

Strategic Plan Document for 2013-14

Greater Manchester West Mental Health NHS Foundation Trust

<p>Executive Summary</p>	<p>We are an organisation that is committed to continually improving the experience of our service users and the safety and effectiveness of care provided. This strategic plan details how we will deliver this commitment, in 2013/14 and onwards, in the context of the increasingly challenging economic backdrop, more open competition, increased regulatory scrutiny and embedding of new commissioning arrangements/NHS reforms.</p> <p>We have a strong track record of delivering all required financial, performance and quality targets/standards and have plans in place to maintain this record going forward.</p> <p>Our strategic plan can be summarised as focusing on the following areas:</p> <ul style="list-style-type: none"> • Promoting and delivering quality and performance agendas • Acting on patient experience feedback to deliver continuous improvements • Promoting recovery through education • Responding to tender opportunities • Developing new strategic partnerships • Strengthening existing relationships • Proactive workforce planning, development and management • Strengthening infrastructure • Delivering our financial plan – including the delivery of significant income and expenditure surpluses to improve service quality through re-investment in our buildings and estate. <p>The identification of our strategic priorities followed engagement with our lead clinicians and senior management teams in a rigorous business planning process, as well as Trust Board and wider stakeholder engagement through the Council of Governors. We have given regard to the views of our Council of Governors in developing this strategic plan.</p> <p>Our planned income over the lifetime of this plan is £161.4million (2013/14), £161.9million (2014/15) and £150.6million (2015/16). Annual savings of £5.0million will be delivered via planned cost improvement programmes (CIPs) and we are forecasting net surpluses of £6.2million (2013/14), £11.5million (2014/15) and £4.9million (2015/16).</p>
<p>Strategic Context and Direction</p>	<p>GMW's Strategic Position in the Local Health Economy, including Threats and Opportunities from Changes in Local Commissioning Intentions</p> <p>Competition and Market Share:</p> <p>We are currently commissioned to directly provide a range of general and more specialist NHS services and, as such, operate in a number of markets at both local and national level. Services provided include:</p> <ul style="list-style-type: none"> • Community and inpatient mental health services • Adult forensic mental health services • Adolescent forensic mental health services • Adolescent psychiatry services • Mental health and deafness services

- Community and inpatient alcohol and drug services
- Prison in-reach services

Within a number of these service areas, effective joint working and resource sharing with local authority partners (governed via Section 75 agreements) continues despite the need to deliver challenging efficiency requirements in recent years. We also operate a number of sub-contracts with third sector and private sector providers.

Local Commissioning Strategy and Tendering:

Patient choice does not currently apply to our services. Of the services we provide, only psychological therapies fall within the remit of Any Qualified Provider (AQP) but these services have not been selected for patient choice under AQP by our local commissioners. As such, competition for the markets we operate in is initiated by commissioners choosing to market test or re-tender existing contracts or establish frameworks of preferred providers. Buyer power is strong. In line with national strategy, our experience has demonstrated that decisions on which services to open to the market are informed by intentions to improve patient care and service quality. Clearly, given the current economic climate, improving value for money has also proven influential. As an organisation that is committed to continually improving the experience of service users and the safety and effectiveness of care, we support both these intents. Our ability to compete on an equal footing with non-NHS competitors can, however, be constrained by distortions in both cost and flexibility. We have, and will continue to seek, alternative sources of competitive advantage to offset this. These include our positive reputation; strong financial standing; experienced and, in some cases, nationally recognised and award winning workforce; established governance structures; and our ability to innovate and deliver economies of scale.

With the implementation of the NHS Reforms from 1 April 2013, and the associated changes in commissioning for both general and specialist mental health services, there is an expectation that all our market areas will become more open to competition and new entrants going forward. Whilst other NHS providers of mental health services remain key competitors, the continually growing competition from private and third sector organisations will pose the greatest threat. We are confident about our ability to compete based on the sources of competitive advantage identified above and our scope to, and experience of, adapting to changes in the strategic environment. Our strategic plan reflects this confidence.

