clinical services (to be identified as part of a structured process)
- Corporate health and well being services and other corporate support services
- Links with international healthcare systems

The main objectives of investing in commercial services developments are to:

- Generate additional new non-NHS income to contribute to OHFT's surplus, enabling investment in service development and contributing to achievement of the long term financial plan.
- Enable innovation and improvement in service delivery
- Enable capital investments to improve things like facilities

- Support the implementation of best practice in other regional organisations and other countries, improving the health and wellbeing of their populations
- Increase awareness of Oxford Health NHS FT, enhance the organisation's image and reputation and grow the Oxford brand, strengthening its position in the market place.

Since it was authorised as a Foundation Trust, OHFT has generated approximately £20m of income that is not directly NHS commissioned, through Oxford Pharmacy Store (OPS) supplying pharmaceuticals to healthcare providers and various services such as consultancy, corporate occupational health and well-being services and financial and estates management services to other NHS commissioners and providers. During the first 12 months of commercial services development, it is anticipated that the project will recover its initial start-up funding, generating £0.9 million new income (approximately 0.3% of the Trust's total income) and produce at in the region of £330,000 surplus.

The Commercial Services Manager will be part of the Operations Senior Management Team and will work with Divisional Directors and Clinical Leads to ensure that non-NHS developments benefits to the delivery of the organisation's core services.

He or she will work with teams that are delivering commercial services, direct management coming from the relevant clinical or functional division. Each new commercial service proposal will be required to meet minimum criteria, including providing confirmation of full compliance with all NHS operating standards and evidence that the undertaking will not divert resources or attention away from NHS service provision. On meeting the criteria the Commercial Services Manager will support the services to develop full business cases that include a quality and clinical scrutiny by the Medical Director and/or the Director of Nursing prior to submission to the Trust Executive for approval.

In most cases, new services will start with a test phase, where services are delivered by existing staff through paid overtime and using existing facilities, out of hours, or using temporary staff or staff on short term contracts to either deliver services or backfill into existing services.

The development of commercial services is part of the Trust's Business Plan and progress, impacts, risks and issues will be monitored and reported at Divisional, Executive and Board of Directors as part of the Trust's performance management process.

Prior to the end of the 12-month period, the results of the commercial services team will be evaluated and a decision will be made as to whether to continue funding the service either in its existing form or an adapted one, or to close it down.

1.5 Collaboration, Integration and Patient Choice

The Operational and Clinical Leadership teams throughout the Trust are leading a Service Remodelling Programme aiming to maximise the benefits of integration of health and social care, to improve quality and efficiency of services and patient experiences and outcomes. The programme of work will deliver a locality model of care for children and young people, adults and older people in collaborationwith primary healthcare teams and partnerships with other providers of acute, community and mental health services,including the third sector. A number of projects within the programme have partnership working with other providers as core elements.

The programme is structured around three care groups: Children and Young People, Adults and Older Adultsand service models within these are being developed that align across various care pathways. Improving the management of transitions across the pathways is an important element of the programme in order to ensure that patients have a seamless experience of care. Furthermore, the work of this programme will enhance the partnership working with providers of acute and social care as well as the voluntary organisations that act either as patient advocacy groups or care providers. Overall this approach will improve the value of healthcare by ensuring that the right people are diagnosed, seen and treated in the most effective and efficient way by the right clinical teams.

Two core quality improvement programmes , Productive Care and Safer Care, act as enablers to support this work and are woven into the entire operational programme, to improve the impact and efficiency of all service changes and provision interms of both productivity and quality.

2.0 Approach Taken to Quality

This year, a number of discrete priority areas or "Quality Activities" have been identified that link back to the Trust's Strategic Framework. These priorities and objectives have been selected against national and local context as well as feedback from service users, staff, governors and external bodies such as Monitor, the Care Quality Commission, commissioners and LINks.

The improvements in each area were selected by considering the requirements and recommendations from the following sources, some examples of which are shown after each, which we have sought to include within our own priorities given in the following pages:

- Department of Health
  - National priorities
- Care Quality Commission
  - Quality Risk Profiles
  - Feedback from visits
  - National patient and staff surveys
- Monitor
  - Reporting requirements, particularly in the Statement of Directors' Responsibilities towards the Quality Report, Quarterly Governance Declarations and Governance Framework.
- NHS Buckinghamshire and Oxfordshire cluster (lead commissioners)
- Oxfordshire Local Involvement Network (LINk)
  - Personalisation of care, care for people with disabilities and localisation of services
- Oxfordshire Health Overview and Scrutiny Committee (HOSC)
  - In- service integration, access issues, suicide rates, localisation of services
- Buckinghamshire HOSC and Buckinghamshire LINk
  - Importance of community care support
  - Equality of access to services through GPs
- South Central Specialised Services commissioners and Swindon Wiltshire, Bath & North East Somerset and Milton Keynes Commissioners
- Internal assessment of Care Quality Commission (CQC) Outcome compliance
  - Review of Prevention and Management of Violence & Aggression procedures
- Internal audits
  - Improvements in monitoring specific aspects of care
  - Enhancements in training in particular areas
  - Modifications to certain methods of working
- Serious case reviews
- Formal feedback from coroners

The priority Quality Activities, and the link to the Trust's strategic framework, are summarised in Table 1. Details are given for each in the following pages.

