

Forward Plan Strategy Document for 2013-14

Version 2 - Abridged

Northumberland, Tyne and Wear 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 7th June 2013

Approved on behalf of the Board of Directors by:

Name <i>(Chair)</i>	Fiona Standfield (Acting Chair)
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Approved on behalf of the Board of Directors by:

Name <i>(Chief Executive)</i>	Dr. Gillian Fairfield
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Approved on behalf of the Board of Directors by:

Name <i>(Finance Director)</i>	James Duncan
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Signature



Executive Summary

Northumberland, Tyne and Wear NHS Foundation Trust (the Trust) was authorised as an NHS foundation trust on the 1st December, 2009. The Trust provides a wide range of mental health, learning disability and neuro-rehabilitation services to 1.4 million people in the North East of England across the six geographical areas of Northumberland, Newcastle, North Tyneside, South Tyneside, Gateshead and Sunderland. We are one of the largest mental health and disability organisations in the country with an income of circa £300million and over 6,000 staff. We operate from over 100 sites and provide a range of mental health and disability services.

This Annual Plan (the Plan) for the three year period 2013/14 to 2015/16 sets out how the Trust intends to continue to deliver high quality and cost effective services for its patients, on a sustainable basis. It is based on the Trust's five year Integrated Business Plan (IBP) which was approved by the Board of Directors in September 2012, and it also reflects the changes in the NHS brought about by the Health and Social Care Act 2012, the increased focus on quality of care brought about by the Winterbourne View Review and the Francis Report, and the requirement to deliver financial efficiencies year on year in line with the Quality, Innovation, Productivity and Prevention (QIPP) agenda.

The Trust's current vision for the future, developed following consultation with our partners, staff and users and carers, is as follows:

'We will improve the wellbeing of everyone we serve through delivering services that match the best in the world'

Section 1 provides an overview of the Trust's strategic position within the Local Health Economy.

Section 2 outlines the Trust's approach to quality and governance.

Both the Board of Directors and the Council of Governors have reviewed and reflected on the findings of the Francis Report. As a result of the review the Trust has reflected on the current governance and assurance systems in place with the aim of ensuring events such as these never happen in the Trust's services and that all who work in the organisation uphold the values of the NHS.

Section 3 outlines the Trust's Clinical Strategy including the main service developments planned over the period of this Plan. The clinically led Service Model Review carried out in 2010 is the catalyst for the way that the Trust is re-shaping the delivery of its services, through its Transforming Services Programme.

The Trust's approach to leadership and the workforce is set out in Section 4. To deliver the Trust's Transformation of Services Programme the Trust will ensure that its workforce is able and skilled across all areas of its operations.

The Trust's Transforming Services Programme is integral to the delivery of our productivity and efficiency plans, as it is based on whole system change. The aim of this Programme is to deliver integrated, standardised, clinically effective and safe care through the design and implementation of Principal Community Pathways. Delivering effective, evidence based pathways in the community, which enable people to live more safely and securely at home will reduce our reliance on in-patient beds. Section 5 outlines our approach to increasing productivity and achieving efficiencies, and the Trust's plans over the period of this Plan.

Section 6 summarises the Trust's financial plans over the period of this Plan. Our financial plans reflect the nature of our income, the national Operating Framework and recognise that our local commissioners are not planning for growth in funding in relation to mental health and disability services. Key financial data for the three years covered by this Plan is illustrated in the table below.

Table 1: Key Financial Data 2013/14-2015/16

Key Financial Data	2013/14 £m	2014/15 £m	2015/16 £m
Income	298	294	291
Income and Expenditure Surplus	3.7	3.7	3.7
Efficiency Target	11.8	10.9	10.8
Cash Balance	23.1	23.3	26.1
Capital Programme	46.8	27.2	12.0
Asset Sales	10.1	4.4	4.0
Loan Drawdown	20.6	17.5	4.8
Risk Rating	3	3	3
Normalised Risk Rating	4	4	4

The Trust's Council of Governors have participated in detailed discussions regarding the Trust's Transformation of Services Programme/Service Development Strategy, Quality Priorities/Quality Account and this Plan and we thank them for all of their work and continued commitment to working with us to improve our services.

All of the components of this Plan are interlinked and interdependent. As we face the challenge of ensuring that we continue to deliver high quality and cost effective services for our patients we believe that this Plan forms a solid basis on which to move forward over the next three years.

Detailed information on all elements of the Trust's work going forwards is included in the full Annual Plan submission, version 1.

1. Strategic Context and Direction

1.1 The Trust's Strategic Position within the Local Health Economy

The local health economy consists of eleven NHS Foundation Trusts in the North East of England. This includes eight acute hospital trusts, one ambulance trust and two specialist trusts providing mental health and disability services, including this Trust.

Forecast Health, Demographic and Demand Changes

The Trust's catchment population is projected to grow by 2.7% between 2009 and 2019. This compares with a national projected increase of 7.8% in England and a regional growth of 3.5% in the North East. Furthermore the pattern of population change is not equal across all age bands. There are significant projected falls in the age bands 15-24 and 40-49, which are greater than the falls predicted for England over the same timescale. In common with the rest of the country there are significant projected increases in the older population aged over 65. However, while the national population projected increase in this age group is 23.4% the increase in the Trust area is 19.1%.

The Trust recognises that this increase in catchment population is likely to be reflected in increased demand for services. It should be noted, however, that demographic changes are not directly proportional to an increase or decrease in prevalence of mental illness and learning disabilities within the population. For example, the decline in the number of working age adults in the area may not necessarily be associated in a reduction in demand as those with mental illness and learning disabilities are less likely to be in employment or migrate away from the area to find a job.

Impact assessment of market share trends over the life of this Plan

The Trust has built a picture of its position in the marketplace through an analysis of commissioner intentions, policy environment and demographic demand factors.

The Trust's Marketing Strategy focuses on not only the retention and strengthening of existing core business but also on maximising opportunities for targeted growth through market penetration, product development, diversification, and market development strategies.

The major planned service developments over the life of this Plan are summarised in Section 3.

1.2 Threats and Opportunities from changes in local Commissioning intentions

Overview of the Trust's Key Competitors

The Trust faces competition from providers in the public and private sector across all service lines. These comprise:

- NHS Mental Health, Learning Disability, and Acute foundation trusts;
- Local Authorities;
- Independent (private) sector organisations;
- Community and Voluntary Sector Organisations and Third Sector Organisation Trading Arms;
- Care homes and housing associations;
- Private individuals.

Of the NHS organisations identified, two neighbouring mental health NHS foundation trusts and local acute trusts that have absorbed mental health services as part of the vertical integration of PCT provider arms, are perceived to be the Trust's principal NHS competitors. It should be noted that many of these competing NHS providers appear to provide a similar portfolio of services to the Trust.

The independent sector is characterised by a growing presence within the region, two specific groups having developed a strong presence. Both of these organisations are perceived to present a significant threat as they are starting to develop a critical mass within the area and are delivering a widening portfolio of services.

A number of voluntary sector competitors were also identified that pose a threat to the Trust. These organisations provide alternative provision for our learning disabilities services, many of which we plan to divest from. Our main threat in this regard is our ability to manage change and to redeploy our staff to deliver more specialist models of care.

The Trust has, however, developed partnerships with NHS organisations, the community voluntary sector, and independent sector which we highly value.

Assessment of the Trust's areas of strength/weakness relative to Key Competitors

The Trust has undertaken a comprehensive market assessment through which it has built a picture of its position in the market place. This has provided the context for our plans for service developments. The key factors driving demand over the next 5-10 years are an increase in our local population with an attendant increase in the number of people with mental health problems and learning disabilities. Benchmark data has been used to understand how our service compares to other providers. These sources confirm that the Trust performs well relative to others, and is particularly strong in terms of the clinical quality of the services. Data from the Care Quality Commission patient and staff surveys have been used to consider perceptions of the Trust. The data indicates an extremely high level of patient satisfaction with our services and

that the Trust has a positive working environment. Staff intention to leave their jobs is lowest for the benchmark peer group. This information has been used to underpin and add objective weight to the strengths, weaknesses, opportunities and threats relating to our service developments, and also informs our approaches to the marketing of our services.

Commissioning Strategies/Intentions

The Trust has analysed commissioner intentions by reviewing their plans for 2013/14 and beyond, and have considered the implications for our services. This analysis is set out in our full Annual Plan submission.

QIPP and Demand Management

The Trust's Transformation of Services Programme has, with the support of commissioners, already contributed to local QIPP targets and over the period of this Plan we will continue to contribute to the national QIPP Strategy through the delivery of our Transformation of Services Programme outlined in Section 3.

With regard to demand management in developing the Trust's Transformation of Services Programme due regard has/is being made by both commissioners and the Trust to the demand for services and demand management issues with these being reviewed and addressed in each Business Case developed in respect of the individual Service Developments which make up the Programme.

