



Strategic Plan Document for 2013-14

Camden & Islington NHS Foundation Trust

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

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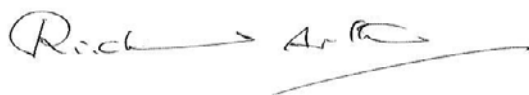
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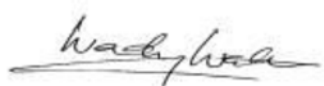
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EXECUTIVE SUMMARY

Introduction

This plan sets out Camden and Islington NHS Foundation Trust's (C&I) strategic plan for the planning year 2013/14 (and 2015, 2016). It builds on the 2012/13 plan and takes particular account of the new NHS landscape and operating context.

During 2012/13 we have undertaken a significant programme of work to co-create with service users and staff a new set of values and behaviour standards that we believe are consistent with the values and standards of the NHS Constitution and the recommendations of the Francis Inquiry report. These are set out in section A together with our vision, strategic aims and principal objectives for the year ahead.

Our strategic context and direction takes account of the new NHS operating landscape. Our aim is to seek organic and inorganic growth both within our sector of North Central London and in the broader London market. Whilst we face increasing competition from other statutory mental health and third sector providers in our local market, we will pursue new opportunities across London to ensure the long term sustainability and development of the trust.

Our Clinical and Quality Strategy is summarised in section C and is designed to ensure continuous quality improvement is embedded into our culture, delivering high quality health and social services and placing service users at the centre of everything we do. The recommendations of the Francis Inquiry report into the failings at Mid-Staffordshire NHS Foundation Trust will be embedded within this strategy to ensure the care we provide is safe, effective, compassionate, and of the highest quality.

C&I has delivered unprecedented levels of productivity and efficiency over the last three years. We recognise the need to continue to deliver improved value for money whilst retaining our focus on improving quality and outcomes. Key elements of our plans are provided in section D and are designed to ensure that C&I remains responsive and able to maintain and grow our portfolio of services to ensure we remain clinically and financially sustainable for the coming years. Our plans are set within the context of QIPP and build on the successful implementation of previous schemes.

Financially, C&I go into this planning period with a strong financial risk rating of 4. During 2011/12 C&I delivered a total of £12m CIP savings for local commissioners,

with a further £7m delivered in 2012/13. Combined, this level of savings equates to circa 14% of pre 2011/12 expenditure, which we understand to be one of the highest percentage savings target achieved across all foundation trust providers in the country. We continue to face pressure to deliver further efficiency and productivity improvements. Whilst the NCL financial pressures have had an impact on the trusts in the sector during the contracting round for 2012/13, these pressures are not expected to impact on CCGs in 2013/14.

In 2012/13, the Trust returned a surplus position of income over expenditure of £2,627k, and an EBITDA surplus of £7,636k, both of which are comfortably ahead of the planned year end position. This is a welcome reflection of the Trust's financial controls, and in particular of a strong final quarter performance, which indicates highly positive run rates moving into 2013/14. This return constitutes a successful year for the Trust financially, and places the Trust in a good position to continue to deliver strong financial performances.

The Trust has identified a savings requirement of £4,900k in 2013/14, with commensurate levels in subsequent years, dependent upon national and local pressures on income levels. This level of savings is predominantly based on the national efficiency targets of 4% and adjusted for local commissioning intentions.

This CIP position is consistent with the Trust earning annual surpluses of £2,000k over the planning period. The Trust is also planning to invest £7,444k in its asset base during 2013/14, and retain cash balances of £40,000k. The Trust expects to retain its financial risk rating of 4 throughout the planning period.

SECTION A

Introduction

This document sets out Camden and Islington NHS Foundation Trust's (C&I) strategic plan for the planning year 2013/14 (and 2015, 2016). It builds on the 2012/13 plan and takes particular account of the new NHS landscape and operating context.

C&I's Board has reviewed this 3 year strategy with particular reference to the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry, and the very clear message from Robert Francis QC that improvement should be driven by cultural change and that patients (service users) must come first and be at the centre of everything the Trust does.

The Board also confirms C&I's commitment to the values of the NHS as set out in the revised NHS Constitution, which are strongly reflected in our vision, values and strategic aims set out below.

C&I's vision, strategic aims and values

C&I will continue to be a **partner in care and improvement** and will be known as a high-quality, innovative and trustworthy organisation within and outside the field of mental health and recognised as such by our service users, staff, commissioners and the public.



C&I is a strong performing, ambitious organisation with a focus on providing high quality, safe and innovative care to our service users and their families.

Our vision

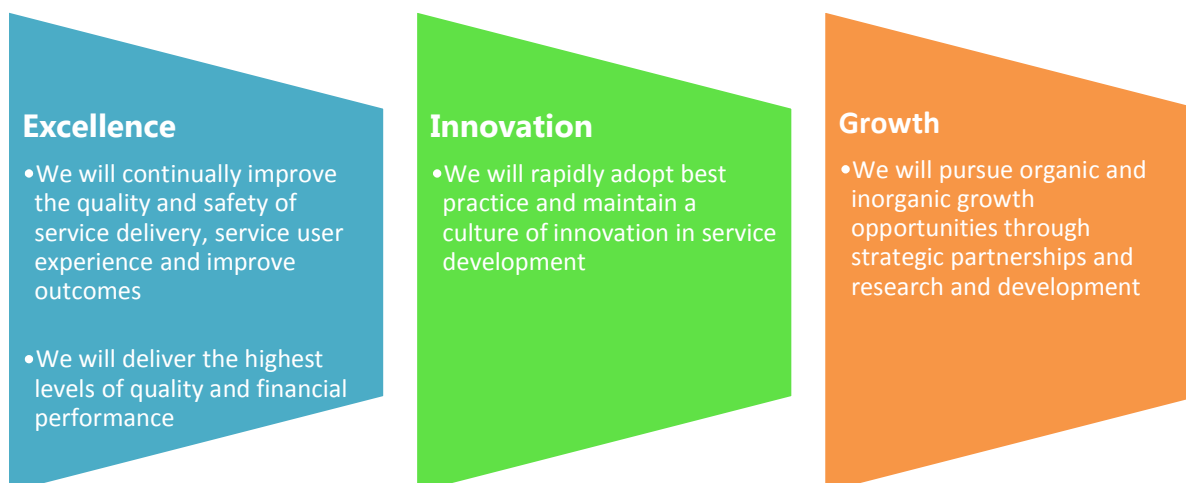
Our vision is underpinned by four strategic aims (below) that are categorised under the headings of Excellence, Innovation and Growth.

We will rapidly adopt emerging best practice against evidence base and incorporate these approaches within C&I to improve outcomes and add value.

We will develop and implement new models of care and therapeutic approaches, which will be evaluated and will contribute to the research and evidence base. There will be practice innovation across the full range of services evident year on year.

C&I will look for both organic and inorganic growth opportunities on a proactive basis whilst accepting that difficult market conditions may limit flexibility and opportunity. Our services will be extended to increase the range of mental health and associated services provided by the Trust where there is sufficient size to ensure the associated risks are mitigated. We will look for opportunities using our existing services outside our current geographic locations.

Our strategic aims



Our shared values – Changing Lives

One of our principal objectives in 2012/13 was to engage with our staff and service users to co-create a common set of values and behaviour standards. These values and behaviours were developed by over 500 service users and members of staff. They describe how we consistently aim to be with service users, carers and each other, and set out our ambition to provide an excellent experience for everyone we work with.

This programme, known as our 'Reconnecting Campaign' included leadership interviews, compliments analysis and a programme of engagement and listening events with service users and staff, referred to respectively as 'In Your Shoes' and 'In Our Shoes'.

Our values which are set out below will be embedded throughout the organisation during 2013/14 as part of our drive to put in place a values-led culture. This programme will be known as 'Changing Lives'.

