Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

# Strategic Plan Document for 2013-14

# Tees, Esk and Wear Valleys NHS Foundation Trust

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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):**

| | |
|---|---|
| **Name** | **Sharon Pickering** |
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| **Date** | **28 May 2013** |

**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.**

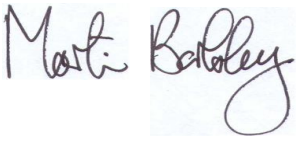
**Approved on behalf of the Board of Directors by:**

| | |
|---|---|
| Name *(Chair)* | Mrs Jo Turnbull |

**Signature** 

**Approved on behalf of the Board of Directors by:**

| | |
|---|---|
| Name *(Chief Executive)* | Mr Martin Barkley |

**Signature** 

**Approved on behalf of the Board of Directors by:**

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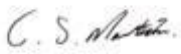
|---|---|
| Name<br>*(Finance Director)* | Mr Colin Martin |

**Signature**



# Executive Summary

This Business Plan sets out the key priorities that the Board of Directors have identified for the period 2013/14 to 2015/16 in light of its analysis of the external and internal environment. It has been developed by following our robust Business Planning Framework which ensures the engagement of management and clinical leaders. This framework has recently been subject to continuous testing by our auditors which has provided significant assurance on this critical process.

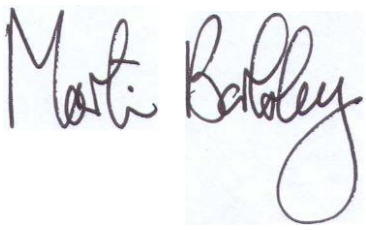
Whilst the Board recognised the significant change in the environment that has, and will continue to take place over the life of the plan, it concluded that the current Strategic Direction of the Trust remains appropriate (as outlined in the diagram overleaf).

However, during 2012/13 the Board reviewed its Business Development Strategy as a key enabler to the delivery of the Strategic Direction. The new Business Development Strategy, approved by the Board in January 2013, identified that our long term clinical and financial viability will be achieved though a continuous focus on raising the quality of our services and increasing the value that we provide to commissioners. The Board agreed that a focus on quality and value will safeguard our market position in the short term and provide opportunities for growth in the longer term.

In light of the above the key themes that underpin the Business Plan are as follows:

- Further focus on improving the quality of our services;
- Further focus on adding further value to commissioning which will include supporting them in delivery of QIPP and national policy requirements across the local health economies, for example addressing the requirement of the Winterbourne Review, development of Acute Hospital Liaison Services and repatriation of out of area placements;
- Reinvesting surpluses to continue to make improvement to service delivery and our estate.

Finally the Business Plan has been developed on the back of a stable financial position that has been in place since the Trust became a Foundation Trust in 2008. The financial strategy of the Trust ensures we can continue to maintain this position by continuing to take a prudent approach to financial planning in order to ensure that the delivery of our clinical strategy is supported by a strong financial position.

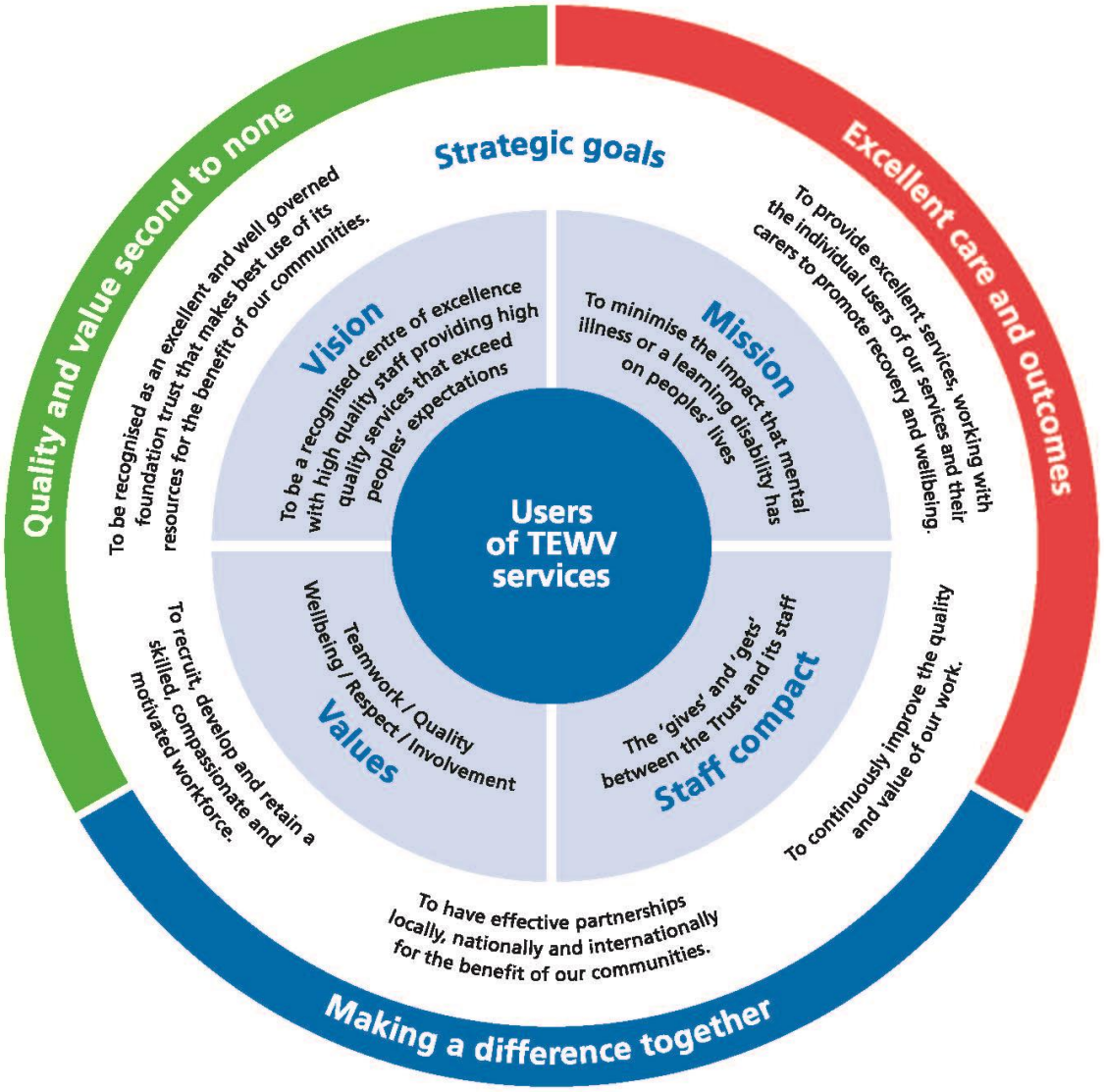


**Martin Barkley**

**Chief Executive**

**Tees, Esk and Wear Valleys NHS Foundation Trust**

# The TEWV approach



# 1.Strategic Context and Direction

## 1.1 Overview of the Trust

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provides a range of mental health, learning disability and substance misuse services for the 1.6 million people of all ages living in County Durham; Darlington; the four Teesside boroughs of Hartlepool, Stockton, Middlesbrough and Redcar and Cleveland; the Scarborough, Ryedale, Hambleton, Richmondshire and Harrogate districts of North Yorkshire and the Wetherby area of West Yorkshire.

