



## **Strategic Plan Document for 2013-14**

**Cambridgeshire & Peterborough 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	24/05/13

**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)	David Edwards
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Attila Vegh
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Darren Cattell
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Signature



## Executive Summary

This Strategic Plan Document has been developed shortly after the resolution of a number of critical issues that the Trust faced during FY13, these principally were:

- Responding to the concerns and warning notices placed on the Trust from the Care Quality Commission.
- Responding to the decision made by Monitor to place the Trust into significant breach of its terms of authorisation and the resulting work to improve basic corporate, quality and financial governance systems.

Due to this work and the significant board level changes that have occurred over the past 12 months, this plan focuses on delivery over the coming 12 months. The Board of Directors has commissioned the development of a longer-term service strategy which is due to be completed during Summer 2013 which is intended to outline the direction of the Trust through to 2020. This strategy will provide the roadmap to achieve our vision of being a top 5 provider of community and mental healthcare in England.

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

- The Trust is forecasting significant increases in demand for services within our core mental health services as a result of both population growth in Cambridgeshire and Peterborough but equally the pressures resulting from the forecast growth in the number of people diagnosed with dementia.
- This significant increase in demand is within the context of comparatively low investment in mental health services from our commissioners and limited prospects of significant new investment given the issues faced by acute providers within the Cambridgeshire and Peterborough health economy.
- The Board has committed to undertake robust negotiations with commissioners over the development of a medium term investment plan in our core services, the Board has determined that if such investment is not forthcoming then there will need to be a reduction in the services provided by the Trust in order to maintain expected service safety standards.
- The Trust continues to work to improve efficiency, notably through a significant change in the operation of our adult acute inpatient units in Cambridge and the restructure of our community teams.
- Despite these challenges, the Board believes that it is well placed to lead and facilitate the integration of physical and mental health and social care services for the population we serve and is committed to developing innovative and leading edge ways of working to achieve this. In particular we believe there are significant opportunities in the integration of care for the frail elderly and children.
- In addition to our focus on Cambridgeshire and Peterborough, we are committed to the continuing development of our portfolio of specialist services and to build on our progress in expanding our role in the provision of education in conjunction with improved utilisation of our network to be one of the leading organisations for mental health research within the UK.

Alongside these aspirations for the future, the Board is committed to ongoing improvements in its approach to quality and has implemented governance processes to assure the safe and effective operation of Trust services, as well as their improvement. Over the past year this work included strengthening the role of

Governors within the organisation, for instance through their involvement with the Board of Directors and its supporting committees and work groups.

These improvements in governance have been supported through the appropriate use of external reviews and audit to obtain independent assurance on areas of risk within clinical operations. These arrangements will oversee the delivery of the three priority areas identified by the Board for improving quality during FY14:

- To improve the experience of our patients and staff.
- To strengthen the culture of safety.
- To improve outcomes of care for our patients.

This plan also outlines our financial plans for the next three years and we plan to reduce costs by c.4.5% in each of the next three years. This assumption is on the basis that we receive no additional investment in core services from commissioners. The delivery of these cost improvement plans will continue to be overseen through the Trust Programme Management Office and supporting governance arrangements, which include the requirement for Quality Impact Assessments to be undertaken for all CIP projects.

The plan also outlines that although the Trust has taken significant steps towards recurrent income and expenditure balance and that overall Trust finances are stable, it cannot continue to provide services that are not funded under our existing block contracting arrangement. This has been recognised as the biggest financial threat facing the organisation and in response to this outlines how we will strengthen our informatics, data quality and recording capabilities to support the implementation of Payment by Results during Q3 of FY14.

## Strategic context and direction

### *The Trust's strategic position within our Local Health Economy*

Over the course of the past year, CPFT has been focused on the delivery of a quality, governance and financial turnaround arising from the nature and seriousness of the CQC concerns that the organisation faced alongside Monitor finding the Trust in significant breach in March 2012.

Following the successful delivery of our turnaround plans which culminated in the CQC finding the Trust compliant with all outcome standards in January 2013 and Monitor deciding that the Trust was no longer in significant breach on the 21<sup>st</sup> March 2013, a number of the risks we had highlighted in our last Strategic Plan Document have not materialised and have resulted in a strengthened competitive position.

The Trust provides core mental health, specialist mental health and community children's services and therefore faces a diverse range of potential competitors from both within the NHS sector as well as the independent and private sector, our key competitors are seen as follows:

Competitor Sector	Relative CPFT strengths	Relative CPFT weaknesses
<b>Other NHS Foundation Trusts.</b>	Successful quality and financial turnaround.	Smaller than many other MH Trusts.
	Specialist, research and teaching expertise.	Principally focused on mental health service provision.
<b>Private Sector.</b>	NHS 'brand'.	Inability to provide level of investment required to establish top class informatics capability.
	Established organisation with a number of integrated services.	Smaller than many private

Competitor Sector	Relative CPFT strengths	Relative CPFT weaknesses
		sector service providers.
<b>Third Sector.</b>	Scope and size of services and relative financial stability to third sector.	Comparatively poorer service user engagement and involvement in service delivery.

Within our **core market of the provision of secondary mental health services to the population of Cambridgeshire and Peterborough**, we are forecasting a significant increase in the demands for our services as a result of both population growth of around 30-50% by 2021 and demographic change, particularly a predicted 38% increase in the number of people diagnosed with dementia.

