With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

South West Yorkshire Partnership NHS Foundation Trust

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

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

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Date	31st May 2013

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should 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)*	Ian Black

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Steven Michael

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Alex Farrell

Signature

Strategic Context and Direction	**About South West Yorkshire Partnership NHS Foundation Trust** We are an NHS Foundation Trust providing a range of community, mental health and learning disability services to the 1.2million people of Barnsley, Calderdale, Kirklees and Wakefield. Our Forensic BDU provides specialist medium secure services to the whole of Yorkshire and the Humber. **Our Key Strengths** • Strong track record of service delivery, robust governance and financial stability • Strong track record of partnership working to provide integrated care. During the lifetime of this plan we expect our partnering skills to be highly important for continued success. • Strong track record of engaging with service users and carers. We are working to develop further in this regard, putting co-production and recovery principles at the heart of everything we do. **Our Mission and Values** We are a values driven organisation seeking to enable service users to live their lives and to develop potential in our staff. Our values guide us in how we will behave in the pursuit of our Mission. In 2012/13 the Chief Executive led the Trust in engaging with over 2,000 people to renew our mission and values to focus on recovery principles. The Board view the time invested as a high priority that has set the direction for our future success. **Our Mission** *Enabling people to reach their potential and live well in their community.* **Our Values** *Honest, open and transparent* *Always show respect to all* *Always put the person first and in the centre* *Always strive to Improve and be outstanding* *Relevant today, ready for tomorrow* *Families and carers matter* **Our Key Planning Priorities for 2013/14** • Do the Day Job Well: Strengthening the Trust's reputation as a high quality provider of mental health and community services. • Deliver service transformation linked to improved outcomes for service users, clinical effectiveness and value for money. • Strengthening partnership working with local authorities, Clinical Commissioning Groups and local providers. These priorities strengthen our reputation in existing services and therefore put us in a good position to retain market share and develop new services. These priorities are underpinned

by a clear and structured approach to marketing and stakeholder management.

The Size of our Main Markets

The Trust primarily operates in four geographical areas at present (Barnsley, Calderdale Kirklees and Wakefield), with the exception of the Forensics Business Delivery Unit (BDU) which primarily serves the wider Yorkshire and the Humber region. Our management structure is based around geographically based BDUs. The majority of our income relates to NHS activity and is achieved under contracts with CCGs.

The table below is based on 2011/12 Primary Care Trust (PCT)data returns as part of the National Programme Budgeting exercise. It covers PCT's reported spend on Mental Health, Learning Disabilities and Community Healthcare. This has been compared with the Trust's contract income from those commissioners.

Commissioner	Programme Budget Spend	SWYPFT Income	Market Share
Barnsley	£129m	£76.7m	59%
Calderdale	£55m	£18.5m	33%
Kirklees	£81m	36.7m	45%
Wakefield	£95m	£36.9m	39%

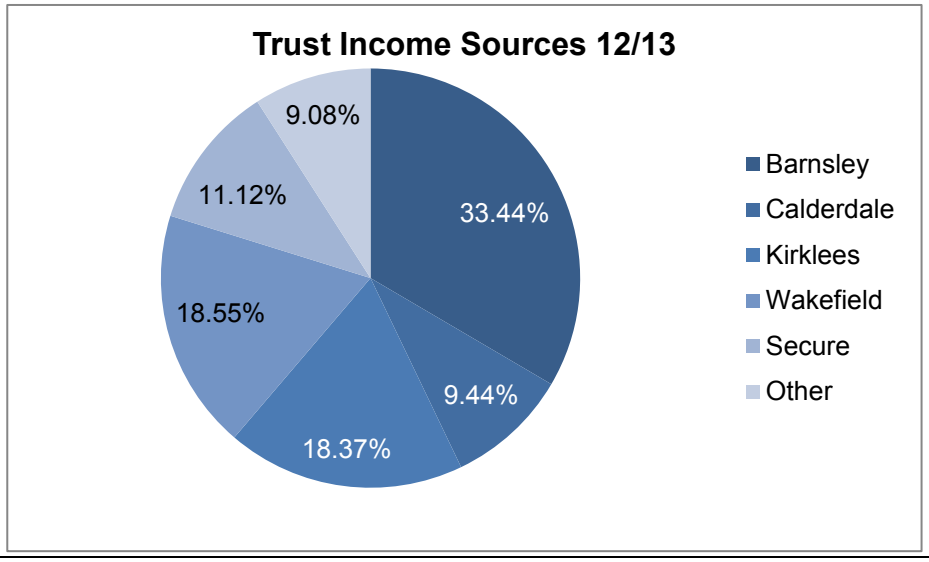
In common with most secondary care mental health providers this picture is shows that secondary care mental health is less than 50% of commissioners' total spend on Learning Disabilities and Mental Health. The Trust is the main provider of mental health services in all four of the local BDUs, and in Barnsley we are also the predominant provider of community healthcare services.

For forensic services we are the main provider of medium secure services for the region and provide significant element of NHS commissioned capacity for male low secure and learning disability.

Within these market segments if the Trust continues to maintain and improve core services the organisation will be well positioned to engage with commissioners and be considered a natural partner to contribute to system redesign in community and mental health services.

Our Sources of Income

The Trust has relationships with many commissioners. However our major sources of income are from the following CCGs and Specialised Commissioners:



Clearly the relationship with these commissioners and the maintenance of these income sources is of major significance to the Trust's continued viability; and therefore the reason for stakeholder and partnership working being one of 3 key priorities..

Competitor Analysis

The Trust maintains an open mind about the possibility of collaboration with other providers. At the same time we recognise the competitive nature of the modern NHS and consequently evaluate the strengths and weaknesses of all those who operate in proximity to our footprint, and those who deliver similar services on a local or national basis.

Our competitive strength currently lies in the provision of integrated teams working in mental health and social care. In Barnsley this extends to include community physical health services. There are a number of local NHS providers that could expand their community service provision in terms of an integrated care offer. The Trust is fully engaged in local health economy transformation programmes led by CCGs and Local Authorities. These will shape the future of social care and health pathways, and the development of community services. In terms of non NHS providers the areas of greatest competition are in forensic mental health services and in talking therapies.

In response to these competitive challenges the Trust will seek to nurture positive working relationships with local acute and community providers Calderdale & Huddersfield NHS FT (CHFT);Mid Yorkshire Hospitals NHS Trust (MYHT); Barnsley NHS FT (BNHSFT); the social enterprise community providers Locala, and Spectrum ; and the provider arm of the local authorities.