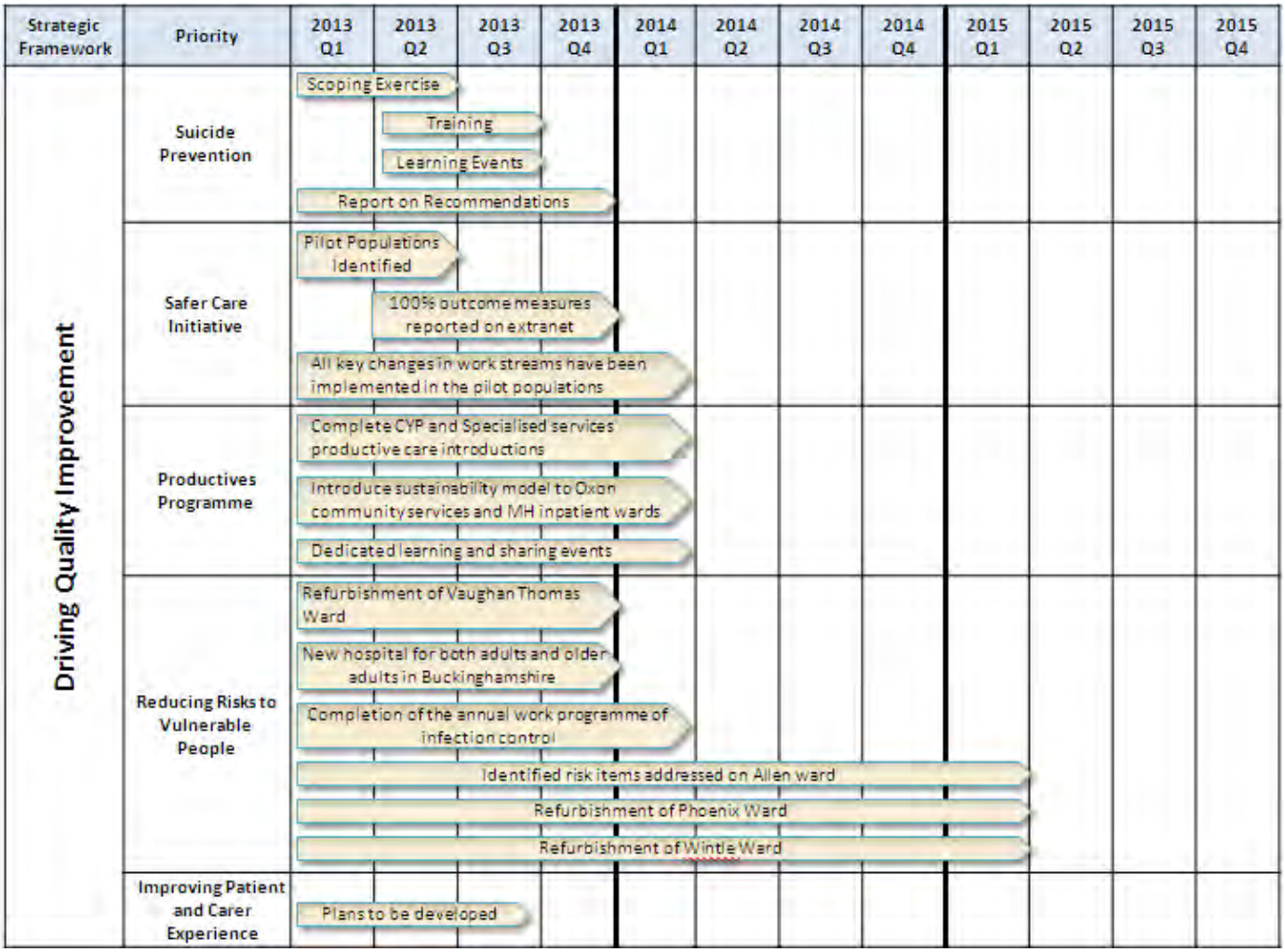
Table 1

Strategic Framework	**Quality Framework**
Goals	**Quality Activity**
Improving Patient Safety	1. Specific improvements in patient safety
	2. Prevention of suicides
	3. Infection Control improvements
	4. Environmental Improvements
Improving Clinical	5. Develop & implement integrated care pathways for children and young people

Outcomes	6. Develop & implement integrated care pathways for adults
	7. Develop & implement integrated care pathways for older adults
Improving Patient and Carer Experience	8. Trust-wide improvement of culture of care
	9. Improve patient & public engagement
	10. Measuring and Improving Patient, Carer and Commissioner Feedback
Cross-cutting	11. Productive Care
	12. Use of technology to support care

Trust Priorities – Driving Quality Improvement

Our strategic framework is the foundation to structuring our priorities in the coming three years through to the individual objectives of staff at Oxford Health NHS Foundation trust. The diagram below shows the priorities within 'Driving Quality Improvement' to support our goals of 'Improving Patient Safety', 'Improving Clinical Outcomes' and 'Improving Patient and Carer Experience'.



An outline of existing quality concerns (CQC or other parties) and plans to address them:

- Following all announced and unannounced visits or inspections by the CQC an individual action plan is developed and approved by the Director of Nursing (CQC nominated individual for Trust) before being submitted to the CQC. Two of the three minor concerns raised relate to safety and suitability of premises and in response the Trust

has identified funding and developed a priority list to carry out refurbishments/ removal of ligature points and new build work to acute mental health wards.

- Demonstrating assessment of capacity and discussion of consent with patient/ carer (source: internal clinical audit and CQC MHA visits). It is now included as a standing item at ward clinical review meetings and MDT reviews in Community Hospitals.
- Consistency of where to record clinical information on RiO (source: clinical audits and SIRI reviews). A Trust wide proposal is in draft about essential fields on the mental health version of RiO to be completed in respect to clinical information. This piece of work is being led by the Clinical Effectiveness Quality Improvement Committee.
- Implementation of Carers Strategy to work on improving carers' experiences of services (source: carer survey and announced CQC visit in Oxfordshire mental health services). A Carers Survey will be repeated in 2013/14 and revised in light of the integration work within the organisation. It is out for consultation and will be presented at Board of Directors.
- Bed management processes and staffing challenges on the adult acute mental health wards (source: CQC announced visit and complaints). To support staff we are now having on duty senior nurses rather than on call staff thus allowing ward staff to remain focused on the care of current patients. The Division has appointed single Consultant Psychiatrists to wards so that the management of admissions and discharges is led by one person rather than multiple Consultant Psychiatrists. The Division is also looking at the option of increasing the administration support for effective bed management.
- Explaining (possible or actual) side effects of medication and documentation especially in community of monitoring side effects during treatment in inpatient and community mental health services. (Source: national patient surveys and national clinical audits). The Trust has good information produced by Pharmacy on medications and their side effects. The action above to improve the consistency of where to record clinical information on RiO will provide evidence that medication is being regularly reviewed.
- Wintle Ward - Improved privacy has been achieved with all bedrooms now being single occupancy; some of the anti-ligature work is completed with the full refitting of the bathrooms expected to be completed by 31/5/13. All sinks have been fitted with industry standard anti-ligature taps. Once completed, the new scheme will not have any taps which will eliminate the risk completely; this work will be complete by 31/7/13.Work to the garden space and fence in relation to patients smoking in the garden will be completed by 31/7/2013.

Managing the key quality risks related to this plan

The Safer Care programme engages front line clinicians to achieve improvements to practice, this ensures that suggested improvements work and clinicians themselves are the leaders of change. A risk this year is the capacity to lead the programme which is currently being addressed; the speed of roll out given the involvement model will be challenging.

The pace and scale of change involved in the service remodelling is ambitious and the need to engage key stakeholders including patients, GPs, staff and commissioners and other external bodies such as Health Overview and Scrutiny Committee (HOSC) will require a high level of organisation and planning. Workforce requirements such as the need for more expertise in certain therapies and the need to redesign roles and up-skill the workforce will be worked through with clinical leadership and involve in HR processes to mitigate the risks as we;; as extensive involvement with staff-side organisations.

Other risks to safety and quality include variation in clinical practice, and other constraints including recruitment to some nursing and therapy roles in certain geographical locations and supply of temporary staff to meet need. These are known and routinely managed and monitored locally by services as well as at a strategic level through senior management teams and the Executive.

Upgrading the physical environments in mental health services in particular is being addressed through the building of the new hospital in Aylesbury and upgrading of wards at the Warneford hospital. Some ligatures removal work in other wards remains and are included in environmental risks to be addressed through capital works in the forthcoming years. The Manchester Risk Assessment Tool has been used to prioritise areas for immediate attention. The upgrading of the secure environment to meet MSU (Medium Secure Unit) standards remains a priority and a risk. Significant investment in Marlborough House in Milton Keynes to enhance security is underway.

The service re-modelling programme will improve the experiences and outcomes of patients using community and mental health inpatients wards, staffing review, having more senior nursing staff on wards, using internal standards,

service user involvement and feedback and AIMS Accreditation to drive improvements will also have major contributions to this work.

Another potential risk is the penalty that OCCG is proposing if the very small number of cases of patients with C Difficile is breeched. This stands at a penalty of £1m if one case breeches from 8 to 9 cases. Route Cause Analysis (RCAs) of last year found no transmission and generally there were no actions that could have altered the outcome, as frail elderly patients needed antibiotic treatment and received first or second line prescribing within the guidelines. Target has not been signed off and we continue discussions with OCC to agree something that adheres to high standards and reduces the risks the in current proposal which could be breeched through normal variation in small numbers of unavoidable cases.

An overview of how the Board derives assurance on the quality of its services and safeguards patient safety

The Board derives assurance for quality and safety through a variety of activities. Each Executive has a clearly defined portfolio and is individually and collectively accountable for the quality and safety of services. Reports to the Board of Directors and the Extended Executive Board manage the key risks and business of the Trust supported by a Board Assurance Framework and Audit programme.

The supporting infrastructure includes use of the Monitor Quality Governance Framework, and work undertaken through all our Governance Committees. For example, the Integrated Governance Committee and its sub committees enable detailed reports to be scrutinised for assurance, these cover all aspects of safety and quality including safety, safeguarding, infection control, clinical effectiveness including NICE implementation, clinical audit, patient involvement and experience within services as well as the safety and suitability of the physical estate. Compliance with CQC standards is derived through the individual Executives leading on standards with assurance drawn from five quality improvement committees covering the three domains of quality and HR/ Workforce management. Effective operational management is overseen through Quarterly Performance Reviews attended by all Executives and two Non-Executive Directors.

Clinical Engagement and leadership is fostered through involvement of senior clinical leaders in the development of the business plan, reviewing CIP plans and leading the service remodelling.