Such significant change needs to be understood within the context of the diversity in the areas we serve: Cambridge, South Cambridgeshire, East Cambridgeshire, Fenland, Huntingdonshire and Peterborough. Factors that will also impact on the future demand for our services include high prevalence of autism, the impact of growing migration and the distortion with an increasing population of young people in our core geography which is likely to result in increasing demands being placed on core mental health services for children and adults.

Within our **community children's services in Peterborough**, we equally forecast increased demands as a result of population growth within the local area as well as the delivery of The Call to Action that will significantly extend the role and workload of Health Visitors over the next two years.

### ***Threats and opportunities from changes in local commissioning intentions***

#### ***Core Mental Health Services in Cambridgeshire & Peterborough***

Within our core mental health services in Cambridgeshire & Peterborough the key challenge faced by the Trust is the prioritisation of these services within a challenged local health economy. At least two of the acute trusts within the Cambridgeshire and Peterborough region have and continue to face significant financial challenges which has resulted in low investment in core mental health services when compared with Trusts providing these services to similar populations.

This comparatively low investment clearly threatens the ability of the Trust to provide sustainable safe services to the people we serve. Therefore, in order to respond to these concerns the Trust has undertaken a robust contract negotiation with our main commissioners for FY14 with the aim of securing additional funding for critical services. The premise that this negotiation is based upon is that demand currently outstrips supply and could lead to unmitigated clinical risk when coupled with a demanding CIP programme. The overall funding situation needs to be viewed within the context of the Trust delivery of a £10 million cost improvement programme in 2012/13.

However, the Trust recognises the need to take steps internally to respond to this mismatch between capacity, demand and the affordability of services through continuing to focus on improving the efficiency and effectiveness of core mental health services, two notable areas of transformation which will be completed during FY14 are:

- The reconfiguration of our adult acute wards in Cambridge that will be completed during Summer 2013.
- The restructure of the core mental health services that we provide within the community to conclude in Autumn 2013.

These two projects will support the effective implementation of evidence based care pathways, deliver expected savings and will support the Trust in readiness for the implementation of Payment by Results for mental health services.

### *Specialist Mental Health Services and NHS England*

The Trust does not anticipate any significant risks or opportunities arising from our specialist service portfolio, although anticipates that this will change for FY15 onwards as NHS England begins the anticipated reconfiguration of specialist services nationally.

During FY14 the Trust intends to continue to influence the national debate on the future of these services through our active engagement in areas such as specialist mental health services for children, secure mental health services and services for people with eating disorders. Alongside this work, we will continue to work alongside NHS England to ensure that our services meet the minimum expected standards for these services.

As part of our development of a new strategy for the organisation we have developed a specific strategic work stream to develop our strategic intent in the provision of specialist services within niche markets.

### *Community Children's Services*

FY14 is the last year of operation of the contract held by the Trust with NHS Cambridgeshire and Peterborough CCG for the provision of Community Children's Services in Peterborough. At the time of writing this plan the intentions of the commissioners on the future commissioning and provision of these services is unclear although it remains the stated intention of the Trust to seek to continue to provide these services in line with our vision to provide integrated community based care.

The Trust believes that these services may be included within an overall commissioner led solution for the community children's services provided by Cambridgeshire Community Services NHS Trust.

### *Collaboration, integration and patient choice*

There is a clear intention of NHS Cambridgeshire & Peterborough CCG to commission integrated services for older people in our local area, as signalled by the decision to not approve the Foundation Trust application of Cambridgeshire Community Services NHS Trust (CCS).

During FY14 we intend to work with the CCG, NHS England and the Trust Development Authority to understand the intentions in regard to the future commissioning arrangements for the services currently provided by CCS and to understand how the Trust can support the integration of our mental health services for older people with physical health services for older people. As part of our development of a new strategy for the organisation, we have developed a specific work stream to develop our long-term approach to the integration of care across the boundaries of existing mental and physical healthcare.

We appointed a Director of Service Integration in conjunction with Cambridgeshire County Council and Peterborough City Council during FY14 to lead our work in integrating our existing service provision with other commissioned services in the Cambridgeshire and Peterborough area, including working more effectively with the third sector and social care.

It is the expectation of the Board that the most significant challenge and change within our local health economy over the next three years is the integration of services for the frail elderly, including community, acute, mental health and enhanced primary care services.

The Trust believes that the integration of physical and mental health is the business we wish to be in and believe the work we have outlined above will well place the organisation to become the provider of choice for our commissioners of integrated services for our local population. Equally, the Board recognises that

such a significant step and change in service provision will require detailed analysis and debate in order for a final decision on the shape and scale of any such integration to be made.

Equally, the Board recognises the need to better support both patients and carers in making decisions about their care and the support they receive from our services. In order to understand this better, the Board approved a patient and carer engagement strategy in quarter 4 of 2012/13 and its' implementation will remain an area of focus over the next three years.

#### *Demand profile and activity mix*

Demand for our services will continue to grow with a predicted population increase at twice the national rate. In previous years we have seen significant population growth with 5 of the 6 principle areas we serve being in the 40 fastest growing areas in the UK. These increases are illustrated in the table below.