Competitive Drivers within our Service Sectors

Analysis of competitive drivers in each of our service segments, and our response is summarised below.

Market	Drivers	Response
Mental Health	Competitors strategies • economies of scale • localised integration of care with physical health and social care	Maximise benefits from both approaches. • Build on experiences of delivering integrated care in Barnsley • Develop integration model further in conjunction with partners
Forensic Mental Health	Private providers offering flexible packages All providers driving price deflation	• Sub-specialisation strategy • Development of full pathway approach
Learning Disabilities	We anticipate private providers seeking to increase their market share	Develop closer partnerships with Local Authorities. • Provide expert clinical input via a consultancy model • Support efficiency and effectiveness of the local LD system including social care and continuing care
Community Health	Competition driven by the need for improved quality and efficiency through integrated care and removal of waste	Therefore it is necessary for us to seek partners with whom we can provide full pathways of care and remove duplication

In addition key developments within the sector include the introduction of Mental health currency which is in its second year of implementation ; and the development of community tariff models e.g. Year of Care.

Impact of Demographic Change

An analysis of the predicted growth of local populations served by the Trust has shown that the populations we serve are predicted to increase over the duration of this plan, and

beyond. In common with national trends the largest areas of growth are in relation to children and young people, and in relation to older people. The working age population will also grow, but this growth is relatively restricted. The table below shows the impact of population growth within each of our geographically based BDUs over the next 5 and 10 years.

Population Growth 2013 - 2023								
	Calderdale		Kirklees		Wakefield		Barnsley	
	5 year % increase 2013-2018	10 year % increase 2013-2023	5 year % increase 2013-2018	10 year % increase 2013-2023	5 year % increase 2013-2018	10 year % increase 2013-2023	5 year % increase 2013-2018	10 year % increase 2013-2023
5-19	4.32%	12.70%	4.15%	11.53%	1.80%	10.09%	2.02%	10.61%
20-64	1.58%	2.42%	1.32%	2.02%	1.81%	2.01%	2.12%	2.70%
65+	10.80%	22.73%	10.08%	20.00%	10.62%	21.92%	9.88%	20.00%

The impact of this level of population growth on the Trust's services will be significant increases in demand, driving higher levels of activity. In the context of block contracts for service provision this creates a productivity challenge and cost pressure for the Trust;in particular growth in activity of approximately 10% in children's services and of up to 20% in older people's services over a 10 year period. The Trust will engage commissioners in reviewing the situation and will take a lead in;

- Developing new models of service and driving productivity in existing services, through our Transformation Programme. We anticipate relatively more community based activity and less bed based activity.
- This will be informed through the use of service line reporting data to closely monitor actual increase in demand and activity.
- Active participation in local health economy transformation programmes that will re-shape patterns of demand. There is potential that these changes start to impact from 2016.
- The predicted impact on activity and workforce related to demographic pressure are modelled in this plan.

Market Trends - Conclusion

During the period covered by this plan the Trust anticipates the following:

- We will engage closely with commissioners to maintain our current strong position in relation to secondary care mental health provision , community services and regional forensic mental health services.
- We will plan for productivity and efficiency gains to take account of increased demand for services driven by demographic change. This will impact significantly on services for older people, community mental health and services for children. This will be achieved through service redesign, planned and delivered through our Transformation Programme
- We anticipate significant local reconfiguration as a result of commissioner led local health economy reviews. We will focus on our partnership skills to maintain service stability. This will support us retaining and growing market share during this planning period.

Commissioning Strategy and Intentions

Our local CCGs are developing and testing their commissioning intentions at present, so the details that follow are only partially complete and subject to further development. Nevertheless they signal a direction that the Trust can respond to in this plan.

Greater Huddersfield CCG has clarified that their commissioning intentions for mental Health involve the delivery of a £700,000 QIPP saving in 2013/14. £350,000 of this is expected to be cash releasing. The Trust will highlight the productivity gains demonstrated in this Plan

Barnsley CCG has signalled that their commissioning intentions include many elements that the Trust is well positioned to respond to. These include; risk stratification and wider use of telehealth to support Long Term Conditions management, a holistic approach to dementia care, and the development of the eating disorder pathway. However the CCG also intends to move more services to AQP contracts and this will require the Trust to ensure that service models are optimised to fit this type of contract.

Calderdale CCG has identified Dementia as a priority for development. The Trust is well placed to respond as this is a priority across all the BDUs.. It has also noted an intention to make greater use of assistive technology to promote independence and resilience. Again the Trust is able to draw upon our experience in this field to help meet Commissioners expectations. Health and Wellbeing services currently provided by the Trust are expected to be tendered. This is an important corner-stone in the Trust's strategic service offering, which we will seek to maintain.

Local Health Economy Strategic Reviews

In addition to the development of individual CCG commissioning intentions there is a significant degree of activity in local strategic reviews in all geographies served by the Trust. It is essential that we effectively engage with and influence these major change programmes. The key reviews with which we must engage are described below;

Greater Huddersfield and Calderdale Health and Social Care Review

This transformation programme covers the geography which we share with CHFT. Key areas for the Trust to contribute include;

- The agendas surrounding 'digitising', 'integrating services' and personalisation in commissioning all fit well with our own strengths and direction.
- To maximise our impact we must engage fully with CHFT and other partners and ensure that we create enough capacity internally to fully contribute to shaping and driving the work
- Our joint work with CHFT around RAID style liaison services has been rated as high priority in commissioner's QIPP plans and this transformation programme

Meeting the Challenge

This is the transformation programme for the Wakefield and North Kirklees local health economies. Key opportunities/ areas for engagement for the Trust include;

- Planned Care/ Mental Health, Care Closer to Home and supporting the effective use of acute hospital resources are areas where we can lead and contribute.
- To maximise our impact we must engage fully with MYHT and other partners and ensure that we create enough capacity internally to fully contribute to shaping and driving the work

Community Task Force

This transformation programme includes all community, acute and local authority providers operating in the Mid Yorkshire geography. It is provider led and has synergies with Meeting the

Challenge.

Inverting the Triangle

This is the transformation programme for Barnsley, led by Barnsley CCG and Barnsley MBC. Key opportunities/ areas for engagement for the Trust include;

- Signposting relates closely to the Health Navigation work undertaken by the Telehealth team
- Dementia is a key priority area for the Trust as a whole and is one where we are well positioned to lead a network of integrated provision

Current known tendering and AQP opportunities

The Trust is aware of a number of areas where commissioners are likely to want to test the market during the lifetime of this plan. This will provide opportunities to grow and consolidate our service offer within local BDUs, but will also require the Trust to sustain current market share in the face of increased competition. This will arise through re-tendering of major contracts and through the increased use of Any Qualified Provider contracting mechanisms. Specifically;

- IAPT services moving from single provider to AQP contracts.
- Calderdale Health and Wellbeing Services (a contract we currently hold) being re-tendered in 2013/14
- Bassetlaw telehealth service following successful pilot scheme delivered by the Trust.
- Re-tendering of Sheffield Stop Smoking Service in 2014.