Our promises to service users and each other



Our commitment to inclusion and equality

Tackling health inequalities and social exclusion is an important priority for C&I. We are committed to taking positive steps to ensure fair and equitable access to services for all. As a major provider of services we need to be pro-active so that we can meet the changing needs of diverse communities and provide fair access for all in an environment where dignity and individuality is respected and promoted. As an employer we will create an organisational culture in which diversity is valued and staff feel able to promote equality and challenge unlawful discrimination. We aim to develop a holistic view of equality, diversity and human rights across the organisation, building upon work that we have already completed in the promotion of inclusion and equality.

Continuing our drive to improve quality and respond to the Francis inquiry report

The major transformational changes that we have undertaken in the last 3 years in relation to improving inpatient and community services has placed us in a strong position to continue with our drive to improve quality whilst continuing to reduce unnecessary costs.

Our strategic aims and principal annual objectives, together with the associated plans set out in later sections of the document describe how we will continue to provide high quality, service user centred care with a focus on improving outcomes and recovery.

The recommendations of the Francis Inquiry report into the failings at Mid-Staffordshire NHS Foundation Trust will be embedded within our plans and strategies to ensure the care we provide is of the highest quality. The C&I Board has agreed to a programme to embed our six Changing Lives values above and the positive behaviours associated with them. This collective endeavour encompasses the central message of the Francis Inquiry report, that is, to place service users first in everything we do.

C&I's Principal Objectives for 2013-14

The Board of Directors has agreed the following seven principal objectives for 2013/14:

C&I's Principal Objectives for 2013-14

We will refine and embed the clinical models, deliver evidenced interventions supporting the care pathways, measure patient outcomes and deliver continuous quality improvement.

We will continue to meet the Trust's financial targets as set out in the forward plan and continue to deliver value for money and efficiencies.

To meet new commissioner requirements, we will agree a joint development and delivery plan with commissioners and develop internal systems to deliver service line reporting, agreed outcomes, pricing and contracting.

We will develop a stakeholder Engagement Strategy which builds strong relationships externally with commissioners and partners, and is founded on strong internal relationships with service users, carers, governors and staff.

We will progress a fit for purpose Estates Strategy to include the St Pancras site and a community sites rationalisation and improvement strategy.

We will create a service user focused culture which is aligned to our values, behaviour and performance, adopting a stepped programme which continually improves our staff and service user experience.

We will continue to strengthen and develop our governance structures for the Board and Council of Governors.

Looking forward

Through 2013/14 we look forward to working closely with GPs, Clinical Commissioning Groups and our partners in developing future service provision with a key focus on embedding our care pathway model, developing new Integrated Care Pathways; Improving service user and carer experience and strengthening further our commitment towards recovery focused care and continuous quality improvement.

The Trust will focus on activities which will prepare for any potential merger opportunities should they arise during 2013/14 – whether as a direct result of trusts failing to achieve Foundation Trust status or otherwise.

Board Leadership

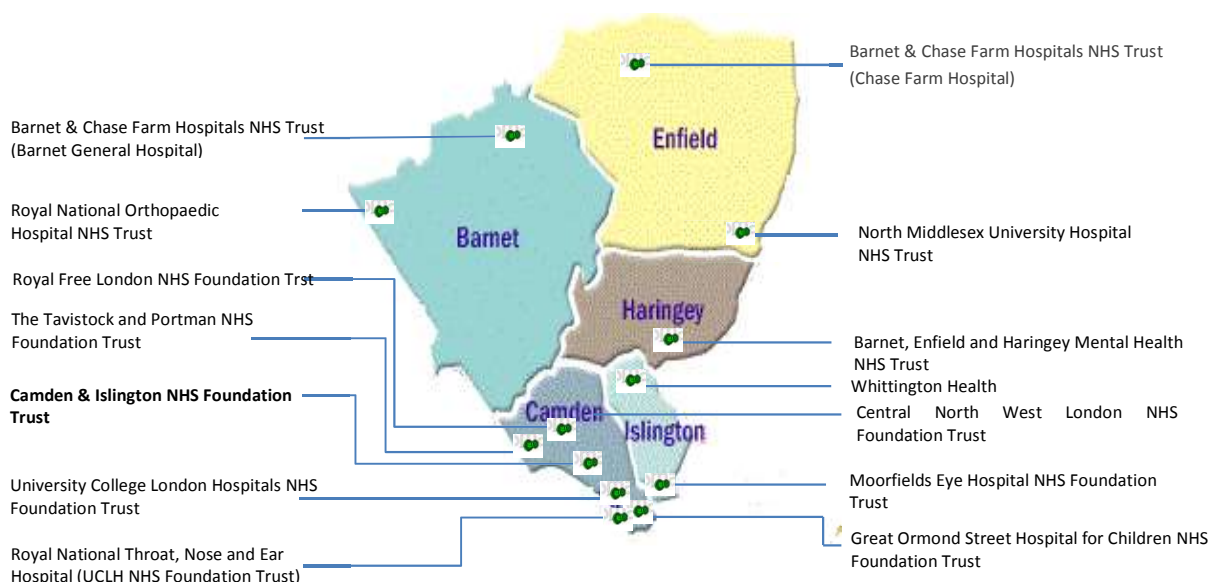
The Board of Directors has reviewed the skills and experience required to lead the Trust through its next phase of development. During 2013, our present Chair, Richard Arthur will retire after a period of four and a half years. During his time as Chair, Richard has provided strong and stable leadership through a period of unprecedented change. Our Council of Governors' Nominations Committee is in the process of recruiting a new Chair who will take up office in August 2013.

SECTION B

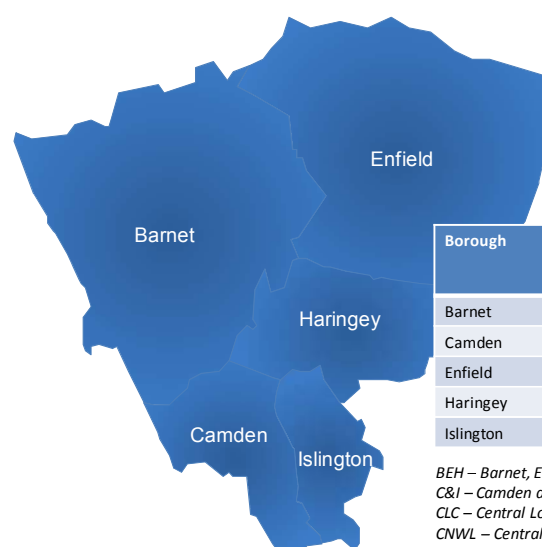
Strategic context and direction

C&I sits within the North Central London (NCL) cluster, which covers the boroughs of Barnet, Enfield, Haringey, Camden and Islington. The cluster has a combined population of 1.35 million people¹ with significant variance both in terms of population demographics, migration, ethnicity, housing and deprivation. Demographics range from the inner urban areas of Camden, Haringey and Islington, through to the suburban areas of Barnet and Enfield.

Acute and mental health NHS service providers within North Central London



Adult Mental Health, Child and Adolescent Mental Health and Community Services Providers within North Central London.



Borough	Adult Mental Health	Child and Adolescent Mental Health	Community Services
Barnet	BEH	BEH	CLC
Camden	C&I	T&P	CNWL
Enfield	BEH	BEH	BEH
Haringey	BEH	BEH	WH
Islington	C&I	WH	WH

BEH – Barnet, Enfield and Haringey Mental Health Trust
 C&I – Camden and Islington NHS Foundation Trust
 CLC – Central London Community Healthcare NHS Trust
 CNWL – Central North West London NHS Foundation Trust
 T&P – Tavistock and Portman NHS Foundation Trust

¹ Office of National Statistics 2011 Census.

Market need

C&I provides services within the inner urban area of London located in the south of the NCL cluster. This area is characterised by wide differences in equality, with wealthy areas closely situated to areas of high deprivation. The area contains communities made up of a diversity of ethnic groups, including black Africans and Irish who experience a higher prevalence of psychosis compared with other ethnic groups.

There is a high turnover of residents, with many in their 20s and early 30s often living alone in rented accommodation. Young adults experiencing their first episode of mental illness is a demographic which is over-represented in Camden and Islington and they are also difficult to reach and treat. This group is also likely to be in rented accommodation, isolated from support networks and vulnerable to changes in circumstance.