#### **Historic Population Increase**

<b>Location</b>	<b>2011 population</b>	<b>2001-11 change</b>
<b>Peterborough</b>	184,000	+16.7%
<b>Fenland</b>	95,000	+13.8%
<b>Cambridge</b>	124,000	+12.7%
<b>Hunts</b>	170,000	+7.8%
<b>South Cambridgeshire</b>	149,000	+14.0%
<b>East Cambridgeshire</b>	84,000	+14.2%
<b>Total</b>	<b>805,000</b>	<b>+13.0%</b>

Source: ONS 2011 Census – nb the CCG, which includes the northern Borderline, covers a population of 864k

The increase can be broken down by age range to show that across Cambridgeshire we see the older age group (85+) has risen by 29.3% in 2010 compared with 24.6% for England.

Within the table below we can see predicted increases over the next decade across Cambridgeshire and Peterborough are well above the national average with the most significant growth in young adults and the older population.

#### **Population Growth**

<b>Location</b>	<b>Population increase by 2021</b>	<b>2011-21 change</b>
<b>Peterborough</b>	30,000	+16%
<b>Fenland</b>	19,000	+29.5%
<b>Cambridge</b>	15,000	+32.8%
<b>Hunts</b>	27,000	+34.2%
<b>South Cambridgeshire</b>	27,000	+48.5%
<b>East Cambridgeshire</b>	15,000	+32.8%

Location	Population increase by 2021	2011-21 change
<b>Total</b>	<b>133,000</b>	<b>32%</b>

Source: ONS 2011 Census

There are forecast to be 38% more people with dementia locally in 2021, and, as people with severe and enduring mental health conditions live longer, they will also become 'older people.' This is the age group that is most likely to need nursing, residential or home care and face long term mental health problems. The continued increase in this age group supports the commissioning intentions of greater integration by the local commissioners.

The prevalence of mental ill health among the working age population is high in Peterborough City because of the demography, new growth, higher levels of crime, alcohol related harm and self harm with 22% of the population of Peterborough living in the most deprived wards in the country. Fenland, in Cambridgeshire also has a high prevalence of mental ill health due to the association between mental ill health and its determinants with deprivation. Suicide rates are high in Fenland.

#### **Future demand assumptions made:**

- By 2015 it is anticipated that 114,000 18 - 64 year old people across Cambridgeshire and Peterborough will suffer at some point from a common mental disorder including anxiety and depression
- By 2015 it is anticipated 3,500 18 - 64 year old people across Cambridgeshire and Peterborough will suffer a psychotic disorder
- By 2015 it is anticipated 6,500 18 - 64 year old people across Cambridgeshire and Peterborough will suffer from some form of personality disorder
- By 2015 it is anticipated 58,415 18 - 64 year old people across Cambridgeshire and Peterborough will suffer from 2 or more psychiatric disorders

#### *Diversification*

The Trust is a member of Cambridge University Health Partners, and we are proud of our affiliation with the Department of Psychiatry at the University of Cambridge, one of the leading departments nationally and internationally.

We intend to continue to exploit our opportunities to expand our income from research and development through our continuing focus on improving our R&D informatics capability through the deployment of the Clinical Research Information System (CRIS) and our partnership with South London and the Maudsley NHS Foundation Trust, Oxford Health NHS Foundation Trust and other mental health trusts in the NIHR Dementia Informatics initiative.

Alongside these actions, we equally have initiated a strategic work stream to develop our longer term approach to build on our geography, and our networks to strengthen our position in respect of education, research and science and how we integrate this into service delivery. This work will build on our established research themes of:

- Improving clinical information systems for research and development.
- Exploring the interface between psychiatry, neuroscience, immunology and other areas of medicine.
- Building capacity of major neuroimaging and the neuro-informatics programme.



## Approach taken to quality

During 2012/13, the Trust implemented an extensive quality turnaround programme following the two warning notices it received from the Care Quality Commission (CQC) in 2011/12. Following the delivery of this programme the Trust was found compliant with all outcome areas in January 2013.

In addition to CQC inspections, the Trust Board has commissioned a series of reviews into the quality of its services in areas where potential risks have been identified, this has included:

- A review of Serious Incidents to identify potential opportunities to improve the quality and safety of Trust services.
- A review of our Learning Disability services.
- A review of our borderline personality disorder unit.

In 2012/13 the Trust implemented the 'Quality Diamond' to clearly articulate the quality priorities of the organisation under four dimensions, three of these directly relate to service quality:

- Patient Experience
- Patient Safety
- Engaged Staff

Our priorities for FY14 across these dimensions are outlined over the coming pages, and shows those areas where the Board of Directors have committed to a 3 year improvement trajectory as part of the implementation of the Quality Diamond.

## PATIENT EXPERIENCE

### Priority 1: To improve the experience of our patients and our staff.

Measures of success	2013/14 Target	2014/15 Target	2015/16 Target
Patient Net Promoter Score	65%	75%	85%
Staff Net Promoter Score	60%	70%	75%
Staff recommending CPFT as a good place to work	60%	70%	80%

### Rationale for Inclusion

- We believe that a basic indicator of quality is when people are happy to recommend a service to their family and friends. We have chosen these indicators as our Net Promoter Score (NPS), in conjunction with the Department of Health (DH) guidance. This also supports the national ambition for the NHS as set out in 'Everyone Counts'.
- We also believe that there is a strong correlation between staff satisfaction and patient satisfaction. If our staff feel respected, valued and supported, this will have a direct impact on the quality of their interaction with our patients and the care that they provide.