Diversifying Income Streams

The Trust already has a relatively diversified commissioner base, with no single commissioning organisation accounting for more than one third of the Trust's income in 2012/13. However we are actively pursuing the following opportunities for revenue growth and diversification to reduce risk and create sustainable service and financial base within the Trust's medium term plans.

- Additional commissions for telehealth and tele-coaching services, based on the model developed in the Barnsley BDU. This would build upon our successful development of similar services in Bassetlaw.
- Provision of telehealth consultancy services, building upon our experience and reputation in this field.
- We will aim to build on the success of the Creative Minds programme to provide a platform to support self directed recovery, possibly enabled by personal budgets.

Partnerships and Innovations

In 2012/13 we have continued to develop a number of innovations in conjunction with our service users and other partners.

One emerging example is the development of RAID (Rapid Assessment Interface and Discharge) services which are being progressed with our general hospital provider partners CHFT and MYHT. These enhanced liaison services will improve the experience and effectiveness of care for people with mental health issues while they are being treated for physical health issues in the general hospital. This will support reduction in acute length of stay, and is a good demonstration of how our holistic view of the physical and mental health needs of people leads us to develop practical partnerships.

In Barnsley the Trust are working with partners in primary care and BNHSFT, the local

	general hospital towards the development of an integrated approach to the improvement of outcomes for people with Diabetes in Barnsley. In 2013/14 we will be particularly focused on the following improvements: • Improving quality of care and outcomes through the provision of psychological support for people with diabetes • Enhancing patient self care and self management through integrated care planning • Supporting staff to enhance their skills and knowledge in diabetes care through an integrated multi-disciplinary specialist diabetes team • Improving communication and sharing of information through care pathway guidance and web-based information **Potential for further partnership and collaboration** In response to the challenges of clinical viability and economic stability within a restricted public sector settlement, the current operating context is favourable for partnership and collaboration. Across local health economies there are several strategic reviews exploring these themes. In addition local NHS provider organisations are exploring options for partnerships and alliances to ensure a sustainable future. The Trust has undertaken a number of analyses which are assisting the Trust's positioning. Our key provider partnerships are with CHFT, Locala and relevant local authorities in the Calderdale and Kirklees areas; with MYHT, Spectrum, and WMBC in Wakefield District, and with Barnsley FT and BMBC in Barnsley.
Approach taken to quality (including patient safety, clinical effectiveness and patient experience)	**Approach to Quality** The Trust adopted a Quality Improvement Framework in 2012/134 which is based on the National Quality Board work. It comprises seven domains and is used by EMT and the Trust Board to enable reporting and assurance on Quality. 1. **Bringing Clarity to Quality** – There must be a clear and accepted definition of quality that is understood and owned by people who use services and their carers, staff and commissioners. Assurance is derived from Service Offer Documents, InPac definitions and Outcome Development 2. **Measuring Quality** – Robust timely and relevant information must be available at all levels of the delivery system in order to demonstrate improvement. Assurance derived from SLR and BDU reporting, and the Performance Dashboard. 3. **Publishing Quality** – By publishing accessible information about quality performance we increase accountability and empower people. Examples include the 'What Matters' report, the Members Council performance report and the Trust Excellence Awards. 4. **Partnerships for Quality** – The Trust needs to work with others to support people. Examples include Integrated CMHTs Spectrum partnerships and the Change Lab. 5. **Leadership for Quality** – Leadership is required at all levels to ensure focus on quality and appropriate system incentives. There is a specific role for each of clinical, managerial and professional leadership. Examples include professional leadership networks and managerial/ clinical partnerships as our approach to service line management. 6. **Innovation for Quality** – continuous improvement requires the Trust to be alert and to seek out opportunities for innovation. Transformation is the key activity for the Trust. 7. **Safeguarding Quality** – It is vital that the Trust ensures essential standards of safety and quality are maintained. Embedding quality in the delivery system will ensure this happens. Through Performance EMT, unannounced visits to services and the Quality Priority Monitoring regime.

Addressing Quality Concerns

The Trust has identified care planning and care reviews as a development area. This has been highlighted in our listening exercises with service users regarding their experience, and also via the CQC community mental health community survey, which indicated a below average performance. However our objective is to improve and be outstanding. Therefore in response to these results work has been commissioned to improve the quality of care plans and care reviews. Working with people who use our services a project team has been established to develop a set of standards that support 'quality' care planning and care reviews with the overall aim of improving a person's experience of care in our services.

Our Quality Priorities and approach to Quality Assurance

We believe that the quality priorities we identified in 2012-13 provide a valuable framework for us to use to continue to put quality at the heart of our services. In 2013-14 we will continue to work in partnership with the people who use our services to deliver improvement. A key facet of this will be the embedding of Recovery Principles through ImROC which is recognised nationally as a model of best practice ..

The measures identified in the Quality Priorities 2013-14 will be reported in the following ways;

- Monthly reporting to Executive Management Team performance meetings for both internal and external (CQUINs) quality metrics.;
- Redesign of Board and BDU performance report to highlight link to KPI and metrics and quarterly update to the Trust Board on progress against quality priorities;
- Development of Quality outcome measures linked to the mental health currency which includes Patient Related Outcome measures (PROM) Clinician related outcome measures (CROM) and patient related experience measures (PREM);
- A 'Quality Account Report' will be produced on a bi monthly basis for the Clinical Governance and Clinical Safety Committee.

Using the Quality Priorities we anticipate making changes in the following areas in 2013/14;

- **Priority 1 Listen to our service users and carers and act on their feedback**. We will use ImROC to embed recovery principles and co-production in all our services.
- **Priority 2 Timely access to services**. We will use technology to support agile working practices. This will drive productivity, leading to improvements in access to services. In addition we will increase the use of group therapies, which will speed up access to psychological therapies.
- **Priority 3 Improve care and care planning**. ImROC will help us to drive care quality and care planning will be truly a shared enterprise with service users and carers. The further development of tariff in mental health services will also support clear care pathways.
- **Priority 4 Improve recording and evaluation of care**. Use of technology and agile working practices will make it easier to maintain high quality timely recording of care.
- **Priority 5 Improve transfers of care by working in partnership**. We will pursue opportunities to develop innovative integrated care models. Dementia care will be a key focus.
- **Priority 6 Ensure that our staff are fit to undertake their duties**. The workforce plan will address the needs of our workforce in terms of productivity , promoting well being and resilience and supporting leadership and talent management..

