

Strategic Plan 2013-16
Incorporating Annual Plan 2013-14

31 May 2013

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

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

Name	Samantha Milbank
Job Title	Director of Service Development
e-mail address	sam.milbank@nhft.nhs.uk
Tel. no. for contact	01536 452054
Date	31 May 2013

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

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has 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 Strategic Plan 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 Directors by:

Name (Chair)	Paul Bertin
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Signature 

Approved on behalf of the Board of Directors by:

Name (Interim Chief Executive)	Angela Hillery
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Signature 

Approved on behalf of the Board of Directors by:

Name (Finance Director)	Bill McFarland
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Signature 

Executive Summary

Our strategic plan 2013/14 – 2015/16 has been developed with input and by listening to the views of our patients and service users, staff, members, stakeholders and governors. Their key messages have been integrated into this plan and are shown in Appendix 7. This plan has been signed off by our Board of Directors.

This plan builds on the strong foundation of delivery in 2012/13 and signals our intention to continue to deliver quality, integrated care for, and with our patients and service users.

This is a dynamic plan which will be reviewed on a continuous basis, not just annually but through the programme approach to implementation that the Board is adopting.

In developing the plan we have fully considered the challenges ahead. There are financial challenges in the local health economy, challenges presented in a changing commissioner and competitor environment and a population that is changing significantly in its demographic and in its expectation of us to provide quality integrated care locally. We have considered the recommendations of the Francis Report and have reviewed our work-streams to ensure that we create a culture with the delivery of compassionate care at its heart. The Trust is positioned well to respond proactively and achieve our strategic objectives. In particular, our successful examples of co-production provide a solid base to enable our vision.

Our financial position and history is strong and borne out of sound internal controls and performance management, illustrated by the financial position in 2013/2014, with a forecast surplus of £0.3 million. The overall planned financial performance will result in a risk rating of 3 in each year of the plan, both under the existing Monitor risk rating system and the proposed new system to be implemented in 2013/2014.

We have credibility with our various commissioners for our past record of delivery and benefit from good relationships as a result; our performance in 2012/13 against our non financial Monitor targets was 100%, and our contractual performance was good.

Strong governance processes our green governance ratings, achieved since authorisation providing confidence about the quality of services we deliver. Our Care Quality Commission assurance remained green overall and we delivered our contractual CQUIN and quality schedule targets.

Whilst developing our internal strength and resilience as a Foundation Trust, we intend to focus our immediate future on the four key transformation programmes:

1. **The Frail and Elderly Programme**, a whole system programme that is targeting the growing population of frail and elderly within the County. Many patients have multiple admissions to hospital and could, through more co-ordinated, proactive and integrated care have better outcomes and a better experience of healthcare.
2. **The Mental Health and Wellbeing Programme** aims to review and redesign community adult mental health services to achieve more accessible and sustainable care pathways. There will be an increased focus on primary care interventions supported by appropriate partnership and interface between specialist mental health services, IAPT (Increasing Access to Psychological Therapies), primary care, social care and the voluntary sector.
3. **The Children's Services Programme** aims to redesign the countywide service provision to encompass wellbeing, specialist physical and mental health care. This will allow the Trust to proactively manage care across a whole pathway, with appropriate step up and step down in care.
4. **The End of Life Programme** in which the Trust acts as coordinator across the pathway with outcomes targeted at improving patient and carer experience, assisting patient flow away from acute care and out of acute care if required.

These programmes aim to ensure synergy in relation to patients' local needs, our commissioner expectations and the Health and Wellbeing Strategy.

This transformation would support the Trust to establish its position as a significant player in the out of hospital care arena in the coming years. Our 4,300 staff provide physical and mental health services in the community - in people's homes, in health centres and surgeries and in our specialist hospitals. Our challenge is to integrate these services to improve outcomes, and experience for our patients, whilst driving efficiencies within the organisation. Our membership strategy (Included in appendix 6) describes how we will engage with our members as the basis for the Trust's accountability to the local population.

We will achieve our vision, focussing on delivering quality services for the people we serve, recognising and valuing them in a true partnership.

1. Strategic Context and Direction within the Local Health Economy

1. Background

Northamptonshire Healthcare NHS Foundation Trust delivers a comprehensive and extensive range of physical and mental health services that are tailored to meet the needs of our patients, service users and carers.

Our services are delivered in the community, through GP practices, and in residential and hospital environments. Where it is possible and right to do so, services are delivered in people's own homes. We provide prison healthcare services in Leicestershire as well as in Northamptonshire, and drug and alcohol services in Bedfordshire. Our services are commissioned by service line and can broadly be grouped together under five categories of care, which are: end of life care; unscheduled or urgent care; planned care or long term conditions; wellbeing and lifestyle; and recovery and rehabilitation. Figure 1 shows how our services are currently commissioned within these five categories.

Service Commissioning					
End of Life Care	Unscheduled / Urgent Care	Planned Care / Long Term Conditions	Recovery and Rehabilitation	Wellbeing and Lifestyle	End of Life Care
Community Palliative Care	Adult Community Mental Health Team (CAMHT)	Community Nursing	Health Visiting	Smoking Cessation	Community Therapy Rehabilitation Team
Specific Specialist Hospital	Older People's Community Mental Health Team (OPMHT)	Specialist Nursing - Cancer Referral	Children & Young People's Nursing Services (School Nursing)	Weight Management	Intensive - Respite
SPC Consultant Outpatient	Crisis Newborn / Home Treatment	Specialist Nursing - Patient Follow Up	Child Health Care Team	Pharmaceutical Services	Food & Hygiene
Maternity Nursing	Adoptive Outcomes	Specialist Nursing - Multiple Sclerosis	Specialist Children's Services	Sexual Health	Mental Health
Nursing @ Home	Adult Inpatient Specialist	Specialist Nursing - Parkinson's Disease Nurse in Disability Unit	Core of Adult Community Facilities	ADHD	Adult Inpatient Referral and Respite
Palliative Care (ambulatory)	Adult Inpatient Nurse	Specialist Nursing - Thrombolytic	Community Children's Nurses	Family Planning	Personality Disorders
End of Life Therapy Services	Older People's Inpatient Nurse	TS Service	Specialist School Nursing Team	Young People Family Planning	Traumatic Brain Injury
Specific Specialist Day Hospital	Adult Inpatient ICU	MSK Specialist Support (Physiotherapy)	Family Nurse Practitioner	Chlamydia Screening	Criminal Justice
Specialist Palliative Care Psychological Services	Adult Inpatient Care Secure	MSK Physiotherapy	Self-referral / GAC	HIV	Forensic
Mental Health Nursing	Early intervention	MSK Occupational Therapy	Swallow	Outreach Contraception (Internal IUD)	Health and Wellbeing
	Adult Care	MSK Podiatry	Children's Therapy Services - Physiotherapy	Universal Children's Services	Prison Health (Onsite)
	Intermediate Care Team	MSK Physiotherapy - Milton Keynes ADP	Children's Therapy Services - Physiotherapy	ADHD	Thyroid
	OT/Community Nursing Support/Respite/Day Unit	Community Podiatry	Children's Therapy Services - GAC	Contraception & Sexual Health Services	
	Community Safety Care Service Chronic Disease/Low Pulmonary Disease/Mental Disposition Team	Endocrine Control Centre (Internal IUD)	Children's Therapy Services - Milton Keynes Schools	Specialist Children's Services	
	Sexual Health	Podiatric Surgery	Specialist Diabetes Service (Physiotherapy)	Children's Diabetes	
	MSK	Diabetes multi-specialist team	Diabetes Community	Specialist Dental Services	
		Diabetes Referral	ID Community	Adult Care	
		Adult Community Physiotherapy Services	ID Inpatient Assessment and Treatment	Adult Diabetes	
		Adult Speech & Language Therapy Services	ID Inpatient Respite	Mental Health	
		Continence Service	ID Inpatient Support	Changing Minds	
		Pain Service	Child and Adolescent Sexual Health Services (CAASH)		
		Wheelchair Assessment Service	ADHD & Aspergers		
		Mental Health	CAMHS Community		
		Early Onset Dementia	CAMHS Inpatient		
		Teaching Dementia			