### Supporting improvement initiatives for priority 1:

#### Patient experience

- Develop Care Pathway services
- Implement the findings from our staffing review
- Develop further effective patient feedback mechanisms
- Continue to roll out our Recovery College East

#### Staff experience

- Continue to roll out the CPFT Academy
- To continue with the 'Quality Heroes' and 'Team Champions' initiative
- Continue to strengthen staff communication, such as CEO blogs, Webex sessions, Town Hall events and Diamond Talkback

## PATIENT SAFETY

### Priority 2: To strengthen the culture of safety in CPFT

Measures of success	2013/14 Target	2014/15 Target	2015/16 Target
InCA Assessment Framework Score (all teams)	95%	95%	95%
Completion of safeguarding adults and children training by staff	95%	95%	95%
Percentage of medication errors per 10,000 bed days causing no harm.	95%	95%	95%
Percentage of our people who describe IT response times as good or very good	60%	70%	80%

#### Rationale for Inclusion

- The quality of assessments, risk assessments and care planning have a direct impact on the provision of safe and effective care. The standards around these are embedded in the InCA assessment framework we have developed and implemented within the Trust to assess the performance of our clinical teams. InCA also covers all 16 CQC outcomes. Compliance with these standards will help us ensure the safety and wellbeing of our patients, visitors and staff.
- Providing a quality service is dependent upon having staff with the right skills, knowledge and experience, and providing them with appropriate systems and processes to do their job. Safeguarding training is mandatory and as of March 2013, our compliance rates were 94% for safeguarding adults and 88% for safeguarding children. We need to improve on these compliance rates to ensure that our staff know how to recognise and act appropriately when they observe safeguarding incidents.
- We also need to focus our attention on medication errors. Our aim is to improve the reporting rate of these incidents to enable identification of any trends and learning from near misses and reduce the incidence of medication errors that cause harm to patients.
- Finally, we need to ensure that our staff have the information that they need in a timely manner to provide safe and effective care. This is dependent upon having IT systems that are appropriate, responsive and fit for purpose.

#### Supporting improvement initiatives for priority 2:

- Regular review of the InCA assessment tool and process, development of service-specific standards and roll out to the rest of our community-based services.
- Pilot the 'No Force First' initiative in selected inpatient services
- Clarify the criteria and threshold of reporting medication errors to improve the rate of reporting incidents, analysis and reporting of results
- Roll out of RiO, our electronic clinical records system, to the rest of the Trust.

## CLINICAL EFFECTIVENESS

### PRIORITY 3: To improve outcomes of care for our patients

Measures of success	2013/14 Target	2014/15 Target	2015/16 Target
Percentage of relevant admissions to acute wards which are gate kept by Crisis Resolution Home Treatment teams.	98%	98%	98%
Proportion of people referred for psychological therapy who receive it	60%	60%	60%
Delivering the physical health monitoring and outcomes commitments as agreed with our commissioners	N/A	N/A	N/A

#### Rationale for Inclusion

- Assessment by the CRHTT prior to admission into acute inpatient units ensures that only patients who need inpatient care are admitted into our wards and that patients have the most appropriate plan of care agreed by all relevant parties, including the patient. As of March 2013, our internal reports show that 95% of patients admitted to CPFT inpatient units were assessed by CRHTT. Data reported by the Health and Social Care Information Centre (HSCIC) as of December 2012 shows the national average at 98% with 29% (n=18) of mental health Trusts achieving 100% compliance.
- NICE guidance and quality standards recommend the use of psychological therapies for the treatment of psychological disorders either on its own or alongside traditional medication. The Department of Health has promoted the use of psychological therapies through the establishment of IAPT (Improving Access to Psychological Therapies) services. As of March 2013, not all of our IAPT services met the national 60% target for the proportion of our patients referred for psychological therapy who receive psychological therapy. We need to achieve this target across the Trust.
- A high level scoping of physical health monitoring in CPFT shows that we need to improve our arrangements in this area. This is supported by findings from national and local audits. We are widening the scope of this work programme to include community services across children, adults, older people and specialist services.

#### Supporting improvement Initiatives for priority 3

- Review and update the Psychological Therapies Strategy
- Review the referral process and pathway into care across all three IAPT services to streamline the process and achieve consistency across the Trust.
- Develop Medications and Physical Health dashboard
- Trust wide review of Physical Health monitoring arrangements (new project) to identify gaps and develop appropriate actions.
- Implement 3-3-3 model in Cambridge wards and implement improvement project in Crisis Resolution Home Treatment.

## ***Mandatory indicators***

The Trust has declared a risk in relation to the achievement of 'Minimising mental health delayed transfers of care' indicator below the threshold of 7.5%. This is as a result of recent improvements in the identification and reporting of delayed transfers of care (DTOC) in order to improve the utilisation and effectiveness of our beds, particularly in respect of our older people's inpatient units. Delivery of this indicator is dependent on partner agencies, notably Social Care and Continuing Healthcare and we are working through multi-agency forums to address this issue whilst running a parallel process to ensure appropriate contractual remedies are in place.