Decommissioning

Over the period of this Plan the Trust will work with commissioners towards decommissioning the following services:

- The transfer of social and residential care services for people with learning disabilities, provided from small homes in Northumberland to alternative providers.
- The transfer of individuals living in three residential homes in Northumberland to alternative care providers allowing the Trust to focus on the provision of care for those with more complex health needs.

Potential "Any Qualified Provider" Tenders

The introduction of Any Qualified Provider (AQP) is intended to strengthen patient choice, and a national AQP roll out of eight services currently includes one mental health service; adult psychological services although locally commissioners have yet to apply AQP to this service provision; with the potential to add Attention Deficit Hyperactivity Disorder (ADHD), autism diagnostic services and mental health spot placements. The Trust will be responding to these developments in accordance with its Marketing Strategy.

Shifting care delivery outside of hospitals

The Trust worked with commissioners and key stakeholders on the Service Model Review (SMR) with the aim of identifying a model for that better enabled the effective flow of patients through services, with individuals receiving the right service at the right time by the right staff to meet their needs, reducing the reliance on inpatient beds and enabling commissioners and the Trust to redirect and reallocate resources to meet these needs, whilst reducing the overall cost of the system by 20%. The SMR has subsequently informed the development of the Trust's Transformation of Services Programme outlined in Section 3.

Reconfiguration Plans

There are no service configuration plans associated with the Trust's services prompted by commissioner's strategies over the period of this Plan, however our plans for service transformation are fully consistent with Clinical Commissioning Group commissioning intentions and strategic planning.

How the Trust has factored these considerations into our Strategy

In developing the Trust's Clinical Strategy, including the proposed Transformation of Services Plans (Section 3) the Trust has had due regard to all of the factors outlined above.

All specific Service Developments identified in the Trust's Clinical Strategy (Section 3) are, where required, the subject of consultation and the development of Business Cases which have regard to clinical need, demand, demographics, commissioning, and draw upon best practice.

How the Trust is diversifying its income streams

• Tendering for Services

Over the period of this Plan the Trust will continue to tender for services, including new business, in line with its Marketing Strategy.

• Research and exploiting intellectual property

The Trust's aim, in line with its Research and Development Strategy (2012) is to maximise the opportunities for National Institute for Health Research (NIHR) portfolio investment in the Trust. The Trust is part of the Academic Health Services Network and has a Policy for the Management of Intellectual Property (2010 currently under review)

which supports the development, recognition and exploitation of IP. Intellectual Property is now one of the Trust's CQUIN targets agreed with commissioners.

- **Private Patient Income**

Income from private patients currently accounts for <1% of Trust income and the Trust is currently exploring opportunities to increase that percentage within our specialist services portfolio.

1.3 Collaboration, Integration and Patient Choice

The Transforming Services Programme supports the integration of services across the whole pathway, leading to better care and more efficient service delivery. Our developments for 2013/14 and future years are illustrated in Table 3.

Partnerships and Collaborations

Partnerships and collaborations have been formed to deliver a range of services including;

- Care UK who were successful in winning the North East Offender Health Tender, but invited the Trust and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT) to work in partnership to provide mental health input to the North East prisons;
- Our limited liability partnership with Mental Health Concern Oakdale Ltd who we work with in the provision of IAPT services for adults in Newcastle;
- The partnership with TEWVFT and Revolving Doors in the implementation of the Big Diversion Project;
- The provision of a new model for Tier 3 Children and Young Peoples Services South of Tyne in partnership with Barnado's, Action for Children and Investing in Children;
- A partnership with TEWVFT, Combat Stress and The Royal British Legion to deliver Veterans Wellbeing Assessment and Liaison Service in the North East;
- A partnership with TEWVFT to deliver Veterans Awareness Training in the North East;
- A partnership with The Cyrenians and Turning Point to provide the Northumberland Integrated Drug and Alcohol Recovery Service;
- Partnership working with Northumbria and Cumbria Probation Trusts to develop Community Personality Disorder services within the respective Probation Trust areas;
- Hosting of the North East Quality Observatory System (NEQOS) in partnership with South Tees Hospitals NHS Foundation Trust.
- The Trust, as part of the Care Pathways and Packages Consortium, has led the development of new currencies for mental health services, which have now been adopted nationally, as part of the drive towards a Mental Health Payment by Result (PbR) system.

The Trust has responded positively to the demand of the increasingly competitive environment, have entered into 24 tenders and funding bids since April 2010, and winning seven out of nine during 2012/13, working in partnership with other providers where this has been deemed mutually beneficial.

Impact of proposals in relation to competition rules

In responding to tenders, AQP opportunities and planning service developments or exits, irrespective of whether a partner is involved or not, consideration is given to the competition rules to ensure no actions are taken that can be construed as acting against the best interests of patients, and that benefits and positive healthcare outcomes are clearly articulated.

Patient Choice in Mental Health

The phased implementation of patient choice of Any Qualified Provider began in 2012/13 starting with a limited set of community and mental health services which included Primary Care Psychological Therapies for Adults (IAPT). To date the AQP process has not been applied locally.

The NHS "friends and family" test is to be introduced in 2013 with the aim of improving patient care to identify the best performing services and give patients the information they require to inform their decision making on where to seek treatment. The Trust is to roll out the "friends and family" test ahead of the national mandatory requirements during 2013/14 as part of its quality priorities.

2. Approach taken to Quality

2.1/2.2 An outline of the Trust's existing quality concerns, key quality risks and plans to address them

The principal risks are considered as those rated over 15 at a corporate level on the standard 5 by 5 risk assessment measure. The table below summarises the key quality risks/concerns and the key controls as reported in the Board Assurance Framework and Corporate Risk Register. All quality risks/concerns identified below are considered as in year and future risks. Table 2 below illustrates the Trust's key quality risks and concerns and plans to address them.

Table 2 Key Quality Risks and Concerns		
Ref:	Key Quality Risk/Concerns	Key Controls
SO1.1	That we do not develop and correctly implement service model changes	<ul style="list-style-type: none"> - Evidence base developed through Service Model Review Governance arrangements, including programme management structure under Trust Programmes Board. - Clinical Reference Group - Business Case Process
SO1.2	That we do not effectively engage commissioners and other key stakeholders leading to opposition or significant delay in implementing service model review changes and other major planned service changes	<ul style="list-style-type: none"> - Partnership arrangements, including Customer Relationship Management, Engagement with Clinical Commissioning Groups - Membership of Health and Wellbeing Boards for 4 out of 6 localities - Staff Side Engagement & Partnership Agreement - Service User & Carer Network Groups - Community Strategy
SO2.7	That we do not meet compliance and performance standards and/or misreport on these through data quality errors	<ul style="list-style-type: none"> - Financial and Performance Management reporting systems; other business critical systems - Trust Essential Standards Working Group - Group Governance – Q&P Committees / Essential Standards sub groups - Quality Accounts – Action Plan - Data Quality Policy
SO2.10	That we do not effectively monitor & review progress in implementing the IBP & Supporting Strategies	<ul style="list-style-type: none"> - Performance Management Framework - Programme Governance Arrangements - Project Management Structure for Capital Schemes
SO3.1	That we do not effectively manage significant workforce and organisational changes, including increasing staff productivity.	<ul style="list-style-type: none"> - Workforce Strategy - Workforce Programme Board - Workforce KPIs monitored through Q&P Committee - Group/Directorate Workforce Plans - Time & Attendance and e-rostering system - Transitional Employment & Development Approach (TED) - Revalidation process
SO5.1	That there are risks to the safety of service users and others if the key components to support good patient safety governance are not embedded across the Trust	<ul style="list-style-type: none"> - Monitoring of Quality Account Goal 1 (reducing harm to patients) - Complaints, Litigation, Incidents, PALS and Point of You (CLIPP) reporting system in place across Clinical Services. - Patient Safety Incidents reporting system, including Serious Untoward Incidents - Incidents Policy Infection Prevention and Control Policy and Practice Guidance Notes - Medicines Management Policy and Practice Guidance Notes - Safety Alerts Policy
SO5.2	That there are risks to the safety of service users and others if we do not have safe and supportive clinical environments	<ul style="list-style-type: none"> - Care Quality Commission inspections and action plans - Clinical Environment Risk Assessment (CERA) process - Capital programme to improve facilities
SO5.3	That there are risks to the safety of service users and others if the key components to support good care co-ordination are not embedded across the Trust	<ul style="list-style-type: none"> - Care Co-ordination and Care Programme Approach Policy and Practice Guidance Notes - Care Co-ordination training
SO5.4	That there are risks to the safety of service users and others if the key components to support good Safeguarding and MAPPA arrangements are not embedded across the Trust.	<ul style="list-style-type: none"> - Safeguarding Children and Safeguarding Adults Policies, Trust Action Plan. - Local Safeguarding Boards; - Trust-wide structure for Safeguarding in place - Trust Safeguarding – Public Protection Meeting