	• **Priority 7 Improve the safety of service users, carers, staff and visitors**. We will support an open learning culture to promote safety as the fundamental basis for everything we do. By improving the collection and reporting of service user feedback to clinicians to encourage improvement in service delivery and quality. **Managing Risks to Quality** The Trust has identified a number of risks to the implementation of our transformation agenda and Quality Priorities. The following risks are being actively managed; • Risk that organisational focus on transformation activity leads to a lack of attention to quality within the day to day delivery of services. This risk is being addressed through clear and regular monitoring of quality indicators in all services (see Quality Priorities table) which is reported to EMT and the Board. In addition clear structures and accountabilities are in place for both operational delivery and transformational change. This ensures that clinical and professional leaders are empowered to highlight issues and act upon them within appropriate governance structures. • Risk that service users and carers perceive a diminution in quality as our clinical approach transitions from a professional expert approach to a co-production/ empowered service user model. This will be tracked through service user experience measures and listening mechanisms. In addition the agreement of Quality Priorities with service users and other stakeholders helps set the mandate to move to a progressive recovery focused approach. • Risk that the skills and competencies of our workforce do not match our future operating model, which is based on recovery principles and co-production. The workforce plan will seek to address this, building confidence and capacity in areas such as negotiation skills, informed risk taking, and partnership working.
Clinical Strategy (Consistent with information contained within the Trust's published Quality Account).	**Clinical Strategy** Recovery principles will drive the Trust's clinical strategy in both mental health and physical health services. This means that we increasingly see ourselves co-producing solutions along with empowered service users and a range of partners in organisations stretching beyond the health sector. Recovery is not something we can do *to* people, but we must create a supportive culture in which they can flourish. The ImRoc partnership will be a key support and guide for this work, which must permeate our approaches to all of our services. • The trend towards community delivery of interventions will continue and accelerate. We will support people to find their own suitable accommodation, and packages of care will be designed around their needs in their home environment. • Assessment of needs is at the heart of our approach. Assessments will be regular, thorough and conducted together with people and their carers. Absence of suitable supports to meet an individual's need will be considered to be an opportunity for innovation and partnership working, rather than a challenge to be avoided. • Increasingly we will place senior clinical decision makers at the 'front-end' of pathways of care as this has proved to be an effective way of ensuring high quality care and efficient processes. • We will find more ways to involve service users and patients in the delivery of care as experts through experience. Peer support workers may be one way that our clinical staff are supported to offer a holistic service. • We will drive efficiency and encourage service users to form supportive networks through the facilitation of more group therapies, and comparatively fewer one to one sessions. This will be important within services such as IAPT where current service

models and case mix presents a challenge in terms of contribution to surplus.

- As noted in the workforce strategy section, the delivery of more flexible community based support will require us to support staff with agile working technology and high quality hub and spoke estate solutions from which services can be provided.
- We will increasingly work in partnership with other providers to develop more holistic approaches to care. RAID (Rapid Assessment Interface and Discharge) services and Dementia services will be two key developments
- We will further develop sub-specialisation in response to market needs. These areas would include, but not be confined to:
  - Forensic Enhanced Medium Secure
  - Eating Disorders
  - Autistic Spectrum Disorder
  - Chronic Fatigue Syndrome
  - Perinatal Psychiatry
  - Post Traumatic Stress Disorder

Service Line Strategy

The Trusts primary approach to Service Line Management is through our BDU (Business Delivery Unit) structure, which is led by our three Delivery Directors;

- The Forensics BDU Director provides both clinical and managerial leadership for the Directorate, and is supported by two general managers.
- The District Director for the Barnsley and Wakefield BDUs is supported by three deputy district directors and formal clinical leadership roles, which will be introduced in all BDUs in 2013/14.
- The District Director for the Calderdale and Kirklees BDUs is supported by two deputies and Clinical Leads.

The Trust supports the local responsiveness of BDUs with a coherent and efficient package of support from co-ordinated corporate support services 'The Quality Academy'. This includes all the usual corporate services.

During the lifetime of this plan the following incremental improvements will be made to this system in order to further develop clinical leadership and to support the commercial capabilities of the organisation.

- BDUs will increasingly use operational and clinical experts to engage with clinical commissioners as part of a coordinated marketing and partner relationship management approach, supported by Customer Relationship Management (CRM) systems.
- BDUs will increasingly use and own the Service Line Reporting (SLR) data made available through Qlikview. This will drive improvement and internal benchmarking.
- Within BDUs individual Service Lines will be jointly led by managerial and clinical leadership partnerships. Clinical Lead roles will be introduced to support District Directors and head up clinical leadership within each BDU.
- Intra-BDU relationships will become increasingly important as more emphasis is placed on the sharing of best practice/ quality challenge between similar services across the Trust. Development work to improve processes, drive quality and efficiency will be shared across BDUs to avoid duplication of effort.
- The Quality Academy will continue to support BDUs through a business partnering model, backed up by efficient shared services for transactional work.
- The Quality Academy will triangulate data from HR, finance etc in order to identify opportunities, constructively challenge BDUs, and support BDUs to respond.

- The Quality Academy will co-ordinate and support innovation and partnership through the provision of frameworks, tool kits and practical consultancy.

Supporting the Service Line Strategy - SLR

In 2013/14 we will use Service Line Reporting (SLR) to support the transformation agenda and to inform BDU operational plans and identify efficiencies. We anticipate completion of the rollout including training by the end of June 2013. SLR will also support clinical ownership and engagement within the BDUs.