## ***The key quality risks inherent within this plan***

The key strategic risks that are inherent within this plan and are reflected through the Trusts' Corporate Risk Register and Board Assurance Framework, as well as the mitigating actions which have been put in place are outlined within the table below:

<b>Risk Description</b>	<b>Mitigation</b>
<b>Patient safety compromised as a result of us not being able to meet demand for Trust services.</b>	<p>The Trust has clinical risk assessments in place for all referrals and the overall waiting lists for services. For areas where risk has been identified, action plans are being implemented to manage waiting lists to safe levels.</p> <p>The Trust has in place a redesign process to understand the level of service that can be provided within available resources alongside on-going work with our Commissioners on the future funding and shape of service provision.</p>
<b>Patient safety compromised as a result of us being unable to safely staff our wards.</b>	<p>Operational staffing meetings are in place to regularly review and confirm staffing levels across all inpatient units.</p> <p>Dedicated and on-going recruitment campaign to nursing posts to reduce vacancy levels within the Trust.</p> <p>Trust wide project in place to confirm and challenge establishment levels with operational teams.</p> <p>Improvement project implemented in regard to the activities of the Operation Centre to improve fill rate for unfilled shifts.</p>
<b>Failure in operational delivery as a result of the transition to the new service structures and associated redesign work.</b>	<p>The overall service design and transition work is being managed through a Project Management Office (PMO) supported project, with dedicated resource being allocated to the project alongside enhanced monitoring systems through our PMO project governance structures.</p> <p>A Quality Impact Assessment is in place for the service change projects which are reviewed regularly by clinical leaders and reported alongside project status reports on a fortnightly basis.</p> <p>Governor, staff, patient and commissioner engagement</p>

Risk Description	Mitigation
	has been a central element of the development of the redesign and implementation proposals.

In addition to these risks, should further investment not become available for core mental health services and therefore reduction in service provision become necessary for the Trust a number of further risks will materialise which will need to be considered by the Board. These risks include:

- That reductions in service may be a difficult message for members and the general public to understand and appreciate.
- Equally, this may be a difficult message for staff to understand as it may lead to uncertainty regarding jobs and services.
- The impact that any reductions may have on the wider population in regard to health inequalities and the overall wellbeing of our local communities.

### **Quality Governance**

As part of our governance improvement plan which was delivered in 2012/13, the Trust has overhauled its approach to quality governance which has been articulated by the Board of Directors within the Framework for Quality Governance which was approved by the Board of Directors in February and is publicly available.

Our new quality governance systems and approach is structured on a 'bottom up' basis from our operational teams through to the Board of Directors and has resulted in a number of new ways of working including:

- A minimum expected standard for team, divisional and organisation wide governance.
- The implementation of dedicated governance training for all staff from band 7 upwards.
- The implementation of new forms of information across all levels of the organisation to allow them to better understand how they are doing and the risks arising from service delivery.
- The implementation of a 'Divisional Accountability and Governance Agreement' which are agreements between the Board of Directors and Divisional Leadership in regard to governance, quality and safety, performance and finance which are supported through self-declarations of compliance and on-going independent assessment and review.

This work has been supported through the implementation of a new divisional structure during FY13 in which greater focus has been placed on clinical leadership, with the basic governance systems and processes being embedded from formation within these divisions. During FY14 we intend to continue to operate these new ways of working in order to ensure that these processes and systems become embedded in the day to day working of all our people.

Alongside our work with teams and divisions, we have also restructured our governance at an Executive, Committee and Board level. Notably we have now rationalised the formal Board and Committee structure to three principle committees: The Board of Directors, the Audit and Assurance Committee and the Quality and Performance Committee. The Board of Directors has also commenced a Board Development

Programme which will run throughout FY14 to support the on-going development of its members both individually and collectively.

#### *The role of the Board of Directors*

The Board of Directors has clear responsibilities for clinical and integrated governance, defined by the Monitor Compliance Framework, Quality Governance Framework and Department of Health guidance.

The Board derives assurance on the quality of its services through the principal two board committees, the Audit and Assurance Committee and the Quality and Performance Committee. These two groups are required to explore issues in detail which are identified through Executive Groups and Divisions to either obtain assurance of the quality and safety of Trust services or to take action where there remain unacceptable risks to quality or safety.

In order to obtain assurance regarding the sufficiency of the systems and processes to support quality governance within the organisation and to support the decision of Monitor in regard to de-escalation the Board commissioned independent assessments of both the arrangements for Quality and Corporate Governance within the Trust which identified no major areas of concern.

#### *The Council of Governors and membership*

The Board of Directors has identified the need to both ensure that the improvements which have been made by the Trust over the past 12 months continue to be embedded and that continuous improvement in governance is maintained and has now formally established a 'Corporate Executive' comprising the Chairman with Executive, Non-Executive and Governor attendance at these meetings to oversee the delivery this work.

During 2012/13 the Trust took a number of steps to strengthen the involvement and voice of Governors within the activities of the organisation. This included governor attendance at both public and private board meetings, involvement within a number of working groups (including the review of the Trust Constitution), the annual plan and the quality turnaround programme. In addition, the Trust took steps to provide additional capacity within the Trust Secretariat to support this work and secure effective and on-going engagement with governors and members in shaping the work of the organisation.

As at 31<sup>st</sup> March 2013 the Trust had 11,374 members: 1,279 patients, 7,860 public and 2,235 staff members. The Trust maintains communications with its membership through public meetings of the Council of Governors, the Trust website, newsletters and email alerts. Member events provide an opportunity for members to meet with Governors as well as staff.