Ref:	Key Quality Risk/Concerns	Key Controls
SO5.6	The risk that high quality, evidence-based and safe services will not be provided if there are difficulties in accessing services in a timely manner and that services are not sufficiently responsive to demands.	<ul style="list-style-type: none"> - Service Model Review - Urgent Access Model - Waiting Times Monitoring & Management
SO5.7	The risk that high quality, evidence based and safe services will not be provided if we do not have robust clinical effectiveness processes in place, including the implementation of NICE guidance	<ul style="list-style-type: none"> - NICE Guidance implementation policy - Clinical Audit Policy - Group & Trust-wide Clinical Audit programme - Research & Development Policy - Clinical Effectiveness Committee
SO5.10	That we do not ensure that we have effective governance arrangements in place to maintain safe services whilst implementing the Transforming Services Programme	<ul style="list-style-type: none"> - Governance Arrangements - Programme Management arrangements - Decision Making Framework - Board Assurance Framework
Corporate Risk Register	Risk of injury or death of an inpatient from ligature use, including compliance with the Trust's Observation Policy	<ul style="list-style-type: none"> - Observation Policy and training arrangements - Serious Untoward Incident review process - Anti –ligature programme - Clinical Environmental Risk Assessment process and programme

2.3 Overview of how the Board derives assurance on the quality of services and safeguards patient safety

The Trust's Governance arrangements were reviewed in May 2013 with the Clinical Governance arrangements being reviewed and strengthened in January 2013 to ensure their robustness in the context of the Trust's overarching integrated governance arrangements. They take account of the Integrated Governance Handbook (Department of Health 2006), Monitor's NHS Foundation Trust Code of Governance and other best practice guidance, which recommends integrated governance arrangements and a streamlined committee structure.

Our system of control is based on an on-going process designed to:

- Identify and prioritise the risks relating to our policies, aims and objectives outlined in the revised Integrated Business Plan (2012) and this Plan;
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and
- To manage them efficiently, effectively and economically.

The Trust's Governance Arrangements

The Board of Directors

The Trust Board of Directors consists of a Non-Executive Chairman plus six Non-Executive Directors and six Executive Directors. During 2012/13 there were some changes to the Board of Directors with the Chairman leaving this Trust to become Chair at a Trust in Yorkshire in September 2012 and Fiona Standfield taking on the role of Acting Chair in October 2012. Work is currently being progressed on the appointment of a new Chair during 2013/14.

The Board of Directors meets regularly and sets the Trust's strategic aims, taking into account the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and review its performance.

Medical Leadership continues to be provided by the Medical Director supported by the Group Medical Directors. At the level below Clinical Directors take joint responsibility for a major aspect of care giving clinicians the opportunity to shape and develop services, bringing to bear their specialist knowledge and expertise in partnership with a senior manager and senior nursing colleague. Responsibility for Clinical Governance together with research, innovation and clinical effectiveness rests with the Medical Director, thus enabling the Director of Nursing and Operations to focus on the delivery of standards.

The Council of Governors hold the Board of Directors to account for its performance and compliance with its NHS Provider Licence.

Standing Committees of the Board of Directors

A number of Standing Committees of the Board support governance within the Trust. Standing Committees include: the Audit; Remuneration; Mental Health Legislation; Quality and Performance; and Finance Infrastructure and Business Development Committees.

Audit Committee

The Audit Committee is required to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

The Audit Committee's membership is made up of three Non-Executive Directors, one of which chairs the committee, and, in addition to attendees including senior management they also include the Trust's external auditor, internal auditor and local counter fraud specialist.

The Audit Committee is required to review the work of other Trust committees, whose work can provide relevant assurance to the Audit Committee's own scope of work. This particularly includes the committee with the remit for clinical governance, i.e. Quality and Performance Committee, and any other committee business covering risk management.

Remuneration Committee

The Remuneration Committee's remit covers all aspects of the remuneration of the Chief Executive and Executive Directors.

Mental Health Legislation Committee

The Mental Health Legislation Committee is chaired by a Non-Executive Director and ensures that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and ensure compliance with associated codes of practice and recognised best practice.

Quality and Performance Committee

The Quality and Performance Committee is chaired by a Non-Executive Director and brings together clinical governance and performance in an integrated process. The committee provides oversight to the performance and assurance framework, Trust risk management arrangements for both clinical and non-clinical risk, and has full responsibility for assuring the Trust's performance against essential internal and external standards of care and performance.

Finance Infrastructure and Business Development Committee

This committee is chaired by a Non-Executive Director and is the vehicle to monitor and review financial delivery. It also provides assurance to the Board of Directors on the delivery and processes for the management of contracts, capital plans and expenditure, informatics, estates, facilities and new business opportunities in line with corporate priorities.

Trust-wide Programmes Board (time limited Committees)

The Trust-wide Programmes Board provides assurance to the Board of Directors in relation to the delivery of the activities of the Trust Programmes ensuring programmes of work are appropriately governed, aligned with the Trust's strategic goals and that interdependencies within programmes are managed. There are two core programmes reporting into the Trust-wide Programmes Board: Transforming Services Programme and the Safety Programme.

There are also a number of supporting programmes, namely: Workforce; Service Line Management; Continuous Improvement and Knowledge; and Care Packages and Pathways Programmes.

Performance Management and Reporting Framework

The Trust has an integrated performance reporting structure, which mirrors the key reporting requirements of the "Intelligent Mental Health Board" and is therefore aligned to our strategic objectives.

The Trust has developed the use of Dashboards with a clear set of Key Performance Indicators reflecting not only national targets but local targets linked to the Trust's strategic and annual objectives balanced across clinical, operational, financial and staff dimensions. This ensures that our strategy, objectives and targets are linked to ensure delivery, with strengthened accountability for performance using key metrics.

In addition to providing a robust analysis of new and existing quality and performance targets and the risk register, the report provides evidence links for the Trust's compliance to CQC registration requirements and supports Board assurance in its annual Monitor self- declaration process.

The Trust's Quality Goals/Priorities

The organisation's Quality Goals underpin the provision of all of the Trust's services and achievement of the Quality Goals throughout the period of service transformation is a priority.

Using feedback from complaints, compliments and serious untoward incidents the views of the Council of Governors, our patients, service users, staff and partners we identified three Trust wide Quality Goals covering the period 2009-2014 based on safety, patient experience and clinical effectiveness.

- **Quality Goal One: Reduce incidents of harm to patients;**
- **Quality Goal Two: Improve the way we relate to patients and carers;**
- **Quality Goal Three: Ensuring the right services are in the right place at the right time for the right person;**

Capacity to handle risk

The Trust has structures in place, as described above, together with systems in place to support the delivery of integrated risk management across the organisation.

The Standing Committees of the Board of Directors ensure effective governance for the major operational and strategic processes and systems of the Trust, and also provide assurance that risk is effectively managed.

Operations for the Trust are managed through an organisational structure, with operations divided into three Groups, and each has governance committees in place for quality and performance and operational management.

The Risk and Control Framework

The Trust continually reviews its risk and control framework through its governance and operational structures. It has identified its major strategic risks, and these are monitored, maintained and managed through the Board of Directors Assurance Framework and Corporate Risk Register, supported by Group and Directorate Risk Registers. The Trust's principal risks and mechanisms to control them are identified through the Assurance Framework, which is reviewed by the Board of Directors every two months.

Quality Governance arrangements are through the governance structures outlined above, ensuring there are arrangements in place from ward to Board. Review, monitoring and oversight of these arrangements takes place through the following among others: Board of Directors; Quality and Performance Sub-committee; Group Quality and Performance Committees and Senior Management Team meetings

Registration with the Care Quality Commission (CQC)

The Trust is registered with the Care Quality Commission and has maintained full registration, with no non-routine conditions, from 1st April 2010. During 2012/13, the CQC undertook a number of registration visits to Trust sites. Where compliance actions were identified through these visits, the Trust delivered these in full and on time. The Trust is fully compliant with the requirements of registration with the CQC. As at the 31st March 2013 the Trust had two moderate concerns outstanding, regarding Medicines Management and Staffing at St. George's Park, for which full action plans are in place and have been approved by the CQC.

Registration compliance is managed through the above quality governance structures and is supplemented by a Group Director being responsible for the oversight of all compliance assessments and management of on-going compliance through the Trust Essential Standards Management Group. This Group reports into the Senior Management Team. There is a central log of all evidence supporting registration requirements and a process in place through the governance arrangements highlighted above to learn from external assessments and improve our compliance. In March 2013 it was agreed that the Essential Standards Group will co-ordinate and ensure a programme of clinical audits across all 16 outcomes under CQC Standards.