These services include inpatient and community services as follows:

- Children and Young People Mental Health Services (CAMHS), including Children and Young People Learning Disability services.
- Adult Mental Health Services (AMH), including Acute Liaison, primary care psychological therapies and substance misuse.
- Adult Learning Disability Services (ALD).
- Mental Health Services for Older People (MHSOP), including Complex Care, Acute/ Care Home Liaison, Memory Clinics.
- Forensic Services, including Forensic Learning Disability, Forensic Mental Health and Offender Health.

The Trust's services are organised primarily on a locality-basis as follows:

- Durham and Darlington,
- Tees,
- North Yorkshire,

with a fourth Directorate covering Forensic Services. Each is led by a Director of Operations and a Deputy Medical Director who report to the Chief Operating Officer.

Clinical leadership is aligned through the Senior Clinical Directors across the four Divisions which cross-cut the whole Trust area:

- Adult Mental Health (including Substance Misuse)
- Mental Health Services for Older People
- Children and Young People Services
- Adult Learning Disability Services

Our inpatient services are delivered from our hospitals at:

- West Park, Darlington
- Roseberry Park, Middlesbrough
- Lanchester Road, Durham
- Cross Lane, Scarborough
- Sandwell Park, Hartlepool
- West Lane, Middlesbrough (CYP)
- Auckland Park, Bishop Auckland (MHSOP)

We also deliver services from wards within:

- The Friarage, Northallerton (owned by South Tees FT)
- Harrogate District General Hospital (owned by Harrogate FT)

We deliver our community services from a wide range of venues including GP practices and patients' homes as well as properties owned or leased by the Trust.

## 1.2 Environmental Drivers

The table below summarises the key environmental drivers, which will impact on the Trust over the lifetime of this Plan and our planned response to them.

| Driver | Response |
|---|---|
| Financial context, including that of local NHS commissioners | • Work with commissioners to identify investments with TEWV that will release resource elsewhere in the system (e.g. acute liaison, repatriation of out of area patients)<br>• Increase community team productivity |
| Requirement to find year on year cash releasing efficiency savings (CRES) | • CRES schemes identified through our Business Planning Framework (There is significant clinical engagement in the development of CRES schemes and a number of opportunities for the Board and clinicians to challenge the schemes)<br>• Increased community team productivity<br>• Increased use of TEWV Quality Improvement System (QIS) – based on Toyota Production System / Virginia Mason Production System, including use of Model Lines (Model Lines is the deployment of clinical pathways which incorporate lean methodology across all team processes)<br>• Reduced reliance on inpatient beds |
| Payment by Results (PbR) implementation | • Continue to be a key participant in the national Care Pathway and Packages (CPP) work and influence the national approach to PbR implementation<br>• Implement monitoring of Clinical Outcome Measures (CLOMs) as part of PbR to demonstrate improvement delivered by our care |
| Financial environment of Local Authorities | • Continue to be a key player in Health and Well Being Boards<br>• Review of partnership arrangements |
| Increased focus on delivery of quality post Winterbourne View report and Francis Inquiry | • Continue to collect quality data and ensure it is used analytically to identify any areas of concern<br>• Maximise contact time with patients by reducing data entry burdens on clinical staff through use of digital input / digital dictation technology, development of model lines and implementation of recommendations of CPA review<br>• Continued use of QIS methodology across the organisation |

| Driver | Response |
|---|---|
| Demographics and demand:<br>• Ageing population with<br>  • resulting increase in patients with organic illnesses<br>  • increasing number of older patients with physical frailty in addition to mental health issues<br>• Increased demand for alternative care packages in the community for learning disability patients in response to Winterbourne View inquiry recommendations<br>• Increased demand for Children and Young People's services evidenced by increasing referrals<br>• Increased demand due to economic conditions and changes in benefit systems | • Increased productivity of community teams<br>• Further implementation of acute hospital and care home liaison services<br>• Continued move to more care provided in the community with less reliance on inpatient beds<br>• Proactively respond to commissioning intentions (e.g. dementia, liaison, autism, enhanced CAMHS services, peri-natal services)<br>• Work with commissioners to repatriate out of area patients<br>• Review Learning Disability assessment and treatment capacity and focus<br>• Engagement with Health and Well Being Boards |
| Competition<br>• Increased competitive tendering of Substance Misuse services, which include a focus on wider recovery models for substance misuse services rather than "medical" model<br>• Any Qualified Provider<br>• Specialised services (Eating Disorders, Offender Healthcare, Forensics)<br>• Introduction of choice in mental health services | • Respond to tenders expected in 2013/14 and 14/15<br>• Implement appropriate partnerships with Voluntary and Community Sector organisations to respond to tenders thereby increasing "offer" to commissioners<br>• Review service delivery in light of first 12 months as a qualified provider for Primary Care Psychological Therapies<br>• Continue to focus on improving the quality of services using our QIS<br>• Further roll-out of patient experience data collection, with continuing reporting and action on feedback received<br>• Introduce standard Patient Reported Outcome Measures (PROMs)<br>• Implement and embed a recovery approach across the Trust |

## 1.3 Summary of key strengths and weaknesses

The tables below detail the Trust's main strengths and weaknesses.

| Strengths | Implications and Actions |
|---|---|
| Quality Improvement System (QIS) | The Trust has implemented its QIS which is based on the Toyota Production System and Virginia Mason Production System. This provides us with a systematic way of improving the quality of our services, reducing waste in our processes and increasing the value added of our services. The QIS has been recognised externally both in terms of awards the Trust has won, but also in a growing demand from other Health and Social Care organisations for us to support the development of their own approach to quality improvement. It will be through the significant use of this system that the elements of this plan will be delivered – in particular increasing the productivity of community teams and the development of model lines. |
| Clinical Leadership and engagement | Since its inception the Trust has recognised the need for strong clinical leadership and engagement. It has therefore replicated the relationship at Board level between the Chief Operating Officer and Medical Director at several management levels throughout the organisation: e.g. there is a Director of Operations and Deputy Medical Director in each of the 4 Operational Directorates within the Trust and operational Heads of Service are paired with a Clinical Director and both have leadership responsibilities. In addition, there are Senior Clinical Directors who provide specialist input for each clinical Division on a Trust-wide basis (e.g. AMH, LD etc). This emphasis on clinical engagement has been fundamental in ensuring that our CRES plans have been clinically appropriate and ensured clinical "buy-in" to the Business Plan. |
| Financial Stability | The Trust has a history of low reference costs and financial stability which has allowed it to invest in improving services since becoming a Foundation Trust in 2008. The Trust's 2012 Reference Cost Index (RCI) is **74** for those non clustered services (21% services) and **91** for clustered services, combining to an overall Trust RCI of **85.** The Trust has a Monitor Financial Risk Rating (FRR) of 5. The financial plan for 2013-2016 identifies that the FRR will be 4 over the lifetime of this plan. This means that the Trust will be able to continue to develop services and improve quality – particularly in terms of estate because we will be able to fund capital developments (see section 3.3). |
| Payment by Results (PbR) readiness | The Trust has taken a formative and active role in the CPP national group which has been supporting the Department of Health's development of PbR for Mental Health since the inception of the programme. This has placed the Trust in a strong position both in terms of the current implementation of clustering but also in terms of influencing the national development of PbR for Adult and Older People's mental health services. The Trust is also engaged nationally in the exploration of PbR for Children and Young People's services and Forensic services. |
| Size | As one of England's largest Mental Health and Learning Disability providers we are able to:<br>•Use comparative data from different teams within the Trust to challenge poor performance and identify best practice;<br>•Invest in strong, Trust-wide corporate services which can build up skills and knowledge and use these to support operational managers delivering on the front-line. |