### **Clinical Strategy**

#### *Service line management*

As discussed earlier within this Plan, during 2012/13 the Trust has principally focused on securing the financial and quality turnaround of the organisation. As such the overall strategy for the organisation is still under development with the intention of a new Trust strategy to be approved by the Board of Directors and Council of Governors during autumn 2013.

The overall development of the strategy is focused on three key themes:

- Integrating physical and mental health within Cambridgeshire & Peterborough.
- Exploiting our expertise to further develop our provision of specialist services in niche markets.
- Strengthening our position as a leading academic and teaching mental health trust.

The immediate actions being taken by the Trust to develop clinical services during 2013/14 are outlined below:

### **Implementing the 3-3-3 model for adult inpatients in Cambridge**

The Trust is currently implementing a new model of care for adult inpatients in Cambridge, following the successful implementation of this model in our Peterborough adult wards which will see the following model of care being implemented:

- Up to 3 day stay on an assessment unit.
- Up to 3 week stay on an acute ward.
- Up to 3 month stay on a rehabilitation ward.

This new model of care is based on best practice adopted from other mental health trusts and is based on the Trusts' own evaluation of the implementation in Peterborough which has seen improved patient outcome and experience from this service, alongside an overall reduction in the number of beds.

### **Re-designing our community mental health services**

The Trust is currently undertaking a significant programme of the redesign of all commissioned community mental health services with the purposes of:

- Providing a structure from which the implementation of evidence based care and interventions can be better provided to patients.
- Clearly articulating community service capacity, whilst increasing overall efficiency through providing more joined up services.
- Improving ease of access and signposting to mental health services through the establishment of a single point of access for GP referrals, the Advice and Referral Centre.
- Supporting the implementation of Payment by Results for mental health services.

### *Clinical workforce strategy*

The Trust's strategic objectives over the next three years have significant workforce implications. The specific priorities relating to the clinical workforce are to:

1. Set safe, affordable staffing levels in both community and inpatient services within the context of a redesigned workforce where service and workforce capacity is matched. We will maximize staff productive time by ensuring that vacancies, sickness rates and the ratio of temporary to substantive staff are sustainable at 5% or less by the end of FY14. Over the life time of the annual plan, the overall clinical workforce will reduce by 200 WTE through a range of workforce redesign initiatives within the CPFT Re-organisation Programme. This will be achieved without impacting the quality of care. The proposed reductions will be principally achieved through vacancy removal and natural wastage.
2. Improve Trust staff survey engagement scores in order that every member of staff will be involved with, committed to and satisfied with their work for CPFT. Our plan is to introduce an intensive staff engagement programme in 2013 identified through our 'Big Conversation' initiative that is intended to increase our staff net promoter score to 60%, 70% and 75% respectively from 48% over the three years of the plan.
3. Ensure that every CPFT clinician has the knowledge, skills and attitudes to perform to required standards. We will work with Anglia Ruskin University and Cambridge University Health Partners to create a CPFT Academy which will integrate the provision of medical and non medical education with

clinical skills and leadership development. Our goal is to ensure that 95% of clinical staff will receive appropriate training relevant to their job role, particularly Health Care Support Workers. In addition to this all Band 7 and 8A's will have completed an appropriate Leadership Development Programme and 95% staff will have received an appraisal and competency review.

The specific pressures that the workforce strategy seeks to reconcile are:

- the need to set safe staffing levels on both wards and within community teams within the context of a significant cost improvement programme and projected high levels of future service demand.
- Reducing temporary staffing deployment and spend within inpatient areas from £2.4m to £0.9m
- Remedy poor national staff survey scores in 2011/12 following the Trust's turnaround programme.

Our plans to set safe staffing levels will be addressed within two specific projects in 2013. The PET (Productivity, Establishment and Temporary Staffing Project) has reviewed inpatient staffing levels and shift patterns on all our wards and recalibrated them on the basis of nursing hours per patient day. A change management programme will be implemented that will maximise staff productive time by ensuring that vacancies and sickness rates are sustainable at 5% or less by year end 2014. This will enable us to reduce the ratio of temporary staff to establishment from the current 15% to 5% during the same time period – a saving of £1.5m. We will also tackle a range of personal and restrictive shift patterns that have developed over time within the workforce.

The Community Redesign Project will address the issue of safe staffing levels in community settings by matching future staff numbers to the level of services that we are commissioned to provide. A £2.2m savings programme will be achieved through a mixture of workforce redesign (the removal of 55 posts following a 'lean' service redesign programme) and working with the CCG to manage service demand within commissioned capacity. The workforce reductions will be principally managed through the removal of vacancies, redeployment and turnover.

As described earlier, our approach to addressing poor national staff survey scores in 2011/12 following the Trust's turnaround programme is to introduce an intensive staff engagement programme during 2013 as part of our 'Big Conversation' initiative that increases our staff net promoter score to 60%, 70% and 75% respectively from 48% over the three years of the plan.

#### *Clinical sustainability*

The trust continues to monitor its services carefully against national standards. In relation to inpatient wards the trust is amongst the lowest nationally in relation to acute beds per 100,000 of the population. This is managed by the use of home treatment and crisis intervention. The trust's wards, particularly in specialist areas comply with royal college standards. However in our acute adult and older people's mental health wards staffing levels need careful control and monitoring and we remain in dialogue with our commissioners about the implications of the Francis report for staffing levels particularly in the light of increasing levels of severity of mental ill health managed by these wards and growing population need.

