



Forward Plan Strategy Document for 2013-14 to 15/16

North East London NHS Foundation Trust

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

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

Name	Jacqui Van Rossum
Job Title	Executive Director Integrated Care (London) & Transformation
e-mail address	Jacqui.vanrossum@nelft.nhs.uk
Tel. no. for contact	0300 555 1201 ex: 4298
Date	31 st May 2013

Approved on behalf of the Board of Directors by:

Name (Chair)	Jane Atkinson
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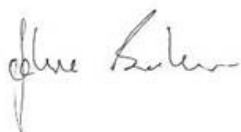
Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	John Brouder
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director (Acting))	Ian Cable
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Executive Summary

North East London NHS Foundation Trust (NELFT) is a provider of both mental health and community health services. Mental health services (MHS) are provided to four London Boroughs: Barking & Dagenham, Havering, Redbridge and Waltham Forest, with some specialist services also provided to Essex and East London. The Trust has a service split of 60% community services to 40% mental health services, spanning both London and south west Essex. The organisation's annual budget is £314 million (in 2012/13) with a workforce of 5,500 staff, treating a population of 1.5 million.

This Plan has been developed in response to our corporate objectives for 2013/14. For planning purposes we have linked them to one additional strategic objective that reflects the collective aspirations of our main commissioners. This is referenced as objective six. The detail of our objectives and their link to objective six are described under the heading of corporate objectives.

The overall strategic context and direction of the organisation as outlined in this plan is:

The Trust is seeing significant emphasis on the demand from commissioners to provide care closer to home and to see real integration between mental health and physical health services.

The Trust is forecasting significant increase in demand for services within our core mental health services, in particular access to psychology therapies (IAPT) and increasing numbers of people being diagnosed with dementia.

The increase in demand is within the context of comparatively low investment in mental health services from our commissioners and limited prospects of significant new investment given the issues faced by our London acute providers.

Two significant whole system health and social care reviews have been undertaken across the two health economies within London, resulting in the development of Integrated Care Strategies for the delivery of cluster based services to provide collaborative care across a number of different care pathways

The Trust's London communities services have been significantly underfunded, however the Trust are committed to redesigning services and integration of mental health and physical health to deliver seamless services, reducing hand-offs, and improving the patient experience at a cluster level; attracting new investment.

Our Essex community services are well placed to deliver innovative solutions to integrated care and are leading a number of large scale change projects in the health economy supporting admission avoidance and care closer to home.

The Trust Board –strongly supported by our Council of Governors- continue to be committed to undertake robust negotiations with commissioners over the development of investment in core services and service re-design to ensure activity and funding are re-profiled into mental and community health services from acute care, and to ensure core services are appropriately funded. If such investment is not forthcoming then there will be a need to be a reduction in the services provided by the Trust in order to maintain expected service safety standards.

The Trust continues to work to improve efficiency, notably through on year on year delivery of CIP and our low reference costs. All of our reference costs are below 100.

Despite these challenges, the Board believe that it is well placed to lead and facilitate the integration of physical health and mental health, and to see real patient benefits for the large scale change projects in Essex and London.

To deliver the challenges outlined by commissioners the Trust is committed to 5 major strategic change programmes which have been mapped across to our corporate objectives:

1. Collaboration, Integration and Patient Choice. Implementation of Integrated care across mental health and physical health, with particular emphasis on frail elderly and children's services (objective 1,2,3 – 4)
2. Development and delivery of a Clinical information/Technology Strategy, incorporating mobile working, use of telehealth / telemedicine, e-clinics and the procurement of a replacement for RiO in 2015 (objective 1,2,3,4 – 5)
3. Year of Care national pilot. The Trust are one of seven pilots across the country, and are entering year 2 of the pilot, to further develop a currency model for Long Term Conditions and to construct a model for contracting and commissioning into year 3 (objective 1,2 – 3)
4. Payment by Results (PBR). The Trust continue to develop PBR in this shadow year (objective 1,2 – 3)
5. Supporting the local commissioners to address acute care demands and the shift to home or community through transformation of local services.(objective 1,2,3,4)

Financial Summary

The Trusts financial performance for 12/13 has again surpassed its plan. We reported a net surplus of £2.4m – which was £3.1m adverse to our plan due to the need to impair a number of building assets following a desk top review by the District Valuer. After allowing for the £3.9m impairment our surplus returned to £6.3m. This is lower than was forecast at Q3 of 12/13 but favourable to original plan and in line with our expected outturn.

The Trusts forward financial strategy is to maintain a minimum acceptable financial risk rating in each of the next three years, ensuring strong liquidity and underlying financial performance to support the clinical priorities of the trust and to generate resources to support our Estates Strategy. To this end the financial plan achieves this.

Our forecast for 13/14 is highly challenging which results in the Trust requiring £17.9m (or 5.6%) CIPS to achieve a planned forecast surplus of £5.8m to provide an overall metric rating of 3.6 capped to a 3 (due to a continuing low EBITDA rating). The Trust governance programme has a robust process of clinical risk assessment against all of our CIPs.