3.0 Clinical Strategy

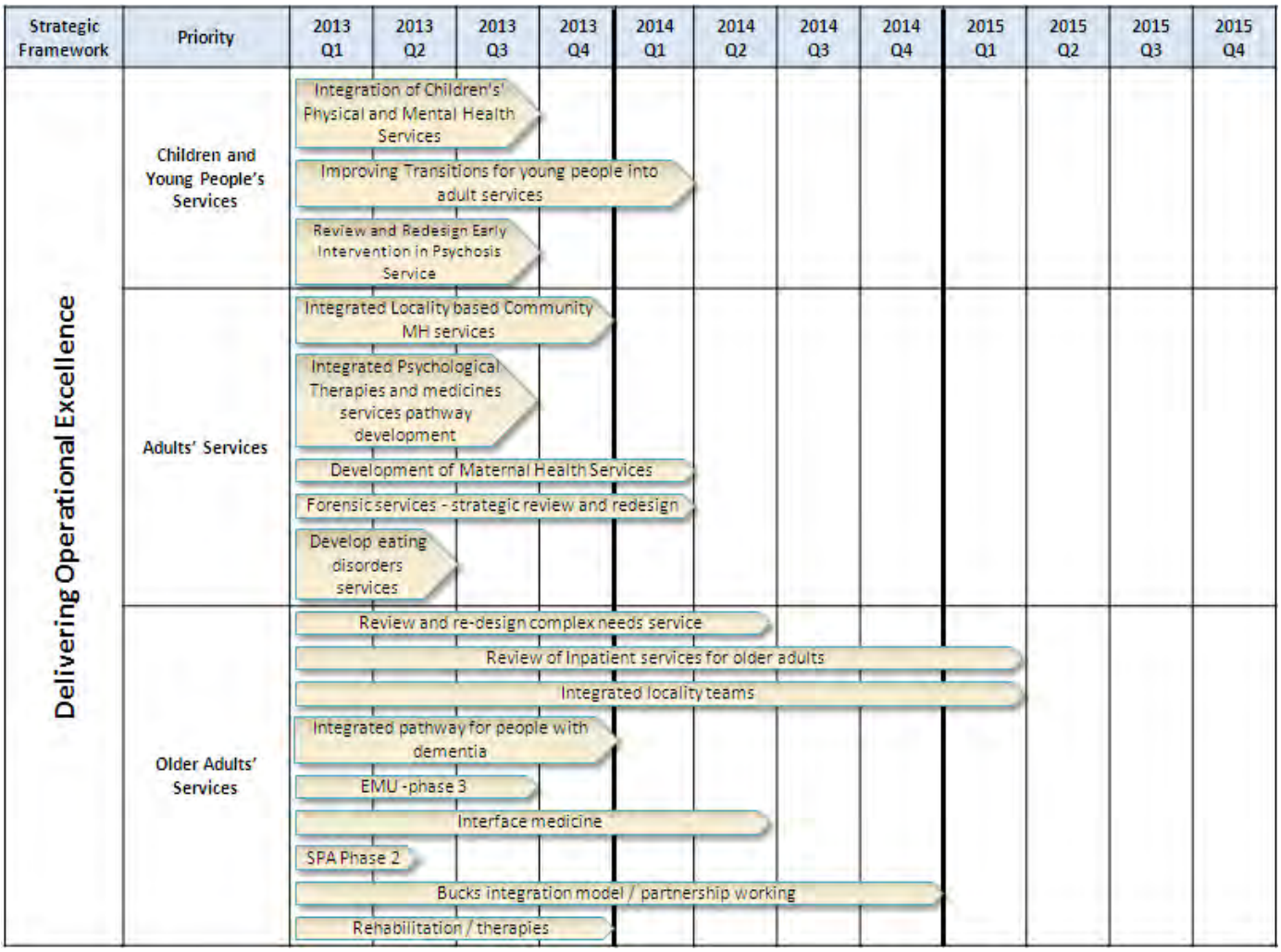
3.1 Service Line Management Strategy:

'Driving Quality Improvement' and 'Delivering Operational Excellence' are two of our key strategic drivers and we want to achieve quality care which is above the national average; In selecting our priorities, we have been mindful of both the national and local contexts, as well as feedback from service users, staff and external bodies which include Monitor, Care Quality Commission and commissioners.

In line with the overall clinical strategy of Oxford Health NHS Foundation Trust, we are developing programmes across clinical divisions with a focus on remodelling services to deliver integrated health and social care. The programmes are supported by information technology, human resources and estates to ensure collaborative and successful implementation. We are six months into the clinically led service remodelling programme, and we have had input from the 3rd sector, commissioners, staff, Board of Directors and Governors to ensure we have a collaborative approach to ensure the best patient care.

Trust Priorities – Delivering Operational Excellence

The programmes have been grouped within three work streams and will be delivered by March 2015



Shared principles

'Cradle to grave' model of care

- Managing transitions
- Physical and mental health integration
- Patient outcomes-focused
- Embedding research and evidence-based practice

Remodelling includes

- Shift patterns to align to model of care
- 24/7 model of care
- Pathways cross traditional age and need boundaries
- Operational, clinical and academic management of pathways
- Working with partners (NHS, CC, and 3rd sector)

Locality single point of access directing to most appropriate care

Children's and Young people's Services

The principles of this work stream are to:

- Have a common point of entry for Children and Young People's services for all referrers
- Retain a tiered approach to care
- Maintain a high level of specialism and expertise to deliver complex interventions
- Develop care pathways that draw in expertise where needed without handing over patients
- Involve young people and their families in care
- Prepare for transition from children and young people into adult services
- OHFT to be leaders in the field in identified care pathways

Adults' Services

The services being developed are primarily focussed with adults between the ages of 18-65. The remodelling of the adult pathway has included team representatives across the mental health division, operational divisions and workshops to ensure consultation and a co-ordinated approach.

Older adults' Services

The challenge for OHFT is to reconfigure available resources to meet the rising demographic of older people with a complexity of health and social care needs.

In line with the quality strategy, the focus has been upon

- Integration of physical and mental health care to provide holistic care to patients
- The default place for care is at, or near, the patient's home, with a focus on multi-disciplinary working within GP commissioning localities
- Integration with adult social care, and enhanced partnership working with primary care and acute services to develop integrated pathways of care

The proposed remodelling consists of 47 services within Oxfordshire community services and older adult mental health services in Oxfordshire and Buckinghamshire to deliver a model of care comprising a number of pathways.

The benefits of a new service model will allow us to:

- Provide co-ordinated care for older people with physical health, mental health and social care needs
- Reduce acute admissions (dementia and physical acute)
- Improve recovery and rehabilitation and improve recovery of independence at home following significant episode of illness
- Improve dementia care for people with physical long term conditions, and improve physical health care for people with dementia or functional mental illness