The reorganisation of our outpatient and community services will bring consultant staff closer to the general practices that they relate to in each area and the overall population served by each consultant remains mainly in line with royal college recommendations.

The trust is an active trainer of junior doctors and participates both in the training of general practitioners and specialist psychiatrists. This training provision has been recently inspected and is likely to be granted conditional approval for a further three years. The trust does not anticipate any difficulty in meeting the conditions that the inspection will set.



## ***Productivity and Efficiency gains with the plan***

The Trust whilst developing the FY13-FY16 financial plan, has prepared a detailed plan for FY14 and understandably at this stage a less detailed plan for FY15-FY16. Within the three year plan, the Trust has only planned to respond to the national efficiency requirements and internal known unavoidable cost pressures. No savings are planned for additional investment in services. We have therefore in value terms planned to reduce costs by c.4.5% in each of the next three years whilst not planning to receive any additional investment in core current services from Commissioners.

Although this is a prudent planning assumption, this is clearly this is not the position the Trust would like to see sustained. The Trust is seeking to negotiate the terms of additional investment from commissioners in terms of a three year investment approach to Commissioners. Being part way through year one of three years, this is not yet certain and therefore this remains a significant risk hence any such investment not being built into our current financial plan. Any increased investment could reduce the efficiency requirement depending on investment prioritisation.

Trust total income is currently £126m per annum but contains a large value associated with particular income to the Trust from a wide variety of Commissioners and partners. These include the Local Authorities, research and education in its widest sense and is all classed as ring fenced funding. Due to these complex partnership arrangements, it is very apparent that the Trust is not able to make efficiency savings without passing this all back to the provider of the ring fenced funding. In value terms this equates to some £40m of Trust income. The expected 4.5% CIP savings therefore equates to approximately £4m in each of the three years of this plan.

## ***Cost Improvement Plan Governance***

The Trust has a Programme Management Office in place together with appropriate governance arrangements such as a Portfolio Board with supporting task and finish groups involving Non-Executive Directors. The CIP programme has an executive sponsor in the Director of Finance and is supported by all other Executive Directors. Each CIP project has a clinical lead.

The Trust plans to continue to use this structure for CIP delivery in FY14 given it's effectiveness in FY13 which saw a 90% delivery of the financial value of the CIP programme which contributed to a Financial Risk Rating of 3 and supported de-escalation

## ***Cost Improvement Schemes - Profile***

The Trust has developed CIP plans for the three year period of this plan. Early on in planning FY14 CIPs it was determined that our significant Community redesign process would look to deliver a significant element of the 3 year CIP requirement in FY14 through a single redesign process rather than multiple redesigns over the same period. We have tried to take this approach across all projects where possible ensuring a smooth phasing rather than run the risk of annual service cuts which collectively would lead to higher clinical risk and the possibility of greater reliance on non recurrent savings.

The value of the CIP requirement remains constant over each of the three years at c4.5% but the contributing projects do vary depending on the timing of saving benefit as for example release of significant estate savings will only be possible in late FY15 and into FY16 through complex planning relating to re-provision of the Ida Darwin site.

## ***Cost Improvement Schemes - Enablers***

There remain a critical number of enablers to ensure successful delivery of the CIP. The PMO and overall governance structure is already in place and is working well within the organisation.

Management information within this structure is developing to ensure informed decision making and will culminate in the Trust implementing PbR in quarter three FY14, underpinned by service line management. This will enable Trust management to review service line profitability in a way that has never been done before.

The development of the service strategy (due to report in the summer of 2013) will be critical in determining the requirements from Estates, Workforce and IM&T. Following greater planning clarity each of the key enablers will require their own strategy. At the present time in terms of planning a number of assumptions have been made most of which relate to the level of workforce required to deliver the funded level of patient demand. All CIP plans have been developed on this basis and will enable the Trust to deliver recurrent financial balance as well as minimising clinical risk after matching demand and capacity. This approach is not without challenge to the clinical body within the Trust and to our Commissioners but is an approach that is critical and has been agreed by the Board. Communications are essential to ensure this approach is understood and the reasons for it.

### ***Quality Impact of Cost Improvement Schemes***

The Board has insisted on Quality Impact Assessments (QIAs) for all CIP and service changes. A rigorous process has been developed and has been shared and agreed with Commissioners.

Each CIP project has a clinical lead that has responsibility for clinical and quality risks within the project. The Divisional Clinical Directors have responsibility for their own Divisional CIPs which are brought together within the governance structure at the Clinical Executive, chaired by the Medical Director and Director of Nursing.

The Medical and Nursing Directors have joint responsibility to sign off all QIAs at programme level on behalf of the Board.

A process is in place to share the QIAs with Commissioners on a regular basis.

If at any stage the impact on quality is thought too great then the project is reviewed for further ways to manage the quality risk or for a different way to manage the project or indeed cancel the particular project.

### **Financial & Investment Strategy**

#### ***Trust current financial position***

Improvements have been made in financial governance as recommended under the PwC financial governance action plan. Improvements in cash management and capital planning have been seen and further improvements are expected as planned. Internal Audit will review these and advise the Board of their findings.

Further improvements in internal controls are planned and will be reflected in the Trusts' Annual Governance Statement submissions in future years.