Figure. 1

The acronym PRIDE encapsulates our core values, which are central to the way we work:

People first, working together for patients in everything we do

Respect, dignity and compassion; valuing each person as an individual

Improving lives; improving health, wellbeing, preventing decline and improving people's overall experience of the NHS

Dedicated to the quality of care; insisting on quality, simpler access and getting the basics right every time

Everyone and equality counts; honesty, active listening and consistency in delivering accessible services to the community

Progress with Transformation

We set out our phased plan to integrated and transform services in 2011/12 in order both to improve our patients' experience, and the efficiency of, our services. The phases are summarised below.

Preparing for transfer of community services from NHS Northamptonshire to the Trust
 Preparing for transformation of service delivery structure
 Organisational transformation

We completed the transformation of the service delivery structure in 2012/13 with the introduction of a locality management structure, which aligns all of our community mental health, physical health and learning disability services with the local populations in eight localities. Our localities (see Figure 2) align with the Nene and Corby Clinical Commissioning Group localities. (Note: the pins indicate our locality managers.)



Fig. 2

Our specialist inpatient services operate in both the north and south of the county, working with localities in delivering pathways of care.

1.1.1. Key Competitors, Strengths and Weaknesses

We are the main provider of physical and mental health services delivered in the community, through GP practices, and in residential and hospital environments in Northamptonshire. We operate alongside two acute district general hospital providers, the county council's provider-arm and several private sector firms (who have recently acquired some smaller, specialist service contracts within the county).

We have had success in 2012/13 in expanding our business through securing £8.8m of business and a net gain in the year of £3.7m. Examples are given below.

Area	Service	Timescale
Bedfordshire	Substance Misuse	Sept 2012
Northamptonshire County Council	Residential short breaks for children	April 2013
NHS Northamptonshire and Milton Keynes	Community in-reach discharge	Sept 2012
NHS Northamptonshire and Milton Keynes	Care Homes	April 2013

Competition is increasing with a rise in whole system market testing in adjacent regions and a drive towards cost reduction as demonstrated in the table of forthcoming opportunities:

Area	Service	Value	Timescale
Cambridgeshire & Peterborough	Frail and Elderly	£750m - £1bn	May 2013
Oxford	Frail and Elderly	£215m	May 2013
Luton	Community Services	c£40m	May 2013

There have also been several competitor wins on and within our local boundaries:

Service	Winning Bidder	Value	Timescale
Milton Keynes Community Services	Central & North West London FT	c£60M	2012/13
Milton Keynes Sexual Health Services	Assura	c£1.5m pa	April 2012
Northamptonshire Drug & Alcohol Service	Crime Reduction Initiative	£3m+ pa	2012/13

The creation of a local authority provider service within Northamptonshire could also increase the potential risk and threat for the Trust.

We have a strong track record of successful delivery within Northamptonshire and have established good relationships with our commissioners, notably the two Clinical Commissioning Groups and the County Council. During 2012/13, the Trust has built on our existing relationships with local provider organisations, strengthening the integrity of the local health and social care system.

We have demonstrated considerable agility in responding to changes in patient needs and commissioner requirements, leading the implementation of a number of projects and initiatives during 2012/13. Through these new initiatives, and continued high levels of business-as-usual performance, we have built confidence with our commissioners and other local providers as both a collaborative partner and leader within the system.

We will continue to strengthen these local partnerships and to collaborate with commissioners, providers and patients in developing safe and effective services.

1.1.2. Forecast health, demographic, and demand changes

Nene Clinical Commissioning Group Area

The registered population for NHS Nene CCG is 634,452 with these patients registered with 70 Nene GP practices. Around 6,000 patients are unregistered, taking the total resident population to 640,500. This population is expected to rise to 710,400 by 2019. The population has a lower than average proportion of older people and people in their twenties but a higher proportion of children. Currently 16% of the resident population is aged 65+; this is expected to increase to 19% by 2020.

The resident population within the NHS Nene CCG area is ethnically less diverse than England or the East Midlands. 91% of the population is estimated to be white; and this is proportionally higher in the older age groups.

The geographical area that is covered by Nene CCG has an average deprivation score of 17.5 which is lower than the England average. While less of the population (as a whole) is living in deprivation across Nene, deprivation in children and/or older people is not being hidden by the more affluent working population.

Corby Clinical Commissioning Group Area

Corby borough is an area of rapid population growth and had a resident population of 61,200 in 2011, with nearly 17,000 (28%) people living in areas classified as the most deprived 20% nationally. A number of patients living outside the area choose to register with a Corby GP Practice. Corby CCG is therefore responsible for commissioning healthcare for a population of over 70,000 patients. Corby is predicted to have one of the fastest rates of growth of any area in England with the resident population expected to grow by a further 16% over by 2021.

Deprivation is higher than average and 2,675 children live in poverty. Life expectancy is 6.4 years lower for men and 3 years lower for women than South Northamptonshire. The early death rate from heart disease, respiratory disease and cancer is worse than the England average. 35.9% of the Corby 16+ population smoke. 26.4% of Corby's population aged 16+ is classified as obese.

Emergency admissions with Ambulatory Care sensitive conditions are high and patient satisfaction with the Out of Hours GP service is low in Corby. There are high rates of readmissions to hospital within 30 days of discharge.

The Trust has taken these demographics into account in developing our plan and responding to the requirements of the two CCGs.