Whilst the south end of the NCL cluster has a predominantly young adult population, there is also an aging population which increases as the population moves to suburban areas in the north of the cluster. This aging population is driving increasing demand of age related mental health problems such as dementia and co-morbid mental and physical healthcare needs.

With four main rail terminals (Kings Cross, Euston, St Pancras, St Pancras International), there are a large number of new arrivals to London. These people arrive from across the UK and overseas, some have mental health and substance misuse problems and are picked up by the police, from hostels or present themselves at A&E in the major acute hospitals from where they are transferred to C&I for treatment and care.

Your local partner

C&I is the largest provider of mental health and substance misuse services to residents within the London Boroughs of Camden and Islington. We also provide substance misuse services in Westminster, a substance misuse and psychological therapies service in Kingston; and, mental health and substance misuse services in HMP Pentonville. We have two inpatient facilities, at Highgate and St Pancras, as well as community based services throughout the two boroughs of Camden and Islington.

We have a strong and long history of working in partnership with our local commissioners, both within health and social care. Over the previous two years we have effected significant changes to our organisation to deliver cost improvement programmes for commissioners. A key factor in the success of these programmes is input from commissioners, GPs, politicians, service users, staff and the wider local community through a structured consultation process. Working in partnership with the local community ensures that there are no surprises and that all stakeholders with an interest in the quality of services provided by C&I have a chance to input into

the change process. This has enabled C&I to achieve one of the country's largest, as a percentage of income, cost improvement targets whilst maintaining quality and staff, commissioner and service user engagement.

Whilst we do not envisage such high levels of cost improvement in the short to medium term, the principles of partnership working, structured consultation and community engagement are a key part of our service development. We will continue to work closely with our current and future commissioners to proactively change services to meet the needs of the local health economy.

Competition in the local market

Commissioners are increasingly opening up mental health services to new market entrants. This historically has been focused in Local Authority commissioned rather than NHS commissioned services, such as substance misuse. However, changes in health commissioning, the introduction of payment by results (PbR) and Any Qualified Provider (AQP) is placing an increasing emphasis on competitive tendering across a much wider range of services where C&I has existing provision.

Service provision in the NCL cluster, unlike many other sectors, has a multiplicity of traditional statutory mental health and an increasing number of alternate providers. C&I is one of three mental health organisations providing mental health services, the other two being Barnet, Enfield and Haringey Mental Health Trust and Tavistock and Portman NHS Foundation Trust. In addition, there are eight acute hospital providers and four providers of community services (some run by mental health trusts).

Competition for mental health services is not limited to statutory mental health providers, with statutory non-mental health and third sector providers also offering competitive services, e.g. Whittington Health (acute provider) working with Barnet, Enfield and Haringey Mental Health Trust to provide IAPT services in Barnet, Enfield and Haringey; and, CRI providing substance misuse services in Islington.

C&I already faces strong competition within our local markets and this will increase with the introduction of further market liberalisation following the introduction of Payments by Result (PbR) and AQP to mental health services.

As a provider of social care services, C&I is already subject to competition for services that we provide. In some instance we have experience from the commissioner's perspective, for example we manage spot placement budgets for commissioners in Camden. We are very aware of the financial pressures placed upon providers and the need to balance the cost and quality of services provided. This is driving innovation in service delivery and specifically closer partnership working with third sector providers.

During 2012/13, C&I signed a local partnership agreement with One Housing Group, a housing association providing housing, care and support across London and the South East. The purpose of this partnership is to develop innovative solutions

addressing the needs of service users who also require accommodation. Our first service, launched in November 2012, provided 15 units of accommodation in Kings Cross, Camden for high needs service users who had previously been accommodated out of borough at higher cost to the commissioner. The service is jointly delivered by both C&I and One Housing Group, with C&I providing clinical input to the service to provide training and support to One Housing Group staff that enables them to meet the service users' needs and manage increased risk. We will continue to work with One Housing Group to develop further propositions, and also seek other partnerships which meet the needs of service users and commissioners.

Opportunities in the broader London market

In 2012/13, C&I was successful in winning a contract to deliver the Kingston Community Wellness Treatment Service. This service is a unique combination of substance misuse and IAPT interventions addressing a broad range of needs within a primary care environment. The service was competitively tendered by Kingston PCT and the deciding factors for the commissioners were: our reputation for delivering high quality services; our partnership with Lifeline, and their reputation for quality services; and, the innovation in our service model.

C&I delivers IAPT services in Camden, Islington and Kingston; and Substance Misuse services in the same boroughs plus South Westminster. For each of these services we work in close partnership with third sector providers, with each party delivering to their core strengths – in C&I's case the quality of our clinical staff and evidence based interventions. We will continue to grow these services in partnership with third sector organisations, with the intention of achieving sufficient economic scale to sustain ongoing innovation within a competitive health economy.

We will continue to pursue opportunities to deliver services commissioned across London where we are able to compete on the quality and innovation of the services that we offer. Whilst we remain committed to delivering value for money, this does not necessarily mean the lowest price. We will, therefore, avoid tenders where price is the predominant element in the scoring of tenders.

Niches and vertical market segments

C&I has, for several years, provided high quality psychological therapy services from our Traumatic Stress Clinic. During 2012/13 we launched our Veterans service addressing the needs of ex-military personnel across London. This service works with third sector organisations to identify and signpost service users to locally provided NHS services, and where these do not exist provides treatment services from a convenient central London location. We will continue to develop this service seeking out specialist need in other niche markets which are not being adequately addressed by current service providers. For many service users our central London location and services tailored to their specific need facilitates their engagement and recovery.

We will continue to expand our provision in vertical segments with significant mental health requirements, such as criminal justice. The local area is host to two major prisons, HMP Holloway and HMP Pentonville, plus a busy magistrates court at Highbury. Over 50% of clients passing through the criminal justice system have a mental health or substance misuse problem, many with a combination of both. Addressing the needs of these clients both within a custodial and community environment is essential to breaking the offending cycle.

Local commissioning intentions

Mental health remains a high priority for Camden and Islington commissioners reflecting both the high prevalence of mental health need within the boroughs and the impact that mental health has on other parts of the health economy. Commissioning intentions aim to address specific needs within the local health economy, these are also reflected to a greater or lesser extent in other boroughs where we are providing services.

Integration across the health economy

Mental health has an impact across the health economy, particularly within acute hospitals where mental health issues may not be immediately recognised by staff. C&I has been offering a mental health liaison service within local acute hospitals for several years. We are working with commissioners to further develop these services, targeting specific patient groups where we can deliver support to acute staff which in turn provides an improved patient experience and clinical outcomes, and savings for the acute service provider and commissioners arising from reduced average length of stay.

Transitions from child to adult services

C&I does not currently provide Child and Adolescent Mental Health Services (CAHMS). This has the potential to create a disjointed transition between CAHMS and adult services at a critical stage in a service user's life. C&I is working with commissioners and other providers to improve the quality of transition between the two services to better meet the needs of service users.

Managing service users in primary care

Not all service users meet the referral threshold for secondary care services and need to be managed within a primary care environment. There is a risk that, if not managed, the service users condition worsens and potentially triggers a crisis and potential inpatient admission. To minimise this risk and increase primary care provision, C&I is working with commissioners to address the needs of primary care to improve their capacity to meet the needs of service users who do not meet the referral threshold for secondary care services.

Reducing the impact of alcohol abuse

There is a small, but significant, group of people in the local population who abuse alcohol and place high demands on health services, frequently turning up in A&E departments. C&I is working with local commissioners and third sector providers to develop an enhanced alcohol care pathway specifically targeting this group with the intention of reducing cost across the local health economy.

Addressing the physical healthcare needs of our service users

Service users with a mental health condition have worse health outcomes than the general population, driven to a large extent by worse physical health. In order to improve health outcomes for mental health service users C&I is working with commissioners in developing roles and services within the trust specifically targeting physical healthcare needs. In 2012/13 we launched a smoking cessation service in Camden which works across both primary and secondary care to address the needs of the mental health service users.