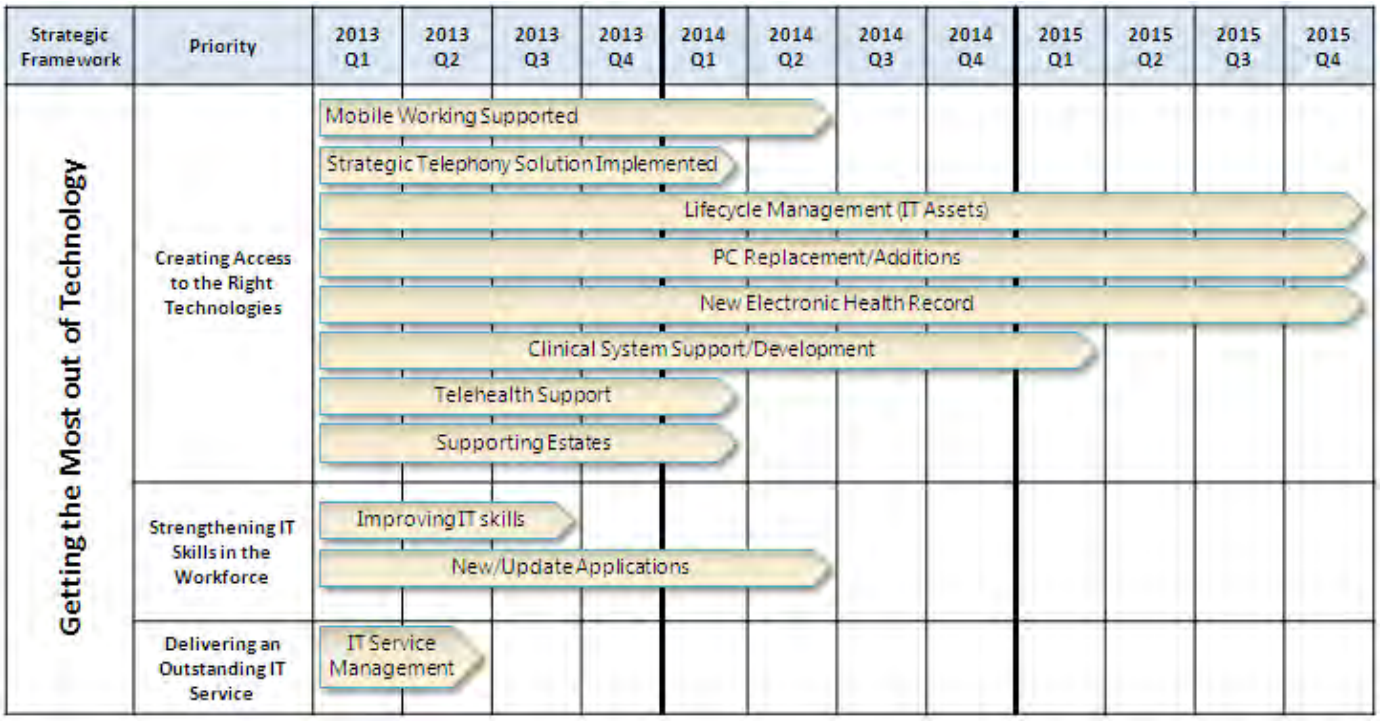
3.2 Productivity & Efficiency

Developing and providing the right technology and the right systems for staff , patients, carers and other stakeholders is fundamental to improving productivity and efficiency and underpins a number of our priorities in the coming three years. We will have anewfully integrated electronic health record system which provides the platform that contains all clinical and non-clinical and patient information that staff, patients and carers need where and when they need it.

We are creating a business intelligence system which will enable us to consolidate data into a single source of information, which will provide a fast and effective way of accessing information and translating information into knowledge using dashboards and reports. Finally, we are introducing patient level information and costing system (PLICS) which provides a more direct approach to interactions and events related to individual patientsand the associated costs. This will bring more transparency to cost and allow us to drill into the cost of each individual patient.

Trust Priorities – Getting the Most out of Technology

The priorities below provide a more comprehensive list of the work supporting service remodelling and productivity and efficiency:



An overview of potential productivity and efficiency gains built into plans

Division	Priority	Rational	Target FY13/14
Specialised Services	Reduction in the Length of stay for Inpatients	In line with CQUIN Framework, and reducing the period of time Forensic Inpatients are in each stage of their care pathway from admission to either discharge or reduced security level	Reduce the LoS in MSU by 5% Reduce the LoS in LSU by 5% reduce the LoS in PDU BY 10% from FY 12/13 Figures taken on a monthly comparative
Mental Health		Increasing inpatient staff and management, developing community services to ensure admissions are reduced and flow through the wards are more efficient	Current LoS 35 Days, Target of 28 Days
Children's and Families		The Division aims to continue to reduce ALOS on all wards, the last few years have shown a significant reducti on in ALOS	To continue to achieve 50-60 days for CAMHS and 80-95 for Adult ED wards

Specialised Services	Reduction in the usage of Bank and Agency across the Division	if all patient care areas are sufficiently and safely recruited to, the need for Bank and Agency could be reduced, to only cover when Observations are such that requires additional staffing and to cover A/L and any long term periods of illness	Reduce the level of bank and agency to the trust standard or below <5%
Mental Health		If all patient care areas are sufficiently and safely recruited to, the need for Bank and Agency could be reduced, to only cover when Observations are such that requires additional staffing and to cover A/L and any long term periods of illness	Reduce the level of bank and agency to the trust standard or below 5%
Children's and Families		The Division has implemented an intervention to allow use of overtime (tight controls) for bands 5 & 6 as an efficient alternative to higher expense of agency staff.	Reduce the level of bank and agency to the trust standard below 5%
Specialised Services	Maintain bed occupancy at agreed contractual levels across the acute wards	The SCG purchase 100% of the Forensic beds, and only allow 14 days in between a discharge and an admission to each bed, therefore working on an Occupancy rate of 98%	Achieve 98% bed occupancy across all the forensic wards
Mental Health		To enable safe emergency admissions required, need to ensure bed occupancy levels to admit quickly	Achieve agreed bed occupancy across all the wards
Children's and Families		Once the occupancy is agreed the Division will plan accordingly and further develop the inpatient pathways and integration with community services to endeavour to adhere to the contractual requirements and provide service within financial requirements without comprising patient care and safety which remains the priority for the Division.	All the Divisional inpatient activity is now purchased via the SCG, the SCG are proposing to purchase beds for CAMHS and Eating Disorders at 85%
Specialised Services	Minimise the need for Emergency readmissions	On discharge a patient is provided with 2 weeks' trial leave and on-going support from the Forensic CMHT. The Forensic service would like to minimise the need for emergency readmissions back into secure services	Reducing re-admission within 28 days of a discharge
Community Services	Roll out of Venus Leg Ulcer Pathway	Roll out venous leg ulcer pathway to community services (OHFT)	Reduction to 20 weeks' healing time for patients managed on the new pathway or if not healing timely referral to tissue viability

Community Services	Redesign of frail elderly and complex rehabilitation pathway	In line with the CQUIN framework - Improve the continuity of care for patients by reducing the number of hand offs the patient experiences Change the delivery model by increasing the number of clinics, gym and group activity to reduce the travel time and increase the face to face contact time. Introduce personalised re habilitation plans to improve the choice and control patients have over their rehabilitation Move to a 7 day working model to provide 7 day access and continuity to service for Occupational Therapy and Physiotherapy.	New model designed by Q2 Pathway implemented by end Q4.
Community Services	Implementation of Discharge Pathway Team in Community Hospitals	To review the patient and confirm they are on the correct pathway. Reducing the length of stay for patients in Community Hospitals and ensuring that the estimated discharge date is set at a realistic timescale specific to the patient needs	Reduce Average LoS to 18 days excluding DTOCs by Q4(following implementation of interface medicine and supported discharge pathway)

3.3 Clinical Workforce Strategy

High performing, motivated staff that work well in teams are fundamental to the delivery of the care we provide for patients and carers and the experiences and outcomes will be determined by them. The Trust has a qualitative and quantitative workforce plan, reviewed and amended quarterly. These plans are developed and agreed at divisional level and aggregated to provide an organisational picture. This is then layered into an overarching workforce plan, reflecting organisational priorities and strategy.

As our service models develop it is essential that we are all able to work collaboratively, across traditional or cultural divisions and organisational boundaries . We are creating a multi-disciplinary team that has clinical leadership at its heart and by working closely with the Local Education and Training Boards (LETBs) we are ensuring that the training, learning and development of clinical workforce meets these needs.

Internally we are actively spotting talent and supporting the development of the best staff that we have throughout the organisation so that we are able to maximise our potential, ensure that we are able to deliver the best possible quality of care. There is a programme in place to increase the prominence of medical leadership who wil be able to lead the organisation over the coming months and years.

Central to the development of our organisation, the improvement of our services and increasing innovation is the embedding of research and development in our work. Our clinical workforce will build strong relationships with academic institutions, they will be involved in research and development activities by leading academics and translate innovation into practice. We are increasing our joint posts as well as introducing honorary contracts to further improve the partnership working with academic institutions.

The consultant cover that exists throughout the organisation is appropriately aligned to the recommendations outlined by Royal Colleges and meets the required standards that are set by our own internal arragnements.

It is expected that the staffing levels and skill mix structure will remain static during the first half of FY13/14. A significant service re-modelling programme, due to be implemented from Sept 13 is taking place this year; this will have a large impact on workforce resourcing in terms of both staffing skill profiles and location.