There are a number of financial risks to delivering the 13/14 plan as detailed within the body of the narrative and work continues in all of these areas to manage and mitigate the risk. For 13/14 all contracts have been signed off to Heads of Term stage and financial values agreed. This has been challenging with some contracts not being signed off until mid-May.

The target surplus for each of the forecast years are assumed on the basis of each business unit within the trust achieving a surplus equivalent to 2% of its income. This equates to achieving a surplus against income of 1.8% in 13/14 and 2% in both 14/15 and 15/16 – requiring CIPS of £14.6m in 14/15 and £10.1m in 15/16.

When tested against the new RAF metrics, the Trust achieves a solid 4 on its continuity of service rating and also a solid 4 on the liquidity rating to give an overall 4 for the Trust.

The income deflator assumptions built in to the financial model follow from discussions had with commissioners about their underlying positions and assumptions around the national economy. Further details on this are given later.

The Trust has progressed a strategy of seeking to acquire self-financing new business opportunities over the last few years, successfully acquiring SW Essex and the former ONEL community services in 2011/12.

Although there are unlikely to be transactions of the same material scale going forward, the Trust will seek further local opportunities where it can be seen to generate a return and defray corporate costs and help to manage risk. In 13/14 we have put forward a proposal to support the integration agenda in Waltham Forest through the provision of a community bed service as well as a community rehab service – we await the outcome of this proposal from Waltham Forest CCG but this has not been built into the financial forecasts due to its uncertainty.

We are continuing on completing the needs of the Trusts clinical service provision going forward in line with phases 2 and 3 of the Trusts Estate Strategy. To this end, we are looking to spend capital sums of £9.4m, £6.9m and £9.6m over the three planning years. This also incorporates the potential for proceeds resulting from sales of surplus assets through estate rationalisation.

The costs are expected to change over the duration of the plan relating to service change and estate strategy. The specific costs and planning assumptions will be assessed when the business cases come forward for review.

Summary

Despite of all these strategic challenges highlighted above the Board feel confident that we have a very mature and established system of effective governance that maintains quality and clinical effectiveness as a priority. Because of the economics of the local markets, workforce and its costs are a very clear priority for external benchmarking such that workload does not become a driver for increased clinical risks. On this basis and our analysis of our local economies we believe that the plan outlined below is robust enough to be delivered as stated.

Corporate Objectives

The Trust continues to focus on its 5 corporate objectives and has assimilated national and local economic or change programmes under one of our five headings. Our five corporate objectives as identified earlier are defined below:

Improve service quality and productivity, ensuring we focus on quality and best value in all we do (Objective 1).

Deliver service transformation and improve local environments, recognising the importance of embedding a culture of continuous improvement to ensure our services are competitive (Objective 2).

Deliver improvement on financial and performance targets, to allow the organisation to build on solid performance against contracts (Objective 3).

Deliver new business opportunities, recognising the importance of a robust commercial strategy to deliver sustainability across the next 3 years (Objective 4).

Improve capability and capacity, with a continued focus on fitness for purpose and taking account of changes in demand, both internally and externally, in local health systems (Objective 5).

Responding to challenges faced within the three health economies, active involvement in developing integrated care patient centred solutions and delivery of financial efficiencies. (6)

In order to deliver tangible change in each of these five strategic areas we have identified specific work-streams falling under one or more of these headings. Many of these work-streams also map to external programmes which stretch over two to three years but have deliverable components this year. They include:

To develop as an integrated health care provider organisation to increase the opportunity for patients to have the majority of their health care needs met by a single organisation. There are 12 deliverable components to this work-stream in 2013/4.

To widen the organisations business portfolio in order to generate more treatment opportunities for patients. There are eight deliverable components to this work-stream in 2013/4.

To increase our use of technology to deliver efficiency and productivity and provide a more modern, innovative service for patients. There are 20 deliverable components in this work-stream in 2013/4.

Actively manage key partner relationships to ensure patient experience between different organisations is improved. There are five deliverable components in this work-stream in 2012/4.

Provide or develop innovative solutions to national and local commissioning challenges in key areas to ensure patients are provided with the most up to date services. There are twelve deliverable components to this work-stream in 2013/4.

Alignment of estates and commercial strategies to changing clinical demands to ensure patients get treated in the most up to date environments. There are eleven deliverable components in this work-stream in 2013/4.

To use our positive financial position to pump prime services agreed with commissioners and invest in technologies that deliver the most up to date service solutions for patients. There are three deliverable components in this work-stream in 2013/4.

To address specific workforce challenges in order to ensure that patients receive treatment from well qualified and trained practitioners. There are 11 deliverable components in this work-stream in 2013/4.

Drive up quality in clinical services in order to enhance patient experience. There are 23 deliverable components in this work-stream in 2013/4.

Develop and implement the next phase of our informatics strategy including patient information. There are 3 deliverable components in this work-stream in 2013/4.

Continued implementation of our communications strategy to allow patients and staff access to more information. There are 6 deliverable components to this work-stream in 2013/4.

Ensure that NELFT is and continues to have a strong brand that is recognisable to patients and staff. There is one deliverable component to this work-stream in 2013/4.