Addressing the needs of an ageing population

C&I is working closely with commissioners to address the needs of an ageing population. Additional capacity within the Memory Services is being funded to meet increasing local need. Islington has the highest detection rate for people with dementia compared with predicted prevalence within England and Wales, and C&I has the lowest rate of anti-psychotic prescribing for dementia within the United Kingdom.

We are also working with Commissioners to redesign pathways and accommodation for older people with mental health problems where existing provision is inadequate for need.

SECTION C

Clinical & Quality Strategy

The C&I Clinical and Quality Strategy ensures continuous quality improvement is embedded into our culture, delivering high quality health and social services that are safe, effective and accessible, and places service users at the centre of everything we do. We recognise that it is vital that this focus on quality is embedded throughout the Trust and this is central to our clinical and quality strategy.

Our strategy reflects our divisional management and reporting structure, which supports our framework for clinical care pathways that are based on nationally agreed clusters of care. The strategy is clearly linked to our strategic aims of excellence, innovation and growth (as detailed in section A), driven by our co-created values and is fully embedded and aligned with divisional plans, team plans, individual objectives and delivered through a new performance management framework.

The recommendations of the Francis Inquiry report into the failings at Mid-Staffordshire NHS Foundation Trust will be embedded within this strategy to ensure the care we provide is safe, effective, and compassionate and of the highest quality.

C&I staff provide excellent care and treatment now and we intend to support our staff to improve service user outcomes even further. Through this clinical and quality strategy together with the Changing Lives programme, we will create a culture that promotes positive attitudes and behaviours and an excellent experience for everyone. The key aims of our strategy are set out below:

Our clinical and quality strategy aims to:

Drive our delivery of excellent mental health and substance misuse services;

Clearly define C&I's approach to clinical and quality governance;

Promote culture that ensures we learn the lessons when things go wrong and celebrate and share best practice;

Ensure C&I actively measures and responds to our service users' experiences and embed the service user voice into our clinical and quality monitoring;

Organise our structures and processes to enable our Board of Directors and Council of Governors and members to receive appropriate assurance through measurement of outcomes that matter;

Ensure a co-ordinated and standardised approach to clinical and quality governance is adopted by our divisional structures;

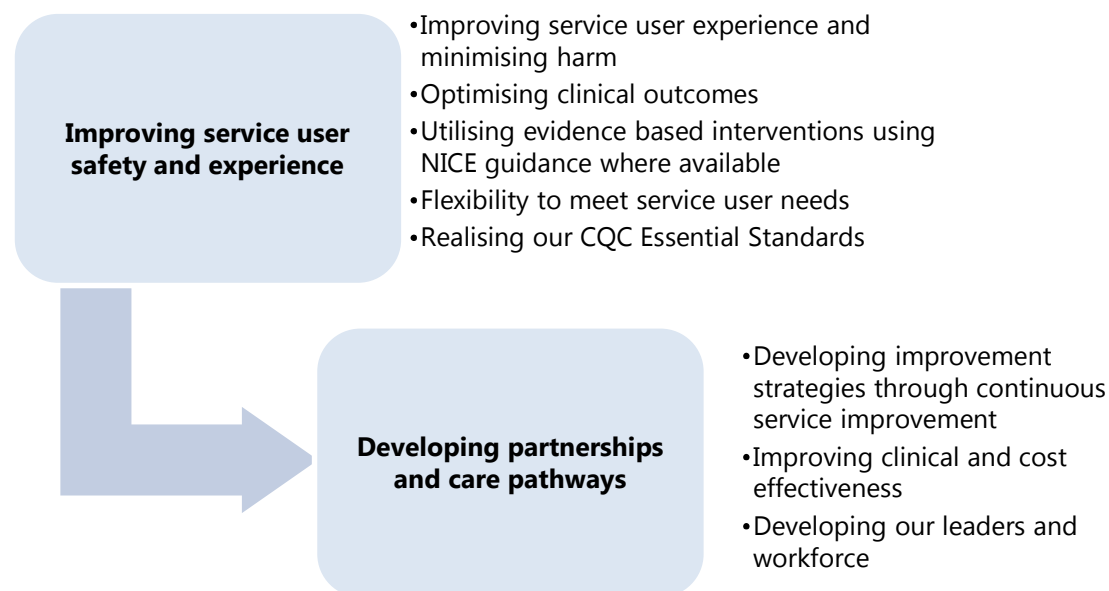
Ensure that our staff understand and have due regard to our obligations to meet regulatory standards and drive continuous improvement.

In refreshing our clinical and quality strategy, we have considered the new NHS operating context and have worked closely with our commissioners in planning services to meet the needs of the population we serve and to agree Commissioning for Quality and Innovation targets and outcomes (CQUINs).

An overview of C&I's clinical services and plans 2013-2016

The clinical visions and associated plans of this revised strategy have been developed by the divisional clinical leaders and divisional managers and their teams. It embodies an organisational principle of services being clinically led and managerially supported. It brings the Trust's clinical plans up to date and covers the next stage in our development covering the period 2013-2016.

The key principles which underpin the divisional clinical strategies are:



How clinical services have developed in C&I

For the last decade C & I has had a localised integrated community mental health team (CMHT) model. The community mental health team had been the first port of call for all referrals and had managed all conditions requiring on-going care in secondary mental health services.

The model had been a huge success in the management of psychosis and chronic conditions, in the implementation of the care programme approach and the packages of integrated health and social care for service users and their carers. Research supported the model as successful for people with chronic psychosis.

However, the teams became less expert in assessment and management of conditions they encountered less frequently. There was also significant variation

between teams in terms of the interpretation of thresholds for referral, on-going care and discharge.

Social care, recovery and social inclusion have been embedded in our mental health teams. However the effectiveness of the systems used for recording and monitoring social care performance indicators and outcomes needed review in order to ensure continued improvement. This is particularly important in the areas of personalisation, individual budgets, and safeguarding.

Since 1998, through the successful local implementation of the National Service Framework (NSF) for mental health, we have benefitted from new teams, crisis intervention, assertive outreach teams and early intervention teams for psychosis, which have been carefully evaluated through research. The evidence base for service models and interventions has moved on in the last decade. This means that mental health services moved to a more specialised approach to treatment. We have adopted the specialised treatment models and are now embedding a care pathways approach; this sometimes initially generates difficulties around waiting lists for specialist treatments.

Our approach to reviewing community mental health provision is to consider the evidence base, the activity, quality and outcomes of the services. This is helped by the national work on Mental Health payment by results (PbR) and the accepted approach to the nationally defined 'needs based clusters'.²

Clusters are determined following assessment by the mental health clustering tool (a needs based assessment tool) and sound clinical judgement.

Care pathways and delivering services within an integrated care model

We have organised all our operational services around the service user journey – or their care pathway. We provide a number of fully integrated health and social care pathways within each division. The implementation of care pathways will improve the quality of mental health services by focusing the attention of divisions on key steps along the journey of care. An important aspect of this is the recording, analysing and acting on variances, allowing the comparison of planned care with care actually given and enabling the implementation of continuous quality improvement.

We will continue to work closely with social care services, primary care and acute hospital services to further develop this approach.