Currently, our community-based alcohol and drugs services operate in the most contested market. This market is fast-moving and subject to political scrutiny, intensive performance management and increasing diversity of providers. Opportunities for expansion of our existing alcohol and drugs services and, equally, risks of losing existing business, arise frequently. Like other NHS providers operating in this market, we have seen a number of our core contracts re-tendered. In the last 12-18 months alone, we have successfully tendered to provide the full drugs and alcohol treatment system in Cumbria and retained intake, medical interventions and harm minimisation services in Wigan and Leigh. We participated without success in the re-procurement of our services in Bolton and Manchester.

We have a dedicated, skilled and experienced alcohol and drugs workforce and remain committed to being a key player in this market. Our strategy for competing in the alcohol

and drugs market moving forward is therefore two-fold:

- To retain current business/market share where commissioner specification, model and resource envelope meets our essential quality and safety standards
- To evaluate and, where considered viable, respond to new opportunities i.e. increase market share either in new geographical sectors or through service development

Given the pace and uncertainty of the alcohol and drugs market, it is difficult to predict and impact assess market share trends with any accuracy over the life of this plan (2013/14 to 2015/16). Based on our current position and experience to date, it is our expectation that we will continue to hold a significant share of the north west alcohol and drugs market. This share may be more geographically diverse, due to commissioners increasingly segmenting treatment systems into lots (often with an outcome being a mixed economy of provision).

Forecast Health, Demographic and Demand Changes:

The following demographic changes in communities we serve, and associated impacts on demand, are expected during the lifetime of this plan and beyond:

- Demand for general mental health services for adults of working age in Bolton, Salford and Trafford is likely to increase.
- Demand for dementia and other services used by older people is likely to increase significantly.
- Demand for services from black or minority ethnic populations will increase, as these populations grow. This will be accompanied by the need to ensure that services are appropriate to individuals' cultural needs as well as specific mental health needs.
- Changing patterns of demand will focus as much on the nature and quality of services provided as on the quantity.
- Demand arising from schizophrenia or other psychotic disorders linked to severe psychiatric morbidity among adults of working age is expected to remain relatively steady. The prevalence of psychotic disorders will continue to reflect levels of socio-economic deprivation i.e. remain higher in our inner city communities.
- Demand for alcohol and drugs services is likely to continue to increase. This will reflect changing patterns in drug and alcohol use.
- Demand for forensic services is likely to increase because of pressures in the criminal justice system and expectations that more appropriate services are provided for mentally disordered offenders.
- Demand for other specialised services will depend more on government and commissioner policies than on changes in the population or the epidemiology of mental illness.
- Other changes arising from the continually challenging economic climate may also influence the demand for services.

Changing Demand Profile and Activity Mix:

Based on changes in demand and the marketplace, we will be increasingly flexible about the services we consider as our 'core business' in future. Our strategic development

plans (see Appendix 1) during 2013/14 to 2015/16 represent a mix of market penetration, service development, market development and diversification.

Shifting Care Delivery Outside of Hospitals:

A key element of our future quality and cost improvement programmes in our district services (Bolton, Salford and Trafford) focuses on continuing to 'shift' care delivery outside of hospitals. Alongside the reconfiguration of our older adults inpatient services in 2012/13, we have invested additional resources in our older adults community services. These resources are aimed at delivering improved patient care and experience, by supporting more effective management of individuals with dementia and challenging behaviours in the community and reducing admissions, as well as significant efficiencies. During 2013/14, we will continue to develop these new community resources and evaluate their impact on inpatient activity. We will also focus on strengthening our bed management functions, and the role of our Crisis Resolution Home Treatment Teams, to support early discharge and reduce length of stay and numbers of inappropriate admissions.

We are also working with commissioners to agree and implement RAID-type psychiatric liaison services (Rapid Assessment Interface Discharge) in our local acute hospitals in Bolton and Trafford. Further detail on the development of psychiatric liaison services is provided in Appendix 1.