Nene CCG's Five Areas of Transformation



Northamptonshire County Council Health and Wellbeing priorities

The NCC commissioning strategy also reflects some co-production with the Trust with a particular focus on remodelling services that are commissioned through the public health department of the council. NCC's eight Health and Wellbeing priorities are:

- Priority one** Every child is safe and has the best start in life.
- Priority two** People choose healthier lifestyles and exert greater control over their health and wellbeing.
- Priority three** Vulnerable adults and elderly people are safe and able to use services and support that helps them to live as independently as possible.
- Priority four** Improve the health and wellbeing of those communities and individuals with the worst health in our county. These communities may be groups of people or certain geographic areas in the county.
- Priority five** Health, social care and public health services work together in all areas and services are joined-up where people have both health and social care needs.
- Priority six** The numbers of people experiencing emergency, unscheduled care is reduced.
- Priority seven** Businesses focused on improving health and wellbeing operate successfully in communities across Northamptonshire.
- Priority eight** Led by NHS and Local Authorities, employers throughout the county promote the health and wellbeing of their employees.

1.2.2.1. QIPP and demand management

We are collaborating with CCG commissioners and partner providers in delivering the QIPP plan within Northamptonshire. All provider organisations have QIPP targets and we are planning to achieve QIPP savings from our own block contract and are supporting the local CCGs in the delivery of an overall community QIPP saving in 2013/2014. The Trust has set up a joint QIPP programme Board to ensure joint accountability and delivery for the whole system.

1.1.3. Impact assessment of market share trends

We will build on our strengths by maintaining and developing our market share in community services, to better support the transformation of community services, to support reduced inpatient care and the Healthier Together initiative, strengthening the ability to deliver the Trust's out of hospital treatment strategy. In the period of the plan the Trust will work to better understand the impact of the changes on its market share and to respond accordingly.

1.2. Threats and opportunities from changes in local and national commissioning intentions

1.2.1. National commissioning strategy

The national commissioning strategy provides threats and opportunities. Whilst the number of commissioning bodies has increased and there is a general downward pressure on prices for provision of services from local authority commissioners in particular, there are opportunities for the alignment of services and the possibility of integration of services across commissioning bodies.

There are other aspects of strategy that will impact on the Trust, for example integrated health and social care projects, pricing and competition will be regulated by Monitor through new wider powers and patient choice will be strengthened through the introduction of Personal Health Budgets (PHBs).

1.2.2. Local commissioning strategies

The Trust has influenced the development of local commissioning strategies, collaborating with commissioners on a number of key commissioning initiatives. The Trust's priority service transformations for the next two to three years are therefore closely aligned with commissioning strategies (set out below).

Corby CCG Priorities for 2013/14



A large proportion of the QIPP plan is based on the avoidance of unnecessary activity within secondary care services. NHFT's Intermediate Care Team (ICT) and wider community nursing teams play a central role in managing demand for secondary care services, by avoiding unnecessary admission to, and in facilitating early discharge from, the county's two acute district general hospitals.

We are therefore expecting to increase the impact of its ICT and community nursing teams between 2013 and 2016 to deliver the desired commissioner savings on secondary care services.

1.2.2.2. Decommissioning

A number of commissioners' QIPP schemes will affect our services during 2013/14 and beyond, as services are re-commissioned/provided in a more cost-effective manner. Two significant examples are:

The first scheme revolves around a re-designed, lower cost mental health and wellbeing service as described in section 1.3 below. We are anticipating a new contractual offer for our mental health services in 2013/14 (a mid year change), along with new proposed service models for patients that fall within identified mental health Payment by Results (PbR) clusters.

The second scheme involves a commissioner led review of the neuro-degenerative pathway. Early engagement with commissioners suggests that a new contractual vehicle (such as the Personalised Health Budget) is likely to be utilised to deliver the service to patients in the future. This is likely to involve the re-commissioning of some of NHFT's services that contribute to the neuro-degenerative pathway during 2013/14. Coproduction is pivotal to ensure the impact of changes on quality and safety are fully considered.

1.2.2.3. Potential 'Any Qualified Provider' (AQP) Tenders

Northamptonshire commissioners chose to pursue Any Qualified Provider tenders for Musculoskeletal Physiotherapy and Podiatry services during 2012/13. The Trust is registered as a provider of these services and is delivering successfully in relation to the requirements. We are not currently aware of any commissioner plans to expand the number of services commissioned via the AQP approach.

1.2.2.4. Shifting care delivery outside of hospitals

Local CCG commissioners have seized the opportunity to increase the amount of care provided in patients' own homes. Since we have delivered a number of successful initiatives to support people to remain in their own homes when they would otherwise have been admitted to hospital, we are anticipating an increase in demand and funding for services provided to key priority groups, such as the frail and elderly, and to further develop preventative services for people with long term conditions.

1.2.2.5. Reconfiguration plans

Healthier Together

The work being done by the Healthier Together programme (looking at options for closer working between the five hospitals in Kettering, Northampton, Milton Keynes, Bedford and Luton and Dunstable) is being taken forward in Northamptonshire by the county's two new Clinical Commissioning Groups

from April 1 2013. Corby and Nene CCG's will be responsible for moving forward the work begun by Healthier Together. These new arrangements reflect local priorities and circumstances and will ensure that the proposals which are developed meet local needs. It will provide a platform for whole system connectivity, including the development of an out of hospital strategy.

The Trust was a member of the Clinical Senate Board of the original Healthier Together programme and has since become a core member of the Partner Board set up for the local programme.

1.2.3. Local Commissioning Strategy

We have worked closely with local commissioners to understand the impact of proposed changes to health and social care system configuration and the effect on demand for our services. The Trust's activity plans for 2013/14 have now been confirmed with commissioners and the Trust continues to work in partnership with commissioners on developments to the system for the future.

1.2.4. Evolution of our demand profile and activity mix

The Trust has seen an increase in demand for its services supporting people in the community in the last year, which is expected to continue to increase during the lifetime of the plan. Demand for inpatient services is reducing in line with the increase in community care and treatment options.