3 Clinical Strategy

3.1 The Trusts overall clinical strategy over the next three years – the Transformation of Services

In acknowledgement of the need to radically change and improve the way we provide services the Executive Directors asked a group of clinicians from across the organisation to form a Clinical Project Group to draw together all of the evidence and best practice relating to service provision, to seek feedback from a range of interested parties in mental health and disability services, to produce a vision for future services that truly does what is right for service users and carers. The result (the Service Model Review) is a high level model, which is underpinned by a single set of values and principles key to its quality and success.

- You can reach us, simply and quickly;
- The earlier the better;
- To get the right care, safely and easily;
- From our flexible and skilled workforce;
- In collaboration with families, carers and partnership organisations;
- So that you can gain/re-gain independence, as far as possible;
- By making smooth and sustainable steps forward;
- Reaching us again, simply and quickly.

Our service redesign is underpinned by information derived from the Care Pathways and Packages approach which is mandated by the Department of Health and endorsed by the Trust. It ensures that service users consistently receive the right service, at the right time and in the right place: depending on the nature of the problem, the level of complexity, the urgency and the risk. The fundamental aspects of the model include:

- Improved access to services
- Stepping up and stepping down the intensity of care according to need
- Scaffolding the clinical workforce

The success of this model depends on the Trust's ability to implement all aspects of it. The key recommendations from the Clinical Project Group form the basis of the Trust's Clinical and Quality Strategy which is as follows:

- **Reconfigure Services**
- **Develop and improve clinical systems and processes**
- **Increase the capacity and capability of the clinical workforce**

The Trust's Transforming Services Programme is the vehicle for implementing the new service model and is configured as a set of delivery projects that will change over time, supported by a central clinical reference group and a communications and engagement group. The objectives of each component element of the Programme over the period of this Plan are summarised below. Key milestones, risks and mitigation strategies are shown in the Service Development Template (table 3).

Access Project

The strategic approach is to develop an access system in partnership with commissioners and other partner providers. In the light of the success of the Sunderland pilot, the Trust will progress:

- The introduction of the Urgent Care Access model into North of Tyne localities as a CQUIN target for 2013/14;
- The development of Planned Care Access in Sunderland and South Tyneside as a CQUIN target for 2013/14.
- During 2013/14 the Access Project is being integrated into the Principal Community Pathways Programme

Whole System Working

The Whole System Pilots (Sunderland and Newcastle) are a way of concentrating effort in specific localities whilst simultaneously validating and evaluating the new service model.

The work relating to developing whole system working through the development of integrated Care Pathways will be taken forward in 2013/14 by the Principal Community Pathways Programme – see below. Aligned to this, further work will be undertaken in Newcastle relating to the interface between primary and secondary care.

Principal Community Pathways Programme

The Principal Community Pathways Programme is responsible for implementing the changes required across all community services in order to deliver new community-based care pathways.

The Programme will commence design, test and implement effective, evidence based interventions focussed on recovery and effective support for people to live and work in their own communities thereby reducing reliance on hospital beds in Sunderland and South Tyneside in 2013/14 before rolling out the model Trust wide during 2014/15. The Programme will redesign services to meet the following needs in adults: Psychosis; Non psychosis; Cognitive disorders and Learning Disability.

The PRiDE Development (including the reprovision of Cherry Knowle Hospital)

The PRiDE development (providing improved mental health and learning disability environments in Sunderland and South Tyneside) is a keenly awaited development to provide state of the art, inpatient and support services to replace the Cherry Knowle Hospital (Hopewood Park – due for completion April 2014), and also includes a Specialist Dementia Care Centre at Monkwearmouth Hospital (scheduled for completion October 2013).

Inpatient Project

The Inpatient Project is responsible for the design and implementation of the future configuration of inpatient services based on patient need. These will form the cornerstone of augmenting services as articulated in the Service Model Review and will include:

- The review of the dementia care pathway in Newcastle, particularly long term care provision, with the aim of the Trust focusing its service and resources on the provision of care to those at an earlier stage of the illness who may exhibit challenging behaviour;
- The review of long term complex care services North of Tyne as a part of the move towards an improved stepped care pathway;
- Expansion of hospital liaison services across North and South of Tyne improving these services in line with the nationally recognised Rapid Assessment, Interface and Discharge (RAID) model. In 2013/14 work will focus on the implementation of the new model in Sunderland, South Tyneside and Gateshead;
- Realignment of female adult mental health assessment and treatment services in South of Tyne to align capacity with the agreed PRiDE model of care;

- Realignment of female adult mental health assessment and treatment services in North of Tyne, in line with demand;
- Realignment of adult learning disability assessment and treatment services North of Tyne, in line with national policy relating to people with learning disabilities being supported to access mainstream services, where practical, and the need to improve early intervention, address delayed discharges and reduce excess capacity.

Social and Residential Care Services

The Trust has historically provided social and residential care services to adults with a mental illness and adults with a learning disability. In partnership with commissioners we will:

- Complete the refocus of social and residential services for adults with a learning disability, including the transfer of the remaining services in Northumberland to alternative providers;
- Transfer residential care services for adults in Northumberland to alternative providers.

Specialist Care Services Programme

The Specialist Care Services Project is responsible for ensuring the Trust retains sustainable specialist services as part of the overall service model and the work of this project will include:

- The further review of Neurological Services to ensure long term sustainability;
- Marketing the medium secure services for mentally disordered young offenders to maximise occupancy following completion of the upgrading/remodelling works to the unit;
- Reviewing the Trust's Forensic Services, and developing a Service Strategy to ensure long term sustainability;
- Securing approval for the development of an assessment and treatment unit for people with Autism.

Scaffolding the Clinical Workforce

Scaffolding is a fundamental aspect of the model and is the mechanism by which the clinical workforce is supported to work at its maximum potential in a sustained way: through the information, advice and supervision they need. It is essential to the successful operation of the model – both in terms of improved outcomes and effective flow of patients through the system. Over the period of this Plan we will review the impact of clinical scaffolding on the services provided by the Trust.

3.2/3.3 The Trust's Service Line Strategy over the next three years and the input used to develop this strategy

The Trust has followed Monitor's recommended Service Line Management approach with each Operational Group representing a Trust Service Line. The Trust's Integrated Performance and Assurance Report produced monthly has evolved over time in line with relevant guidance and is underpinned by the Trust's in house data warehouse which brings all business critical information sources together in an easily accessible Dashboard reporting tool, now presented in terms of the Trust's Service Line Reporting and Management. In 2012 the Trust used the Monitor Self-Assessment Tool to identify areas requiring further work and the summary of key deliverables progressed in 2012/13. The Service Line Management Programme will progress:

- Implementation of Service Line Dashboard integrating Finance, Quality and Workforce Dashboards;
- Development of Benchmarking functionality.

Ref	Development	In IBP 2012?	Key Actions	Key Risks	Regulatory requirements	Resource impact							Measures to track and assess
Table 3 Summary of key service developments						Activity	Finance			CIP	Staff	Site	
							Income	Costs	Capital				
1. Transforming Access													
1.2	Urgent Care Access	✓	Roll out across North of Tyne during 2013/14 – 2014/15	Internal and external partnerships not met to support delivery	None identified	✓	✓	✓			✓	✓	Principal Community Pathways
1.2	Planned Care Access	✓	Roll out across Sunderland and South Tyneside during Q1-4 2013/14	Internal and external partnerships not met to support delivery	None identified	✓	✓	✓			✓	✓	Principal Community Pathways
2. Principal Community Pathways													
2.1	Principal Community Pathways (Non psychosis, psychosis, cognitive disorders, learning disability)	✓	Roll out across Sunderland and South Tyneside during 2013/14 to 2015/16	Programme is unaffordable, impacting on resources available	CQC registration	✓	✓	✓		✓	✓	✓	Principal Community Pathways
2.2	Implementing Care Pathways, Mobilising the workforce and Multi-disciplinary working (supports 2.1)	✓	Roll out of the three schemes during Q1-4 2013/14	Roll out is not met within resources available, impacts on schemes and 2.1	CQC registration/ Data Protection Act	✓	✓	✓		✓	✓	✓	Principal Community Pathways
3. Transforming Inpatient Services													
3.1	PRIDE - Re-provision of Cherry Knowle Hospital (Hopewood Park)	✓	Completion of construction by Q4 2013/14	Slippage/ Cost over run	CQC registration	✓	✓	✓	✓		✓	✓	PRIDE Project Board
3.2	PRIDE – Specialist Dementia Centre Monkwearmouth Hospital	✓	Completion of construction by Q2 2013/14	Slippage/ Cost over run	CQC registration	✓	✓	✓	✓		✓	✓	PRIDE Project Board
3.3	Rationalisation of Newcastle Dementia Pathway	✓	Vacate Ashgrove upper floor by Q3 2013/14	Service Users unable to move on	CQC registration	✓	✓	✓	✓	✓	✓	✓	Transforming Services Programme Board
3.4	Rationalisation of Long Term Complex Care Inpatient Services North of Tyne		Service User discharges and transfers in Q's 3 and 4 2013/14	Service users unable to move on	CQC registration	✓	✓	✓	✓	✓	✓	✓	Transforming Services Programme Board
3.5	RAID Model - Expansion of Hospital Based Liaison	✓	Roll out liaison services into local Acute Hospitals during 2013/14-2015/16	Current ad hoc arrangements do not meet needs	None identified	✓	✓	✓			✓	✓	Transforming Services Programme Board