Diversification of Income Streams:

Our primary source of income will remain NHS commissioned services during the lifetime of this plan. In addition to this, we have a number of other income streams including:

Local Authorities - With effect from 1 April 2013, commissioning for drug and alcohol prevention, treatment and recovery services will be the responsibility of public health departments of Local Authorities. All funding previously routed through the NHS becomes part of a wider ring-fenced public health budget as a result of this change. Planned income delivered through our A+DD (Alcohol and Drugs Directorate) over the lifetime of this plan will therefore derive from the respective Local Authorities rather than NHS. We have identified and quantified a number of risks associated with this in this Strategic Plan

Research and Development (R&D) – We have an established and well-regarded R&D function, which will continue to provide an alternative income stream in future years. Apart from funding for specific projects, the primary income stream for R&D is Research Capability Funding (RCF) for National Institute of Health Research (NIHR) grants submitted by our academic researchers. The level of RCF funding for 2013/14 has reduced due to the qualifying grant income dropping. Other funding (.e.g. to cover the cost of portfolio research) has been confirmed at 2012/13 levels.

In line with NIHR targets, there is an expectation that recruitment to clinical research studies will increase year on year. Financial implications for the Trust overall as an outcome of this – support costs link to recruitment - are expected to be minimal.

Recovery Health and Wellbeing Academy Income Generation – The first prospectus of our Recovery Health and Wellbeing Academy was published in April 2013. The prospectus offers access to a range of free, learning opportunities provided across a

number of locations within the Trust footprint. Longer-term, our plans are to develop a physical 'hub' for our Recovery Health and Wellbeing Academy on our Prestwich site. Capital funding of circa £5million has been identified for this (see capital expenditure section of Appendix 1), though this scheme is still at business case development stage. There is an expectation that the Recovery Academy hub will provide a small opportunity for income generation through, for example, hiring training or conference rooms.

Collaboration:

Partnership Working:

We recognise the benefits of partnership working from the perspectives of patient interest, competitive advantage and opportunity to share learning/expertise. We currently operate a number of partnerships with non-statutory providers, which are managed via sub-contracting arrangements. We have experience of being both prime contractor and sub-contractor. As contracts provided in partnership come up for expiry and renewal over the lifetime of this plan, we will evaluate the effectiveness of the current partnership arrangement in light of any changing commissioner requirements and take the decision to continue the existing partnership, seek a new partner or bring service provision in house. This decision will be made on a 'case by case' basis.

With effect from 1 April 2013, we will be working in partnership with Spectrum Community Healthcare CIC (Community Interest Company) to deliver primary healthcare services at HMP Styal. This partnership follows a successful tender submission during 2012/13. Within this arrangement, Spectrum are the prime partner with the primary and secondary mental healthcare elements of service contracted to GMW. This development represents an extension of existing service provision for GMW, as we previously provided secondary care mental health services at HMP Styal with a different partner. As a relatively new organisation, and a social enterprise, Spectrum bring a different and innovative perspective to this partnership. Based on experience to date, both parties are confident of a successful partnership, which has the potential to work for relevant future opportunities.

At the time of writing, we are also exploring an opportunity to develop an innovative partnership with a private sector provider for the provision of secure services. (We have existing, positive experience of working with a private sector partner, via a sub-contracting arrangement, to deliver a 24-bedded medium secure unit in Salford.) There are a number of risks/challenges associated with the proposed new partnership, and timescales are tight, therefore our preference is to establish a contractual joint venture rather than sub-contract to progress this. As this development is in its infancy, income forecasts are yet to be calculated for inclusion in our financial plans. Further detail on this development is provided in Appendix 5.