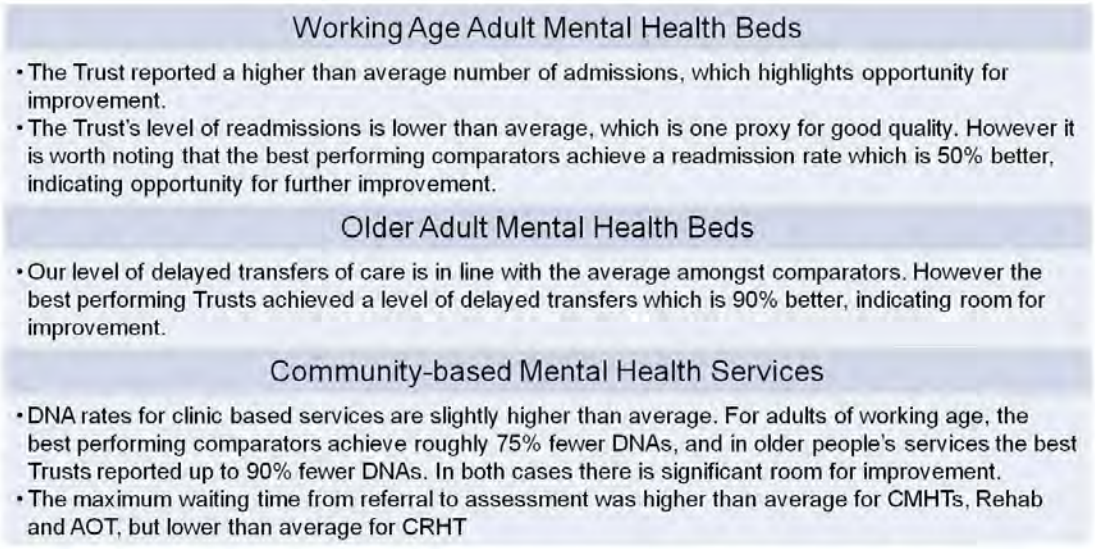
SLR has provided the Trust with a clearer understanding of the contribution made by each BDU and has informed the latest round of contract discussions with commissioners. Service Line Information has been provided to inform the 2013/14 planning process, in particular unit costs, cost analysis and benchmarking data has informed the Transformation Programme and the marketing analysis work. During 2013/14 information will be available electronically to BDUs through Qlikview to support decision making.

The Trust has identified the key risks in the delivery of benefits through SLR being a lack of ownership within BDUs; and a risk that staff do not have the skills to access and interpret it. Both risks are being mitigated through the involvement of BDU Directors in the design of the rollout programme and through the training and engagement of Extended EMT as champions of service line reporting. In addition the Trust OD Plan recognises SLR skills as being an essential development during 2013/14.

Supporting the Service Line Strategy - Benchmarking

The Trust is committed to benchmark performance (internally and externally) wherever possible. We will use this to identify opportunities for CIP and quality improvement.

A summary of the improvement opportunities identified from the 2011/12 NHS Benchmarking Club (43 Trusts) mental health benchmarking exercise (Calderdale, Kirklees and Wakefield Adult and Older Peoples Mental Health Services only) is set out below.



Workforce Strategy

To meet the service and financial challenges ahead, the Trust has developed a strong HR Framework to deliver the required workforce changes whilst maintaining service and organisational resilience.

The HR Framework consists of 3 integrated workforce streams:

- Workforce QIPP: Robust workforce planning linked to service transformation and financial resources
- Wellbeing and Engagement: Supporting organisational, team and individual resilience which maintains Service Quality and Safety during change
- Leadership and Management Development: Providing effective leadership and management to support change programmes including strengthening clinical leadership

The Workforce QIPP is being delivered through a model of strategic and operational workforce planning. The Trust's strategic 3 year workforce plan is built upon individual BDU workforce plans. The annual BDU plans focuses on 6 key areas:

- Delivery of Workforce Cost Improvement Programme within the service and financial plan.
- Using E-Rostering to deliver workforce productivity within in-patient areas through reducing agency, bank and overtime whilst ensuring safe staffing levels.
- Benchmarking skill and grade mix.
- Investor in People standards to ensure best practice in employment aligned to service objectives.
- Redesigning workforce to deliver service transformation.
- Workforce Equality and Diversity to ensure the Trust is representative of the population served.

The impact of the workforce QIPP is to reduce staff numbers over the life of the plan by 443 w.t.e.

The Trust created an additional £2.5m provision in 2012-13 accounts to recognise the anticipated costs of reconfiguration and the Trust is operating a local MARS scheme during 2013-14 to facilitate workforce redesign.

BDUs were developed using the principles of service line management and designed to enable greater devolved decision making closer to the frontline, strengthen clinical leadership and engagement and ensure clinical, operational and financial objectives are integrated. The BDU workforce plans have enabled strong operational clinical involvement and ownership to the workforce changes. This is in addition to the Medical and Nursing Directors providing the Trust Board with assurance around the impact of workforce changes on clinical quality and safety.

In 2012-13 the Trust invested in the development of 13 w.t.e as Practice Governance coaches working within each BDUs as part of its approach to safeguarding quality. The trust has continued to internally fund investment in supporting quality in 2013-14. These new posts will work directly with frontline services to support service changes, develop clinical practice and provide assurance on meeting regulatory standards.

The workforce plan also reflects the impact of additional services which have been commissioned from 2013-14 which include CAMHS service for Calderdale and Kirklees; medium secure forensic service for women and additional investment in psychiatric liaison into acute providers.

The Strategic and BDU workforce plans will be reviewed quarterly to ensure that workforce trajectories remain aligned to service changes and the agreed Cost Improvement Programme.

There are two key risks for the organisation which are being addressed through two other HR work streams:

- The first is the potential for drop in service performance and quality during period of significant change. To mitigate this risk the Trust has built up a strong programme of staff, well-being and engagement. This includes the Middleground Programme, which in

2012-13 was delivered to over 500 senior/middle managers and clinicians to build organisational, team and individual resilience and aligning performance, values and behaviours. The Trust has developed and agreed a Social Partnership Agreement to support active staff side consultation and engagement in significant workforce changes.

- The second risk is effective clinical leadership to support service transformation. The leadership and management development plan has clinical leadership development as a major area of on-going investment. Whilst currently clinical leadership is strong the Trust has recognised the need for succession planning

Clinical Sustainability

The Trust has not identified any services which lack critical mass or have consultant cover below Royal College guidelines. We have enjoyed long term stability in this regard, further aided through the growth that the Trust saw in 2011 as the Barnsley BDU joined the Trust through the Transforming Community Services programme.

Nevertheless this is a situation that we will keep under review and we recognise that a number of emerging service developments such as Eating Disorder Services and our Perinatal Mental Health offer will require a Trust-wide/ cross-BDU approach in order to achieve the necessary critical mass in terms of demand and defining appropriate clinical roles.

One of the main strategies that the Trust adopts in order to ensure the clinical viability of its services is the clinical pathway approach to the delivery of services which supports multi-disciplinary team working, as opposed to a consultant clinic model. This provides service users with the right mix of professional input for their needs and avoids the fragmentation of professional groups. In turn this enables the Trust to meet commissioners' expectations regarding both clinical excellence and improved efficiency.