Ref	Development	In IBP 2012?	Key Actions	Key Risks	Regulatory requirements	Resource impact							Measures to track and assess
Table 3 Summary of key service developments						Activity	Finance			CIP	Staff	Site	
							Income	Costs	Capital				
3.6	Realignment of Female Assessment and Treatment services South of Tyne	✓	Closure of Bede2 as enabler for PRIDE by Q4 2013/14	Demand for inpatient services cannot be met	CQC registration	✓	✓	✓		✓	✓	✓	Transforming Services Programme Board
3.7	Realignment for Female Assessment and Treatment services North of Tyne		Reduction in inpatient capacity at St Georges Park by Q4 2013/14	Demand for inpatient services cannot be met	CQC registration	✓	✓	✓	✓	✓	✓	✓	Transforming Services Programme Board
3.8	Realignment of Learning Disability Assessment and Treatment Services North of Tyne		Service User discharges and transfers by Q4 2013/14	Service users unable to move on. Impact of Winterbourne View	CQC registration	✓	✓	✓	✓	✓	✓	✓	Transforming Services Programme Board
4. Transforming Social and Residential Services													
4.1	Transfer Northumberland Adult Residential Learning Disability care services to alternative providers	✓	Work with Northumberland County Council to transfer remaining homes to other providers by Q2 2013/14	Stakeholder approval Transfer of Staff under TUPE	CQC registration TUPE	✓	✓	✓		✓	✓	✓	Transforming Services Programme Board
4.2	Transfer Northumberland Adult Residential Mental Health care services to alternative Providers	✓	Work with Northumberland County Council to transfer two homes to alternative providers by Q3 2013/14	Stakeholder approval Transfer of Staff under TUPE	CQC registration TUPE	✓	✓	✓			✓	✓	Transforming Services Programme Board
5. Transforming Specialist Care Services													
5.1	Review of Neurological Services		Review all Neurological services to maximise productivity 2013/14-2015/16	Staff engagement Commissioning arrangements	None identified	✓	✓	✓			✓		Transforming Services Programme Board
5.2	Remodelling of Roycroft Services (Alnwood)	✓	Meet CQC recommendations re accommodation Revise service model Q2 2013/14	Ability to fill beds and generate required income	CQC requirements	✓	✓	✓	✓		✓	✓	Transforming Services Programme Board
5.3	Review of Forensic Services	✓	Review all Forensic services to maximise productivity 2013/14-2015/16	Staff capacity to support review process	None identified	✓	✓	✓	✓		✓	✓	Transforming Services Programme Board
5.4	New Assessment and Treatment Unit for people with Autism	✓	New build for the Autism service on the Northgate Site 2013/14-2014/15	Securing funding Slippage/Cost over run Winterbourne View	None identified	✓	✓	✓	✓		✓	✓	Board of Directors

4 The Trust's Workforce Strategy

4.1 Overview of Workforce Strategy

The Trusts workforce comprises over 6,000 staff from a wide range of clinical and non-clinical backgrounds, as illustrated in table 4 below;

Table 4 - Staffing		
Staff Group	Head Count	Whole Time Equivalents
Medical and Dental	259	219.00
Nursing and Midwifery (Registered)	1869	1670.38
Allied Health Professionals	236	209.16
Scientific and Technical	311	265.04
Healthcare Assistants	2075	1677.91
Administrative and Clerical	1154	978.39
Estates and Ancillary	612	473.93
Total	6516	5493.80

Over the period of this Plan the Trust will be focusing on achieving the Transformation of Services. Using our expertise and knowledge to manage change successfully we acknowledge that the transformation of services, as described in Section 3, together with the cost improvement plans (Section 5) requires a further step change in the way services are provided and the deployment of resources. We will continue to apply a "bottom-up" workforce development approach, with each unit being responsible for identifying, planning and implementing necessary changes to ensure that the objectives are delivered. The Trust has a workforce plan which we continue to refresh to encompass the changes required by the Trust's Transforming Services Programme.

To support the management of the workforce changes the Trust invested in the establishment of the Transitional Employment and Development (TED) Approach in 2012 to support those members of staff who are affected by these changes and to help them develop new skills to take on the challenges and future employment opportunities ahead. This scheme has proved to be successful and the Trust will continue to invest in the TED Approach during 2013/14. We continue to identify the failure to manage these significant workforce changes as one of our key business risks, however, we have had considerable success in managing large scale change. This has been achieved by close working between service managers and experienced HR professionals and partnership working with staff side organisations. We will continue to use the TED Approach to manage these further changes without compulsory redundancies wherever possible.

We will ensure that frontline clinicians and the wider workforce have the required leadership knowledge, skills and behaviours to drive radical service redesign, transformation and improvement. Over the period of this Plan, the Trust will continue to support the development and involvement of leaders at all levels who are innovators and entrepreneurs in acknowledgement of the critical role they will play in delivering the radical service redesign, transformation and improvement plans necessary to enable us to deliver our strategic objectives, this Plan and the revised Integrated Business Plan (2012).

The Trust also acknowledges that training and development plays a key role in the achievement of strategic goals and targets of the Trust. A major factor in the organisation's effectiveness is the need to transform services and the successful management of change will be key. Work has been carried out to identify the emerging training needs required as we transform our services and a skills analysis has been completed in order to determine current skills levels. Training has been prioritised and will be carried out during 2013/14 to support the transformation agenda. We have already identified and are delivering on new training subjects related to values and attitudes (now linked to the Francis Report), clinical risk and a range of informatics topics and will be building on these as we move forward.

The Revalidation of Medical Staff

During 2012/13 the Trust put in place robust local systems of appraisal and clinical governance to support the national requirements relating to the revalidation of Medical Staff. These have been scrutinised by Internal Audit and this has provided assurance that systems are in place. The Trust has in place a 3 year rolling programme, with the aim of all Medical Staff completing the revalidation process by 2014/15. As a part of this work the Trust is working on quality assuring the appraisal process itself and seeking effective ways of identifying any key themes/patient safety concerns that may be raised by Medical Staff as a part of the process. All of this work is in line with the recommendations of the Francis Report.

4.2 Key Workforce pressures and plans to address them

The key Workforce pressure and plans to address them are summarised in table 5 below:

Table 5: Key Workforce Pressures and Mitigation Plans

Workforce Pressure	Plans To Address Workforce Pressure
Managing workforce and organisational changes	<ul style="list-style-type: none"> • Partnership Agreement with Staff Side in place; • Group/Directorate workforce plans developed and regularly reviewed; • Investment in the Transitional Employment and Development (TED) Approach; • Continued investment in leadership, training and development courses to ensure staff have the skills required to carry out their new roles and support new Service Models; • Organisational Development Team to support service changes.
Recruitment and Retention of Issues- Medical Staff	<ul style="list-style-type: none"> • Creation of floating Consultant posts; • Closer links with education establishments to attract students into psychiatry: encouraging trainees at the end of their training to take up positions in the Trust. • Exploring “alternative” recruitment techniques; • Workforce Planning discussions; • Introduction of new roles in line with the Transforming Services agenda; • Reviewed job planning process.
Reduction in the use of Bank and Agency Staff	<ul style="list-style-type: none"> • Continue roll out of electronic time and attendance system; • Effective performance management systems; • Introduction of staffing “pools” across the Trust; • Implementation of streamlined recruitment processes
Sickness Absence Rates	<ul style="list-style-type: none"> • Review Occupational Health contract; • Roll out revised Policy and training; • Fast-tracking of Occupational Health appointments for stress, muscular skeletal and post-operative issues; • Additional workforce resource to support absence management
High volume of Discipline and Grievance cases	<ul style="list-style-type: none"> • Review of Case Management approach to discipline and grievance cases; • Revised Disciplinary and Grievance Policies; • Revised training package for those involved in investigations and hearings.
Staff Engagement	<ul style="list-style-type: none"> • Early engagement/involvement in Transforming Services Plans; • Chief Executive 150 Events; • Staff 250 Events; • Review of the Trust’s Values
Age profile of the Workforce	<ul style="list-style-type: none"> • Assessment and monitoring of staff eligible for retirement over the next 5 years • Linking replacement of retired staff to the Transforming Service Programme • Assessment of each replacement with respect to revised skill mix, roles • Focus on training and development of staff at bands 1-4 to improve skill base and relieve pressure on higher graded staff

4.3 The impact of the Workforce Strategy on costs

The Trust is planning to deliver cost reduction through the Transformation of Services Programme, which is clearly one of the key objectives of the Workforce Strategy. Transformation of the workforce is essential to deliver these changes, the skills and mix of staff in the community will change to reflect the requirements of the pathways for patients with different needs (as identified by the cluster of care they are allocated to). Also as the Trust reduces the number of beds and wards, the number of staff working in in-patient services will reduce. The remaining in-patient units will however have consistent staffing establishments appropriate to the condition and acuity of the patients being cared for.