Membership:

We will continue to use our freedoms as an NHS Foundation Trust to involve our staff, service users, carers and public members in developing our services. We view this as vital part of our planning process and critical to improving patient experience. Our current membership is representative of the diverse communities we serve, significantly exceeds the targets we set ourselves and complies with the terms of our constitution. Views of our members are represented at our Council of Governors by elected and appointed governors. A breakdown of our current membership is provided within the accompanying

	<p>financial templates. In 2013/14, a sub-group of the Council of Governors will be responsible for review and developing our membership targets and work-streams.</p> <p><i>Service User Involvement:</i></p> <p>We have a strong track record of enabling our service users and carers to access opportunities that support their recovery journeys.</p> <p>We recognise, however, that a more cohesive approach is now needed to develop this work and innovate. We are in the process of establishing a customer care and quality hub - 'CARE' (Compassion and Recovery-focussed Everytime) - for this purpose. CARE will become operational in 2013/14, will have an appointed lead and will focus on:</p> <ul style="list-style-type: none">• Further strengthening our commitment to service users and carers• Providing meaningful opportunities for planned volunteering• Developing peer mentors within our mental health services - Peer mentors already have a key role within our alcohol and drug services and we will learn from this experience• Working with our User Action Team (UAcT)• Developing approaches to gathering real-time feedback from service users and carers <p>CARE will have our new Trust Values at its heart and work closely with our local Healthwatch organisations, commissioners and our Recovery Academy.</p>
<p>Approach taken to quality (including patient safety, clinical effectiveness and patient experience)</p>	<p>Our Trust Board hold ultimate accountability for the quality of clinical services provided by the Trust. In order to ensure that there is a robust quality governance framework operating, the Board has established a sub-committee with delegated authority to set the strategy for quality and to ensure delivery against it. The Quality Governance Committee (QGC) is chaired by a Non-Executive Director and includes other Trust Board members, lead clinicians from all clinical services and corporate leads with responsibility for risk and quality management. The structure and business of the Quality Governance Committee has been informed by an assessment against Monitor's Quality Governance Framework, with guidance and advice from Deloitte. The Quality Governance Committee have an agreed Quality Governance Framework and leads on setting and measuring performance against the Trust's quality priorities as set out in the annual Quality Account.</p> <p>We continue to be registered without any concerns with the Care Quality Commission (CQC). The outcomes of the monthly Quality and Risk profiles from CQC are reviewed at Trust Board via the monthly performance report. The current profile (March 2013) indicates no areas of concern with all outcomes rated as High Green, Low Green or Low Neutral. The Trust Board also receives monthly data on CQC visits to monitor compliance under the Mental Health Act. There have been a total of 21 CQC on-site visits to services in 2012/13 with all outcomes generally positive and only a small number of areas where improvements were identified and actioned. In 2012/13 the Trust also received a Dignity and Nutrition Inspection from CQC, along with a Multi-agency Admission and Assessment visit which both resulted in positive outcomes.</p> <p>Trust Board and Quality Governance Committee members are visible within clinical services and undertake monthly walkabouts. This provides members with opportunities to triangulate evidence, speak to service users and staff about their experience and to</p>

ensure that there is an open and transparent culture within the Trust. The NHS Staff Survey for 2012 placed the Trust in the top 20% of mental health trusts nationally in Key Finding 1 (Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver) and above average in Key Finding 24 (Percentage of staff recommending the trust as a place to work or receive treatment).

The Trust Board have recently undertaken an initial listening exercise following the publication of the Robert Francis QC report into the failings at Mid-Staffordshire NHS Foundation Trust. The Board have sought views from the Council of Governors, including service user representatives, clinicians, and local trade unions, and reflected on the outcomes from the report and impact on its own services as part of this exercise. A number of existing sources of positive quality assurance have been identified, some of which are described in more detail here, and can be summarised as follows:

Board Level Assurance & Conduct:

- Codes of Conduct for Directors and Governors
- Externally-facilitated Director appraisals
- Quality Governance Committee - responsible for developing and monitoring our approach to quality improvement
- Quality Account – with external auditor assurance
- Incident reporting to the NHSLA – high level of reporting/low level of harm
- CQC planned and unannounced inspections – prepared for and with positive outcomes
- Board level leadership of Serious Incidents Panel
- Board level service visits ('walk-arounds')

Nursing Care:

- GMW Nursing Strategy (2011-2015) – including plans for developing our nursing workforce and promoting nursing values and practice. Implementation of this strategy is led and monitored by our Nursing Leadership Board
- Trust-wide review of shift systems – thorough review with recommendations implemented and routinely monitored
- Later Life inpatient care review – recommendations implemented
- Positive relationships with training institutions and placements
- Number and role of Matrons
- Essence of Care –focus on the fundamentals of high quality care
- Improving dementia care
- Physical healthcare focus