² Department of Health Mental Health Clustering Booklet (V3.0) 2013/14

Recent service changes – responding to feedback and the evidence base

In the last two years C&I has implemented a number of clinically led service changes in response to the evidence base and feedback from stakeholders including service users, GP's and commissioners. ***Key factors and principles which underpin the development of C&I's clinical service changes are summarised below:***

IMPROVING ASSESSMENTS & ACCESS TO SERVICES

- GP surveys and feedback locally led to piloting different models of assessment in the Trust.
- GPs and other stakeholders suggested that a responsive single point of access to mental health services for new service users would be helpful and reduce 'bouncing' of referrals around the system.
- There is a need to standardise responses to referrals to jointly deal with health related and social care related issues and ensure a uniform threshold and quality.
- The threshold for assessment and advice should be lower than that for providing an on-going service.
- Pilots of assessment services have shown comprehensive skilled assessments mean fewer people have on-going assessments due to uncertain needs.
- Clear understanding of the evidence base for effective treatments will lead to fewer people receiving interventions that do not improve outcomes.
- Sessions by clinicians with expert knowledge meets the need for specialist assessments and this will allow for specialist expertise to be strengthened, e.g. for Asperger's, adult ADHD.
- Services based on needs with upper age limits removed for accessing mainstream mental health services

DEVELOPMENTS IN ACUTE CARE

- The most developed care pathway has been acute care, due to the essential need to maximise productivity and innovation, driven by the high cost of hospital service, coupled with a commitment to improve the service user experience³.
- Having the right multidisciplinary teams of skilled practitioners in place and 'lined up' is the first stage of a successful care pathway. Process mapping with full involvement of all staff stakeholders from each component of the care pathway has served to reduce the blockages and improve interface issues. Having clear accountability for clinical and operational managerial leadership has ironed out any disincentives between services.
- Assessment wards, which are entirely focused on assessment and diagnosis to provide a deliberately short intervention, with daily ward input from the consultant, working together with crisis teams committed to alternatives to hospitals and patients' early discharge, appear to be having an impact on the length of stay.
- Clear identification of the treatment goals for the acute ward, in order to achieve rapid access back to home treatment, and also swiftly addressing social factors that may impact on timely discharge have been the other successes that have helped us to achieve improved outcomes and supported our ability to reduce overall bed numbers.
- Close working with housing services and accommodation teams who are part of the pathway has helped to promote a clearer flow through service for service users, by releasing tenancies earlier in supported housing projects when it becomes clear that someone is not able to safely return within a reasonable period (one year). This has markedly reduced delayed transfers of care.

³ Tang, S., Ch. 4, The care pathway approach: A contemporary, inclusive and outcome-focused rationale for service provision (2012). Working in Mental Health: Practice and policy in a changing environment.

RESPONDING TO THE EVIDENCE

Assertive Outreach Teams (AOT) and Community Mental Health Teams (CMHTs)

- Research trials on AOT show CMHTs are as successful for health outcomes however the AOT model has higher satisfaction⁴
- We consider satisfaction as a very important measure and is also part of the National outcomes framework moving forwards
- We have high numbers of people in the clusters relating to AOT services, greater than the capacity of the service.
- Features of the service that are valued are team working, extended hours, and the ability to supervise medication and to increase and reduce input as required.
- The Functional Assertive Community Treatment (FACT) model from the Netherlands allows these features to be retained but with an increased caseload. This is a flexible model based on need, which allows for larger total caseloads⁵.
- This model also allows a focus on recovery (daytime activities, meaningful relationships, physical activity) rather than just the traditional focus on engagement and active treatment.
- 66% of the community mental health team caseload in the Trust was allocated to people with on-going psychosis and needs around daily living skills. This requires a community focus on rehabilitation and recovery.

RECOVERY MODEL APPROACH IN SUBSTANCE MISUSE SERVICES

- The new emphasis on recovery will often be best addressed by recourse to constructing personalised recovery care plans which include reintegration and peer support.
- Closer adherence to the compelling evidence for effective Opioid Substitute Treatment (OST), and the existing guidance based upon it, will deliver many of the improvements required.⁶
- Some people entering treatment have a level of personal and other resources (often called recovery capital) that will enable them to stabilise and leave treatment more quickly than others as long as they are provided with the support they need. Many others have long-term problems and complex needs – their recovery may take a long time and require long-term treatment to build their recovery capital.
- Recovery measured by assessing and then tracking improvements in severity, complexity, and recovery capital, and by using this information to better understand how to tailor interventions and support to improve an individual's chances of and progress in achieving recovery.
- Drug treatment – together with support from peers and families the model provides direct access, signposting and or facilitated support to opportunities for reducing and stopping drug use, improving physical and mental health, engaging with others in recovery, improving relationships (including with children), finding meaningful work, building key life skills and securing housing.

PROVIDING EXPERT CARE

- The integrated community mental health team model is an excellent model for delivering services to those with on-going psychotic illnesses but the same model is not evidenced for other disorders.
- Care coordination, whilst a successful model in delivering integrated care is not an intervention, but a method of coordinating the interventions required. Care coordination in some areas has sometimes become a substitute for the therapeutic interventions. It can also de-skill professional staff. These factors supported our case for change.

⁴ Nelson, T, Johnson S and Bebbington, P (2009) Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health teams

⁵ Drukker M van Os J et al (2011) Functional assertive community treatment (FACT) and psychiatric service use in patients diagnosed with severe mental illness.

⁶ National Treatment Agency for Substance Misuse: Medications in Recovery, Re-orientating Drug Dependence Treatment (2012).

- For non-psychotic disorders there are very clear NICE guidelines for interventions that are proven to work.
- It is not possible to be expert in treating a condition unless one sees people with the condition frequently. It is important to develop specialist services in order to have experts in diagnosis and treatment of those conditions, particularly for non-psychotic conditions.
- This supports the need locally for trauma services, personality disorder services, Improving Access to Psychological Treatment (IAPT) and others.
- Unfocussed interventions can lead to longer, chaotic use of various services without improvement and this is what we are moving away from with our new clinical model.

OUR CLINICAL WORKFORCE

- There has been a focus on one to one relationships and interventions rather than team approaches to delivering interventions and care. Team approaches are believed to improve satisfaction with services.
- Service users have told us that it is difficult to change care coordinators. The team approach allows relationships to form with more than one worker with flexibility on who takes the lead.
- Sometimes skilled and expert professional staff are being used to carry out tasks that do not require their expertise and could be done differently. To be most productive we need the right workforce to deliver the interventions.
- A uniform approach to care coordination does not recognise the distinct contributions of different professionals.
- There is a need to identify both the shared expertise of individuals and their professional background and their unique skills and expertise.
- Once professionals identify their unique and collaborative skills, the trust will consider the skills and expertise required in each division and ensure that learning and development resource is offered and matrix working is established.
- A recent study on morale shows that CMHT staff show more evidence of psychological strain when compared with other teams⁷. This is supported by previous studies that show morale is better in AOT and crisis teams. This is thought to be due to a clearer service model and purpose.

INCREASING CAPACITY FOR CLINICAL WORK

- Teams currently share buildings and by using space and technology more effectively, efficiencies can be delivered by reducing management costs, office costs and administrative costs whilst protecting front-line services (e.g. mobile working and placing teams who work across a pathway together).
- Reduction in duplication will increase the capacity for clinical work, for example multiple assessments or where an individual has multiple workers and 'occupies' a whole place on each worker's caseload.
- Faster escalation of interface issues and greater recognition of the 'whole' system we now operate Trust wide through multiple MDTs releasing clinical time through quick resolution.
- Delivering the strongest evidence based care may reduce the duration of treatment due to health improvements and we are committed to interventions based on quality research findings.

INTELLENT USE OF INFORMATION & DATA

We have carried out an analysis of our caseload data and diagnosis using the Mental Health Clustering tool. This analysis together with local needs analysis and commissioning priorities confirm that we need to continue to provide and develop:

- Services for patients with common mental disorders, depression and anxiety, such as low intensity IAPT (improving access to psychological therapies);
- Services for complex depression and anxiety;
- Specific services for personality disorder which can meet the whole care pathway, including support, management and specialist therapies, support in reintegrating into society and supporting GPs to

⁷ Johnson S, Osborn DP et al (2012) Morale in the English mental health workforce: questionnaire survey.

- manage care either if not engaging or on discharge from services;
- Services to treat on-going psychosis with patient focussed rehabilitation and recovery models;
- Services for patients who do not engage and have psychotic illnesses; and
- A range of dementia services.

Quality Governance

C&I has a strong legacy of quality service delivery and governance including a history of CQC compliance and consistent green ratings for quality governance. The Board has reviewed quality governance at a Board Seminar in 2012 and KPMG carried out an internal KPMG review of quality governance in 2011. As a consequence of these internal reviews, C&I has examined the capabilities and experience of our Board members and reviewed our committee structure and our reporting and assurance processes.