Demographics and Morbidity

The population the Trust serves provides some significant challenges to the delivery of care. We know that we have a growing under 18 population in Barking and Dagenham, an increasing older adult population in many parts of the economy, with a very sharp peak in Havering. We have a diverse and transient population, with an increasing younger eastern European population presenting with substance misuse, particularly in Waltham Forest. We have high prevalence of diabetes in some elements of south Asian population and this population are also presenting with high prevalence of multiple long term conditions.

Threats and opportunities: *Innovation, transformation, competition, decommissioning*

Over the last 12 months we have focused on consolidating our portfolio, as well as progressing service improvements, to continue to ensure our services offer the best possible patient experience and outcome. Much has been achieved since we launched our transformation programme 'Quest4Excellence' which has had positive impact across the organisation.

The Board are aware of operating in an increasingly competitive environment. In the last 12 months we have been successful in securing new business in the areas of community dentistry in Redbridge and Waltham Forest as well as the Children's Services in Redbridge. In addition, we have taken the national 'Any Qualified Provider' (AQP) agenda seriously and have been awarded AQP status for continence services in our London Boroughs. We have a commercial strategy approved by the Board together with a richness of data and good performance to ensure our services are ready for market testing.

Going forward, we are considering opportunities which may be beneficial following the recent changes Monitor have made to the 'private patient cap'. We will progress this work during 13/14.

We continue to keep under review the possible threats and opportunities from changes in commissioning intentions and service delivery changes including any impact from Local Authorities and NHS England as they take on the commissioning of some of our health improvement, children's and complex services. Through the contract negotiation cycles we are committed to working through any potential threat from decommissioning plans to ensure any impact is reduced and mitigated. We are equally committed to evaluating tender opportunities so we may compete and win business.

We are aware of the opportunities that can be realised from Intellectual Property (IP) rights. We already have a relationship in place with Health Enterprise East who support the organisation and provide advice

on such matters. We are commercially aware and proactively protect our IP as we make innovative developments in software development and health appliances.

Like all NHS organisation we are also faced with decommissioning some of our service lines all of which are the result of the efficiency demands from their respective organisations. The net value of decommissioned services in 2012/3 was £770k, these included weight management services through local authority leisure facilities, podiatry and healthy schools programmes. These losses are balanced against a net gain of business at an approximate value in excess of £10m the vast bulk of which was won through competitive tendering.

Research, Development and Academic Partners

2012/13 proved to be another successful year for our Research and Development Department (R&D). We successfully started the £2 million National Institute for Health Research, Valuing Active Life in Dementia (NIHR VALID) Research Programme, which is now underway with recruitment. In addition, new research programme grant applications have been submitted to the National Institute for Health Research (NIHR), Economic and Social Research Council (ESRC) and Health Technology Assessment (HTA) bodies, many of which have been shortlisted to the final round of screening and approval stages. The PhD Club which is led by PhD students working within R&D has proved to be very successful in providing peer support and educational seminars to PhD students across the organisation. In the past year, we have increased our number of portfolio studies as well as the number of research investigators across the Trust. We ranked second overall in the Essex & Herts Comprehensive Local Research Network (CLRN) league tables for recruitment of research participants into studies. The R&D department also had a significant restructure of its staff infrastructure and we now have a full time Research Management & Governance Facilitator, full time site coordinator and a part time Data Manager to support our expanding research portfolio.

The Trust has a key role in the UCL Partners application to host a CLARHC (Collaboration for Leadership in Applied Health Research and Care) and leads on the theme improving dementia care. The R&D department will be supporting the submission of more research grant applications as well as the strategic appointments of academic posts in the Trust. There are potential plans which are being discussed for the development of an Academic/ R&D Centre at the Trust.

Our Governors

The Trust continues to hold its well established monthly Governor Information Forum in which governors meet the Chair and Chief Executive along with other key senior members of staff. This forum provides an opportunity for governors to obtain regular updates on key matters of strategy, performance and governance. Governors are kept up to date as to any new business opportunities and progress against on-going strategic objectives. The Trust has worked with governors to develop a strategic dashboard which enables them to hold the Board to account for performance against strategic objectives.

The Trust holds an annual planning workshop in February for governors and members of the Board. This provides governors with information about strategy for the coming year and includes detail on cost improvement programmes within each business unit/corporate services, improvement priorities detailed in the Quality Account and issues of strategic importance contained in the Annual Plan.

Governors have also been engaged in agreeing improvement priorities for inclusion in the Quality Account via the governor forum. Governors have also been engaged with working on the recently published governor/director interaction report in order to develop a new engagement strategy in light of their responsibilities as contained in the Health & Social Care Act 2012. The Governors have also taken on the responsibility of membership on teams carrying out mock CQC inspections across the clinical services provided by the Trust and its partners.

Approach taken to Quality

Clinical Strategy

The basis of the Trust's Clinical and Quality Strategy is contained in our 'Framework for Care 2012-2015'.