Towards the latter part of this Plan we will increasingly focus on delivering the release of resource through skill mix changes and the introduction of new roles and ways of working as our value stream maps show us that a number of interventions could be more effectively delivered by more appropriately qualified staff, freeing up some of our more expensive resources in Consultant, Psychology and higher banded nursing time. We will achieve this by greater use of support and peer support workers within our community services, where this is appropriate to the care provided. Where deemed appropriate some resources released from service changes will be re-invested to support the remaining services to ensure appropriate skill mix and delivery of services to the required quality.

The Trust will continue to fund the TED Approach to support the changes to services and support staff redeployment. Specifically funded training programmes have also begun in specific areas to support the transformation of services. While the number of posts will reduce through the delivery of the Transformation of Services Programme the Trust will manage this reduction through vacancies and natural wastage wherever possible. In 2013/14, the Trust has also invested in additional workforce support to deliver reductions in the levels of sickness. This will be monitored through the year.

4.4 Findings of benchmarking or other assessment

The Trust achieved Investors in People status in August 2010 which supports the organisation in transforming its business performance, and reaccreditation will be sought during 2013. The Trust will continue to use the findings from benchmarking other assessments and recognised best practice to improve sickness and absence rates. We also benchmark the Trust against comparable organisations using the National Staff Survey. In response to the findings of the 2011 Staff Survey the Trust focused on listening and involving staff in improving staff engagement and communications. Our work in 2013 will focus on the quality of appraisals.

The Trust also works alongside other Providers and the Health Education North East Board to plan the regional educational programme for non-medical staff required to ensure the right numbers of trained staff are available to meet forecast service needs. There is input at Director level to this process from the Trust.

As the Workforce Strategy is further developed to meet the needs of the Transforming Services Programme it will use benchmarking and other assessment tools to support the process. This will include for example using the Centre for Workforce Intelligence and the Department of Health Workforce Health tool.

4.5 Clinical Sustainability

The Service Model Review addresses clinical sustainability, with transformation of the workforce central to delivery. As the Trust reduces the number of inpatient beds in favour of a community based model, staffing establishments will be revised to take account of the changing need of patients. Where available, national standard establishment guidelines (e.g. from the Royal Colleges) are taken into account. For services where current establishments may be at risk of falling below national guidelines e.g. Mental Health Services for Older People, cross cover arrangements are implemented and vacancies filled temporarily through locum and agency staff.

The age profile of the Trust's Medical staff is such that there are a high number who may retire over the next 18 months. Therefore consideration is being given to making sure they are replaced in line with service needs using best guidance where appropriate. Nine new consultants have been recruited in the last month. Plans to address any potential gaps in medical staff recruitment include:

- The creation of floating Consultant posts;
- Closer links with education establishments to attract students into psychiatry;
- Exploring "alternative" recruitment techniques;
- Improved Workforce Planning;
- Revised multidisciplinary teams
- Introduction of new roles including non-medical prescribers, nurse consultants, responsible clinicians etc

4.6 Innovations in Care Delivery

The Trust has a reputation for delivering innovations in care delivery, for example;

- During 2012/13 the Initial Response Team, Universal Crisis Team and Home Based Treatment Team models were piloted in Sunderland and evaluated. The evaluation confirmed the success of improving access to Urgent Care services and the quality of care provided. This model has therefore been adopted on a permanent basis in Sunderland and is being rolled out across the Trust.
- Our Children and Young People's Mental Health and Learning Disability Services (Ferndene) have won a range of awards for innovation in relation to involvement, sustainability, construction design.
- A partnership with The Cyrenians and Turning Point has been established to provide the Northumberland Integrated Drug and Alcohol Recovery Service and the innovative collaborative model that was developed between the partners was instrumental in ensuring a successful tender for the service.
- During 2013/14 we will progress the implementation of new multidisciplinary teams to deliver our Principal Community Pathways initiative.
- In January 2013 we developed a joint venture with South Tees Acute FT for the North East Quality Observatory whose expert clinical quality measurement service underpins clinical work across the North East.

5 Productivity and Efficiency

5.1 Overview of productivity and efficiency plans

The Trust's productivity and efficiency plans centre around its Transforming Services Programme, led and managed by the Transformation Support Office. Our modelling sets out that to deliver clinically effective and safe care focused on recovery, and supporting patients in their own communities we will need to increase productivity levels in terms of time spent in direct patient care from the current levels of around 25% to 40-50%. This is dependent on maintaining the levels of overall investment in community services broadly at current levels. This will require fundamental re-design of the systems processes and structures of delivering community based care.

Delivering effective, evidence based pathways in the community, which enable people to live more safely and securely at home will reduce our reliance on in-patient beds. In order to deliver our Financial Strategy in full a reduction from the current 723 beds to around 425 beds (excluding Specialist Services) will be required. Benchmarking of bed numbers nationally suggests this is possible, but the implementation of such a strategy must be evidence based. Therefore the Trust plans to reduce its bed numbers incrementally over the next three years, with each stage being evidenced by reduced levels of demand. We aim to manage to an average length of stay across our adult acute services of 21 days (52 days as at 1st April 2012, 32 days at 1st April 2013), and are in the process of defining standards for all in-patient areas. During 2013/14 we aim to release over £4m from reductions in in-patient wards and £21m over the life of the Financial Strategy. During 2012/13 emergency admission rates for mental health wards were 8.4% and Learning Disability for 16.5%. Occupied bed levels across the Trust at the end of 2011/12 were 80.9%, and 81.7% at the end of 2012/13.

As a mental health and disability provider the Trust does not provide theatre services.

The Trust has a range of initiatives to reduce nursing and medical agency spend. We are introducing nursing pools across our core sites at St Nicholas Hospital, St. George's Park and Cherry Knowle, and have an aim to reduce agency spend to a minimal level in 2013/14 (15% of 2012/13 levels). We aim to reduce medical agency spend by £2.6m in 2013/14 from £5.2m in 2012/13 through more effective recruitment, use of floating locums and introduction of alternative measures of cover.

We are reviewing delivery of corporate services with release of £1.4m of savings planned for 2013/14. A more radical review of the provision of corporate services will be undertaken during 2013/14 with the aim of developing a longer term strategy to reduce corporate costs by 20% by the end of this Plan.

Across our Specialist Services our aim is to maintain overall levels of profit at that delivered through 2011/12. This means that reductions in contract imposed through the national tariff adjustment, net of any CQUIN gains, will be met through improved occupancy rates, entry into new markets, withdrawal from non-profitable service lines where this is appropriate to the overall Trust strategy and productivity gains linked to overall pathway improvement, and absorption of additional demand.

Towards the latter part of this Plan we will increasingly focus on delivering release of resource through skill mix changes and the introduction of new roles and ways of working as again our value stream maps show us that a number of interventions could be more effectively delivered by more appropriately qualified staff, freeing up some of our more expensive resources in Consultant, Psychology and higher banded nursing time. We will achieve this by greater use of support and peer support workers within our community services, where this is appropriate to the care provided.

5.2 Cost Improvement Programme (CIP) Governance

The Trust's Financial Delivery Programme (Cost Improvement Programme) is developed through the Trust's Transforming Services Programme Board, as it is focussed on whole system change. It is led and owned by the Executive Director of Nursing and Operations. The overall strategy for transforming services is set and owned by the Board of Directors who also approve the Annual Plan for delivery through the Trust's Financial Strategy. The Financial Delivery Programme is scrutinised for its impact on quality and the use of resources, and every change in service associated with the Programme is subject to final Business Case approval from the Board of Directors and its Commissioners. The Trust has in place robust project management systems and processes for each project, supported by the Transformation Support Office and the Project, Information and Knowledge System. Appropriate levels of consultation and engagement are undertaken on each service change, which again is overseen by the Transforming Services Programme Board, approved by the Senior Management Team and agreed by the Board of Directors through the Final Business Case. The Programme Board receives assurance around the processes of governance for all Trust Programmes. The Finance, Infrastructure and Business Development Committee reviews performance against the plan on a monthly basis and this is also included in monthly Board reports, which are considered by the Board of Directors and the Senior Management Team. Plans for service transformation and financial delivery are also scrutinised by the Board of Directors through quarterly Confirm and Challenge meetings at which the Board review overall delivery with the Directors and wider Management Teams of each of the Groups.