| Weaknesses | Implications and Actions |
|---|---|
| Demonstrating outcomes | The routine use of clinical outcome measures is variable across the Trust. The lack of an agreed set of outcomes for mental health has resulted in the Trust finding it difficult to demonstrate the value its services add for patients and commissioners. As one of the leaders in the implementation of PbR the Trust is now implementing the HONOS outcome measure as part of PbR and has plans in place to ensure the accurate recording of outcomes will become routine in Adult Mental Health and Mental Health for Older People services in 2013/14. The Trust's engagement in Children and Young People's IAPT delivery will also drive the use of outcome tools routinely for this client group during 2013/14. |
| Variable estate quality | The Trust has invested heavily in new hospital buildings in the areas that formed part of the Trust at its formation. However, this high standard only serves to highlight the much lower standard of accommodation found in Harrogate, Hambleton and Richmondshire, much of which is rented from Acute Trusts and cannot be easily redesigned to create the kind of environment found in our own hospitals elsewhere in the Trust. The Trust is developing options for improving estate quality in this area, but this must be linked to an understanding of what and how services will be delivered in the future. There are also some community clinics and team buildings in North Yorkshire and elsewhere in the Trust which are below the standard we set for ourselves and our capital plan will continue to address these in a planned and sustainable way. The Trust will continue to use its Service Improvement Space Utilisation Programme (SISUP) programme to review and rationalise its estate, improving buildings that remain essential for delivery of services and selling sites which are not suitable for modern healthcare or which are surplus to requirements. |
| Patient Experience Monitoring | The Trust recognises the importance of having systematic ways of capturing patient experience and then acting on this feedback in order to improve services. We have therefore over the past few years been implementing methods of routinely capturing feedback from patients Trust wide. However to date these have only been rolled out within AMH, Forensic and MHSOP inpatient services. Therefore we do not have Trust wide systems for capturing patient experience in other specialities. During 2013-14 our implementation plan concentrates on further roll out of Trust wide systems into CYP and LD services. Furthermore to support this critical area we have agreed additional recurrent investment within the Patient Experience Team. |
| GP Satisfaction | Our biannual GP survey has demonstrated that whilst GP are extremely satisfied in terms of their experience of our MHSOP Services this is not consistent across all our other services. Our latest GP survey did show that the level of GP satisfaction had increased compared to the results in 2010, particularly with regard to adult services. This reflects the action that was taken following the 2010 survey. In response to the results of the 2012 survey we have produced detailed action plans to address the concerns. Progress against these action plans will be monitored on a regular basis and intelligence will continued to be gathered via meetings with CCG/GP leaders on an ongoing basis. |

## 1.4 Our Strategy

TEWV has a well-established business planning process, which ensures its financial, workforce and quality improvement plans are developed in an integrated way. This process ensures that the Board develop planning priorities based on a robust PESTLE and SWOT analysis, that those priorities are discussed and challenged by clinical leaders, service managers and Governors, and that actions to implement the priorities are identified by front line services.

Although the external environment is changing, along with our commissioning organisations, the Board's assessment is that our core vision and mission remain appropriate. Therefore, our mission remains:

**To improve people's lives by minimising the impact of mental ill-health or a learning disability,**

and our Vision is also still:

**To be a recognised centre of excellence with high quality staff providing high quality services that exceed people's expectations.**

The Board has also retained the Trust's existing 5 Strategic Goals with some very minor revisions. These are:

**Strategic Goal 1**
**To provide excellent services working with the individual users of our services and their carers to promote recovery and well being.**

**Strategic Goal 2**
**To continuously improve the quality and value of our work.**

**Strategic Goal 3**
**To recruit, develop and retain a skilled, compassionate and motivated workforce.**

**Strategic Goal 4**
**To have effective partnerships locally, nationally and internationally for the benefit of our communities.**

**Strategic Goal 5**
**To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of our communities.**

However, given the changes to the environment, the Board reviewed its Business Development Strategy during 2012/13 and has agreed that the earlier strategic focus on expansion is no longer appropriate. Our view is that in the current environment, our long term financial and clinical viability is best promoted through continuing to focus on further raising our quality and hence the value that we provide to commissioners of mental health and learning disability services. We believe that a focus on quality and value will safeguard our market position in the short term and provide opportunities for expansion in the longer term. We expect this expansion will be possible as existing and new commissioners will recognise the quality of the services we provide as being "second to none" and the added value this will give to them and their patients / population. Furthermore, we do not intend to embark on any significant diversification activity as part of this Business Development Strategy. We will work also with other organisations to ensure quality and improve delivery of outcomes where this is appropriate – for example Acute Hospitals for liaison services, local councils and care homes in the treatment of dementia, and with the voluntary sector in Substance Misuse services. We will also facilitate learning about our QIS for health and social care providers (as part of demonstrating how this delivers value to the tax payer) and sell our expertise in this area to

organisations who we believe are committed to fully implementing the philosophy which is a fundamental part of the QIS.

# 2. Our Approach to Quality and Assurance

## 2.1 TEWV's commitment to Quality and Improving Quality

TEWV has a strong and demonstrable commitment to quality as demonstrated by its second Strategic Goal: *To continuously improve the quality and value of our work* which is a key driver of our Business Plan. In addition, the Board of Directors has made a commitment to patient safety: **Tees, Esk and Wear Valleys NHS Foundation Trust wants all of its staff to be aware that it is committed to delivering safe high quality care with an emphasis on continuous improvement.**

Our focus on quality can also been seen in our new Business Development Strategy which, as described earlier, commits the Trust to quality improvement rather than a focus on acquisition or diversification. We have invested significant resources in the development and use of our QIS as the methodology through which we are mistake-proofing our processes and reducing defects as part of driving out waste and increasing value. A strong team of experts in our Kaizen Production Office (KPO) support and train managers, clinicians, medics and administrative staff in the tools of quality improvement. We ensure that all senior managers who are certified QIS leaders conduct at least one major quality improvement review, taking up approximately 11 working days every year. We also recognise the role that technology has in improving quality, and have invested in setting up a Integrated Information Centre which will improve the way in which we are able to use data to identify current or future quality problems so that they can be addressed.