Innovations in Care Delivery

The Trust is committed to partnership as an approach that enables us to deliver those elements of pathways for which we are most appropriate provider, and to work in conjunction with partners for other elements which enrich the service users experience and outcomes. For example in Calderdale we work together with Alzheimer's Society to deliver a more holistic package of support in memory clinics. In Barnsley our telehealth services are delivered alongside telecare services provided by Barnsley MBC, so that the installation and maintenance of equipment in service users homes, and the provision of a 24/7 call centre are provided by BMBC, supplementing the Trust's telehealth offer.

Implementing Recovery through Organisational Change (IMROC) Perhaps the most fundamental area of innovation in care delivery for the Trust will be the commitment to recovery-based approaches in both physical and mental health services. We will use the ImROC approach to support us on our journey to embed this in everything we do.

The **Creative Minds** programme works with partner organisations and service users to co-produce creative approaches to recovery. This approach was originally conceived from feedback from service users and carers who wanted more creative approaches to improving their health and wellbeing. We further developed the strategy through a series of workshops involving service user, carers, Trust staff and other community partners. To date over fifty projects and partnerships have been developed. Early evaluation shows positive improvements to service users' health and well being delivered through non-medicalised models of care.

	Customer Service Excellence . The Trust is currently undergoing assessment for the Customer Service Excellence accreditation which is a Cabinet Office benchmarked accreditation programme to give assurance on the effectiveness of the customer service model operating within organisations. The Trust was successful in piloting 2 directorates in 2012-13 . The latest evaluation is for the whole organisation. The **Right First Time** initiative asks staff to walk in the shoes of their customers, whether these are service users or internal customers, in order to re-think the approaches, attitudes and processes applied in our everyday interactions. This in turn will lead to the identification of opportunities for improvement. Feedback from staff and service users also directly contributes to the ideas generation process through the review of incidents, complaints, and surveys including the Friends and Family test. The **Change Lab** programme has been successfully operating within the Trust since 2011. It supports innovation using a prototyping approach. Currently there are 8 prototypes underway, which are championed by Directors and regularly reported to Board and EMT to ensure they are appropriately enabled and connected to mainstream Trust activity.
Productivity & Efficiency	**Productivity and Efficiency** The Trust currently operates within a block contract framework for mental health and community services. However we are using SLR, benchmarking and engagement in local Year of Care work to prepare for new funding models, whether these are Payment by Results tariff based or weighted capitation models as in Year of Care. The assumption in the plan is that demographic growth in demand will be absorbed within the current funding envelope, generating a QIPP productivity gain for commissioners. The Trust has successfully delivered recurrent CIP programmes in the last 3 years which have met the National Efficiency requirement s of at least 4 % .There are 4 key areas which deliver productivity and efficiency gains included in the plan: • Workforce Efficiency: this includes optimising staff deployment through e-rostering; reducing bank and agency spend; reducing travel expenses and reducing sickness levels. • Workforce Redesign and Management costs: this includes re-profiling and standardising staff roles and grades using benchmarking ; renegotiation of terms and conditions linked to pay structure and reducing management costs through improved delivery of management and back office functions. • Service Redesign: this includes redesign and transformation of the service offer under 4 “big ticket “ headings Mental Health, Forensic Services Learning Disabilities and General Community. The transformation programmes plan to generate savings based on service improvement methodology and comparator to best practice for e.g time on caseload; length of stay for inpatients; reduction I in 1 to 1 consultations and increased use of group work and indirect contacts facilitated by technology. • Estates and non-pay efficiency: this includes reducing estate foorprint and costs through agile working ; achieving best value through procurement of goods and services ; reducing costs and carbon through adopting sustainable practices in the management of Estates and IT.

Cost Improvement Plans 2013/14 and beyond

The CIP plan for the 3 years is summarised below:

2013-14 £8.6m 4 % efficiency
2014-15 £12.1m 5.5 % efficiency
2015-16 £11.8m 5.5.% efficiency

The level of CIP is designed to maintain financial sustainability through generating around 5 % EBITDA ; continue to create a surplus which will fund capital plus create a level of revenue funding and flexibility which can be reinvested in services both of which will be necessary to deliver service redesign.
The focus for generating CIPs does shift across the plan with focus on achieving efficiency in existing services in 2013-14 .The following year requires a significant contribution from savings from service transformation and redesign and in years tow and three the CIP plan includes CIPs generated from increasing contribution by marketing and developing key service areas.

Leadership

All of the Trust's major change initiatives have Director leads. Directors perform the role of Sponsor and are accountable to the Trust Board. Programme leadership roles are vested in the most appropriate director, determined by reference to the needs of each specific programme. As a health organisation clinical leadership is essential in all major change. The specific nature of clinical leadership required is determined on a case by case basis. Prior to commencement of implementation all CIPs have been Quality Impact Assessed by the Director of Nursing and Quality and the Medical Director.

The leadership approach for each of the Trust's major change programmes is set out below:

	Transformation	Quality Care	Cost Improvement Programme
Sponsoring Director	Owned corporately by the Director of Transformation, with Director Leads for each Workstream	Owned corporately by the Director of Nursing	BDU and QA Directors accountable for delivery of directorate savings
Clinical Leadership	Clinical Leads for each workstream jointly accountable with Director Lead	Clinical Leads for each workstream jointly accountable with Director Lead	Supporting clinical input within each BDU
Delivery	Trust-wide thematic	Trust-wide thematic	BDU/ QA delivery

Assurance

CIP proposals are developed by BDUs and assessed by a multi-disciplinary group to ensure strategic fit, attractiveness and feasibility. Prior to commencement all CIP proposals are Quality Impact Assessed. This process is led by the Director of Nursing and Medical Director to ensure that the CIPs proposed do not have a negative impact on quality. The results of Quality Impact Assessment are reported to the Board and shared with commissioners as part of the contract renewal process.

During implementation there is a comprehensive monitoring process which is primarily undertaken through BDU management teams with oversight and escalation to Performance EMT and the Board. Support for this process is provided by the Programme

Management Office.