5.3 Historical Performance

The Trust has delivered its Financial Delivery Plan on a recurring basis year on year. At the beginning of 2012/13 the Trust set out its service transformation plans based on the Service Model Review. This set out our direction for developing more effective integrated care pathways and reducing reliance on in-patient beds. The Trust has a Transformation Support Office, with a core team plus additional support recruited specifically to support projects. The Transformation of Services Programme is led by the Deputy Chief Executive/Director of Finance. Leadership for the Financial Delivery Plan sits with the Executive Director of Nursing and Operations, while the Medical Director leads the core Safety Programme, which provides assurance that the transformational change programme is being planned and implemented safely. The Trust and its partners has invested year on year in the transformational change programme, and this is critical to its future success. Table 6 below shows our historical performance in delivering our Financial Delivery Plan.

Table 6: Financial Delivery Plan Historical Performance	2008/09	2009/10	2010/11	2011/12	2012/13
	£m	£m	£m	£m	£m
Target	9.7	8.1	9.7	11.7	11.1
Actual	9.7	8.2	9.7	11.7	11.1

5.4 Cost Improvement Programme Profile

There are plans in place for the full delivery of the Trust's Financial Delivery Plan (Cost Improvement Programme) in 2013/14. The Trust's main schemes for 2013/14 revolve around ward closures and currently there are no significant risks to the five ward closures due to take place in 2013/14. Over the life of the Plan the targeted reduction in beds would see the release of around £21m recurring of the total target of £44m. The release takes into account required levels of investment in clinical staffing

on the remaining wards to ensure safe and effective care. A further £14m is released from Specialist Care Services through a range of productivity, income generation measures, and potentially service withdrawal. Just under £6m will be released from streamlining corporate services and further savings are driven through agency, non-pay, drugs costs, on-call and technical measures. A summary of the Financial Delivery Plan is shown in table 7 below, and the top five CIP schemes are included in Appendix 2.

Table 7: Summary Financial Delivery Plan	2013/14	2013/14	2014/15	2015/16	2016/17	TOTAL
	In Year £m	Full year £m	Full year £m	Full year £m	Full year £m	Full Year £m
In-Patients	2.0	4.8	5.3	3.0	7.0	20.1
In-Patients Sites Release				1.8		1.8
Specialist Care	1.4	1.8	4.0	4.0	4.0	13.8
Agency	1.7	1.9				1.9
Drugs	0.5	0.5	0.2	0.2	0.2	1.1
Corporate incl Estates & Facilities	2.0	2.0	1.5	1.5	1.4	6.4
Trust Wide, Technical & Other	3.6	2.1				2.1
Non-Recurring Initiatives	1.1	0.0				0.0
Total	12.2	13.0	11.0	10.4	12.6	47.0
Reinvestment	(0.4)	(1.2)	(1.6)			(2.8)
Net Savings	11.8	11.8	9.4	10.4	12.6	44.2
Inflation Benefit			0.8	0.4	(1.2)	0.0
Total	11.8	11.8	10.2	10.8	11.4	44.2
Shortfall			0.7	(0.0)	(0.7)	(0.0)
Target	(11.8)	(11.8)	(10.9)	(10.8)	(10.7)	(44.2)

Overall the Plan is set to deliver in full although further work is required to consider managing the shortfall between years. Over 2013/14 the main effort will be in designing, testing and implementing Principal Pathways in Sunderland and South Tyneside. This will enable us to further review and determine the impact on beds and confirm or alter our on-going strategy through the year.

5.5 Cost Improvement Programme enablers

The Trust's core Transformation of Services Programme builds on the work of the Service Model Review, which was clinically led. The Transforming Services Programme Board involves a wide range of clinicians, including all of the Group Nurse Directors and Medical Directors and each programme and project has a Clinical Lead. A Clinical Director for Transformation challenges delivery of the model to ensure that it is in line with the vision set out in the Service Model Review and also provides the link to the Clinical Reference Group, a body of clinicians who consider and challenge proposals developed through the Transformation Board. The Principal Pathways Programme has two Programme Directors, a Consultant and a Group Nurse Director. The value stream maps for Principal Pathways were developed through workshops attended by over 100 practising clinicians across the Trust. The Principal Pathways Programme is jointly sponsored by the Deputy Chief Executive and the Medical Director

The Trust has invested in a range of IT initiatives including the full roll out of clinical information systems, mobile working, digital dictation, e-rostering, and technical support for the new Trust access model. Project delivery resources are in place through the Transformation Support Office and through other corporate departments such as IT, Finance, the Commercial Support Team and Human Resources.

The Transformation of Services Programme also includes resources for backfilling clinical expertise, pump priming initiatives such as the Access Project, double running costs for service change and other key requirements. A breakdown of our planned investment strategy to support transformation is shown below:

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Table 8: Planned Investment Strategy Non-Recurring Funds Identified	2013/1 4	2014/1 5	2015/1 6
	£m	£m	£m
Reduction in surplus	3.0	3.0	3.0
PRiDE Reserve	2.5	0.5	
North of Tyne (NoT) Non recurring support	0.9		
Transfer from Uncommitted Recurring Reserves	0.6	0.1	0.0
Total Funding	7.0	3.6	3.0
Proposed Investment	7.0	4.9	4.9
Further Non –recurring Commissioner Support Required		1.3	1.9

On-going discussions with commissioners will determine the level of additional non-recurring investment that they will make over years 2 and 3 of the Plan.

5.6 Quality Impact of the Cost Improvement Programme

The Financial Delivery Plan is developed through the Transforming Services Programme Board, and approved by Senior Management Team and the Board of Directors. All schemes are considered for their impact on quality and safety and the Trust Safety Programme has the specific remit to assure this. There is strong clinical representation on the Transforming Services Programme Board including the Trust Medical Director, Director of Nursing and Operations, Group Medical and Nurse Directors, and professional and pathway clinical leads. All schemes impacting on services are subject to Business Case agreement which considers the impact of the change on quality and safety. These Business Cases are the subject of appropriate consultation and engagement and are subject to commissioner approval. The Board of Directors considers quality and safety impacts through development of strategy, approval of the revised Integrated Business Plan (2012), Annual Plan, approval of Business Cases and on-going review of quality, through monthly reporting and the quarterly Confirm and Challenge meetings.

This is a two way process whereby Operational Groups present to the Board of Directors their contribution to and delivery of the Trusts strategy and operational performance. The Board are then able to confirm and challenge the work of the Groups.

6. The Trust's Financial and Investment Strategy

6.1 Purpose and Background

The Trust's Finance Strategy for the period from April 2013 to March 2017 describes the key strategic financial risks and issues faced by the Trust and the impact, issues arising and key issues to be resolved in pursuing our service development strategy over the next four years and beyond. Our revised Integrated Business Plan (2012) and this Plan are focussed on the following three key areas:

- To transform how we deliver community based services;
- To ensure that in-patient environments are properly staffed and designed to promote recovery;
- To ensure that our specialist services, are sustainable for the long term.

This Strategy will continue to see a reduced reliance on in-patient beds, which over the next 4 years will see reductions in the numbers of wards and sites that the Trust operates from.

The financial environment in which we work has not changed significantly since the approval of our last Financial Strategy. Health as a whole has been relatively protected compared with the rest of the public sector, with funding maintained at just above GDP deflator. This means that the overall NHS budget is expected to rise by 2.5-3% per annum in line with the underlying levels of cost growth across the economy. At the same time it is expected that demands for increased quality and demographic change will lead to increased cost pressures in the NHS of around 4-5%, which is in line with the historical trend. The gap between funding and expected cost pressures on the system gives rise to the expected funding gap, which equates to around 4% per annum.

The onus for the delivery of this funding gap has shifted to providers of care. This has been held at 4% for the last 3 years and this is expected to continue over the life of this strategy. Furthermore, due

to the continuing sluggish nature of the recovery across the UK and beyond, it is expected that restraint in public sector spending will continue beyond 2016/17.

The Financial Strategy includes plans to meet the financial requirements set out in the planning guidance, which means meeting current demands for services, while improving the quality of our services and managing a reduction in resources available by 4% year on year. We assume no growth in funding. Similarly we make no assessment of the impact of demographic changes, as this will be subject to on-going negotiation and discussion with commissioners. Funding is available within commissioner budgets to meet these pressures, although risks remain about the degree to which they will be protected for mental health and disability services.