Consultation papers being drawn up will require consideration of the following amongst other issues: working patterns, potential reorganisation of teams and redeployments – training plans for re-skilling staff are being developed. Consultant cover is appropiately aligned to the recommendations outlined by royal colleges

Other considerations

- % CQUIN uplift on achievement of performance targets. 1% of this to be included in 2013-14 pay budgets
- 4% efficiency saving across organisational income streams to be made recurrently through the CIP process
- 2 to 2.5% inflation uplift

New techniques and technology are being introduced to healthcare at an ever increasing pace. The increased use of non-invasive medical techniques and the significant increasing need for IT skills to support Clinical Care records has an impact on skills and competence of the workforce. All of these advances involve more trials and research, the development of individuals in the workforce and significant communication with patients.

With changes to the retirement age and pension changes there is a potential impact in the overall profile of the organisations workforce. This is reinforced with the predicted changes in the overall Oxfordshire/Buckinghamshire and Wiltshire demography and the legislation regarding the employment of those over the age of 65. As the younger population reduces in some areas this workforce supply could become more relevant to Oxford Health NHS FT in service delivery.

Revalidation of the medical workforce is now satisfactory and is fully underway and is fully supported within Oxford Health NHS FT. Local work is on-going to support revalidation within Oxford Health NHS FT.

Patients, carers and public also have a greater expectation of receiving their care and treatment locally and having a greater influence over this as a partner in their own care. There is an emphasis on locality based integrated care teams.

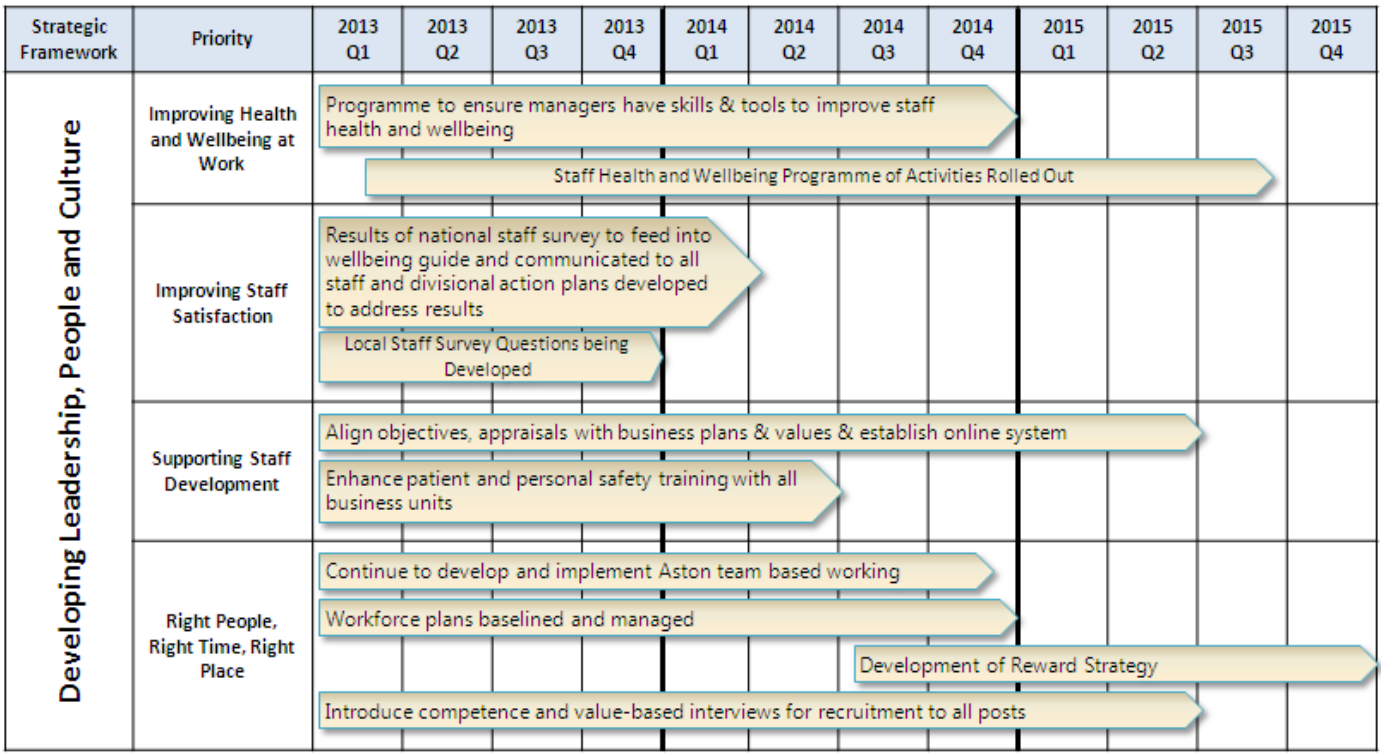
General Workforce Strategy

The Workforce Strategy priorities to create a flexible, available, adaptable and affordable workforce are as follows:

Active and positive staff engagement	Continue the good practice of engagement and consultation in service redevelopment and organizational change. Further development of established reward and recognition schemes; removal of historic cost of living supplement (COLS) and introduction of new recruitment and Retention scheme to address areas of most need.
Reaching our potential	Investment in learning and development for all, based on established Performance & Development review process to identify needs. Clearly defined priorities for Learning and Development supportfor service remodeling plans. Structured allocation of training funding to meet quality improvements in patient care. Dedicated development programmes which support and enable staff to make improvements at work (e.g. Productive Care, Safer Care, Improvement Champions). Review longer term education/training programmes for nursing, AHPs and non-registered staff to meet relevant Francis report recommendations.
Clear workforce plans	Divisional workforce plans have been created through a collaborative process involving divisional, clinical and management as well as HR and finance teams. Introduction of e-rostering to better apply and track staffing of inpatient wards. Trialingnew standardized shift patterns for consistency and simultaneous review of skill mix. Use of Mutually Agreed Resignation Scheme (MARS) to support further development of skill mix.
Developing leaders and managers	Leadership and management development framework in place using the NHS Leadership competency standards. Regular programme of learning and development including supportive coaching and other informal development tools. Design and delivery of clinical leadership skills programmes to underpin new care pathways.

Promoting wellbeing at work	Wellbeing and culture group is leading work to interpret and act on staff survey results and drive wellbeing initiatives. Wellbeing strategy in development and will be launched in April 2013. Improving staff survey results
Building and supporting effective teams	Service remodeling strategy focuses on building integrated teams. Aston University team working programme has been launched and continues to roll out Team effectiveness improvements. Increase in team away days including use of Myers Briggs Type Indicator (MBTI)
Excellent HR practice	Professional HR department structured to provide support to operational services. Comprehensive policy framework in place, Recruitment Solutions being further developed to provide temporary unqualified staff; internal bank being considered. Greater values based interviewing being developed following the Francis Report.

Priorities – Developing, Leadership, People and Culture



4.0Cost ImprovementProgramme

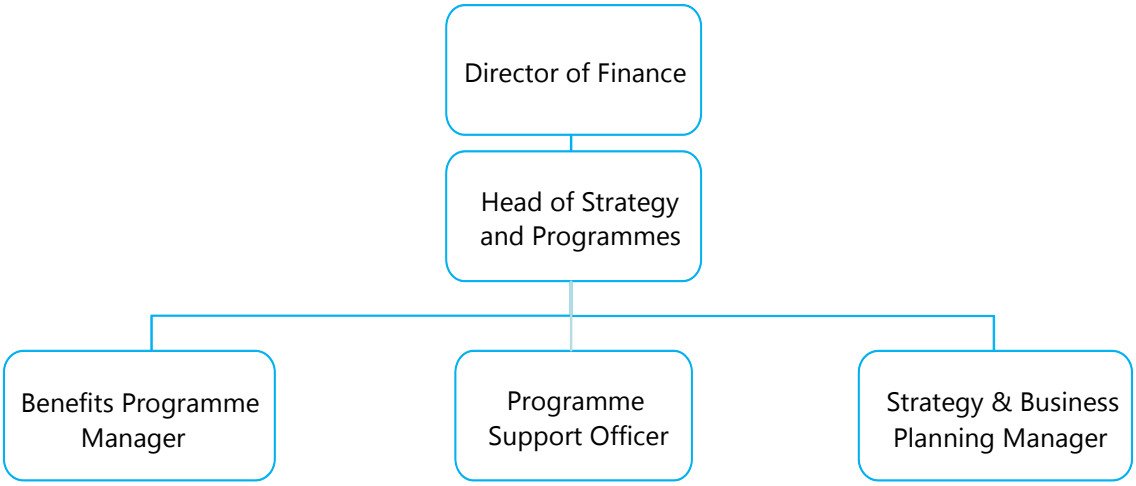
OHFT has performed well historically against its CIP requirements. In the past 2 years it has delivered 88% & 83% of its targets, and perhaps most importantly, has been able to do this on a 100% recurrent basis.