The Framework for Care aims to:-

- Enable patients/clients to make choices about their care and improve their quality of life
- Provide the necessary programme of care, treatment, support and advice that addresses all the factors that contribute to an individual's physical, psychological and social well being
- Through the principle of clinical governance, improve the provision of care through the implementation of evidence based practice.

The Framework for Care is designed to draw together a number of inter-related work streams into a coherent service wide development framework that has set the direction of travel for clinical development across the organisation. It sets out the clinical standards that reflect the priorities of the organisation in relation to our patients/clients and it enables us to benchmark against these standards and develop plans to ensure that all key areas of clinical development and governance are achieved.

This is the second year of our 3 year strategy and we are making good progress in embedding the framework and progressing quality initiatives. To support consistency in the rollout and on-going monitoring of the strategy, a task and finish group has been established. Phase 1 approach has focused on establishing timelines for the reporting of progress and monitoring of business unit and corporate framework of care action plans. Phase 2 (2013/14) will subsequently focus on the on-going updates of action plans as local improvements and developments progress.

As detailed below, the Framework covers five broad areas of the clinical and quality agenda and throughout the last year improvements have been made in all of these areas. These are some examples of improvements:

1. Patient involvement and experience – a patient information leaflet and poster on the prevention of pressure ulcers has been developed with patients and distributed to clinical areas and key stakeholders. The leaflets are provided to patients as part of their care and treatment.

2. Patient Safety – the NHS safety thermometer has been rolled out and clinical teams are submitting data each month. This has facilitated the targeting of improvement work streams and subsequent sharing of practices across teams. We have seen a reduction in patient falls and grade 3 pressure ulcers.

3. Clinical Pathways – Integrated health and social care pathways have been piloted within the Thurrock locality (Rapid Response Assessment Service) and Essex locality (Single Point of Referral) and on review have shown to improve the patient journey and enabled people to remain in their own homes.

4. Professional Integrity/Leadership – Leadership training and development has been delivered to senior staff and further development programmes are planned for 2013/14.

5. Transformation and Innovation – Individual staff and team's success for innovative work are acknowledged and celebrated at the annual staff award programme. A recent innovation competition across the organisation encouraged and supported staff to come forward with innovative ideas to improve services for patients and deliver care more effectively. Winners included 'use of augmentative and alternative systems in the Community Dental service' and 'tailored medicine information at your fingertips'

Each of the five domains is structured in a way that identifies key principles and sub-strategies together with measures of success so that we have an objective means of continuously monitoring measurable progress.

Going hand in hand with the Clinical Strategy is our Quality Account which has been informed by sources within the Trust, from frontline staff to the Trust Board, by external stakeholders and the public. We have listened to views on the services we deliver well and to those identifying areas where improvements are needed. Three hundred and sixty eight returned quality account consultation questionnaires, along with areas identified through complaints, have directly informed our improvement priorities for 2013/14. These priorities continue to be, quality of treatment, communication and length of waiting times. Progress has already been made in these areas as identified in our 2012/13 Quality Account and work will continue, and will be strengthened, to meet our targets in 2013/14.

We are determined that its focus on quality improvement is equal to or greater than that given to maintaining financial balance. We believe that quality is the responsibility of every member of staff and we have established systems to ensure that quality is embedded at every level. We have implemented a strategic, inclusive approach to both ensuring and assuring high levels of care through our governance processes. Our corporate objectives are aligned and consistent with our commitment to delivering quality services.

Key Quality Risks

All NHS organisations have to ensure robust risk management is in place. Below we outline our current risks to quality along with mitigating actions.

Non-Financial Risks:

Category of risk	Description of risk (including timing)	Potential impact	Mitigating actions / contingency plans in place	Residual concerns	How Trust Board will monitor residual concerns
Current external risk	Difficulty in recruiting sufficient numbers of Health Visitors to ensure that the trust meets statutory and performance targets.	May lead to serious safeguarding incidents involving potential loss of life or serious neglect/harm. Serious reputational risk	Working with health visitors, commissioners and NHS London to agree a forward plan that addresses current issues to mutual satisfaction. HV recruitment and retention strategy in place along with skill mix review and resource allocation. Caseload controls and monitoring.	Delay in confirming medium-term investment plans from commissioners. Inability to recruit to posts.	Risk contained on the BAF which is monitored monthly at the Board. Also monitored at the Quality & Safety Committee (QSC) and Executive Management Team (EMT).

Current internal risk	Failure to implement a robust system of delivery and monitoring of statutory and mandatory training	May lead to a reduction in the ability to provide safe, high quality clinical care in particular: Safeguarding Infection control Health & Safety Fire	MDs leading a review defining more consistent approach to content and refresher frequency and target audiences Introduction of performance team information at team and BU level. Implementation of AT Learning across the trust Commissioning additional training in priority areas	Performance reporting currently in transition Work structures need rebuilding in ESR	Monitored monthly by the QSC and reported monthly to Board. Monitored monthly by EMT.
Current internal risk	Poor quality and standard of accommodation	May lead to reduction in ability to provide safe, high quality clinical care due to reliance on delivery from sub-standard premises.	Phase 2 SOC approved, Phase 3 initial planning approved, PCT Estate transfer planned for April 13/14	Inability to influence planning policy/ process and market conditions	Finance & Investment committee and Board monitoring PCT Estate transfer regularly