6.2 The Trust's current financial position

The Trust ended 2012/13 with a surplus before exceptional items of £14.6m (£2.1m after exceptional items), against a planned surplus of £6.7m. Operational services over-delivered against plan by £2.4m and a further £0.5m was delivered by over-delivery on debt, interest and dividends. The Trust received non-recurring funding of £6.4m in 2012/13, including that carried forward from previous years, of which £1.8m was unutilised. In addition, £3.1m of other reserves were unutilised during the year.

The over-delivery in operational services was largely driven by vacancies in staffing, particularly in supporting clinical professions and nursing, and also by over-delivery against targets for drug expenditure.

This was partially offset by a shortfall against income targets, particularly driven by low activity on Neuro-rehabilitation, Forensic rehabilitation (Learning Disability) and Children's and Young People's Medium Secure Services. The latter two are non-recurrent issues with capital investment in improving environments being completed to allow both areas to be fully functional through 2013/14. Under-activity across Neuro-rehabilitation is more long term and is subject to review by the Specialist Care Group.

Going forward into 2013/14 much of the activity risk across specialist services commissioned through NHS England has been removed by agreement on block contracts, which include funding for additional care packages. This will see a much more stable income stream across these services and support more effective workforce planning. Activity risks remain in neuro-disability services and forensic rehabilitation and low secure services.

6.3 Key financial priorities and investments

Our base case strategy reflects the Trust service and transformation strategy and is based on:

- Maintaining levels of current investment in community services, but delivering significant gains in quality, safety, capacity and ability to deliver effective therapeutic interventions through productivity gains, increasing the level of direct patient contact from the current level of 25% to 40-50%.
- Through delivering more effective care pathways in the community, reducing our reliance on in-patient beds, with a target of reducing overall beds to a level of around 425 across non-specialist adult services by March 2017.
- At a minimum, maintaining the overall profit across Specialist Care Services at the level budgeted at 1st April 2012. This required Specialist Care Services to absorb the tariff adjustment, expected at 4% year on year. This will be achieved through productivity gains, increasing levels of activity, development of new services and withdrawal from non-profitable services where appropriate.

Table 9: Summary of Income and Expenditure	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
Operating income	298.5	294.4	290.9	287.4
Operating costs	(276.4)	(270.4)	(265.2)	(258.5)
EBITDA	22.1	24.0	25.7	28.9
Impairments	0.0	0.0	0.0	0.0
Depreciation	(7.8)	(9.1)	(10.2)	(10.8)

Net Interest/Other	(5.4)	(5.7)	(6.3)	(5.8)
PDC dividend	(5.2)	(5.5)	(5.5)	(5.6)
Net surplus / (deficit)	3.7	3.7	3.7	6.7

A surplus of £3.7m a year will be delivered across the first three years of the Financial Strategy as £3m will be invested non-recurringly each year to support the transformation process. Income is expected to be stable over this period, excepting tariff deflation. We are not assuming any significant changes in activity, either in terms of increased activity due to demographic changes or reductions due to loss of services or shift in activity. Our marketing analysis has shown that there are not expected to be significant changes in the population over this period apart from increased numbers of older people, which will increase demands on services for this client group. This will be the subject of on-going discussion and negotiation with commissioners, but at this stage we make no assumptions. Local Clinical Commissioning Groups (CCG's) have signalled an intention to focus on integrated pathway development rather than seeking an increase in competition, and where tenders are put forward the Trust has a good record of success. Much of the existing activity risk within Specialist Care Services has been removed by a shift to block purchasing of beds, which includes appropriate funding for additional care support. As the Specialist Care Services Strategy is further developed, this will be reflected in appropriate and counterbalancing adjustments between income and expenditure, as opportunities for growth are delivered. The Trust is at the forefront of developing the national approach to Mental Health PbR, and has contracts in place with its commissioners reflecting national guidance. It is not expected that the introduction of choice in mental health will have a significant impact on patient flows, given the geographical size and boundaries of the Trust catchment area, but it may present new opportunities if extended to Specialist Services. Again no assumptions are made in this area.

As described above, overall surpluses are reduced in 2013/14, 2014/15 and 2015/16 as non-recurring investment is made to support the transformation programme. £3m has been set aside in each year for non-recurring investment by reducing the planned surplus. In 2013/14 this is supplemented by non-recurring investment from commissioners and recurring Trust reserves. On-going discussions with commissioners will determine the level of additional non-recurring investment that they will make over years 2 and 3 of the Financial Strategy. All CCGs are required to spend 2% of their allocation each year on a non-recurrent basis. On contracts with the Trust this figure equates to just over £4m.

6.4 Financial Delivery Plan

The Finance Strategy assumes that the efficiency requirement remains at 4% going forward and that the Trust will continue to ensure it delivers the following savings requirements.

Table 10: Efficiency Requirements	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
Efficiency Target	11.8	10.9	10.8	10.7

6.5 Key risks to achieving the financial strategy and mitigations

From a clinical, service user and carer perspective, the emphasis on re-designing community pathways is seen as the most viable option to maintain and improve quality with the resources available to the Trust. The proposed model of 425 beds will only be deliverable through the design of principal pathways, and the full impact of these changes cannot be fully described without further evidence from their implementation. Benchmarking information provides support for the overall direction but no more. A level of 568 beds is seen as a more cautious estimate of bed reduction, further levels of reduction from this level to the level in the base case strategy would be seen in the last 18 months of the Financial Strategy. Therefore there is time to accumulate further evidence on the efficacy of the principal pathways during and after our process of implementation, which will be completed by the end of 2014/15. The Trust has modelled the impact of a lower reduction in beds to 568 and alternative strategies to mitigate this risk. The Trust has also considered:

- The potential impacts on income arising from the developing market in the NHS;
- Failure to deliver transformation in Specialist Care Services.

The alternative strategy would be to plan a reduction in community staffing. Such a community staffing review would require a scaled back model of principal pathways, enabling a reduction in posts of 190 posts (25%) from the current level of 758. Our current working assumptions on principal care pathways require an increase in productivity of over 60%, and therefore, this level of reduction is

potentially deliverable. However, it will not enable full delivery of the quality improvements enshrined within the Principal Care Pathways Programme.

The Trust has modelled the downside risks and mitigating strategy. The impact of the combined downside scenario on surplus and cash are shown graphically in the charts below.

Chart 1 - 4 year Surplus projections (£m)
Base Case against combined and mitigated downside

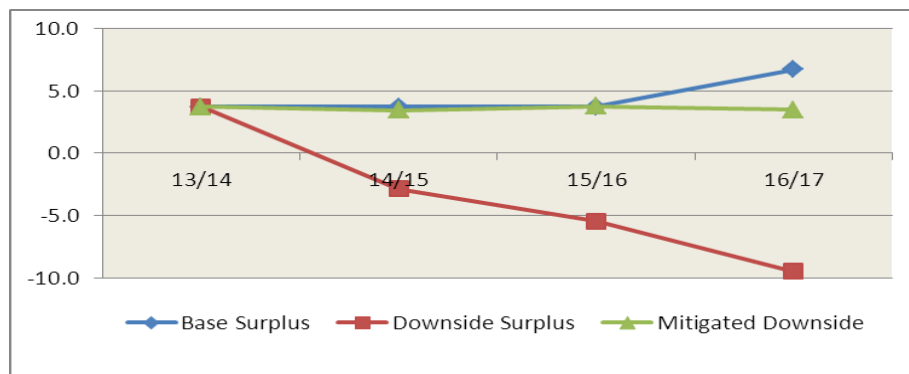
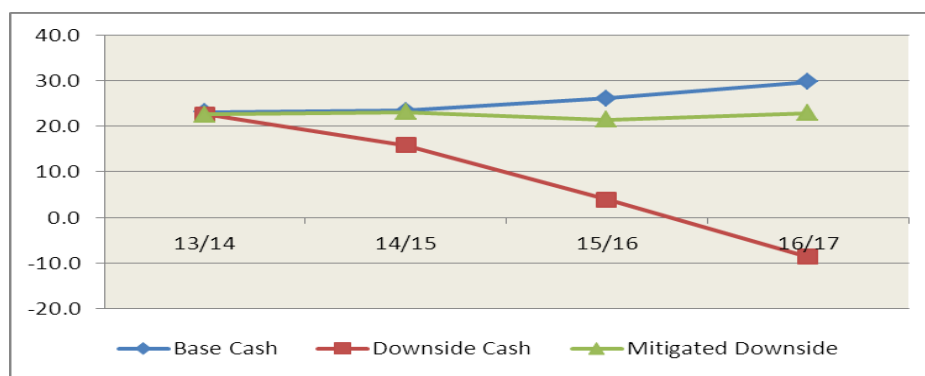


Chart 2 - 4 year cash projections (£m)
Base Case against combined and mitigated downside



The Trust has identified the significant risks to the delivery of its core strategy and has identified measures which will enable it to manage those risks as they develop. Further work will be undertaken to review the quality impacts of the mitigating strategies through 2013/14.