Programme Management Office (PMO)

The PMO supports the delivery of change across the Trust. It provides;

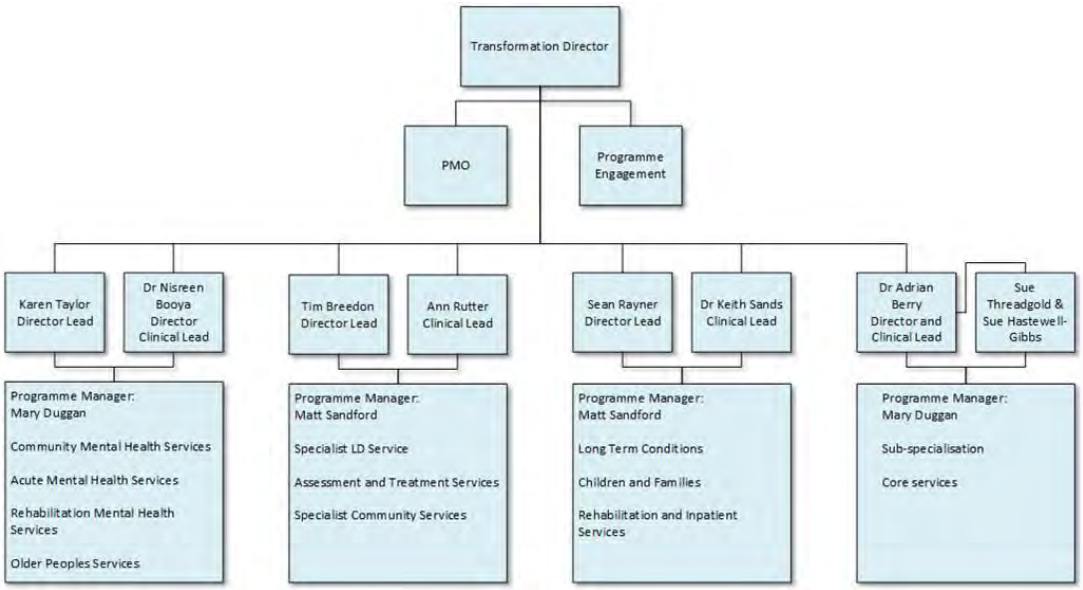
- Support for programme and project governance
- Ensures timely and accurate information to support decision making
- Supports delivery of programmes and projects through guidance and coaching for those involved in change, and promotes the use of the Trust's methodology.

The PMO provides dedicated support to Performance EMT relating to their role as the programme board for the CIP programme. The PMO also ensures that connections are maintained between the CIP and the Trust's Ensuring Quality Care and Transformation Programmes. This is key as the most complex and wide-reaching set of changes currently undertaken by the organisation. Lighter touch input is provided on all other Trust-wide change initiatives. Input to the CIP programme includes reporting, change control and tracking of benefits and dependencies.

Key CIP Schemes – Transformation Programme

The Trust CIP will support the organisations plans for reinvestment and address income deflation. In Years 2 and 3 as the benefits of the Trust's Transformation Programme begin to be realised the CIP will be increased from 4% to 5.5%.

The Transformation Programme will support the Trust in moving away from the provision of long stay accommodation for most service users, and will move us in the direction of becoming an enabling organisation that supports people to live in their own communities wherever possible. The diagram below describes the Programme structure.



Clinical Engagement in CIP Development and Delivery

Each year the operational delivery directorates (BDUs) and the support services directorates (Quality Academy) identify sustainable cost improvement opportunities needed to ensure continued financial stability including meeting the Trusts requirement for re-investment funds.

Every BDU has at least one Head of Service who is a practicing clinician working in

	partnership with a general manager. In addition each service line has a clinical lead representative. The CIP programme is designed by the BDU clinicians and managers. As part of the sign off process clinical leads and the BDU Director ensure that the plans have the support of BDU colleagues and that the responsibility for action is owned and understood.
	CIP Quality Impact Assessment The Trust has a Quality Impact Assessment process which is led by the Director of Nursing and the Medical Director. CIP programmes undergo clinical review and challenge process from which a Quality Impact rating is derived. The results are summarised and reported to the Executive with recommendations for action or mitigation. The purpose of the impact assessment is to ensure that any CIPs proposed do not have a negative impact on service quality schemes are and operationally safe and sustainable. . The results of the Quality Impact Assessment are reported to the Board as part of the approval of the Annual Plan and budgets; and shared with commissioner as part of the contracting process. **CIP Monitoring of Quality** During the year CIPs delivery is monitored monthly through performance reporting within BDUs and at Performance Executive Meeting. The monitoring uses a balanced scorecard approach to ensure that the implementation of CIP savings is firstly being delivered to plan and there is no impact on risk or service quality. Performance on quality , risk and CIP delivery is reported monthly to the Board..
Financial & Investment Strategy	**Financial Performance** The next three years are potentially the most uncertain and challenging for NHS providers and commissioners due to the scale of functional restructuring and the level of financial challenge. The financial and clinical strategy for the Trust therefore needs to put the organisation in the position where it can • Capitalise on its strengths – Continue to do the “day job” well and maintain quality of services and market share; • Align achieving quality with the use of resources to generate areas of improvement and cost reduction. • Drive productivity and efficiency so that existing services are competitive; • Drive service improvement and innovation so that existing services can be redesigned to be more integrated with physical and social care in order to meet demographic need within reduced resources • Identify opportunities for new business through expansion and growth in services; • Create the right conditions externally in terms of managing stakeholders and internally in terms of having the right capacity and skills to realise those opportunities. This is consistent with the Trust’s mission ***Enabling people to reach their potential and live well in their community*** **Assumptions** In setting the financial plan the LTFM reflects the key principles agreed by the Board in the financial strategy. • The drive in determining the use of resources is the link to quality. International evidence has shown that improving quality also reduces costs and therefore the financial plan and strategy is predicated on quality being the key driver. • Maintain a normalised EBITDA of 5 % • Maintain a recurrent underlying surplus of 1.5 % which is increased non-recurrently

to fund the capital programme.

- Generate cash reserves through surplus to fund a significant capital investment programme to 2016/17 to support and enable redesign of services and reduce estate running costs;
- Maintain a Financial Risk Rating (FRR) of 3 or above using the 2012-13 Financial Risk rating criteria ;
- Aim for FRR of 4 based on the new risk rating which comes into effect in 2013-14 which is more focused on demonstrating strength of liquidity and going concern position.
- Demonstrate efficiency of between 4 to 5.5 % through the Cost Improvement Programme (CIP)
- Have effective contingency planning for downside scenarios due to changes in providers, outcomes of tenders and future commissioning intentions.
- The plan also reflects the requirement for providers to create efficiencies across health and social care pathways through better integration of services. This is particularly pertinent in years 2 and 3 of the plan.