Current external risk	Relationship with commissioners, CCGs and acute trusts	Failure to establish effective commissioning relationships with newly forming CCGs, CSUs and public health leads in local government. May lead to a loss of income and long term loss of business for the Trust	Continue to identify key partnerships and build stakeholder relationships. Work to deliver 13/14 contract agreements by 31 March 13.	Rapid rate of change and slow formation of new organisations; inability of the Trust to engage wide number of partners in short time.	Executive Team, Board and Annual Planning group
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A monthly report is provided to the Trust Board from the Quality and Safety Committee (QSC) and the Performance Committee which details a review of the business unit's compliance with quality standards; these include regulatory standards and quality indicators as agreed by the Board in the forward meeting plan. The high level risk register and BAF are reviewed and managed by EMT and Board on a monthly basis.

The Framework for Care – Clinical Strategy 2012-15 provides staff in all parts of the organisation with a set of key principles to underpin services. Measures of success are monitored within the business units.

All risks raised within the organisation are reported and managed via an IT solution 4risk, a web based tool which is accessible to all staff. New risks are reviewed within the business units on a monthly basis and any scoring 11 or higher are reported to the QSC via the business unit quality and safety groups.

When a risk to quality compliance has occurred, e.g. compliance with mandatory safeguarding training, managing directors have been charged by QSC with specific timelines for improvement. The outputs are reported to and monitored by the QSC.

The QSC receives regular reports on key quality issues including:

- Serious untoward incidents
- Incidents, complaints, compliments and claims
- Safeguarding
- Infection control

There is a risk management strategy that has been approved by the board. This outlines that committee structures and lines of reporting for patient safety and is reviewed annually

Quality issues

Across the organisation key actions are in place to continuously improve quality. Key areas and actions are outlined below:

Quality issues and measures	Contribution to the strategy	Key actions and delivery risk	3 year targets / measures for 2012/13, 2013/14, 2014/15
<p>Implement learning from mid staff</p> <p>To improve staffs awareness of medicine management issues relating to patient safety and quality care</p>	<p>Improving quality</p> <p>Improving quality</p>	<p>Action plan to be in place and show progress</p> <p>Completion of medicine management training and competencies programme across business units 9e-learning package and 3 year refresh programme)</p> <p>Regular audit of adherence to the medicines policy which sets out the standards for prescribing, administration, supply and storage of medicines.</p> <p>Increase in the number of medication errors reported on Datix to instil a culture of learning from errors and near misses.</p> <p>Training records that staff have completed</p> <p>Medicines Management working group –review number of Datix, emerging themes and action.</p>	<p>Self-assessment and gap analysis completed which has informed the development of themed work streams. May 2013</p> <p>Monitoring of actions from themed work streams will be reviewed monthly by OSC.</p> <p>2013/14</p> <p>Audits completed at least quarterly on the key issues in the medicines policy</p> <p>Target is for managers to review and take any necessary remedial action for all errors within 14 days of the incident, working with staff member involved & supported by Trust policy and NMC medicines Administration Guidance. This target is reviewed regularly at QSG</p> <p>All medicines errors will be reviewed at local MMWG, any themes identified and used as 'learning the lessons' and linked to the relevant policies in the MM newsletter every 3 months.</p>
<p>Quality domain: Patient Safety</p>	<p>Improving quality & safety</p>	<p>Improve patient reported outcomes. Evidence will be gained from patients, feedback, compliments, reduction in Datix</p>	<p>QPS will monitor number of incidents reported on Datix – timescale to be agreed.</p>

<p>Quality Domain; Service user experience</p>	<p>Improving quality & patient experience</p>	<p>Base line to be established from 2011/12. Reduction in the number of moderate and serious medication errors reported on Datix</p> <p>Improve patient reported outcomes. Evidence will be gained from Patient feedback, compliments, reduction in Datix.</p> <p>Evidence of actions relating to Rapid Response Reports, Patient Safety Alerts, Safer Practice Notices and compliance with NICE through Health & Safety Committee and Health Professional Group.</p> <p>Harm free care evidence of progress towards the 95% target across the health economy</p> <p>Safety thermometer data-base line data for each, realistic target for reduction to be agreed for each harm. Narrative regarding cross boundary working from improvement work streams. Review incidents where issues relating to communication have been identified and develop a</p>	<p>QPS will monitor number of incidents reported on Datix – timescale to be agreed</p> <p>QPS will monitor number of incidents reported on Datix – timescale to be agreed.</p> <p>QPS monitor datix incidents monthly. Patient Safety Alerts/Safer Practice Notes (CAS) are received from the DH & cascaded throughout the Trust to key contacts according to the type of alert (Estates and Facilities, NPSA, Drug Alerts and Medical Devices Alerts, as well as certain communications intended for Chief Nurses and Chief Medical Officers). The first responders are asked to consider the content of the alert and take further action as needed within their services, & feedback to H&S team. Plan to move the management of this function to Datix in the next 12 months.</p> <p>CAS responses reported to Business Unit H&S Groups and Strategic Health and Safety Group Exceptions reported to QSGs or QSC.</p> <p>2014/15 audit to be undertaken to review progress.</p> <p>This to be confirmed with commissioners</p>
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CQUIN- NHS safety thermometer	Improve quality & local environments	<p>business unit plan to improve communication Monitor to show progress, Reduction in incidents relating to communication issues</p> <p>Each service to contact 5 service users per month to discuss experience of care and ask 5 agreed questions. Data through SNAP. Narrative through collation of comments. Action to improve experience identified.</p> <p>Potential CQUIN- support for carers of people with Dementia. '3 Million lives', 'child in a chair in a day' (Everyone counts: planning for patient 13/14) further discussion will be needed with commissioners)</p> <p>Establish the number of current service users in inpatients and ICT teams that have a diagnosis of Dementia</p> <p>Use Safety Thermometer Flag to identify numbers – 1st years Pilot improvement work streams to high reporting areas using the Butterfly Scheme</p>	
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Clinical Workforce Strategy