## 2.2 Existing Quality Concerns

During 2012-13 there were 6 CQC reviews of Trust services. The reports following these inspections highlighted that four of the services reviewed met full compliance requirements. Two services, however, were identified as requiring action as follows:

**Auckland Park, Bishop Auckland** – The CQC inspected this unit in August 2012 and found that we were not providing sufficient opportunities, encouragement and support to patients within our older people's organic service in relation to their autonomy and independence. We responded to their recommended compliance actions with an action plan which committed us to implement a number of measures, including:

- Producing intervention plans for each patient that promote a more personalised approach to managing risk and maintaining patient dignity;
- Increasing opportunities for indoor and outdoor cognitive stimulation;
- Providing better information for patients and carers about the clinical grounds for any restrictions on patients;
- Improving the recording of risk assessments on our patient record in response to CQC concerns.

However, a further CQC inspection in April 2013 found that there had been insufficient progress on implementing the action plan. As a result a Warning Notice was issued to us. The Chief Operating Officer is leading the work programme to introduce the required changes to processes and procedures which will be rapidly implemented during June 2013. The Chief Executive has commissioned an independent review to investigate the circumstances that led to the Trust receiving a Warning Notice and to make recommendations to help the Trust ensure it never happens again.

**Clozapine and Lithium Clinics** – The CQC found that patients were not sufficiently protected against the risks associated with these medicines because we did not have appropriate

arrangements in place to safely manage them. In response we will implement improved processes, which draw on good practice from elsewhere in the Trust by 31st August 2013. This will include the use of electronic visual control boards which show monitoring and dispensing status for each patient. This will be able to accessed and updated by nursing and pharmacy staff so that outstanding monitoring or supplies can quickly and easily be identified. Repeat prescriptions will be linked to the electronic system and dose changes will be recorded and fully auditable.

In addition, the CQC made four Section 64 requests asking the Trust for additional information in regard to their concerns. These related to:

- Incidents relating to a medication error within the Springwood Unit in Malton;
- A list of our Clozapine and Lithium Clinics;
- Provision of our statement of purpose;
- Information around the three unexpected deaths notified by ourselves relating to the Tunstall Ward at Lanchester Road Hospital.

In terms of the 3 unexpected deaths, and a further death in an associated community team, the Trust immediately took action. It suspended admissions into that Ward for a short period and then appointed Malcolm Rae, former Director of Nursing at the Department of Health to provide an external review. He will report his findings to the Trust's Board in July 2013. CQC inspected the ward in April 2013 and have fed back that there are no compliance issues.

There were 28 CQC Mental Health Act monitoring visits to the Trust between April 2012 and March 2013. A minority of these visits identified issues, and these are set out alongside the action the Trust has taken below.

| **MHA monitoring visit finding** | **Trust Action** |
|---|---|
| **No documentary evidence of the Responsible Clinician's (RC) assessment of capacity of patients within the first 3 months of detention, or immediately prior to the end of the 3 month period when consent from the patient must be sought.** | *The Medical Director wrote to all RCs to remind them of their duty to fully document their assessments of capacity to consent before treatment commences and immediately before the 3 month period ends.*<br>*The Trust's MHA Department will not accept the T2 Consent to Treatment form unless accompanied by the documented assessment of capacity.* |
| **Patients were not informed by the RC of the Second Opinion Appointed Doctor's (SOAD) reasons for authorising treatment.** | *The MHA Department writes to the relevant RC following every occasion the SOAD authorises treatment to remind the RC of their duty to discuss with the patient (documented) the reasons for the SOAD's decision.* |
| **There is no mention of CCTV in patients' information leaflets, nor CCTV notices for patients or visitors** | *There is clear signage present at the entrance to the ward blocks notifying of CCTV in operation. Information regarding the use of CCTV is to be added to patients' information leaflets*. |
| **There was no information about Independent Mental Health Advocacy for staff or patients on the ward** | *Information leaflets are now available on the wards and laminated posters are being devised for every ward to display* |
| **Blanket restrictions on detained patients within the Forensic Service** | *Security Differentiation Group has been established that meets monthly and is currently looking at 4 major issues:18 media; unescorted leave to resource activities; patients' visits; and unescorted access to internal courtyards.* |

We have also had a concern raised about staffing levels in one of our inpatient units raised under our Whistleblowing policy. We are working with the Royal College of Nursing (RCN) to investigate the issue, and our open approach has been complimented by the RCN and the whistleblower.

Our approach to collecting patient experience data, then using it to drive improvement has continued to develop. We now routinely survey patients in 72 clinical areas using 44 portable electronic devices and 2 static kiosks, one in the community adult mental health service in Parkside, Middlesbrough, and one in the community mental health services for older people in Auckland Park. Approaches for CAMHS and LD are being developed. Compared to 2011/12, the number of service users and carers who responded to our surveys in 2012/13 increased by 25%, from 3,054 to 3,820. We have now confirmed ongoing funding for the team that maintains and develops the patient experience data collection and reporting systems.

The data collected shows that we are improving patient experience in areas such as carer involvement in decisions and treatment; explaining the side effects of medication to patients and the overall rating of care quality. There are also some measures where we are maintaining high levels of satisfaction, for example the percentage of patients reporting that they are treated with dignity and respect has been maintained at 97%.

However, we recognise we still have work to do. There are aspects of care that our service users and carers say through our surveys that we need to improve. For example, satisfaction scores with care plans in Community Mental Health Services for Older People vary between 45% and 88%. Further work has identified that service users and carers sometimes do not value the care plan as they do not easily recognise it within their documentation. These will be key areas to be addressed within the implementation of our CPA Review recommendations which commences in 2013/14.

## 2.3 Quality Risks and Mitigations in our Plan

As previously outlined, we have a robust business planning process which ensures that the priorities set by the Board are based on an environmental assessment which Operational and Clinical Leaders have input into. The development of milestones to address the Board priorities by clinical services is done by managers and clinical leaders working in the services. Our Business Planning framework ensures that the detailed plans developed by our clinical services in this current Business Plan are challenged by:

- other Executive Management Team (EMT) members;
- Governors, Trust Board and senior clinical and managerial leaders (in a workshop setting)

In addition we have implemented a Quality Impact Assessment (QIA) process for our Cash Releasing Efficiency Schemes (CRES) which is described in more detail in Section 4.3.

We have also presented the evidence of its QIAs to our commissioners who acknowledged the robust process that we have in place for developing our Business Plan and the CRES schemes within it. It is recognised that as the plan is implemented additional risks may arise. The impact of these will be mitigated by the following:

- Use of proof of concepts to test assumptions before full roll out;
- Use of QIS tools, including development of “Model Lines”;
- Development of care pathways following appraisal of NICE guidelines;
- Continued use of validation and internal peer inspection programme;
- Improvements in the ability to use quality data from different sources to build up a picture of current issues, including ability to “stop the line” if necessary;
- Regular review of key quality and activity data (as well as financial) by Board and EMT
- Ongoing real-time patient feedback collection;
- Board and EMT visits to clinical teams (inpatient and community) and corporate services.

## 2.4 Board Quality Assurance

Our corporate and clinical governance arrangements are underpinned by our risk management systems and processes which are designed to provide on-going assurance to our Board on the achievement of our Strategic Goals.