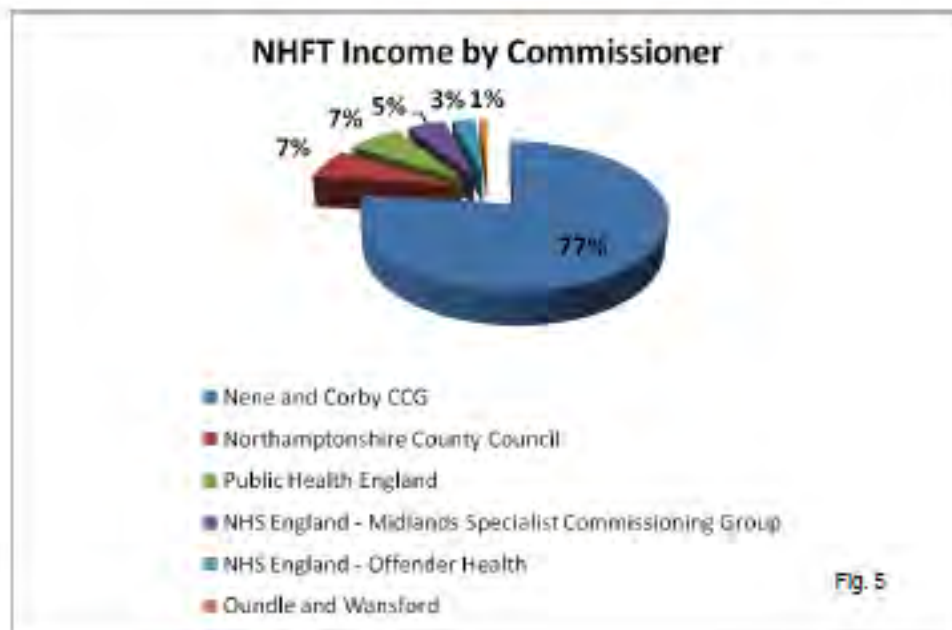
1.2.5. Diversification of Income streams

The Trust's income for 2013/14 is shown by source in figure 5 below, which shows that we receive approximately three-quarters of our income from Corby and Nene CCGs. This compares to a situation in 2012/13 where NHS Northamptonshire and Milton Keynes accounted for nearer 85% of Trust income. Much of this income is based on a block contracting arrangement with the CCG health commissioners. Over the 2012/13 financial year, the Trust saw health commissioners begin to test new contracting models, such as Any Qualified Provider or Personal Health Budgets.

We anticipate that commissioners will want to explore new contracting models during the lifetime of this plan as a result of early conversations regarding services for the Frail and Elderly. Until more is known about commissioners' intentions regarding alternative contracting models, we are treating this potential change as a risk and an opportunity.

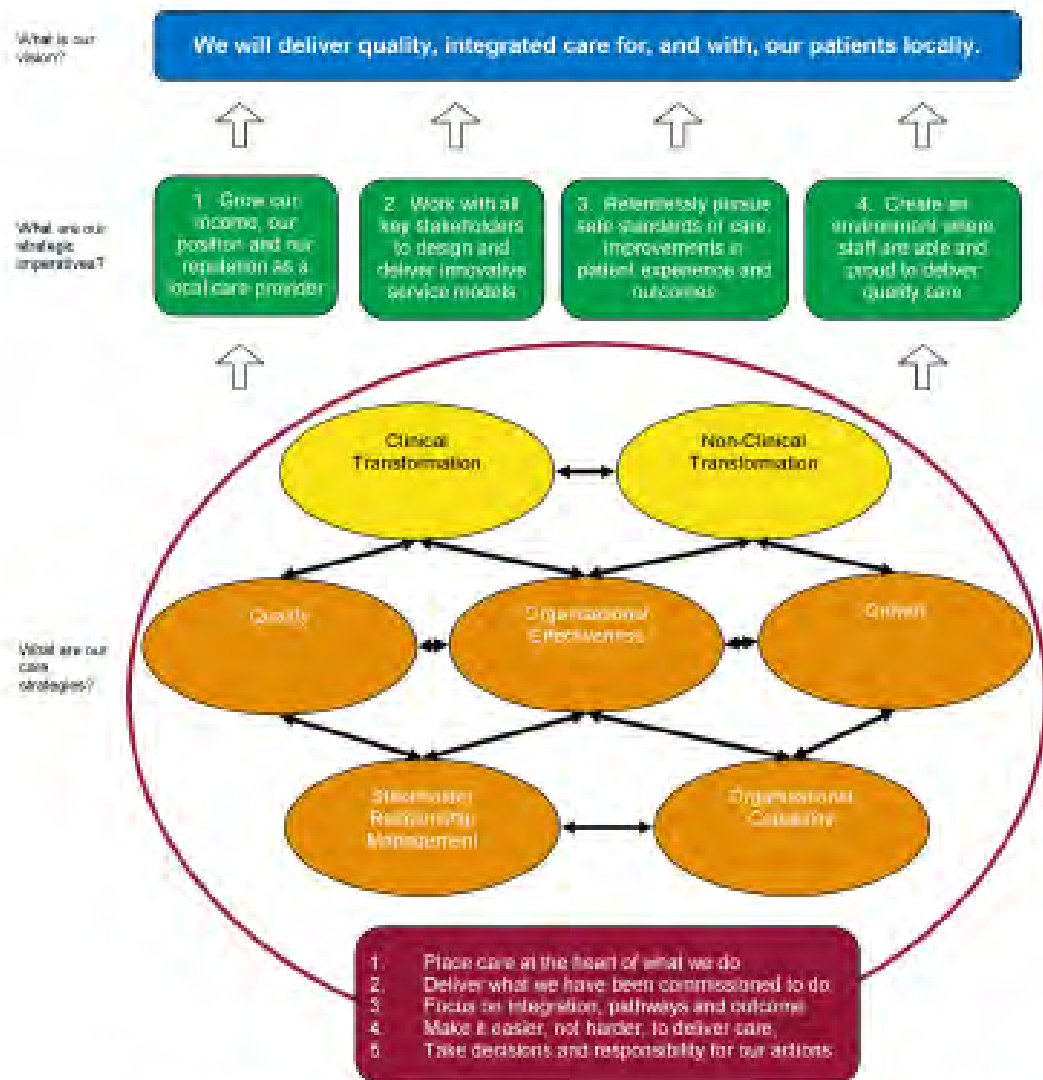
As referenced later in the plan, the Trust is looking to expand its community services portfolio, building on the Trust's existing strengths. Expanding the Trust's portfolio is likely to involve establishing relationships with different commissioning bodies and hence would represent a diversification of income streams.

The Trust is exploring the use of different ways of delivering services to respond to the changes for example through the establishment of Community Interest Company and partnership working. It is also exploring the use of Intellectual property to safeguard its innovations.



1.3. Collaboration, Integration and Patient Choice

Strategic Plan on a Page



We will deliver our core strategies via a portfolio of change as shown in the schematic below.



An Overview of Key Change Programmes and Projects

Frail and Elderly Programme

- This is a whole system programme that is targeting the growing population of frail and elderly people within the county, many of whom have multiple admissions to hospital and could, through more coordinated and proactive, integrated care have a better experience of healthcare and better outcomes.
- An Ideal Model of Care (IMOC) for the frail and elderly has been developed through the programme and is now being put into operation via a phased implementation. Much of the IMOC is based on NHFT's own proven service models.
- NHFT has been indicated as lead provider for the phased implementation although a commissioner business case is awaited to confirm. The Trust is adopting a positive risk position to build the capacity to provide the enhanced levels of service required.
- NHFT anticipates that a phased roll-out of the IMOC will begin from Q2 2013/14 and will be completed in 2014/15, followed by a 'test and learn' period of some 12 months. NHFT will be working in collaboration with the provider arm of Northamptonshire County Council and other relevant partners to deliver the phased implementation.