Clinical quality is reported and monitored in a number of ways. Including:

- Each division has an agreed annual programme of clinical and quality improvements which are approved by the Trust Executive and monitored through the year using a well-established Balanced Scorecard process and at divisional performance meetings;
- The Quality Committee, chaired by a Non-Executive Director monitors the delivery of the clinical and quality priorities and the delivery and effectiveness of the strategy and provides assurance to the Board of Directors and Council of Governors;
- The Trust Board receives a quarterly integrated performance report which covers all national indicators, agreed commissioner quality indicators and locally agreed quality measures. This is further supported by Electronic Performance Dashboards, which allow staff to monitor performance in a more dynamic way;
- Clinical audit plans are in place for each division as well as an overarching annual clinical audit plan overseen and supported by the Quality Committee;
- A programme of Patient Experience Tracking (PET) is in place across all services using hand-held touch-screen devices, which give service users more opportunities to influence improvements in their care and treatment, as well as providing the trust with comprehensive measurement of service user experience ;
- Through our service user alliance model, which is embedded within each division, we receive important feedback about service user experience in all

our services and the model ensures service users are involved in planning and shaping service developments and quality improvements;

- The CIP programme has a specific quality monitoring report that monitors identified potential quality impacts from major CIP projects and particularly the early warning signs of service degradation due to change processes, so that mitigating actions are taken;
- The Board has an annual seminar to review Quality Governance.

Board Assurance Framework key quality risks

As part of the Trust's Board Assurance Framework, five high level quality-related risks have been identified.

Each of these risks is being added to the Trust-wide risk register, with controls and gaps being identified and a clear action plan for mitigation. These will be monitored by the Audit & Risk Committee at each meeting with regular reports to the Board of Directors for assurance.

The identified key quality risks relevant to this plan are detailed below:

Key quality risks

PRINCIPAL OBJECTIVE 1	HIGH LEVEL RISKS	L	C	SCORE	DIRECTOR LEAD
We will refine and embed the clinical models, deliver evidence based interventions supporting the care pathways, measure patient outcomes and deliver continuous quality improvement.	Failure to develop and implement divisional service plans which embed a co-ordinated, affordable, PbR ready and systematic approach to effective care pathway delivery will minimise the effectiveness of the clinical model and lead to a deterioration in the patient experience.	4	4	16	Paul Calaminus
	High vacancy factor in divisions impacts negatively on delivery to expected timeframe of patient outcomes and quality improvement.	4	4	16	Paul Calaminus
	Adequate information insufficiently integrated into a lean method of working to deliver a lean, effective and outcome based service.	4	4	16	Paul Calaminus
PRINCIPAL OBJECTIVE 5	HIGH LEVEL RISKS	L	C	SCORE	DIRECTOR LEAD
We will progress a fit for purpose Estates Strategy to include the St. Pancras site and the creation of a community sites rationalisation and	Risks around adequate Estates & Facilitates expertise, support & management at C&I sites as a result of transfer of services from	4	4	16	David Wragg

improvement strategy	NHS Camden to BBW. This compromises patient & staff safety, poor performance rating and increased clinical risk. Current risk (NR92)				
PRINCIPAL OBJECTIVE 6	HIGH LEVEL RISKS	L	C	SCORE	DIRECTOR LEAD
We will create a service user focussed culture which is aligned to our values, behaviour and performance, adopting a stepped programme which continually improves our staff and service user experience.	Insufficient meaningful engagement with staff and service users and not hearing and acting on their concerns leads to a culture of cynicism where poor standards may flourish.	3	4	12	Claire Johnston

Safeguarding

There is strong senior management commitment to safeguarding. The executive Director of Nursing & People is the Board lead and chairs the Trust Safeguarding Strategic Group. A safeguarding manager (Named Nurse) and Named Doctor provide professional leadership, promote good professional practice, ensure training is in place, and provide advice and support to staff across the organisation. The safeguarding work programme is overseen by the Safeguarding Strategic Group, which meets every quarter to discuss key areas of safeguarding developments, review areas of risk and agree management plans. DBS checks are completed on all relevant staff and re-checks are required every three years as part of safe recruitment.

A safeguarding strategic action plan provides direction to the work of safeguarding activities in the Trust. Designated nurses within the CCGs for Camden and Islington are members of the Safeguarding Strategic Group and provide external expertise and challenge to the work of the group. Safeguarding operational performance is monitored and challenged at divisional management meetings and a strong culture has developed within the Trust of safeguarding being everybody's business, and poor practice is identified and managed. There is a Trust audit programme that includes safeguarding supervision and safeguarding documentation, and the Trust contributes to regular multi agency audits, including child sexual exploitation, training evaluation, and effective partnership work.

The Trust is represented on Camden & Islington Safeguarding Children and Adults Partnership Boards and relevant sub groups of those Boards. The safeguarding manager also represents the Trust at the London Network for Safeguarding Leads in

Mental Health Trusts, a robust network, which shares good practice, learning and developments.

The Trust has a clear statement affirming its commitment to safeguarding children, young people and adults at risk, which is included in new and updated policies and job descriptions. The statement and policies are available to staff via the Trust intranet and staff are informed about these during Trust induction and at mandatory safeguarding training which must be updated every three years. Training compliance data is reported to and monitored by the safeguarding boards and the CCGs.

Care Quality Commission

As at the end of 2012/13, three Trust CQC registered locations had received a CQC assessment visit; Highgate Mental Health Centre (HMHC), Islington Drug and Alcohol Service and Stacey Street nursing home. The CQC provided extremely positive assessment reports and found us compliant with all sixteen quality standards at HMHC and Islington Drug and Alcohol service. There was one moderate concern in regards to a service provided at Stacey Street, a residential nursing home for which the Trust has recently acquired responsibility, but the CQC found positive improvement in 5 of the 6 essential standards that under the previous management were deemed noncompliant in May 2012.

The report indicates areas of non-compliance in regards to Outcome 4: Care and welfare of people who use services (People should get safe and appropriate care that meets their needs and supports their rights). An action plan has been implemented to ensure and assure compliance by 20th May 2013.

The specific actions being taken to assure and ensure compliance are detailed in an action plan which has been reviewed and signed off by Trust's Stacey Street Quality Group which includes senior C&I staff and local commissioners.

Care Quality Commission – Quality Risk Profile (QRP)

The CQC's primary tool for assuring safety and quality on a continual basis is through its QRP. In total there are 759 indicators that we are rated against which make up the QRP. As reflected in our Quality Account, our QRP provides a very positive picture

with no areas rated as at risk of non-compliance. Our QRP is reported to the Board quarterly and monitored by the Quality Committee.

Clinical & Quality Priorities

All of our clinical and quality priorities are underpinned and categorised by our drive



to improve patient safety, clinical effectiveness and service user experience and are clearly linked to the five domains of the NHS Outcomes Framework.

We have identified a range of clinical and quality priorities in our Quality Account for 2013/4 which has been co-

developed with our stakeholders. This year we held two stakeholder events attended by service users, carers, governors and commissioners, and in March we held a joint Board of Directors and Council of Governors meeting to discuss our forward plans and clinical priorities. Our CQUINs for the year ahead are focused on the following areas:

- Improving physical healthcare
- Recovery orientated practice to monitor how well this approach is implemented
- Collaborative planning of care between service user and clinician
- Smoking cessation

In addition to all the priorities set out in our Quality Account and compliance with mandatory performance indicators, we have identified a range of further clinical priorities which are linked to the quality domains of safety, effectiveness and experience. We have implemented an Outcomes Framework for each of the five divisions and each division has a service improvement plan and a clinical audit plan.

Innovations in Care Delivery

C&I's Islington Crisis Resolution and Home Treatment Team (CRT) was awarded the HTAS accreditation status. The team is one of the first teams in the country to be awarded the Home Treatment Accreditation Scheme (HTAS) which was set up by The Royal College of Psychiatrists Centre for Quality in 2012.

We also have accredited services in Mental Health Liaison and Recovery and Rehabilitation.

Close working between our Dementia services and GPs has resulted in Islington having the highest rate of dementia diagnosis in England. Figures released from the Alzheimer's Society show that rates of diagnosis vary widely across the country, from 31.6% in East Riding of Yorkshire to 75.4% in Islington.

The Kingston Wellness Treatment service - an innovative service that brings together both substance misuse and IAPT to provide an integrated primary care treatment service was launched on 1st April 2013. C&I was selected with its partner, Lifeline, by Kingston Clinical Commissioning Group following a competitive tendering process.