Our integrated governance arrangements are detailed in our Integrated Governance Strategy which is reviewed annually by the Board of Directors and are fully:

- Aligned to key corporate processes e.g. our Planning and Performance Management Framework, Project Management Framework and Quality Assurance activities.
- Embedded within our corporate and clinical governance structures.

Our Chief Executive is responsible for the operation of our systems and processes to manage risks; however, our objective is for all staff to act as risk managers, supported by appropriate training.

Assurance that our risk management arrangements are robust and embedded is provided by our Audit Committee. This assurance is based on:

- The annual External Auditor's opinion of whether our Statement on Internal Control (which describes our risk and control framework) meets the requirements of Monitor and is consistent with information arising from the statutory audit;
- Reviews undertaken by Internal Auditors. Our three year strategic and operational Audit Plans have been developed to provide full coverage of our principal risks.

The Integrated Governance Strategy details our comprehensive risk management model which covers:

- Risk identification;
- Risk evaluation;
- Monitoring;
- Management of risks;
- Reporting outcomes.

**Our Quality and Assurance Strategy**

A key strand within the overarching Integrated Governance Strategy is the Quality and Assurance Strategy which aims to outline the systems used to provide assurance on the quality of our services through governance systems. The challenge for the Trust is to ensure that there are effective mechanisms that enable the Board of Directors to consider the quality and safety of care and treatment and be provided with assurance of that quality and safety within the context of the external regulations and the drive for continuous improvement. This assurance needs to meet the requirements of corporate accountability for registration with the Care Quality Commission (CQC) and our Monitor Licence.

The Quality and Assurance Committee (QuAC), as a sub-committee of the Board of Directors, oversees the assurance processes and clinical governance systems. The QuAC reports to the Board of Directors monthly and monitors regulatory compliance, service and clinical outcomes and quality improvement processes. It utilises the Essential Standards of Quality and Safety as set by the CQC as well as the Monitor Governance Framework to benchmark compliance of service standards. In addition, the Trust runs a programme of internal, unannounced inspections of service. These review and validate compliance statements of services provision against reputation standards.

The Board of Directors, through the QuAC:

- Provides leadership to clinical governance and quality improvement activities by ensuring consistency and cohesion across the Trust;
- Assures itself of the standards/outcomes delivered by the clinical services of the Trust;
- Assures itself of the standards and progress achieved in delivering the Trust strategies;
- Assures itself that the Trust maintains CQC registration;
- Supports the QA Committee to undertake an annual review to ensure it is meeting its objectives and to consider progress against this strategy.

The QuAC is supported by a network of assurance working groups that make regular reports to the Committee at prescribed intervals within the Committee's annual plan. The assurance working groups are:

- Patient Safety and Clinical Effectiveness;
- Patient Experience;
- Drugs and Therapeutics;
- Research Governance;
- Infection Prevention and Control;
- Medical Devices;
- Safeguarding Adults;
- Safeguarding Children;
- Psychological Therapies Governance;
- Equality and Diversity.

In addition, there is a working group that provides a service user perspective and involvement in the assurance and governance agenda. This Essential Standards Service and User Reference group specifically focuses on the first outcome in the CQC Essential Standards – Respecting and Involving People who use services. This group arranges service led inspection visits to Trust services, supported by Patient Advice and Liaison Service (PALS), to monitor the quality of services' provision from the service user perspective.

Each Clinical Division has a Quality and Assurance Group (QuAG) and these provide an assurance report to the QuAC on a six monthly basis, which includes a review of the Division's Risk Register and risk mitigation. These governance groups co-ordinate the activity within the Division that provides information about compliance with CQC Essential Standards in addition to monitoring Division's specific patient complaints, PALS activity, incidents and Serious Untoward Incidents (SUIs).

**Using Data to improve patient safety, outcomes and experience**

Data collection and reporting is an important part of the assurance and improvement process. We collect data on:

- Serious Untoward Incidents (SUIs);
- Safeguarding incidents;
- Other patient safety incidents, including "near misses";
- Patient Experience;
- Complaints and PALS issues and investigations;
- Clinical Audit outcomes;
- Clinical Outcomes (including change between health at admittance to services and at discharge)
- Compliance with CQC Essential Standards of Quality and Safety – from internal validation and service user inspection regimes across services.

This data is reviewed by the QuAGs and by the QuAC. Any actions required to improve quality and compliance are co-ordinated by the QuAGs.

SUIs are also reported on a week by week basis to the Trust's EMT. Serious Incident Root Cause Analysis Reports are quality assured by a panel including both executive and non-executive directors.

Patient experience data and the reports from internal validation reviews and service user inspections are fedback to ward or community team managers shortly after data collection, enabling patient concerns and suggestions to be addressed quickly.

Patient outcome data is measured through "HoNoS" scores, and as this becomes embedded in national PbR for mental health we intend to use the information from clinically recorded patient outcomes to challenge practice where necessary in order to drive up standards so that the most effective practice in one part of the Trust can inform that in others. This approach of dissemination of lessons learned is also used to share improvements and learning from assurance data.

As we develop our Integrated Information Centre we will improve our capability to integrate the reporting and analysis of quality data alongside activity, staffing and financial data. This will assist quality indicators to become more embedded within the business intelligence used by the organisation.

# 3. Our Clinical Strategy

Our assessment of the current environment is that patients, commissioners and other stakeholders wish to see NHS providers focussing on quality and quality improvement and adding value to the wider health economy.

As previously outlined, our Business Development Strategy commits the Trust to focussing on improving quality rather than acquisition or diversification because we believe that the key to long term sustainability as a Foundation Trust is to develop a reputation for providing excellent patient outcomes and experience whilst also adding value to our commissioners.

Our focus on ensuring that quality is consistently achieved is reflected in the priorities of our Quality Account (see 3.1). Our plans to develop services that meet patient and commissioner needs are set out in 3.2, and where significant capital investment in built infrastructure is required, in section 3.3. Section 3.4 confirms our focus on retaining existing business, while section 3.5 sets out key workforce issues that we will address to enable us to achieve our goals. A key underpinning enabler of our clinical strategy is the development of more sophisticated systems for collecting, analysing and acting on quality data. This is reflected among our Information priorities set out in Section 3.6.