Delivery has been aided by tight governance through an integrated PMO, and a keen focus at Executive Director and Board level. This has ensured that the expected benefits of projects are driven through and reported on. A robust planning process also aids CIP delivery, beginning early, allowing appropriate time for scoping and revision of projects before they are committed to the programme.

Looking ahead, it has been recognised that the development of the Trust's Service Models is integral to CIP delivery. It is intended that through a focus on delivery of quality and productivity, there will be substantial efficiency savings to the system. These models are under development currently, and expected to release benefits over the next 3 years.

OHFT has had a PMO since 2010 and has continued to support the development of its structures to coordinate strategy development, business planning and benefit delivery. The PMO is under the management of the Director of

Finance and works closely with the Executive team to support the planning, delivery and alignment of major strategic programmes:



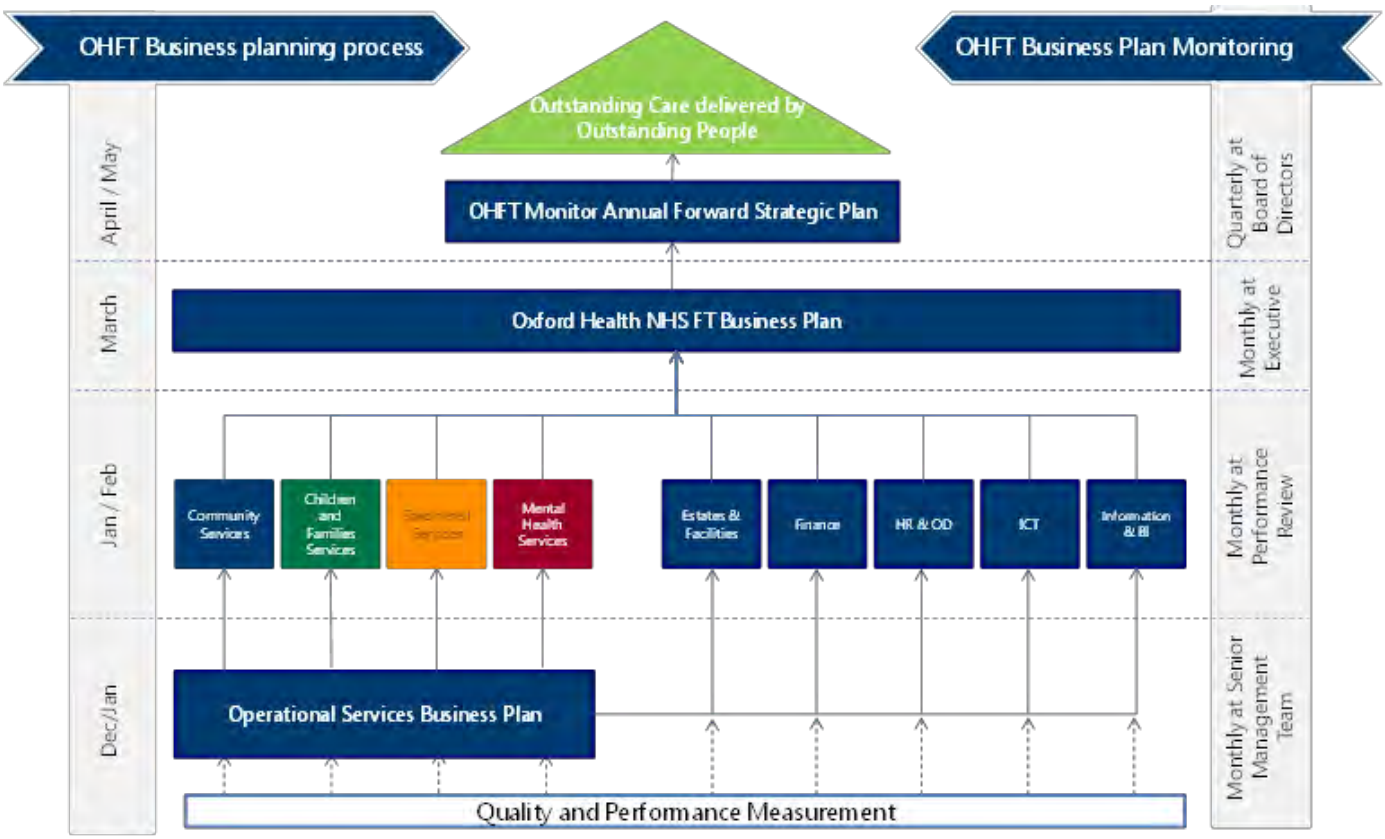
Linking Business Planning and Cost Improvement

As with many health and social care providers in England OHFT faces a significant challenge to reduce its costs while maintaining or improving the quality of its services. In previous years OHFT has developed its cost improvement programme (CIP) as individual, largely transactional projects although it has gradually been moving towards greater collaborative planning to design more longer-term, transformational programmes to deliver cost improvement.

From January 2013 the Executive has led a process of integrated business planning in order to identify and align the major strategic change programmes for the coming 3years. The PMO has coordinated this process and assessed plans for strategic fit, ease of implementation, risk exposure and value. This has culminated in a CIP that comprises transformational plans (from business planning and service re-modelling), impacts of full year effects from existing projects, transactional (less complex) projects and productivity and efficiency plans. The programme will continue to develop throughout the life of this strategic plan.

As part of the embedding of integrated planning processes a senior strategic management team including clinical, nursing and managerial leads from across the organisation has been established meeting regularly since January to refine and develop business plans ensuring dependencies areidentified and managed. Detailed business plans are in place at Board, Executive and operational and corporate divisions, these include critical milestones and key performance indicators for monitoring and work is being done to develop benefit project plans.

The following diagram outlines how business planning has been implemented and how it is intended to link with performance management and CIP delivery for the life of the strategic plan.



Some of the major transformational schemes over the next 3 years include:

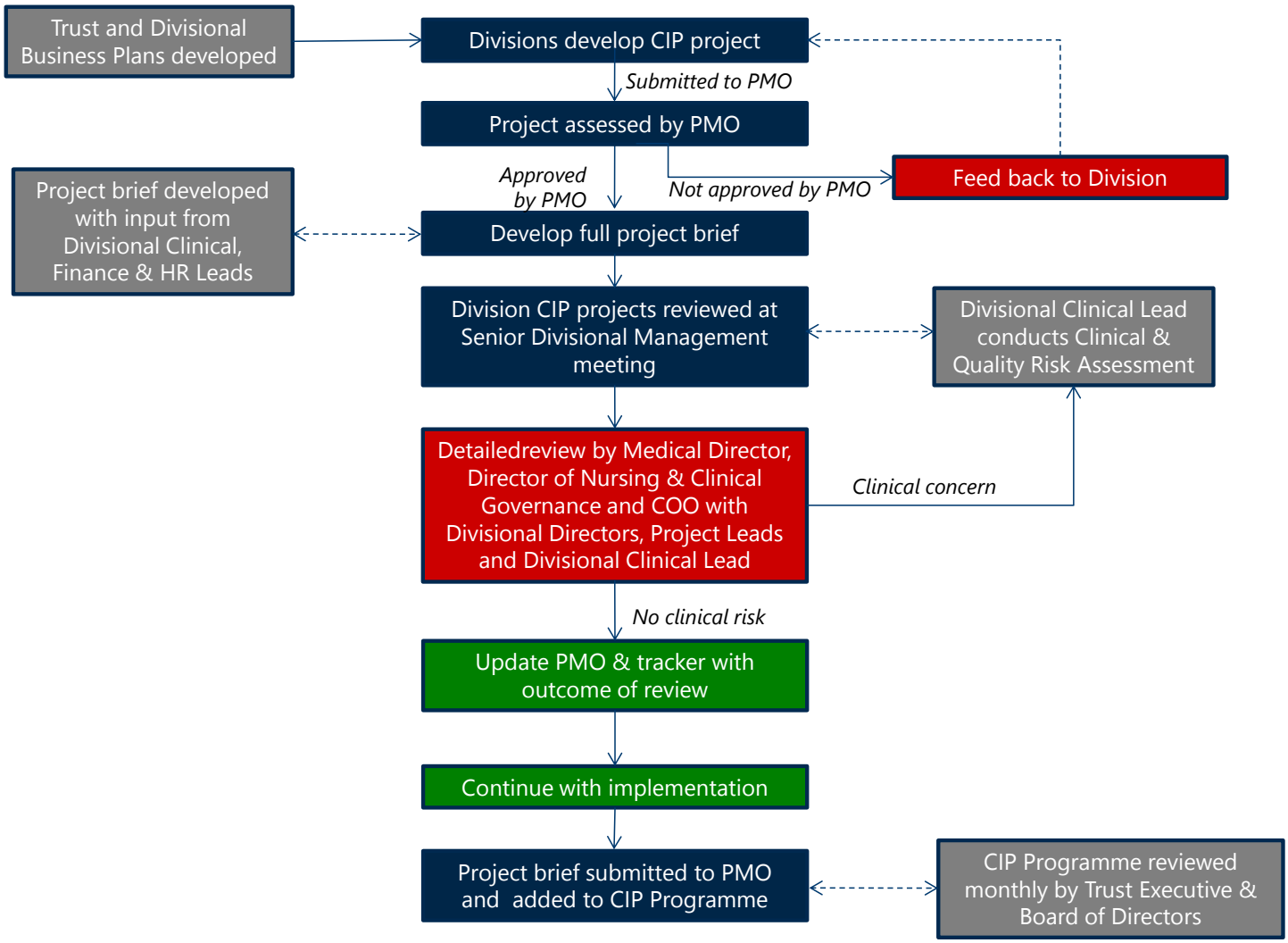
Business Intelligence (BI) System creating astep change in productivity, enabled by the new BI systemturning information into knowledge and enabling evidence-based decisions that lead to efficiency savings.

Service Remodelling Programme remodellingexisting services structures around entire care pathways towork across traditional organisational boundaries to improve quality of services, create efficiencies and re-structuring management, how estates are used and using technology to enable changes.

Developing Care Closer to Home toincrease the range of services available outside the traditional hospital setting to improve patient experience, increasing independence and self-management. This will also allow a reduction in bed provision across the Trust that will further reduce OHFT costs.

Clinical and Quality Assurance Processes

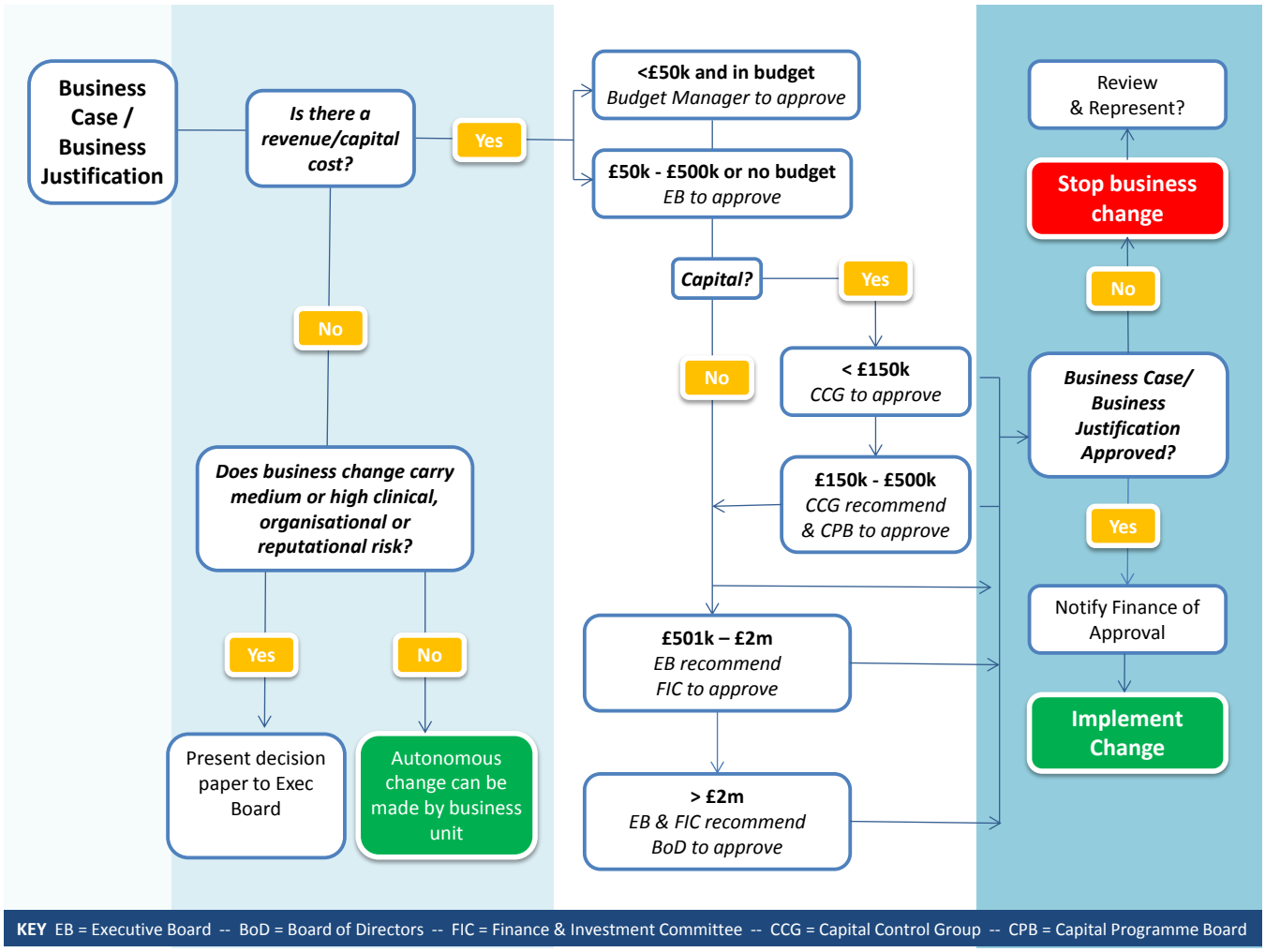
Along with existing clinical and quality governance structures that exist to oversee and ensure that we attain the highest possibleservice standards, the linkage of business plans with key performance indicators including outcome, patient experience and safety provide an opportunity to monitor progress of plans and performance at Board, Executive and Divisional level. Every CIP project is required to complete a clinical quality risk assessment that identifies potential benefits, disbenefits and mitigating actions for patient experience, clinical effectiveness, patient safety and workforce (including staff safety). The process for clinical and quality assurance is outlined below:



CIP Management and Assurance

The Director of Finance is the CIP Director and there are executive leads for each element of the business plan, some of which will either directly deliver cost improvement or collectively deliver benefits that will include cost improvement. CIP responsibility runs throughout the organisation and there have been routine communications and presentations to inform people of the challenge and responsibility for implementation of schemes lies within the organisation. Project documentation commits specific leads and project support by name to each plan.

As with any major business change or investment projects and programmes are required to follow the approval processes outlined in our standing financial arrangement as described below:



The PMO runs the programme and works closely with performance and finance teams across the organisation to monitor progress against plans, impacts through key performance indicators and contributions to cost improvement from budgets. The PMO scrutinises and manages risks and issues at a programme level, escalating this as necessary and offering support internally. There are monthly performance review meetings as well as Business Plan highlight reporting and CIP reporting is contained as part of the financial reporting for the Trust Executive and Board of Directors.