Mental Health and Wellbeing Programme

- The purpose of the programme is to review and redesign community adult mental health services to achieve more accessible and sustainable care pathways with an increased focus on primary care interventions supported by appropriate partnership and interface between specialist mental health services, IAPT (Increasing Access to Psychological Therapies), primary care, social care and the voluntary sector.
- Using Mental Health PbR (Payment by Results) data/learning, activity/performance data, previous mental health review information, national requirements, current best practice and stakeholder engagement to shape and inform proposals and implementation of pathway development/change.
- Whilst initially focussing on non-psychotic mild and moderate conditions, and "stable" psychotic conditions, it will not exclude other mental health conditions where needs can be met in a more primary care focussed and accessible manner.
- The redesign will have the delivery of quality, integrated care, for and with the individual at its core.

Children's Services Programme

- NHFT provides a variety of children's services, ranging from universal to specialist services such as caring for very sick children in their own homes. The commissioning of children's services is also now divided between Northamptonshire County Council and NHS England (Hertford and South Midlands area team) on behalf of Public Health England.
- The plan for the transformation of Children's services is on a similar theme to the other integration agendas. NHFT can manage and provide for children across physical and mental health services but provides part of the pathway with Northampton General Hospital providing some of the more specialist services in the south of the county. Redesigning this service provision to encompass wellbeing and specialist physical and mental health care will allow the Trust to proactively manage care across a whole pathway, with appropriate step-up and step-down care.
- Tenders are anticipated for the children's community services – the one that is currently split north and south – and the Trust wants to build on its recent success of a contract award from NCC for the provision of short breaks for children with learning disability, to provide a countywide, integrated service.

End of Life Programme

- The county's pathway and service provision for end of life care can be fragmented with multiple providers so there is significant opportunity to improve patient experience and outcomes through more comprehensive management of the pathway. NHFT has an agreed model of End of Life Care and currently provides care including the specialist care, within that pathway.
- The Trust is in discussion with CCG commissioners about its role in delivering a coordinated pathway with outcomes targeted at improving patient and carer experience, assisting patient flow away from acute care and out of acute care if required.

Corporate Services Review Project

- Rationalisation of corporate services through removal of duplication, delivery of internal efficiencies, Inter Trust working and exploration of shared services and outsourcing to reduce our overhead and align with efficiencies in service delivery.
- Alignment of corporate services to the needs of the annual plan with focus on value added activities, removal of bureaucracy and new ways of working
- Realignment of director's portfolios and supporting infrastructure in response to annual plan

Organisational Capability Project

- Development of leadership capability through introduction of focussed planning, process improvement, feedback, individual and team development
- Identification of talent needed to deliver plan, gap analysis and implementation of solutions including pipeline development, performance improvement and new models of employment
- Creation of a culture that enables delivery of the business plan, establishes the new psychological contract, removes barriers and responds to the needs of patients and staff

Estates and IM&T project

- Our estates and IM&T strategies to enable the strategic locality focus and integrated care delivery model
- Drive shared use of clinical spaces to reinforce and support the integrated care delivery model
- Ensuring a stable, robust, safe and supported platform for IM&T systems

- Delivery of technology and estates rationalisation to support cost improvement programmes, efficiencies and productivity support, for example, more mobile working

Capital Expenditure Project:

- Delivery of a value for money, considered and prioritised capital investment programme
- Efficient and effective use of Trust resources
- Delivery on plan and on budget
- Ongoing review and development of the plan in line with Trust priorities and with engagement of key stakeholders

Appendix 8 contains detail of the delivery of these schemes over the period of the plan.

1.3.1 Development of partnerships

We have established strong local partnerships with health and social care commissioners and providers within Northamptonshire. Working together, the partnership is tackling high priority issues for the local health economy, such as Delayed Transfers of Care and the phased implementation of the Ideal Model of Care for the Frail & Elderly. We will continue to lead the whole system approach to Delayed Transfers of Care (DTOC) Programme in conjunction with Northamptonshire County Council. This strengthens the Trust's mitigation against the risk of delivery against this Monitor target.

Co-operation with third party bodies

Monitor's Code of Governance requires the Trust's Board of Directors to maintain a schedule of specific third party bodies with which it has a duty to cooperate, ensuring the effectiveness of the processes and relationships are periodically reviewed.

The Board considers that the schedule of third party bodies contained in appendix A of the 2013/14 Compliance Framework represents a comprehensive description of those bodies with whom the Trust has collaborative and productive relationships. The nature and extent of the relationships vary, for example in respect of the CQC, Health and Wellbeing Boards, Universities and Post Graduate Deaneries.

The Board uses a range of different mechanisms for ensuring these relationships remain effective. These processes include:

- the routine use of environmental horizon scanning at Board meetings
- stakeholder analysis as part of the Annual Plan process
- the use of the Board Assurance Framework (BAF) and Organisational Risk Register (ORR) to identify and mitigate relationship risks (strategic focus number 2 within the BAF/ORR)
- Intelligence gathering/feedback from governors
- Board/Committee reports which reference specific third party body relationships, e.g. Monitor, CQC, Commissioners, OFSTED

The Board gains assurance through such processes in respect of the robustness of these third party relationships. Some examples are set out below.

The Trust is working in partnership with two third sector providers, CAN and WDP, to deliver Community Substance Misuse Services and Prison Integrated Drug Treatment Services across Bedfordshire and in HMP Bedford. The Partnership which is formally led by CAN, is delivering quality, recovery oriented services and is supported by local commissioners. The model of delivery is being developed to enable the improvement in positive outcomes.

The Trust was recently successful in retaining the contract to deliver substance misuse services in HMP Onley, which, alongside the Trust's contracts providing Primary Care and Mental Health services, enables the Trust to deliver an integrated health system to offenders. To enhance the value of the contract the Trust started a partnership with a third sector organisation, Phoenix Futures, to deliver the psychosocial and recovery elements of the service.

Following a successful bid to the former East Midlands Strategic Health Authority, a pilot project has been initiated to inform the future commissioning of youth counselling services to ensure that they are evidence based. The University of Northampton is supporting the project by enhancing its counselling children and young people training programme, and providing consultation around evaluation of the pilot. Specialist CAMHS will provide consultation, supervision and mentoring to the youth counselling services.

The Trust has collaborated with Northamptonshire County Council (NCC) to develop a single co-located team for the Physical and Mental Health needs of Looked After Children to ensure better outcomes for this vulnerable group.

1.3.1. Cooperation and Competition Panel

The Trust is not considering any developments that would require consideration of the competition rules, but it is developing its internal systems to better accommodate patient choice as expressed through the use of Personal Health Budgets and choice in the use of services available under AQP.