## 3.1 Our Quality Account Priorities

The process of identifying the key priorities for 2013/14 involved a number of our stakeholders. The process was as follows:

- An internal review was undertaken on the findings of serious untoward incidents, other incidents / 'near misses', complaints, Patient Advice and Liaison Service contacts and audit findings to identify common themes for improving quality;
- An event was held in July 2012 to share these issues with our stakeholders and get feedback on where they think the quality of our services needs to be improved. From this workshop seven key quality themes were identified and these were presented to the Board of Directors;
- At its formal meeting in November, the Board of Directors agreed the four quality priorities for 2013/14 to be included in the 2012/13 Quality Account, and the Business Plan (from the seven key quality themes identified by our stakeholder);
- A second stakeholder workshop was held in February 2013 where our four quality priorities and proposed plans to deliver these were shared;
- The stakeholders' comments on our plans were used in finalising our 4 quality priorities included in the Quality Account as described below.

| QA Priority | Expected outcome by end March 2014 |
|---|---|
| **Improve the consistent use of the Care Planning Approach across the Trust, resulting in improved care planning** | We will:<br>• Consider how care is planned in a way that service users understand. For example, start with 'what does the service user want as an outcome' and end with 'what actions do we need to deliver this outcome'.<br>• Ensure that all service users are correctly allocated to and managed on either the Care Programme Approach or standard care.<br>• Review the process for assessing and managing risk and ensure it fully supports the aim of high quality, safe and recovery focussed care.<br>• Reduce the administrative burden and documentation for people on standard care and reinvest time on more patient focussed care planning.<br>• Clarify with our partners in care the expectations for all health and social care professionals working with the Care Programme Approach.<br>• Consolidate our experience of tried and tested improvements in care planning and spread best practice across the Trust.<br>• Clarify arrangements for Section 117 aftercare, specifically, policy, case management, review and monitoring. |
| **Improve the consistent use of the Care Programme Approach across the Trust resulting in improved communication between staff and patients in terms of their care** | We will:<br>• Reduce the administrative burden and documentation for people on standard care and reinvest time in communicating with service users and carers.<br>• Make best use of time to communicate with service users and carers to increase service user and carer involvement in their care, such that they experience care that is personal, relevant, meets their expectations and assists their recovery.<br>• Implement 'My Shared Pathway' across all divisions. This is a practical tool that helps service users and carers to clarify for themselves and our staff what they want for their life and their care and how this should happen.<br>• Develop a standard approach for a care plan that is meaningful to individual service users and carers (i.e. flexible, personal, avoids technical language / jargon and acronyms)<br>• Seek significant involvement from service users and carers (including young carers) as an expert partner in care to assist in implementation |

| QA Priority | Expected outcome by end March 2014 |
|---|---|
| **Improve Clinical communication with GPs** | We will:<br>• Agree a standard template and complete the project scope by quarter 1 2013/14.<br>• Agree a business case for the implementation of standard templates by quarter 2 2013/14.<br>• Create a standard front sheet and free text template for all written communication with GPs on the patient electronic record (PARIS) building on existing work and GP feedback by quarter 3 2013/14.<br>• Ensure electronic template(s) function effectively within clinical situation by quarter 3 2013/14.<br>• Establish Trust wide use of the template(s) via Senior Clinical Directors and Directors of Operations by quarter 4 2013/14.<br>• Develop a standard process for telephone and email access for clinical advice by quarter 3 2013/14 and pilot in quarter 4 2013/14.<br>• Establish lines of communication most effective for GP practices - e.g. emailing 'letters' by quarter 4 2013/14.<br>• Consider, with GPs, a standard for ensuring a minimum six-monthly update is provided to GPs for service users with long-term conditions. |

Whilst the above are the four key quality priorities contained within the Quality Account it should be recognised that many of the plans outlined in the table below will also contribute to improving the quality of our services.

## 3.2 Meeting patient and commissioner needs

| Priority | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Continue to implement plans to ensure appropriate provision of Adult Rehabilitation Services | Complete the delivery of fully functional crisis beds within Durham and Darlington<br><br>Review the remaining rehabilitation beds across Durham, Darlington and Teesside to ensure they remain appropriate.<br><br>Complete Full Business case for reprovison of rehabilitation beds in North Yorkshire. | <br><br>Implement recommendations of review<br><br>Reprovision in line with Full Business Case complete | |

| Priority | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Develop and implement pathways and model lines | Carry out 12 Rapid Pathway Development workshops<br><br>Develop business case for implementation of model lines to include:<br>• Agreement of methodology<br>• Infrastructure to support implementation<br>• Programme of model lines to be developed | Complete rapid pathway development programme<br><br>Implement programme of model line development | Implement programme of model line development |
| Development of Acute Liaison services (including acute hospital, community hospital and care home liaison) | Complete implementation of pilots in Durham, Darlington and Teesside<br><br>Complete evaluation of pilots demonstrating economic benefit to wider health community in Durham, Darlington and Teesside.<br><br>Develop Business Case to support development of acute hospital liaison service in North Yorkshire and gain commissioner support | Secure recurrent funding for service in Durham and Darlington<br><br>Embed delivery of service in light of evaluation in Durham, Darlington and Teesside.<br><br>Implement acute liaison service in North Yorkshire | Evaluate impact of service on wider health economy |
| Review Mental Health Services for Older People to deliver centres of excellence for functional and organic services | Durham and Darlington –submit a business case to confirm bed base to provide centres of excellence for functional and organic inpatient services<br><br>Teesside – reconfiguration of MHSOP beds to ensure appropriate provision of functional and organic inpatient services across Teesside.<br><br>North Yorkshire – Redevelopment and re-opening of complex care unit (Springwood) in Malton<br><br>Reduction of bed base re provision of service based at Alexander House, Knaresborough (formal consultation complete) | Implementation of business case | |

| Priority | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Review and reconfigure Learning Disability inpatient beds in response to Winterbourne View report and subsequent Government response. | Review current inpatient services across the Trust and identify a preferred option for how these could be reconfigured<br><br>Identify the community infrastructure required to support people in the community, thus reducing need for admission (in conjunction with commissioners)<br><br>Commence implementation of preferred option in Teesside | Complete implementation of preferred option in Teesside<br><br>Commence implementation of preferred option in Durham and Darlington | Complete implementation of preferred option in Durham and Darlington |
| Review and Remodel CAMHS service, including development of CYP IAPT | Evaluate proof of concept on reconfigured CAMHS workforce in North Durham<br><br>Agree next steps for roll-out of workforce reconfiguration across Durham, Darlington and Teesside (subject to positive evaluation of proof of concept)<br><br>Review access arrangements into CAMHS services (including Child Learning Disabilities) including increased opening hours<br><br>Complete implementation of CYP IAPT in Durham, Darlington, Stockton, Redcar and Northallerton<br><br>Submit bid for phase 3 of national CYP IAPT programme to cover Hartlepool, Middlesbrough, Harrogate, Scarborough and Ryedale<br><br>Review Tier 3 service model in North Yorkshire and agree options for future delivery with commissioners | Complete implementation of roll out of workforce reconfiguration (subject to agreement in 13/14)<br><br>Complete implementation of Phase 3 CYP IAPT (subject to successful bid)<br><br>Implement preferred option in North Yorkshire | |

| Priority | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| Improve effectiveness and efficiency of community services | Review current AMH community teams and workforce and reconfigure as appropriate in Durham and Darlington and Teesside<br><br>Complete review of LD community teams in Durham and Darlington.<br><br>Complete implementation of review outcomes for the MHSOP teams in Durham and Darlington and Teesside.<br><br>To review existing forensic community teams and identify preferred option | Implement recommendations from review<br><br>Implement preferred options from review<br><br>Review AMH and MHSOP community services in Harrogate, Hambleton and Richmondshire to develop all-age (18+) functional MH community service. | Implement agreed option |

## 3.3 Improving patient and staff accommodation

The Trust's Capital Expenditure Plan is set out within the "Capex" tab of the financial template. The £56.7m programme is a result of agreed and planned investments discussed (or scheduled) within the Investment Committee and Board. Subject to ongoing affordability, the strategic programme will continue to improve the quality of inpatient and community accommodation in supporting patient care across the Trust, with specific investment into North Yorkshire services and our CAMHS specialist inpatient services based at West Lane Hospital in Middlesbrough.