The award of this contract to C&I reflects the confidence that commissioners have in our ability to provide high quality services, driven by the hard working and dedicated staff within our substance misuse and IAPT services.

Our ICT team were finalists in the UK IT Industry awards for their work with ICT Training and WeBex. The nomination was by the BT N3 Services Group, who run the National N3 Services for the NHS and manages services running over the National Infrastructure, like WeBex/SPINE/Summary Care Record.

C&I has a tremendous reputation in the research field and this impacts both on how we deliver our services and on UK mental health care policy. Last year **89 projects** were active within the Trust and **159 peer reviewed papers were published**. The following are some of the innovations that our clinicians are engaged in:

Innovation and research

- Dr Claudia Cooper – Developing a manual-based coping strategy START (STrategies for RelaTives) programme delivered by supervised graduate mental health workers to family carers of people with dementia
- Dr Fiona Nolan – A comparison study to investigate Protected Engagement Time on acute mental health inpatient wards in England
- Dr Helen Killaspy – Quality and Effectiveness of Mental Health Services for People with Complex Needs
- Dr David Osborn – Improving physical health outcomes in people with severe mental illnesses
- Dr Meghan Craig – Contingency management for the reduction of cannabis use and relapse in first episode psychosis
- Dr Brynmor Lloyd-Evans – Mental health crisis houses; recent, current and future research
- Prof. Chris Brewin – Auditory Pseudo-hallucinations in Post-Traumatic Stress Disorder
- Prof. Sonia Johnson – Researching crisis teams in Camden and Islington and beyond: the CORE programme

Clinical workforce plans

The C&I Human Resources Department will continue to forge partnerships with all parts of the organisation in order to support the Trust to recruit, manage, develop and design the best possible workforce for the future, one that is competent to deliver the highest possible quality of care. This is the Human Resources mission statement that supports the achievement of the C&I vision and strategic aims.

To this end, we have implemented a number of transformational changes in the last two years following reviews of our in-patient and community teams resulting in significant changes to our workforce. Our models of care have changed in line with the evidence base and framework for clinical care pathways that are based on nationally agreed clusters of care. This includes a focus on providing the right skills at the right time with more specialist care appropriate to each service user. We have placed more emphasis on team working and have introduced assistant practitioners and support workers in each care pathway to complement and enhance the work of senior clinicians. We will continue to embed the new models of care and develop the use of these roles to enhance the delivery of care.

Our key clinical workforce plans for the period ahead include:

- A continued focus on developing specialist skills underpinned by training and development plans;
- Developing the capability of Trust managers through first line and senior leadership programmes;
- Improve staff engagement;

- A planned reduction in out of hours on call rotas from 4 to 3 for core trainee grade doctors with agreement of local Acute Trusts;
- Ensuring all staff receive a well-structured appraisal;
- Reducing the number of staff experiencing pressure at work;
- Improving the health and wellbeing of our workforce leading to a reduction in sickness absence;
- Implementation of a new values led recruitment process;
- Implementation of a refreshed Social Work Strategy;
- Implementation of a refreshed Nursing Strategy.

Other workforce related plans are detailed in the Productivity and Efficiency section below and in appendix 1.

SECTION D

Productivity & Efficiency

C&I has delivered unprecedented levels of productivity and efficiency over the last three years. We recognise the need to continue to deliver improved value for money whilst retaining our focus on improving quality and outcomes.

Key elements of our plans are provided below and are designed to ensure that C&I remains responsive and able to maintain and grow our portfolio of services to ensure we remain clinically and financially sustainable for the coming years. Our plans are set within the context of QIPP and building on our previous schemes we will seek to:

- Implement evidence-based continuous quality improvement tools and LEAN (a type of quality improvement methodology) such as the productive series (ward and community) and build further capacity to embed LEAN throughout the Trust to support and drive service improvement;
- Progress improved utilisation of estate as part of our Estates Strategy;
- Review management and administrative support costs;
- Implement a range of workforce measures such as a review and targeted recruitment against current vacancies; continue to focus on reducing sickness absence, reported work-related stress and use of bank staff, and incentivising staff to work more productively;
- Review staffing models and shift patterns within the divisions to enable staff to work productively and effectively, and that appropriately trained staff are deployed in the right place at the right time;
- Consolidate a new Performance Management Framework which will critically assess and review variations in clinical practice, outcomes and service user experience;
- Continue to use advances in technology to support efficient service delivery, such as RosterPro for planning rosters for 24hour services and DocMan, an electronic document management system used to improve document transfer between our clinical services and GPs;
- Further develop our volunteering scheme in the Trust;
- Continue to work with local commissioners to further develop services and provide integrated care pathways.

ICT Strategy

Over the last three years, we have made considerable investment in new ICT Infrastructures that have facilitated considerable change in working practices and culture throughout the Trust. Service led demand for more flexible and agile working solutions has been driven by previous investments in flexible mobile working solutions.

In three years we have moved from thirty-five (35) laptops to four hundred and fifty plus (450+) laptops, shortly to be increased by an additional one hundred (100) tablet devices. For every single (1) desktop PC purchased we buy four (4) laptop/tablet devices. All mobile devices are encrypted and underpinned by fast, secure remote access solutions allowing access to systems from anywhere within the UK.

These investments have allowed C&I to work beyond its traditional geographical boundaries and to take advantage of virtual working uninhibited by geographical location. This current ICT Strategy will continue to support C&I's growth potential and support working in new locations and service areas.

Scope of ICT Strategy

The key priority of the current strategy is to continue to focus on building upon the previous investments already made and ensuring the return on those investments are achieved. Some of the key objectives facilitated by the plan are:

- (Highest Priority) Deploy a replacement Electronic Patient Record (EPR) Solution by 2015;
- Further expand mobile and flexible working linked to changing estate locations;
- Further expand mobile working capabilities in conjunction with new Estates & Facilities changes to site locations and developments;
- Deploy a new C&I Clinical/Patient Portal (C&I P);
- Deploy electronic information sharing with GP's to new practices and areas;
- Improved scope and analysis of data;
- Further development of Tele-health & Extranet Solutions;
- Deployment of faster network Cable Modems to Tier 4 sites (small locations/low headcount);
- Replacement of old Mitel Phone switches with two updated resilient switches;

- Introduce replacement IT services following of 2E2 UK Ltd being put into administration.

CIP Governance

In common with all providers across the NHS, we are constantly working to deliver better value in our services. During 2011/12 C&I delivered a total of £12m CIP savings for local commissioners, with a further £7m delivered in 2012/13. Combined, this level of savings equates to circa 14% of pre 2011/12 expenditure, which we understand to be one of the highest percentage savings target achieved across all foundation trust providers in the country. We continue to face pressure to deliver further efficiency and productivity improvements. Whilst the NCL financial pressures have had an impact on the Trusts in the sector during the contracting round for 2012/13, these pressures are not expected to impact on CCGs in 2013/14.

In the 2012/13 financial year, CIP delivery has been ahead of requirements. Both community and in-patient schemes have delivered above plan savings. This has been achieved by a robust Project Management Office approach to CIP delivery. Delegated CIP schemes in clinical services and estates have been 75% achieved. In both areas, a review of management arrangements has been carried out, and, with the new Trust structure in place, revised CIP plans for the 2013/14 financial year are in place for both.

CIP governance for 2013/14 will continue to be delivered through a project management approach, with performance monitored on a monthly basis through the Trust Performance Management framework. This provides the mechanism for ensuring that CIP plans are on track or that any necessary corrective actions are taken. This framework has been recently approved by the Board (April 2013), and is intended to help develop the service line management framework and capability within the organisation. It will, therefore, be one vehicle for ensuring future CIP delivery and the incentivisation of services to deliver to plan. Regular monthly Board reporting on CIP delivery will continue.

On approval, all Trust CIP schemes have a named Senior Responsible Officer with identified project support and a Prince 2 style project structure is used. All clinical based schemes are clinically approved and have a nominated clinical lead.