The Trust has made significant steps towards a recurrent financial balance in I&E terms under the recent financial turnaround. The Trust finances are stable but as an organisation it cannot continue to provide services that are not funded under a block contract arrangement. This is the biggest financial threat facing the organisation and could lead to unsustainable clinical services if CIP expectations grow without some activity (and therefore allowable cost) reduction.

Current run rate is positive and is expected to continue. The Trust is planning for FRR3 in FY14/15 and will look to improve, but this is critically dependent on its recent approach of either securing additional commissioner investment in services or agreeing with Commissioners that current patient activity demand should be reduced to fit within the funding envelope provided.

There is very low Trust generated funding available for service investment due to;

- Historic low Commissioner investment in Mental Health comparatively.
- A health system that has a number of Provider pressures, both clinically and financially (although an in balance Commissioner).
- Recent significant investment in Quality Turnaround.
- Emerging safety and quality risks due to high CIP levels.

A more robust approach to Commissioners and contract management has started. The aim of this is to either ensure future investment is available or activity demands are reduced to a level that is consistent with funding provided by Commissioners.

### ***Key financial priorities and investments***

The first financial priority is to continue the good work under financial turnaround through improved governance systems ensuring value for money across all Trust transactions to ensure the financial plan is delivered in FY14.

The next financial priority for FY14 is to improve the activity data recording together and linking this to financial systems to develop Service Line Management in support of the implementation of Payment by Results for mental health services and the resultant move away from a Block Contract with Commissioners.

This work will enable the Trust to determine the appropriate funding level for current and any agreed future activity levels from FY15 onwards. This will enable either the creation of an investment fund to be available for service improvement (starting with the core baseline and moving on to agreed developments) or the generation of surpluses to improve the Financial Risk Rating of the Trust.

The Trust is not planning to start any significant schemes in FY14 merely to continue to implement schemes which commenced in FY13, this is for two reasons:

1. A lack on investment funding.
2. A requirement to undertake a period of consolidation to implement our existing plans.

That said the timing for any system wide integration work including any Elderly Care proposals from NHS Cambridgeshire and Peterborough CCG is not clear and should the Trust wishes to take part in any such scheme the contingency reserves, such as they are, would need to be used rather than any ring fenced development fund.

The Trust continues to invest in improving the Governance systems within the Trust, in FY13 alone this investment was in excess of £1m. In FY14 this investment continues to a value in excess of £250k including some new critical posts including the Director of Service Integration and Serious Incident management resources.

Critical financial investments within the Trust are:

- The continued roll out of the RIO informatics system where all Trust services will be covered by Autumn 2013 thus improving the data collection and quality.
- The continued roll out of the Advice and Referral Centre from Peterborough to Huntingdon and Cambridge at a cost of £1.1m pa.

## Key Risks with FY13-16 Financial plan

Risk	Mitigations	Further Actions
<b>Local Clinical Commissioning Group (CCG) do not support Trust position for additional investment in services leading to financial in balance or lower service quality from CIP savings</b>	CCG is one of the lowest investors in Mental Health in Country. Agree investment or if not agree services to be decommissioned and impact on service and risk as a result with Commissioners.	Negotiations with Commissioners will reduce this risk but Contract will be challenging. Greater data quality will provide evidence of Trust assertion about underfunded services; Agreement with Trust Board on course of action to following QIAs.
<b>Variable Income Shortfall in –year from Specialist or other service commissioners</b>	Monitor closely on regular basis and agree action plans to address.	Continuing engagement with Specialist Commissioning Group (SCG) and Local Authorities who are key Commissioners for these services.
<b>CQUIN schemes cannot be delivered within current resources or income is not recovered</b>	CQUIN schemes must be agreed between Trust and CCG so opportunity to influence	Negotiation with CCG on CQUIN schemes to be delivered in-year
<b>CIP Plans do not deliver within required timescales</b>	CIP Plans developed in detail for FY14. CIPs Task & Finish Group in place to monitor Plan development. Project Managers appointed to lead significant CIP projects. PMO to monitor CIP projects in-year. CIP Risk Reserve of 20% included in overall CIP plan.	Continuing engagement with Divisional leads to develop deliverable CIP Plans and mitigations. CIPs Task & Finish Group will continue to meet Longer term detailed planning to continue.
<b>CCG proposed Strategic changes may have an impact on Trust position or services eg Elderly Care</b>	Procure specialist support to understand the changes and any impact on CPFT to ensure the development of the best possible information with which to respond. Develop relationships with key stakeholders to best position CPFT to respond to any such changes	Procure specialist advice and develop relationship management plan with key stakeholders.
<b>Costs of making service changes to deliver savings are prohibitive.</b>	Enabling Fund established to support costs of service change. Full costs captured in CBA's as part of Project Development and monitored regularly.	Continue to assess potential costs of service changes as project plans develop.
<b>Lack of operational surplus and excessive Capital investment over Depreciation and Asset Sales/Grants leads to a lower Cash balance and hence a lower Monitor Risk Rating</b>	Income and Expenditure Plans must deliver planned income and expenditure position including CIPs. Minimise the Capital investment risk through setting appropriate budget based on the figures as left.	Ensure monitoring and risk management though the financial governance structures to ensure delivery
<b>CIP plans have impact on quality of services to be provided</b>	All CIP projects must have a Quality Impact assessment completed and signed off by Medical Director and COO	Ensure QIAs are completed and reviewed at CIPs Task & Finish Group