Generally, once a plan has been assured and agreed by the extended executive group a budget holder is responsible for the agreed level of saving and unless there are exceptional circumstances is expected to mitigate any shortfall from within their area of operations. The PMO endeavours to build in headroom of at least 15% based on previous performances against the LTFM targets where CIP achieved 88% in FY12 and 83% in FY13. Throughout the life of this strategic plan we aim to continue to drive savings, especially from improved productivity and efficiency that are currently not labelled as CIP projects. These will contribute to the contingency and to future years' CIP plans, reducing the pressure on annual programme generation. The PMO will continue to coordinate the administration and portfolio of strategic projects for the Executive Board in order that it has sight of all major projects in the Trust and can incorporate benefit management projects as required.

5.0 Financial & Investment Strategy

2012/13 Financial Performance

Overall, the Trust has continued its strong track record of delivering against financial targets, and has met its key financial targets for the 2012/13 financial year:

- A £2.8m Income Statement surplus, £1.6m above plan
- EBITDA of £15.2m against the plan of £12.5m
- A period-end cash balance of £30.9m, £17.3m above plan
- A financial risk rating of '4', against a planned FRR of '3'

The Income Statement is reporting an excess of income over expenditure of £2.8m, which is £1.6m above plan. Excluding impairments (actual costs of £4.3m actual against planned of £2.5m) the surplus was £7.1m against a plan of £3.7m. The main reasons for the improvement in the EBITDA position are additional one-off income to reflect contract over-performance, strong performance to secure CQUIN, lower than planned organisational change costs due to CIP slippage and reserves remaining uncommitted. Cost improvements of £10.7m have been delivered against a target of £13.0m for the year.

Financial Outlook

The Trust, like the rest of the NHS, is facing an extremely challenging financial environment. We already know that the NHS will receive limited growth funding, small increases in inflation funding and be faced with national efficiency targets of 4% year-on-year. The result of this will be a net real term reduction in income year-on-year.

The financial strategy for the Trust for FY14 to FY16 has been produced in response to this challenging economic environment, to find headroom from within existing resources to maintain and improve existing levels and quality of patient care. It is built on the firm financial foundations laid by the Trust in the previous four years, since becoming a Foundation Trust. The Trust will continue to be proactive in responding to the economic recession and the potential impact on public service funding, through:

- Strengthening financial governance
- Targeting reductions in overhead costs, including support service functions
- Ensuring real health gain in all investments
- Driving increased productivity and quality with no net increase in funding
- Planning for the delivery of cash releasing efficiency targets at significant levels
- Mitigating financial risk through forward planning and contingencies.

The Board of Directors approved the FY14-FY16 Financial Plan and FY14 budget at its March meeting. The key highlights are:

- Normalised surpluses of £5.5m, £5.3m and £5.3m over the next three years, giving a normalised surplus margin of not less than 1.9% per annum;
- Normalised EBITDA margin of 5.6%, 6.3% and 6.4% over the next three years;
- The requirement for cash releasing efficiency savings of £33.2m during this period;
- Capital investment of £47.6m over the next three years;
- A minimum financial risk rating of '3' over the next three years under the existing risk metrics, and '4' under the proposed new risk assessment metrics.

Target	FY14	FY15	FY16
EBITDA – normalised	**16.0**	**17.8**	**17.8**
Normalised EBITDA margin	*5.6%*	*6.3%*	*6.4%*
I&E Surplus/(Deficit)	**(3.2)**	**4.8**	**5.3**
I&E Surplus – normalised	**5.5**	**5.3**	**5.3**
Normalised I&E Surplus margin	*1.9%*	*1.9%*	*1.9%*
Cost Improvement Programme	**11.3**	**11.1**	**10.8**
Cash Balance (year-end)	22.5	22.5	23.1
Capital Expenditure	**29.5**	**9.1**	**9.0**
FRR (current metrics) FRR (new metrics)	3 4	3 4	3 4

Income and Contracts

Total income falls year-on-year as the planning assumption is for the national efficiency saving requirement to be greater than funding for NHS inflation, resulting in a net annual deflator of -1.3% in FY14 and -1.5% in FY15 and FY16. Additional income is included in FY14 for the full year effect of services which commenced in FY13 (mainly Reablement) and new investment agreed for FY14 partly offset by reduced income for services/contracts lost (mainly Bullingdon). The Oxford Pharmacy Store income target has been set on the basis of their latest business plan FY14.
Primary Care Trusts have been abolished and Clinical Commissioning Groups (CCGs) are directly responsible for commissioning health services from April 2013, with the exception of certain services commissioned directly by the NHS Commissioning Board; health improvement services commissioned by local authorities and health protection and promotion services provided by Public Health.

The Trust has not been informed of any significant changes to commissioning intentions for FY14 or beyond:

The Trust has a contract with Oxfordshire CCG for the provision of community services to the end of FY15. The Trust also has contracts in place with its main commissioners, Oxfordshire and Buckinghamshire CCGs, to provide mental health services to their respective resident populations and a contract to deliver child and adolescent mental health services in Swindon, Wiltshire, Bath and North East Somerset.

The services previously commissioned by South Central Specialist Commissioning Group (SCSCG) in FY13 will pass to the NHS Commissioning Board and be commissioned by the Wessex Area Team for FY14. In addition, the Trust has agreements in place with Buckinghamshire and Oxfordshire County Councils' pooled health and social care budgets under Health Act Flexibilities for the Trust to deliver integrated community mental health services.

CQUIN funding of 2.5% is available in FY14; the Trust is in the process of finalising CQUIN requirements with commissioners.

Service Developments

Reflecting the expectation of close to zero growth in central funding and increasing demand for services, especially for people with complex needs and within an ageing population, significant transformations, innovations and service developments are required across the organisation in order for us to continue to provide high quality services within this constrained financial climate and increasingly competitive environment.

The Highfield development was completed under budget and became operational in Q4 of FY13 (young people's inpatient unit re-provision in Oxford) and the Manor House redevelopment is due to be completed and become operational in FY14 (new build inpatient and community services in Aylesbury).

Across the Operational Service Divisions a major programme of Service Remodelling work is underway. The programme aims to maximise the opportunities and benefits of integrated care 24 hours, seven days per week. Three care pathways are being developed – services for children and young people, adults and older adults. These pathways cross traditional age boundaries, and 'managing transitions' is one element of work across the pathways.

The aim is to implement a locality based model of service delivery, operating within a whole system approach to working with partners including the third sector. The service remodelling programme focuses on improving quality and safety and providing an improved patient experience and outcomes.

There are no other significant service developments planned for FY14 at this stage, although the Trust will explore any opportunities which arise during the year that are consistent with the Trust's strategic aims and objectives.

Capital Investment

The Trust recognises the importance of providing services from high quality premises and has a significant capital investment programme of £47.6m over the next three years.

The main areas of investment include the completion of the £42.9m Manor House hospital development in Aylesbury, which is due to be completed in FY14, ensuring that inpatient wards meet required standards and provide best possible environments for our patients. In addition, the Trust will be investing in its infrastructure to ensure that its estate and information technology continue to support the provision of high quality services.

The capital programme will be financed through cash generated from operations and surplus land sales of £12.7m in FY14. In addition, the Trust has utilised £28.1m in loan financing towards the Manor House scheme.

In order to make best use of resources for the provision of patient services, the Trust has agreed to take ownership of community services property previously owned by Oxfordshire PCT. The value of the assets transferred to the Trust from NHS Oxfordshire on 1April 2013 was c. £41m.

FRR

Monitor has been consulting on proposals to change the risk rating metrics. The revised risk metrics will not be introduced until mid FY14, which means that the existing risk metrics remain effective for the first six months of FY14. The FY14-FY16 financial plan has therefore been assessed using both the current and proposed risk metrics.
Under the existing risk metrics, the three year financial plan delivers an overall rating of '3' in each financial year. Under the proposed new risk metrics, the three year financial plan delivers an overall rating of '4' in each year.

Financial Risks

Apart from the challenging economic environment within which the Trust continues to operate, the main risks facing the Trust during FY14 include: the requirement for the continued delivery of significant efficiency savings; continuing to deliver high quality services to patients in accordance with contracts agreed with commissioners, particularly in the context of the transition to new commissioners from April 2013; and delivering a substantial capital investment programme on time and within budget. The Trust has plans in place to deliver its financial objectives for FY14 and mitigation plans to manage these risks.

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