2. Our Approach to Quality

2.1. An outline of existing quality concerns

Northamptonshire Healthcare NHS Foundation Trust achieved registration for all of its services with the Care Quality Commission (CQC) from 1st April 2010, without compliance conditions. The Trust has been compliant with registration standards since that date, a position assured through regular audited self assessment and mock inspection visits. As a part of the CQC's rolling programme of scheduled inspections the Foundation Trust was inspected in May/June 2012. The CQC has not given any compliance actions or taken any enforcement action against the Trust during 2012/2013. Under the registration of Orsted for children centres one of the trust's twelve centres was inspected in September 2012 and was judged as 'satisfactory'. Work was completed on the issues raised before services transfer to new providers in 2013/14.

2.2. Key quality risks

The key risk to quality inherent in the strategic plan relates to the maintenance of satisfactory standards of care during the periods of change both in the management structure and in the periods of service transformation over the next 2-3 years. This general risk to quality is being addressed through ensuring that the localities have established their operational governance systems, supported by the corporate governance and information systems and that there is strong performance management of the quality indicators for services. These will be linked to the specific indicators of quality that have been identified as requiring monitoring in the CIP, QIPP and transformational change projects. The organisation recognises the risks to quality in the delivery of some community services such as District Nursing and Health Visiting where there have been historical issues of lone working and poor supervision. These risks are recognised and monitored in the Trusts' Organisational Risk Register and Board Assurance framework.

2.3. Board Assurance on Quality and Safety

The Board's mechanisms for receiving assurance on the quality of its services and how it safeguards patient safety is set out in its risk management strategy. It has self assessed its systems against Monitor's Quality Governance Framework and has a system of continuous review in place for 2013/14 onwards. It has, and will maintain, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its service users as set out in its Quality Strategy. This encompasses assurance that due consideration will be given to the quality implications of future plans and that processes are in place to monitor their ongoing impact on quality and take action as necessary to ensure quality is maintained.

Our Governance Committee structures its programme of assurance through an annual programme of regular information supplemented by in depth review and challenge of specific topics or services during the year based on concerns and issues arising from the regular information, service reviews and data it receives. The regular reporting to Governance Committee is based around six core standard reports relating to

- Patient safety
- Patient experience
- Clinical effectiveness,
- CQC Assurance
- Organisational risk Register/BAF, and
- Learning from national reports and inquiries.

3. Our Clinical Workforce Strategy

The Trust faces risks to quality, delivery, recruitment and retention if there is not consistent and motivational management and leadership. More than ever, the work and approach across all areas of the Trust must be aligned, mutually supportive and able to work across the tensions of locality based services and county-wide services. The priorities are:

- Culture creation based on performance and values
- Clinical capacity and capability
- Leadership development
- Management capability and practices
- Staff health and wellbeing
- Removing barriers and growing enablers

The clinical workforce strategy is currently being developed for the next 3 years in conjunction with other healthcare providers within Northamptonshire for the East Midlands LETB. NHFT will need to train additional community staff due to national requirements (Health Visitors and Children and Young Persons practitioners), the move to provide more treatment care for people in the community rather than in a hospital setting and to replace community staff who are reaching retirement.

Over the next 3 years the Trust's focus will be on providing quality integrated care locally. The overall focus will be on helping people to remain independent, maximise well being and improve health outcomes.

We will work in partnership with service users, carers and families to provide a positive experience of care. The Trust is committed to delivering quality care that is in line with national guidance and recommendations (e.g. NICE guidance). The impact of this care is measured in a variety of ways in clinical practice including audit, service user, carer or family feedback, staff feedback and outcome measures. The workforce is trained and supported in actively engaging in these approaches to evaluate the care given.

Effective management and leadership of the integrated teams is vital to the delivery of both quality care and productivity improvements. In order to strengthen the leadership of the integrated teams the Trust has appointed high calibre staff into key operational roles. The Trust is committed to developing the leadership and management skills of staff on internal and external training programmes as well as "in job" mentorship, training and support.

There is a lack of data on clinical staffing levels in the community and what data does exist needs to be treated with caution due to variability of the measures used. Nationally, work is underway to develop minimum staffing levels for inpatient and community settings following the Francis Report (2013) recommendations. Over the next few months the Executive Board will produce a workforce development strategy that further develops: rotation of clinical staff; clinical career pathways; skill mix, and practice development to ensure we have the right staff, with the right skills in the right place at the right time.

There is a need to increase the number of Consultants who specialise in the care and treatment of older people due to demographic changes and an increase in older people being treated in the community with complex needs.

It is important that staff are supported and have a positive experience of working in the Trust in order that they thrive, develop and give care, compassion and commitment to service users, carers and families. The Trust actively supports clinical supervision, staff development, training and mentorship schemes and plans to do so into the next three years whilst recognising the challenging economic constraints and environment.

4. Productivity & Efficiency

4.1. An overview of potential productivity and efficiency gains

The Trust continues to focus on improving productivity and efficiency to meet the demands on the local health and care system. We use a number of measures to triangulate the efficiency and productivity analysis, irrespective of whether these are included as contractual performance targets.

Length of stay

Length of stay is within our set parameters and although the redesign work underway will introduce more choice into the system and potentially fewer admissions, the clinical impact and efficacy of the treatment programme can be affected by length of stay. Over the period of the plan we anticipate an impact from the Frail and Elderly systems redesign on our older adults MH but the pace and scale of such impact will only be modelled through once the main programme is more clearly defined.

Bank and agency spend

The Trust has robustly managed agency spend over the last few years, including a strong focus on the recruitment and retention of medical staff and the operation of an effective staff bank that minimises the requirement for more expensive agency staffing. Usage of both agency and bank staffing is analysed on a monthly basis as part of the performance management process. As a result, minimal usage of agency staffing is forecast over the planning period, primarily as a result of appointment in to vacant posts in 2012/2013 (therefore increasing the planned cost of employed staff but reducing the planned cost of agency staff by £2 million in 2013/2014)

Bed occupancy

The Trust now plans to operate at 90% bed occupancy across both mental health and community inpatient facilities. For mental health services, this rises to 95% if leave is included. In 2012/13 improved bed occupancy in the remaining Intensive Care ward and acute mental health wards enabled the closure of an Intensive Care ward and this productivity is being maintained. Measures such as the introduction of twice weekly bed management, daily bed management reporting and improved and sustained concentration on communications between the community, the Crisis Resolution and Home Treatment Team and the in patient facilities at both ends of the county have enabled this to happen.

The Trust has also agreed a business case with NHS England – specialist commissioning services to provide a Child and Adolescent Mental Health Service High Dependency Unit inpatient service, on a cost per case basis, which will improve bed occupancy in the CAMHS inpatient unit, intended to commence in Q3 2013/14. Options of alternative provision of the Learning Disability assessment and treatment services is also under review, which is a small and relatively under-utilised inpatient facility.

Re-admission rates

The Trust tracks readmission rates as an indicator of treatment outcomes. The low rate is indicative of the quality outcomes from our treatment, although will be reviewed within the overall redesign work that is currently underway.