Senior Responsible Officers have a CIP scrutiny meeting with the Chief Operating Officer and finance as part of our Performance Framework. These meetings are held quarterly where progress against the plan is monitored, forecasts updated and risks

are reviewed and schemes 'RAG' rated. If a scheme is rated 'RED' the monitoring is escalated to monthly.

Progress against CIP schemes is reported monthly (as well as when required, on an exception basis) to the Executive Management Committee, which doubles as the CIP Board, and to the Board of Directors. Progress to the Executive Management Committee is reported at both a summary and a detailed level, including forecasts of expected delivery, an assessment of risks and an explanation of material variances from the plan.

Following two years where commissioners have requested large reductions in funding, we are not anticipating any further reductions (above national targets) or disinvestment of services in 2013/14. We are expecting that pressures will return in future years following the introduction of Payments by Results (PbR) and AQP which will provide greater transparency of pricing and benchmarking between providers.

CIP Profile

The CIP programme for 2013/14 builds on the plan achieved in 2012/13. Significant elements of the CIP savings are generated by the full year effect of the 2012/13 plan. Remaining schemes are based around incremental changes, particularly to bed management arrangements, and the review of administrative and support processes to the new service model. Eight per cent (8%) of CIP savings come from an incremental review of clinical skill mix requirements, in the context of recruitment to vacancies. There are no CIP savings that impact on clinical staff currently in post.

CIP Enablers and Process

The majority of the Trust's CIP schemes are clinically led and are transformational in nature, planned as part of an overarching strategy to support the implementation of our clinical and quality strategy.

In 2012 we moved to a Divisional Management Structure from our previous Service Line model. We have five divisions that are each led by a Divisional Manager and a Divisional Clinical Lead. This model is an excellent way of engaging and involving senior clinical leaders in improving performance, outcomes, productivity and efficiency.

Each division and corporate service has prepared its own business plan that includes the following elements:

- Quality and service user safety;
- Experience and outcomes;
- Key performance targets;
- Financial effectiveness and operational efficiencies (CIP),
- Workforce; and
- Income growth.

In preparing these plans as part of a continual planning cycle, a wide range of clinicians, managers and corporate staff were engaged in formulating ideas and contributing to the final plans.

The Trust recognises that CIP schemes need to be supported by a range of corporate support services and that our infrastructure must enable and facilitate delivery of the schemes. The Trust will therefore continue to invest in staff training and development, capital projects and information technology in order to support the CIP process.

Where necessary, specialist external support will be procured in order to support delivery of key projects.

Quality Impact of CIPs

C&I's approach to the management of risk is set out in our detailed Risk Management Strategy. Any risks on our Trust-wide or Divisional risk registers relating to quality and patient safety are categorised as such and are reviewed at the Chief Operating Officer's divisional management meetings and by the Quality Committee.

All CIP proposals are approved by the Executive Management Committee and have a quality impact assessment which is considered. The medical director and director of nursing have a veto on all CIP proposals should they consider that there is a significant risk to the quality of care.

The Board also receives a quarterly report on all aspects of clinical performance, including internal and externally set targets. A specific set of indicators, measuring potential impacts of CIP schemes on quality of care, have been developed and are also monitored at divisional meetings, at the Quality Committee and by the Board. This robust monitoring aims to ensure that any potential negative impact on the quality of clinical services arising from the implementation of CIP schemes is identified and acted on swiftly.

SECTION E

Financial and Investment Strategy

Assessment of Trust's Financial Position

In 2012/13, the Trust returned a surplus position of income over expenditure of £2,627k, and an EBITDA surplus of £7,636k, both of which are comfortably ahead of the planned year end position. This is a welcome reflection of the Trust's financial controls, and in particular of a strong final quarter performance, which indicates highly positive run rates moving into 2013/14. This return constitutes a successful year for the Trust financially, and places the Trust in a good position to continue to deliver strong financial performances.

The Trust recognises the exceptional level of savings that have been required, and delivered, over the previous 3 year planning cycle, and is cognisant of the operational challenges that this delivery has entailed. During 2012/13, significant new staffing structures have been implemented across all community and inpatient settings, while the bed base has undergone the final stages of material reduction. The financial strategy for 2013/14 is, therefore, one primarily based on supporting the consolidation and embedding of these changes, whilst maintaining financial stability.

The Trust has identified a savings requirement of £4,900k in 2013/14, with commensurate levels in subsequent years, dependent upon national and local pressures on income levels. This level of savings is predominantly based on the national efficiency targets of 4% and adjusted for local commissioning intentions.

This CIP position is consistent with the Trust earning annual surpluses of £2,000k over the planning period. The Trust is also planning to invest £7,444k in its asset base during 2013/14, and retain cash balances of £40,000k. The Trust expects to retain its financial risk rating of 4 throughout the planning period.

Financial Priorities and Risks

The Trust recognises that the delivery of a CIP programme of this size within the financial year may result in some form of slippage and potential non recurrent transformational costs, such as redundancies. As a result, the Trust has identified an overall CIP programme of £5,900k, which is consistent with historic, prudent levels of headroom. Therefore there is a sufficient element of in-built headroom within the current programme to mitigate any realistic risk to delivery.

The Board of Directors has determined that growth is a principal priority for the Trust, and significant work is ongoing to:

- Assess the desirability of areas of potential new business and the Trust's readiness to compete for them;
- Secure new income streams; and
- Protect existing income streams.

The Trust believes that growth will not only deliver greater levels of financial security but will also allow synergies and economies of scale. However, although the benefits of growth are recognised, the Trust does not have growth as a pre requisite of a balanced financial position, and its baseline financial plan is based on secured income streams and the achievement of necessary efficiencies.

Healthy liquidity balances of £47,821k were carried forward into 2013/14, which are further supplemented by a committed working capital facility of £11,000k. This level, though in excess of plan, is a reflection of a strong underlying financial performance and effective cash management. This level of cash offers significant benefits to the Trust, not least in providing significant assurance against any short term liquidity crunches or downsides. However, the most significant benefit of holding high cash balances is that it enables the Trust to make material, strategic investment decisions, at timings of its choosing, without the requirement for commercial borrowing.

The Trust recognises the importance of maximising the quality and efficiency of its estate in order that it can support the delivery of clinical care as effectively as possible. Consistent levels of financial surplus have generated the resource for delivering levels of capital investment above and beyond levels of depreciation. It is expected that this pattern will continue, delivering ongoing improvements in the Trust's infrastructure.

In late 2012, the Trust was informed that it was successful in its application to have PCT estate transferred to C&I as part of the PCT estate transfer process and that C&I would be taking over ownership of the St Pancras Hospital site, as well as the Greenland Rd site and the head lease on 207-215 Kings Cross Rd.

The acquisition of St Pancras Hospital, the location of the Trust's headquarters and of significant service provision, is particularly significant and was subject to a thorough due diligence process. The Trust is confident that the site offers material strategic advantages, and recognises that moving forward, the Trust will now incur non-cash

depreciation charges instead of cash based rental charges, which will generate further scope for re-investment.

As a result of these transfers, a complete assessment of all the future potential income and expenditure streams associated with the sites is underway, and prudent revenue assumptions have been included in the base case. However, the Trust is aware that St Pancras Hospital has been subject to significant under investment over a number of years, and significant backlog maintenance requirements exist.

Currently the Trust is reviewing its estates strategy in order to:

- Assure itself that any investment in the asset base is coordinated with the Trust's wider organisational strategy;
- Ensure that the Trust delivers an effective estate from which to deliver quality services; and
- Make an assessment of how the new sites fit into the wider estates strategy.

In 2012/13, the Trust spent £3,636k on its asset base, which made a material improvement in the quality of the estate. In 2013/14, the Trust intends to invest an underlying level of £5,000k plus a significant proportion of any proceeds from property disposals. As a result, total capital investment in 2013/14 is planned to approach £7,500k.

The Trust is conscious that addressing issues at the St Pancras site and associated investments should not be to the detriment of the wider Trust infrastructure. This level of investment will be able to deliver a programme which will not only make available significant funds for addressing issues at the St Pancras site, but also ensure that investment in the wider estate and in ICT is appropriate.