Key workforce pressures and plans to address them

The Trust identifies workforce pressures through a workforce planning process with business units. These workforce pressures include both current and future supply side gaps and requirements arising from expansion of key groups identified in business plans. Groups with shortfalls predicted over the next three years are health visitors, due to both historic vacancies when services were acquired and expansion in accordance with the "Call to Action" national strategy. There is a detailed action plan supported by a task/finish project group across community services, involving innovative recruitment, communications, retention and training work streams.

Business plans predict an increased demand for specialist community nurses. There is a lack of specific training and therefore supply for this professional group. A project based approach is being established in 2013, mirroring the successful health visitor workforce project. It is recognised that longer term, national plans to move care from acute settings will require focussed training and support to facilitate community nursing services to manage higher levels of acuity and to facilitate positive risk taking. There will be a move towards greater integration with social care providers to manage the shift to community focused care, and this will require community nursing services to recognise need and facilitate social care. This

will involve collaboration with acute providers through posts working in both hospital and community settings

In addition NELFT will be reviewing its succession planning for leadership roles both in the clinical setting and managerially as part of its talent management initiative; this is critical to the sustainability of the organisation and its development.

Apart from these two significant deficit areas, the Trust has also identified long terms shortfalls in community paediatric medical staff, medical consultants in learning disabilities, senior Allied Health Professionals (AHPs) in mental health, and middle grade doctors in psychiatry. These are more localised problems relating to workloads in the socially deprived areas served by the Trust, and the high cost of housing in the London area. Middle grade doctors and AHPs availability has also been affected by changes in immigration rules impacting the supply of trained professionals into the NHS initiatives to work with universities, offering placements for students. These gaps are being tackled through local initiatives, both to make individual posts more attractive and to provide services more effectively utilising the available workforce. The Trust is now in a position to develop rotational AHP posts in a wide variety of specialisms across the three business units. This will provide the opportunity to develop the existing workforce and attract new staff to the organisation.

The Trust already employs a number of consultant physicians for older people and wishes to expand the number of these out of hospital roles to enable seamless medical care across care pathways, focussed on long terms conditions. These roles are key in supporting the development of nurse prescribing and the development of specialist nursing roles to provide multi-disciplinary teams.

In addition, the Trust is in the process of implementing measures drawn from the lessons of the Francis report in respect of non-professional staff providing direct care, such as Support Time Recovery Workers in mental health services, and healthcare support workers in community services or wards. There is no shortage of candidates and the Trust already runs recruitment days when values and behaviours of candidates are tested as well as skills and knowledge. The next planned steps are agreement in partnership with trade unions on standardised job descriptions and person specifications, with consistent standards of training and qualifications linked to national competencies developed by Skills for Health. The creation of apprenticeships for such is also being explored

The impact of the Workforce Strategy on costs (short-term and long-term)

The Trust has budgeted for both the short term project costs of recruitment and training, and the overall cost impact of agency staffing whilst posts are vacant. All of the workforce initiatives are based on avoiding long term cost inflation through permanent financial incentives, and therefore do not have a significant adverse impact on reference costs, which are currently well below average across the Trust.

Findings of benchmarking or other assessment

The Trust has a clinical workload measurement policy for community services. Workload measurement is a means used by the Trust to ensure that workloads are manageable whilst meeting service obligations, of which caseloads are only one component amongst travel, meetings, administration and general working practices. Overall, Trust costs are well below national reference costs indicating good labour productivity. In several areas they are as low as 80 reflecting the need for further investment in our London community health services. The priority for NELFT is therefore to ensure that no clinical risks or staff health risks arise from excessive workloads and to engage with commissioners collaboratively to agree service specifications which are achievable. NELFT has also been reviewing qualified nursing numbers in community wards. A number of increases in staffing have been made due to increased acuity of patients discharged for rehabilitation from acute trusts.