Job Planning, Activity and Caseload Management

The Trust also tracks efficiency through job planning, team & individual caseload and activity management as well as admission avoidance and re-admission rates for Intermediate Care services.

4.2. Cost Improvement Plans(CIP) governance

Historical performance in delivery of CIP targets

The Trust has a strong record of delivery of CIP targets, delivering savings of 3.5% in 2010/2011, 5% in 2011/2012 and 4.25% in 2012/2013. The Trust delivered recurrent savings of £8.034 million against an £8.826 million plan in 2012/2013, primarily due to slippage on estates schemes. The £0.792 million balance was managed non recurrently in 2012/2013 and is planned to be delivered recurrently in 2013/2014. Savings in 2011/2012 onwards have been delivered following the successful acquisition of community services from NHSN, under Transforming Community Services (TCS), which has substantially increased the level of absolute savings achieved year on year. The Trust has demonstrated through historical performance that it can deliver efficiency savings of the scale identified within the annual plan.

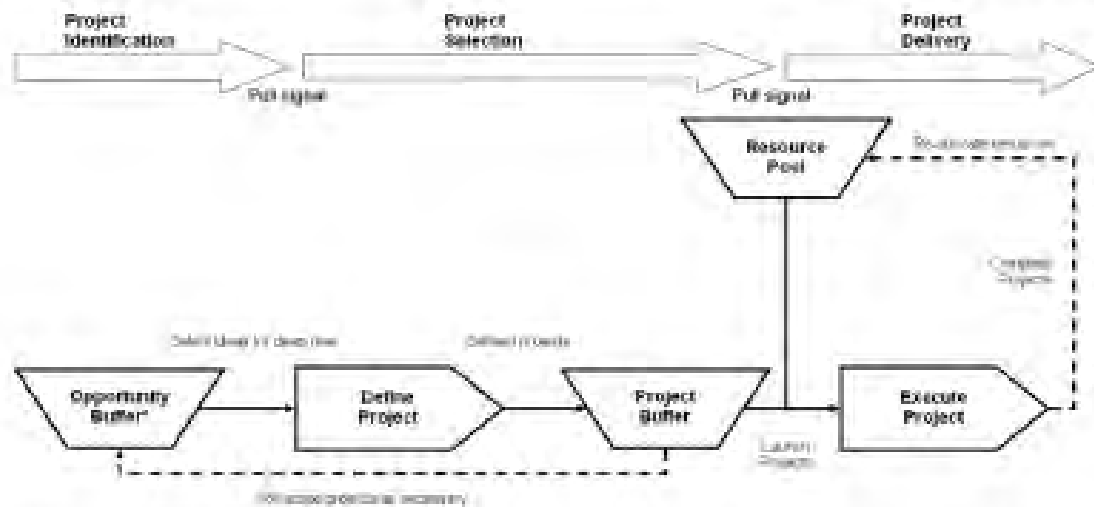
Identification and development of schemes

The Trust is planning to deliver recurrent CIPs of 5% in each year of the annual plan. This is consistent with Monitor's guidance on planning assumptions for new and aspirant NHS Foundation Trusts published on April 17th 2012. This amounts to planned CIP savings of £9.502 million in 2013/2014, including £0.650 million of savings required to offset unrecovered overheads from the loss of the NDAS contract in 2012/13. The Trust is also planning to achieve QIPP savings of £3.842 million in 2013/2014 and is supporting the local CCGs in the delivery of an overall mental health and community QIPP saving of £9.276 million in 2013/2014.

Planning for 2013/2014 schemes commenced in June 2012 and a consistent approach to identifying and developing CIP themes and schemes has been adopted by all directorates. The planning schedule below will be replicated in each year of the plan with an emphasis on schemes that build on efficiencies from transformation and organisational development.

1. Directors agree a timeframe for development and presentation of detailed schemes to the:
 - a. Trust Executive (September to December)
 - b. Finance and Performance Committee (December onwards)
 - c. Private Board meeting (January)
2. Progress of design and sign off of proposals reviewed and challenged through Directors' team meetings preceding Trust Executive consideration.
3. Each service director is required to produce written narrative describing the process in selection of the scheme(s) and its associated impact using an Impact Assessment pro forma, with an ongoing system of individual scheme risk rating;
4. Summary assessment in terms of 'beds and heads' considered by Directors and assimilated into overall head count plan; including an assessment of potential redundancy costs. Redeployment plans for any displaced staff are included in the CIP detailed plans.

The process used to identify and implement cost improvement projects is shown below



¹ Original opportunity identification plus regular review of strategic focus, brainstormed ideas, re-evaluation of financial drivers, process classification, etc.

4.3 CIP profile

4.3.1 Key CIP Schemes

Key CIP schemes are set out in Appendix 2. The biggest proportion of CIP delivery is bound up in the reconfiguration of the management structure, the creation of the fundamental building block for integrated service delivery, (multidisciplinary teams), and skill mix reviews. Further analysis by Directorate (and by service for non clinical services) is provided in the CIP financial proforma.

4.3.2 Achieving Step Change

The Trust has developed schemes within Directorates in order to ensure ownership and clear responsibility for delivery, but schemes have also been categorised into work streams. Of the £9.502 million of schemes identified for 2013/2014, £7.975 million of schemes are green rated. Green rated schemes have been categorised as transformational (£1.885 million), effectiveness and efficiency (£4.280 million), management and support (£1.351 million), estate rationalisation (£0.241 million) and back office (£0.218 million).

The major clinical transformation schemes are as below and are described in the Strategic Context section:

- Frail and Elderly
- Mental Health and Wellbeing Services
- Children's services
- End of Life Care

4.4 CIP enablers

The process of CIP development described above incorporates a process of CIP identification and validation from within clinical teams. All CIPs have been subject to challenge and quality sign off by the Medical Director and Director of Nursing, supported by quality analysis and support from the Trust Governance team. The CCGs have received briefings on the proposed

delivery of CIP through transformation and have been assured through this process of the involvement and engagement of our lead clinicians.

The process also requires consideration of all resource implications including the impact of implementing a number of organisational change processes both on corporate services support and on the continuation of service delivery.

4.5 Quality Impact of CIPs

4.5.1 Assessing the Risks to Quality from CIP

The Trust uses a number of mechanisms to assure itself that CIP plans to not adversely affect the quality of services. It uses information from operational services and corporate teams including the Quality Support Team, Performance Team, Risk Management Team, HR and the Equality and Inclusion Team to enable a complete analysis of any adverse effect on the quality of services provided. Services develop CIP programmes working closely with the corporate teams, who assign a RAG rating to each element of the CIP derived from the potential risks identified; risk actions are then monitored.

4.5.2 Monitoring the quality Impact of CIPs

The Trust monitors the impact of the CIP programme using a number of metrics provided by corporate teams, which have been agreed internally and have been shared externally with commissioner and other stakeholders. There are a number of methods used to monitor the quality of the services and this information is provided at service, locality and organisation wide levels.