Income, Activity and Demand Management

The assumptions for income are summarised below:

- 1.3% deflation in contract income for 2013-14 which is assumed to continue through the life of the plan.
- 2.5 % of income for 2012-15 linked to achievement of quality targets (CQUINS). This reflects the continued focus on quality and outcomes and linking financial reward to quality. The plan assumes that the Trust is able to meet these requirements and secure this income on an on-going basis.
- Impact of mental health tariff. The trust has agreed a Memorandum of Understanding with its commissioners for 2013-14 and set up a joint Steering Group and work programme. The purpose of the group is to understand the current position in terms of service model and quality, expressed by the mental health currency; and agree a transition to a “tariff” model which complies with national requirements and meets local commissioning needs. The Trust shared baseline information on costs and activity in 2012-13. This is moving on to include activity and costs in line with the National guidance and information on quality indicators and outcomes. This will provide a good platform for creating a contracting mechanism which moves beyond the current block contract.
- Impact of Year of Care. The Year of Care project is a DoH sponsored initiative which is testing the feasibility of creating contracting mechanism which devolves a level of funding for a cohort of patient with Long term conditions which will commission all their care for all providers for one year. The project aims to increase transparency on the pathway of care improve quality of outcomes for individuals and create incentives to reduce waste in provider pathways. The Trust has social care provider in Kirklees which is a pilot of the National project. This methodology is being considered as an enabler to support changes in service delivery models in the system wide Transformation models.
- In 2013-14 the Trust is undertaking some rebasing of the contract baseline with commissioners to help create more consistency between commissioners that they pay the same “price” for the same service. This work is being managed through the Mental Health Tariff steering group and the focus for work in the first 6 months is inpatient services.
- Additional investment from Commissioners has been included in the plan from 2013-14 where the Trust has been successful in tendering for additional services e.g. CAMHS; where the Trust has a commitment from commissioners to invest from an Outline Business Case pending final approval in 2013-14 . This relates to expansion of Medium secure forensic services and development of psychiatric liaison service in Calderdale and Huddersfield using the nationally recognised RAID model.
- Detailed capacity and activity modelling is not as advanced in the Trust as in, for example, our acute counterparts. During 2012-13 the Trust has used the

implementation of service line reporting to enhance the modelling of contribution and capacity at service level. This has resulted in significant increases in productivity and reduction in waiting time in psychological therapies and development of AQP model for IAPT. Roll out of the principles of this work is key element of supporting information to create new service models and maximise efficient use of resources to deliver Cost improvement Programmes.

Key Actions to Support the Delivery of the Financial Strategy

The key actions to support the financial strategy are summarised below:

- Completion of the internal transformation plan for incorporation into revised Integrated Business Plan which is due to be presented to the Board in October 2013. This involves completion of the plans for the 4 transformation schemes – Mental Health; Learning Disabilities; General Community Services and Forensic Services – and the contribution of enabling strategies, workforce, estates and IM & T. The Transformational Service Redesign programme will define a clear vision for the future and articulate the service offer; using innovative practice and partnership working to sustain the quality of services in a resource constrained environment
- Development and application of the “Recovery model” concept to the redesign of services which will require investment of time in staff training and development and engagement with service users and carers.
- Maintenance of good working relationships with local provider partners and local health and social care commissioners to ensure that the purpose and value added of the internal transformation programme is understood and supported; and the Trust is able to play a role in shaping the integration of services in the future.
- Manage the transition to a currency model for Mental Health services both internally and externally to minimise the risk of reduced contribution.
- Develop Service Line Reporting through the Business Delivery Units to ensure that all service lines have a sustainable baseline in terms of activity, workforce and resources and to identify opportunities for creating efficiencies.
- Plan and Deliver a substantial Cost Improvement Programme from the redesign of the service offer through the planned Transformational Service Programme.
- Implement the Estates strategy and manage the Capital Programme to support the service redesign and optimise the estate footprint and costs.
- Implement the IT strategy to ensure that robust infrastructure is in place to support innovative use of technology in delivering the revised service offer
- Implement the workforce strategy to drive workforce productivity and support the development, skills and well-being of our staff so they can enable service users to “achieve their potential.”

Description of risk (including timing)	Potential Impact	Mitigating actions / contingency plans in place	How Trust Board will monitor
Data quality and capture of clinical information on RiO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency	reputational and financial risk in negotiation of contracts with commissioners	Data Quality Strategy and associated reporting to Business and Risk Board. The data quality framework is monitored by the data quality steering group which is chaired by the Director of Nursing. All BDUs have a data quality action plan which is reviewed internally. The clinical audit programme includes a focus on the data quality priorities.	EMT and Trust Board monthly review. Supported by reviews by Steering Group of Data Quality Board, PBR Project Board, and RiO system development board - all accountable to EMT
The Care Packages and Pathways project will not deliver an improvement in service quality and outcomes through the roll out of clustering and mental health currency.	Failure to meet service user and commissioner expectations. Challenges to productivity and efficiency.	Accountability arrangements in place for delivery of mental health currency Project. Led by DoF. Project Board includes DoN and MD. Progress reviewed by Audit Committee and Board. Key issues / risks and progress monitored at Performance EMT. Key representation at national level for development of costing by CEO and DoF through CPPP programme.	EMT Progress reports. Audit Committee reports. Regular Board updates
Reduction in Local authority funding and changes in benefits system will result in increased demand of health services and reduced capacity in integrated teams	Challenge to the ability of integrated teams to meet performance targets.	District integrated governance boards established to manage integrated working with good track record of cooperation. Maintenance of good operational links though BDU teams and leadership. Monthly review through Performance EMT of key indicators e.g. delayed transfers of care	EMT (monthly) and Trust Board (monthly)
Risk that the expectations of emerging CCGs for mental health and community services will create a potential reputational and financial risk for the Trust.	Reputational and financial risk for the Trust	Clear accountability at BDU level for managing stakeholder relationships with support from Quality Academy Directors through professional networks. Agreed joint governance arrangements for management of service contracts	EMT (monthly) and Trust Board (quarterly)
Risk that the planning and implementation of transformational change through the Big Ticket programmes will increase clinical and reputational risk in in-year delivery by imbalance of staff skills and capacity between the "day job" and the "change job".	Increased clinical risk, negative impact on quality	Scrutiny of performance dashboards and weekly risk reports by BDUs and EMT to ensure performance issues are picked up early. Weekly risk review by Director of Nursing and Medical Director to ensure any emerging clinical risks are identified and mitigated. Monthly performance review by Board. Engagement of extended EMT in managing and shaping transformational change and delivering in year performance.	EMT (monthly) and Trust Board (quarterly)
Risk that the Trust does not have a clear marketing approach to enable it to maximise opportunities and mitigate threats in an increasingly competitive market.	Missed opportunities for growth/ contract losses	Develop a clear marketing and commercial approach within the organisation, building on existing arrangements. Action plan reviewed by Board and EMT	Monthly strategic and business and risk EMT meetings. Trust Board reports as appropriate.