We operate a national benchmarking system which allows us to compare data to many similar organisations and use several national benchmarking to which we subscribe annually

Clinical sustainability

There are no services provided by the Trust which are clinically unsustainable or potentially lack critical mass, either externally or internally defined. All of the services provided can be scaled up as required to meet national plans for the expansion of community based treatment options or are discrete services which are subject to market testing. Inherited health visiting caseloads are above recommended levels but the active recruitment, retention and training project, together with changes in working practices are being actively managed in partnership with staff and their representatives to avoid clinical or staff health risks.

Productivity & Efficiency

The Trust has a number of productivity and efficiency work streams that have already been outlined earlier in this document under the corporate objectives. Examples include mobile working, e-Rostering etc.

We are expanding our internal staff bank across all business units which is assisting us to deliver efficiencies and helping to reduce reliance on 3rd party staffing agencies

Cost Improvement Plan (CIP) governance

In terms of governance, leadership and assurance the organisation has established a corporate Project Management Office (PMO) where all strategic projects and CIPs can be monitored and tracked through to completion. The membership includes executive directors and finance and transformation leads along with managing directors of each business unit. The PMO meets monthly and produces a quarterly report to the Executive Management Team (EMT). All issues and risks along with mitigation are discussed at the PMO, and any urgent issues are escalated immediately to EMT. In addition, each of the business units report progress against CIPs at their weekly leadership team meetings, and any concerns are raised by the managing directors at the weekly EMT meeting.

Further, all CIPs are reviewed for clinical impact by the Chief Nurse and Executive Medical Director so assurance can be gained of safe service delivery.

The impact of tariff and CCG (formerly PCT) income reductions, pay and price growth and local cost pressures leaves a gap of £17.89m in 2013/14 to be met from CIP's. The CIP target has moved favourably from original planning in December due to local flexibility agreed within contract agreements. The current risk assessment of these schemes at the time of writing stands at 16% red, 31% amber and 53% green. At this stage last year 40% was red/amber and 60% green. The 12/13 CIP performance achieved over 98% recurrently – 88% in year.

The most significant red/amber risks sit within our London community health services with £4.15m remaining. Further work to reduce outstanding risk continues and all schemes are refreshed for risk within the monthly report that goes to the executive management team and the Board. Work is concentrated on identifying 13/14 outstanding CIP but indicative targets for 14/15 and 15/16 are noted for strategic and operational thinking to commence – normally from October to detail these in advance of the forthcoming year. There are over 65 schemes across the Trust ranging from £50k (Adult Therapies) to over £1m for Acute Care Pathway improvement and Operational restructuring.

CIP enablers

Clinical leaders within each business unit are fundamental to the identification of CIPs. Each plan is risk assessed against a set of clinical quality indicators and signed off by the Directors of Nursing and Deputy Medical Director for the business unit.

The Trust Wide Professional Leadership Group undertakes an impact assessment of the professions represented across the organisation to ensure no significant erosion of a specific profession is incurred.

Ultimately, the plans are endorsed by the Executive Medical Director and Chief Nurse with any areas of clinical risk being identified and supported by robust mitigation plans. Where gaps remain these are brought to the attention of the Board.

Quality Impact of CIPs

CIPs have been agreed for each business unit. The plans impacts upon quality were reviewed and risk rated by each management team with specific input from the Medical and Nursing Directors for Mental Health and Community Services. The RAG rated business unit assessments were independently reviewed by the Trust's Executive Medical Director and Chief Nurse. This included triangulating the quality risk rated areas across all of the organisation.

To provide further assurance each business unit has additionally identified its top five areas of potential risk before and after mitigation and these top risks have been reviewed in greater depth through direct meetings with the Executive Medical Director and Chief Nurse and the business units (managing director, nursing director and medical director).

Financial & Investment Strategy

The Trusts Current Performance 12/13

The Q4 position showed an actual weighted average risk rating of 3.8 rounded to a 4. However this is overridden in year due to the Trust reporting a 2 metric within underlying performance and therefore capped to a 3. This was assumed to be the case within our submitted annual plan and therefore was not unexpected and was consistent with the Trusts reported performance throughout this financial year.

This was a favourable outcome to our original 12/13 plan.

Underlying performance reported a 2 metric at 3.7% - down from the previous 3 quarters but consistent with plan due to end of year non recurrent arrangements under our agreed MoU with our local commissioners. Asset transfers for these services are reflected in our accounts from April 2013 and will improve marginally our EBITDA reporting.

Achievement of plan reported a 5 (102.7%) with EBITDA now £0.3m above plan and Financial Efficiency also recorded a 5 metric.

With cash reported at £43.5m (£15.0m above plan) liquidity provided 38.8 operating days and continued to report a strong 4. Under the Terms of our authorisation as an FT we have maintained a working capital loan facility of £17.2m with Lloyds TSB which we have not needed to draw upon.

We reported a net surplus of £2.4m – which was £3.1m adverse to our plan due to the need to impair a number of building assets following a desk top review by the District Valuer. After allowing for the £3.9m impairment our surplus returned to £6.3m. This is lower than was forecast at Q3 (principally due to recognising increased provisions from our challenging CIP targets and local cost pressures arising from 13/14 budget planning) but favourable to original plan.