These methods include the use of clinical audit, which includes audits related to the quality targets agreed with commissioners within the CQUIN and Quality Schedule programmes. Under the CQUIN programme, national benchmarking tools such as the Safety Thermometer are used to measure adverse effects on patient services. The organisation has also agreed to PROMs (Patient Reported Outcome Measures) and PREMs (Patient Recorded Experience Measures), which can be linked to the CIP programme to measure adverse effect on services. Additionally the organisation is engaged in national and local service user and carer feedback mechanisms, using real time reporting and annual surveys.

Quality risks to services are also evaluated using workforce data relating to sickness, turnover, absence and vacancy rates. In addition to this, a robust system of incident and complaints reporting and the use of the PALS, allows us to monitor adverse effects on services. Where concerns are raised the organisation has an additional programme of internal inspection and clinical service reviews, which allows the organisation to verify the outcome of quarterly service self assessments. Feedback is also received from staff via the annual survey, supervision and the appraisal system. This data is reviewed and scrutinised by the relevant committees and feeds to the relevant Board sub committee i.e. Governance or Finance and Performance Committee.

5. Financial and Investment Strategy

5.1 Current financial position

Following authorisation as a foundation Trust in May 2009 the Trust has maintained a sound EBITDA margin performance and has delivered an underlying surplus each year, whilst achieving a risk rating of at least 3. Following the acquisition of community services in July 2011 the Trust has continued to meet or exceed planned financial performance. Underpinning this performance is a strong record of delivery of planned CIPs.

The Trust is in a robust financial position from which to plan the delivery of high quality services whilst maintaining a sustainable financial position, over the period covered by the financial plan. The current policy framework and economic outlook will continue to be challenging throughout the period of this plan, however, which is reflected in the Trust's planning assumptions and in the Trust's financial strategy.

The key assumptions underpinning the Trust's income and expenditure for the next 3 years are:

- A negative 1.3% uplift for inflation on revenue contracts/budgets in 2013/2014 as per national planning guidance, with a deterioration to a negative uplift of 1.5% in 2014/2015 and 2015/2016;
- Pay uplifts for 1% incremental drift and the agreed 1% pay awards staff in 2013/2014, with an assumed pay award of a further 1% in both 2014/2015 and 2015/2016 and further incremental drift of 1% in each year;
- Price inflation at -3.1% in 2014/2015 and 2015/2016 (the plan in 2013/2014 is based on actual agreed budget adjustments for identified non pay inflation cost pressures);
- Cost improvement efficiencies of 5% in each year of the plan, with a further 2.3% QIPP saving in 2013/2014;
- Generic cost pressures and demand driven pressures are funded in budget setting in 2013/2014 and reflected in the plan, with further generic cost pressures and demand related costs assumed of 0.8% in 2014/2015 and in 2015/2016.

5.2 Key financial priorities and investments

The Trust's financial and investment strategy in response to the difficult economic outlook is to:

- Plan to deliver a 5% CIP in order to fund unfunded cost and demand pressures;
- Invest in a high quality, efficient and modern estate and IM&T infrastructure;
- Maintain a relatively high net asset / cash position to mitigate against significant unplanned pressures that might otherwise impair liquidity;
- Manage commitments of significant non recurrent funding streams (such as CQUIN) in order to mitigate against the impact of potential loss of funding; and / or to increase financial flexibility in year;
- Increase the understanding of the relative efficiency and / or financial performance of services through benchmarking, working with commissioners as appropriate in order to improve performance and manage future income

5.3 Key risks to achieving the financial strategy

The key risks to the delivery of the financial strategy and mitigating actions are set out below:

- a. **Delivery of the 2013/2014 Cost Improvement Programme of 5% and the QIPP schemes of 2.3%.** The Trust has a good record of CIP delivery, schemes have been developed through a robust process and risk levels are identified through RAG rating (with 84% of schemes already rated as green). Performance against CIP plans is routinely monitored at service and board level with action plans developed or substitute schemes implemented as necessary. QIPP schemes have been agreed with commissioners and non recurrent funding has been provisionally agreed with commissioners to cover implementation and potential slippage costs. QIPP schemes will be managed internally through a similar process to that in place for CIP schemes and delivery of these will also be monitored through the local health economy's QIPP board. Trust budgets are sufficiently well funded that due to natural vacancy levels there is a historic trend of positive run rates in year, which has enabled the Trust to manage any short term or non recurrent shortfalls on CIP delivery.
- b. **Continued delivery of the Cost Improvement Programme for 2013/14 and 2014/15 of 5% in each year,** releasing 10% of the cost base of the Trust to meet the deflator and forecast cost pressures. The Trust Executive has signed up to the 5% target and the process for planning of future years CIPs is to be brought forward from 2013/2014 onwards, which will assist in terms of potential substitution of schemes in year where necessary. Detailed planning for 2014/2015 schemes is to begin in June 2013, which will be informed by benchmarking and analysis of performance information in order to focus on areas of potential relative inefficiency.
- c. **GUM and contraceptive services are potentially going to be put out to tender by the local commissioner, Northamptonshire County Council (NCC) in 2013/2014.** The Trust has agreed a reduced contract value for these services with NCC and is re-designing the service in order to bring costs in line with or below contracted income in order to ensure that the service offer is competitive.
- d. **For 2014/15, an increasing proportion of Trust revenue will be tariff based,** or similar payment basis, with potential loss (or gain) of income through variation in activity, use of local (or national) prices and application of payment rules. The Trust is in the process of developing a better understanding of its costs through development of costing and benchmarking and in the shadow operation of MHPbR, with shadow income monitoring and shadow operation of payment rules. The Trust is planning further development of costing and is in the process of implementing service line reporting, with mental health services identified as a priority area for implementation.
- e. **Increasing demand with growth in population and potential earlier discharge from local acute hospital Trusts due to reduced funding and pressure on beds.** The Trust will manage this pressure through established positive relationships with commissioners and through the scope for increased flexibility of service provision afforded by the integration of community services. A generic cost pressure / demand driven cost pressure is also assumed in each year of the plan.
- f. **The development of the frail and elderly service is both an opportunity and a risk for the Trust.**

Subject to the assumptions above and the management of the above risks, the plan shows a sound financial position in 2013/2014, with a forecast surplus of £0.280 million, a surplus of £0.022 million in 2014/2015 and a deficit of £0.229 million in 2015/2016. The overall planned financial performance produces a risk rating of 3 in each year of the plan, both under the existing risk rating system and the proposed new system to be implemented in 2013/2014. There is around £1.5 million of flexibility before the capital service capacity rating would drop to a 1 under the proposed risk rating system, but as the liquidity rating is a very strong 4 over the period of the plan, the overall rating would remain at 3 (rounded from 2.5).