The following table summarises the Trust's capital expenditure plans for the next three years:

| Description of Scheme | 2013/14<br>£000 | 2014/15<br>£000 | 2015/16<br>£000 | Total<br>£000 |
|---|---|---|---|---|
| CAMHS Tier 4 (West Lane – Middlesbrough) | 6,436 | 2,242 | 3,020 | **11,698** |
| MHSOP Complex Care (Springwood - Malton) | 3,045 | 0 | 0 | **3,045** |
| In Patient Refurbishments & Reconfiguration (Harrogate General Hospital & Friarage, Northallerton) | 750 | 4,500 | 9,500 | **14,750** |
| NY CAMHS Tier 3 (Manor Court, Scarborough) & NY CMHT (Windsor House, Harrogate) | 728 | 0 | 0 | **728** |
| NY AMH Rehabilitation (The Orchards) | 603 | 2,859 | 0 | **3,462** |
| Life Cycle Maintenance (Trust wide) | 1,572 | 1,899 | 1,436 | **4,907** |
| Estate Rationalisation & Efficiency (Trust wide) | 859 | 250 | 250 | **1,359** |
| Equipment (Inc. Business cases & IT) | 100 | 100 | 100 | **300** |
| Trust wide Schemes (inc SISUP). | 1,323 | 3,188 | 6,493 | **11,004** |
| North Yorkshire and York PCT properties (Vesting) | 5,439 | 0 | 0 | **5,439** |
| **Total** | **20,855** | **15,038** | **20,799** | **56,692** |

The Trust is intending to finance its capital expenditure programme through the use of working capital generated by depreciation, I&E performance and asset sales. There is no intention to access any loans for the purposes of financing capital expenditure.

Costs are calculated using industry pricing indices and standard design and build functional composition. The majority of capital expenditure is procured following formal tenders in line with standing orders. However, in some cases it may be appropriate to consider alternative procurement routes, e.g. procure 21 and this will be kept under review, along with a review of the Trust Capital Projects Procurement Framework.

We held one property for disposal at 1st April 2013, which was sold during April 2013 and is included within the Plan.

At the end of 2013/14 it is assumed that the transfer of properties from North Yorkshire and York PCT will take place. Final NHS guidance is still to be confirmed as to how these transactions will be accounted for, within the plan it is assumed that previous vesting arrangements will be applied and therefore a drawdown of PDC will occur.

## 3.4 Retention and Expansion

As described earlier we have agreed a new Business Development Strategy for 2013-2016. We firmly believe that the key to retaining business and to expanding our business in the longer term is to further improve quality while providing financial value to commissioners. Therefore we will continue to bid for tenders of services we currently provide (if they are tendered) and where we consider the services being tendered to be core services within our current geographical footprint. Further detail is provided within appendix 5.

In addition we will continue to work with commissioners to develop new services that meet their commissioning intentions through variations to existing contracts where appropriate. We will also

continue to work with our commissioners to ensure the repatriation of patients currently receiving inpatient care in facilities outside their home locality. This will be particularly relevant in terms of Forensic Services, Learning Disability Services and Adult Rehabilitation Services. As an efficient provider of services this will help commissioners deliver the QIPP agenda. Appendix 5 gives more detail for Monitor's purposes.

## 3.5 Workforce development

We recognise that the success of the organisation is dependent on having a workforce that is competent, compassionate and flexible. It is the 5389 WTE staff employed by the Trust that will ensure we provide high quality, recovery focussed services to every one of our patients every day. This is recognised in our third Strategic Goal: *To recruit, develop and retain a skilled, compassionate and motivated workforce.* To support delivery of this Goal the following priorities have been identified.

- Improving the health and wellbeing of our staff and reducing absence levels over each of the next three years.

  A combination of sound sickness absence management practices and supportive health promotion/ill-health prevention measures will be used to ensure that a balanced approach is taken, backed up by regular review of progress at directorate and Board level. The level of sickness absence during 2012/13, at just under 5%, was the lowest since the establishment of the Trust in 2006 however, achieving further reductions in absence is the number one workforce priority.

- Developing a workforce that is better able to adapt to changes in best clinical practice, new commissioning demands and organisational change.

  The use of the Trust's QIS, identifying and investing in the right skills for staff and following good human resource practice will be central to efforts to improve the quality of our services by changing the way that work is done and making best use of the resources that we have.

- Increasing leadership and management capability at all levels within the Trust.

  Investing in the development of the next generation of Ward / Team Managers, is underway with a development programme largely based upon a model leadership programme that has proved to be successful with our existing Ward / Team Managers and other clinicians in management. The use of Talent Management practices will be embedded to ensure that we help our staff to make the most of their abilities and enthusiasm for the benefit of our service users, the Trust and staff themselves.

- Recruitment of high quality Consultant Staff

  While the Trust faces few difficulties in recruiting to most of its vacancies, the recruitment of sufficient high quality Consultant Psychiatrists has been a longstanding problem for Mental Health Trusts in the North of England. This difficulty in recruitment is underpinned by a reluctance of trained psychiatrists to move from areas of overproduction (such as London and the South East) to the North of England and, perhaps more seriously, chronic problems in recruiting to Core Training schemes in Psychiatry in the North East of England. To help address this we will:
  - continue to maintain a detailed workforce plan that enables us to identify where pressure points will occur;
  - continue to take a number of measures to ensure that we add further value to Trainees through specialist training in service transformation and leadership and management;
  - seek to increase our number of Higher Trainees within the Trust

- ensure that when we advertise for posts we directly contact areas where there are an excess of Higher Trainees (such as London and East Anglia Deaneries).

- Improving the experience of our staff

  Our staff survey results have continued to improve year on year but we want to improve our results further. The most recent results ranked us in the top 20% of all mental health and learning disability trusts in twenty out of the twenty eight key findings. We believe that these results, coupled with a very recent successful Investors in People reaccreditation assessment provide evidence that our approach to human resources and organisational development policy and practice is sound. This provides a good basis from which to tackle the major workforce challenges that are expected over the next three years. Further details can be found in Appendix 1.

## 3.6 Information Technology Enablers

The delivery of the Information Strategy is underpinned by the Information Strategy Roadmaps. Progress against these roadmaps is routinely monitored through the Trust's project management approach. As part of the business planning process, the roadmaps are reviewed to ensure that they align with the changing environment, the new NHS information strategy and our priorities over the coming years.

Key priorities within the strategy to be delivered during the period of the plan include;

- Further implementation and roll-out of the Integrated Information Centre support performance management and PBR.
- Electronic Patient Record System (PARIS) upgrades and a programme of work to include developments such as Path Labs, Medicines Management, Choose and Book, Patient Outcome Measures and Staff Diary.
- Further rollout of E-rostering for staff to our remaining inpatient services and then to our community based teams.
- Implementation of digital dictation and other digital input devises (which will improve productivity, particularly of community teams)
- Implementation of a Trust wide knowledge management system.