Financial Strategy 13/14 and beyond

The Trust's strategy is to maintain a minimum acceptable Financial Risk Rating in each of the next three years, ensuring strong liquidity and underlying financial performance to support the clinical priorities of the Trust and to generate resources to support our estates strategy. The Trust understands that effective and

responsive clinical services can only be delivered where financial performance is strong as the impact of recovering poor financial positions on frontline services is significant.

The Trust operates in a very challenging set of health economies. In North East London and the City the four local CCG's are seeking £9.8m of extra efficiencies to produce financial balance in 2013/14, over and above the national deflator of 1.3% (£4.0m) and have challenging QIPP targets. Long standing financial problems with local acute providers, particularly Barking Havering and Redbridge University Hospitals Trust (BHRUT) continue to consume all growth funding year on year for CCGs, meaning investment in NELFT's non-tariff services – community and mental health – remains at risk when plans to reduce spending in acute care or elsewhere cannot be achieved. In SW Essex commissioners have been less aggressive, requiring only the national tariff deflator, and where cost pressures exist agreeing localised decommissioning.

Our forecast plan for 13/14 is highly challenging with contracts with our local CCG's agreed and final resolution to the NCB and SCG reached in mid may. This leaves the Trust with £17.89m (or 5.6%) CIPs to achieve a plan forecast surplus of £5.8m. This will provide the Trust with an overall metric rating of 3.6 but will continue to be capped to a 3 due to remaining below 5% within its EBITDA margin rating.

To manage these external risks and internal cost pressures – e.g. pay, drugs costs, non-pay etc. - the Trust has planned to set financial targets for each of its three business units – SWECS, MHS and NELCS – based on a target 2% surplus in each year before allowing for reserves. Depending on the position of commissioners this is likely to require cost improvements of between 6-7% a year for each business unit – for 13/14 it is 6%. The Trust has a policy of not planning to cross subsidise between business units.

Business units have devolved financial responsibilities and are charged with developing long term CIP targets engaging with senior staff and other stakeholders. CIPs are required to be specific in the first year and identified to the level of themes for subsequent years. The Trust also seeks to maximise efficiencies from corporate support functions which are now largely centralised, helping to reduce the impact of CIPs on frontline care. The nature of these schemes are structural as described in the top 5 as detailed within the Appendix.

The Trust has progressed a strategy of seeking to acquire self-financing new business opportunities over the last few years, successfully acquiring SW Essex and the former ONEL Community Services in 2011/12. Although there are unlikely to be transactions of the same material scale going forward the Trust will seek further local opportunities where they can be seen to generate a return and defray corporate costs and help to manage risk.

Work continues on two main areas where business may grow which are mentioned under the Transaction commentary – it is too early to determine whether the Trust will be successful in these areas but both will be primarily cost neutral but are not of material substance.

The Trust's income derives primarily from block contracts for MHS and CHS care, but this is likely to change as moves to implement first mental health and then community tariffs develop. The national timeline for MHS tariff has slipped from 2013/14 but locally CCG's are keen to develop shadow prices and a similar process is likely in CHS. The Trust will seek to minimize risk from this process through effective data capture – both clinical and financial – and by aligning income streams to budget management to ensure the Trust understands its pattern of contributions by service. An agreed MoU is in place to manage financial risk arising from PbR MHS work but there are still (limited) opportunities for CCG's to claw back non recurrent monies as the year progresses.

Key investments have been agreed with our commissioners within MHS services for IAPT, Personality Disorder and Eating Disorder services each of which is financed through extra efficiencies within the Trust. In CHS agreements have been struck for Rapid Response and Call to Action (Health Visitor training and appointments). In addition the transfer of CHS ICT services has been effected from PCT to the Trust.

The TCS asset transfer has been implemented from both SW Essex and ONEL CHS PCT's. The asset value amounts to £21m and has a positive effect on our EBITDA rating but not sufficient to move us out of a 2 rating and the Trust remains 'capped' to a 3 overall.

The key financial risks to delivering the 13/14 plan are as follows:

- Delivery of CIP programme
- London Specialist commissioning income
- HCLA income risk
- Delivery of CQUIN targets
- Deployment of Capital Programme and Asset Sales
- Medical and Health Visitor agency costs
- Management of debt arising from commissioner changes

Work on all these areas to manage down risk continues and the Trust has also built in contingent reserves to mitigate areas of material concern.

The future years are based upon the income and expenditure assumptions as mentioned within Appendix 1 but the key drivers are:

- Income deflation (efficiency) of 1.3% for MHS and SWE CHS 14/15 and 15/16
- Income deflation (efficiency) of 4% for NEL CHS 14/15 and 1.3% 15/16
- Decommissioning assumed as cost neutral
- Generic cost inflation including 1% wage award year on year
- Contingent Cost for assumed internal cost pressures
- Service developments assumed cost neutral or via decommissioning
- CIP requirements of £17.9m, £14.6m and £10.1m over the three plan years
- Loss of HCLA income and Overseas Visitor income
- CHS Asset transfers and revenue implications (PDC and Depreciation)
- Revenue Implications of services moving off of the Goodmayes site.