The resource requirements to support the information strategy have been identified within the financial plan.

# 4. Productivity and Efficiency

## 4.1 TEWV's approach to productivity and efficiency

Our approach to efficiency is that sustainable improvements in efficiency and productivity can only come from improving processes and eliminating waste. Taking out resource without changing and improving processes leads to unstable, poorly performing systems rather than sustained lower resource use.

As described earlier, our QIS is critical in facilitating reduction of costs over time, even though it does not explicitly focus on cost reduction. Changes to services such as reducing inpatient bed capacity and treating more patients in the community are only brought about after involvement of the teams concerned in planning how the new service will work (often using QIS tools such as improvement workshops), putting appropriate operational polices in place and training staff.

TEWV is also committed to carefully considering the impact of financial savings on clinical quality as part of it Business Planning process. This is described more fully in Sections 4.3. To date there is good evidence that TEWV's low costs compared to many other providers have not been at the expense of poor quality services.

## 4.2 Cost Improvement Themes and Profile

The following table provides the detail of the Top 5 Cash Releasing Efficiency Savings (CRES) programme schemes for the Trust over the next three years. Each service has formulated its own Directorate programme and delivery of this is the responsibility of the relevant Director of Operations alongside the Chief Operating Officer.

| Scheme Type | 2013/14 £000 | 2014/15 £000 | 2015/16 £000 | Total £000 |
|---|---|---|---|---|
| **Cost Reduction** | | | | |
| Bed reductions | 1,240 | 2,079 | 1,781 | 5,100 |
| Community productivity | 1,201 | 2,078 | 2,602 | 5,881 |
| Non pay review | 1,524 | 472 | 4 | 2,000 |
| Skill mix | 950 | 734 | 0 | 1,684 |
| Review of management and corporate structures | 566 | 422 | 224 | 1,212 |
| Space utilisation - review of Trust properties | 491 | 0 | 0 | 491 |
| **Revenue Generation** | | | | |
| Forensic medium and low secure expansion | 1,670 | 43 | 33 | 1,746 |
| West Lane site development | 50 | 149 | 19 | 218 |
| MHSOP increased capacity | 0 | 122 | 0 | 122 |
| Aggregated schemes | -366 | 938 | 297 | 869 |
| **Total Identified** | **7,326** | **7,037** | **4,960** | **19,323** |
| **CIP plans under development** | **2,051** | **1,259** | **3,282** | **6,592** |
| **Total CRES required** | **9,377** | **8,296** | **8,242** | **25,915** |

As part of the NHS Planning Guidance for 2013/14 there is a requirement for all NHS Trusts to deliver annual cost efficiency savings of at least 4%. In summary the total CRES identified within the plan at this point for 2013/14 is £7.3m against a target of £9.4m. It is planned that £1m of the

current £2.1m shortfall will be addressed recurrently in 2013/14, with the remaining balance covered by non recurrent schemes.

There are a number developing schemes identified where plans are not yet finalised and equate to £1.3m in 2014/15 and £3.3m in 2015/16. This includes benefits realisation from the investment in IT systems through the Information Strategy in recent years.

In developing its Integrated Business Plan (IBP) the Trust has adopted a financial framework that requires the Trust to achieve approximately £25.9 million of efficiency savings over the next 3 years. These savings were estimated to be sufficient to meet future cost pressures, provide a strategic change fund, and to ensure medium term financial stability.

## 4.3 Cost Improvement Plan (CIP) Governance

Our Business Planning framework incorporates financial planning assumptions from which services' and overall Trust plans are produced. These financial assumptions reflect a prudent view of the current economic position and are informed by Monitor, the NHS Planning Framework and other relevant assessments. The financial assumptions, including efficiency requirements, are provided at an initial Board workshop in October (which also includes senior operational and clinical leaders) and then form the basis for the production of CRES plans developed within Clinical and Corporate services.

CIP / CRES Schemes are developed and identified as described above and approved by the Board of Directors. The Board planning workshops are supported by clinical and corporate business planning days where attendance includes management and clinicians.

Clinical and corporate services business plans are presented by Service Directors and signed off by the Board of Directors following an assessment of financial and clinical governance risks. A Quality Impact Assessment (QIA) workshop was also held for all Localities led by the Director of Nursing and Medical Director to ensure all Clinical CRES schemes did not impact upon the quality of patient care.

The Trust's historical delivery of CRES demonstrates recurrent delivery ahead of annual plans year on year since authorisation in July 2008. The CRES framework is forward looking and aims to identify recurrent schemes by the end of quarter 1 for the following financial year which often results in schemes being delivered earlier than planned.

The Board of Directors and the EMT each receive a monthly Finance report which includes progress monitoring of in year CRES achievement, as well as progress against future years' targets. Sign off of quality impact assessments were reported within the March 2013 budget setting paper to Board.

Accountability is at Board of Directors level and is ratified through the business planning process with delivery monitored monthly at Board of Directors and EMT.

The Trust has in place a project management framework with responsible officers identified to lead specific schemes.

## 4.4 Assessing and Managing the Quality Impact of CIPs

As sections 4.3 explains, we have systems in place to identify and screen out proposals for cost improvement that carry with them unacceptably high levels of risk. Therefore any CRES scheme that is approved is unlikely to then lead to unacceptable consequences for quality. In addition to this, we also have ongoing systems in place to ensure that quality metrics are monitored and appropriate mitigating action takes place if necessary.

Any adverse impact on quality indicators would be identified by the appropriate QuAG for that clinical service and escalated, if necessary to the appropriate Locality Management team or the QuAC. Our QIS includes the concept of "stop the line" and this would take place if new arrangements arising from a CRES plan were having unanticipated and unacceptable impacts on patient experience, safety or clinical outcomes.

As the use of HoNoS scores becomes standard and the Trust's Integrated Information Centre develops our business intelligence will be able easily to identify if any changes in quality metrics performance are associated with actions such as implementation of CRES plans. The Trust is also developing a Post Project Evaluation framework which will further develop the existing requirement within its Project Management Framework to evaluate the impact of all project developments.

## 4.5 Trust's Current Financial Position

Our financial strategy ensures we can continue to maintain our stable financial position and remain financially viable. It is underpinned by the ongoing achievement of CRES, which is key to supporting the delivery of the financial strategy, as the national and local economic position develops. This approach along with the expansion of new services has allowed investment into services and improvements in quality to take place against a background of low levels of financial risk.

We continuously strive to improve efficiency in our use of resources by reviewing systems and processes, evaluating skill mix, optimising the use of capacity and ensuring best value through robust procurement practises.

Our capital expenditure programme continues to improve the infrastructure and ensure the most modern equipment and technology is available for patient care.

Our financial assumptions are based on analysis provided in the Planning Framework, information published by Monitor, and our own analysis on specific issues. Technical commercial assumptions are detailed, for Monitor's purpose, in Appendix 1 financial commentary and these are felt to be prudent and reflective of the current environment. These financial assumptions will continue to be kept under review, as further information is obtained.

Our financial position continues to be stable and forecasts a Financial Risk Rating of 4 over the planning period with significant headroom to a rating of 3, demonstrating a low level of financial risk in maintaining this in future years.