Culture of Respect and Engagement:

- UAcT (User Action Team) and directorate-level service user forums
- Use of peer support and service user volunteers
- Recovery collaborative – co-production
- Carers Strategy, Carers Charter and local Carers Champions
- Service user involvement in PEAT inspections (and PLACE to follow)
- Dragons Den initiative
- Robust complaints handling process – listening and learning
- Positive feedback from staff survey
- Strengthening relationships and activity with new Healthwatch organisations

	<p><i>Personal and Professional Accountability:</i></p> <ul style="list-style-type: none"> • Personal Accountability Frameworks • Appraisal process • Commitment to Personal and Professional Development • Peer supervision for doctors, nurses and psychologists • Medical revalidation – in line with General Medical Council requirements • Externally-facilitated Clinical Leadership Programme <p>Initial areas of potential risks to quality have also been identified following the Francis Review and work-streams have been agreed by the Quality Governance Committee and commenced to progress this. Examples include:</p> <p><i>Culture and leadership</i> – a risk that without an open and transparent culture, pockets of poor practice can develop and the need to ensure the Board and Lead Clinicians continue to engage pro-actively with front line staff and service users. Board members will continue to visibly promote a culture of openness and a recent project involving service users and staff to establish the Trust’s core values and behaviours is rolling out across the trust and being embedded in recruitment, leadership development and performance appraisals.</p> <p><i>Bureaucracy</i> – a risk that current systems and processes can sometimes detract clinicians from care delivery and the need to review some core systems to ensure they are effectively enabling clinical services not hindering. Specific task and finish workgroups are now established to review and streamline the Datix incident reporting systems, Payment by Results systems, CQUIN target systems and clinical risk management assessment tools.</p> <p><i>Staffing levels</i> – a risk that staffing levels and the balance between permanent and temporary staff, particularly in ward areas, if not right can detrimentally impact upon quality. A new trust-wide shift review system has been implemented over the last two years and this set the minimum safe staffing levels required. A review of the current position is to be undertaken to ensure this is still to the required standard by the Nurse Leadership Board.</p> <p>Looking forward the continual assessment of the quality of services provided will be a top priority for the Trust Board. The challenging efficiency agenda will continue to be addressed by driving further service innovation and integration. The quality of these services will be paramount in any discussions about cost efficiency and a robust process is in place via the annual business planning cycle to assess the quality impact of any service developments and cost efficiency plans.</p>
<p>Clinical Strategy</p> <p>(Consistent with information contained within the Trust’s published Quality Account).</p>	<p>Overall Clinical Strategy and Service Line Strategy:</p> <p>We view ourselves as a learning organisation that is committed to continually improving the quality of care we provide. Our clinical strategy over the lifetime of this plan reflects national expectations of no growth, continuous improvements in efficiency and increasingly difficult quality challenges. Within this context our clinical strategy remains focused on delivering our vision of ‘improved lives and optimistic futures for people affected by mental health and substance misuse problems’ and the six objectives that support this.</p>

Our clinical strategy has a number of inter-related strands that can be summarised as follows:

- Promoting and delivering quality and performance agendas, including:
 - **Quality Account** - The eight quality improvement priorities for 2013/14 identified in our Quality Account. We have retained the over-arching themes of our previous year Quality Account improvement priorities, but identified new 'stretch' improvement measures against each priority. Improvement measures have been developed in consultation with key stakeholders including staff, service users, governors, commissioners and other partner organisations. Our Quality Improvement Priorities are as follows:
 - **Priority 1:** Psychological Therapies – Improving Access and Outcomes
 - **Priority 2:** Listening to and Learning from Service User Feedback
 - **Priority 3:** Recovery
 - **Priority 4:** Carers - Improving Identification, Involvement and Engagement
 - **Priority 5:** Enhancing the Quality of Life of People with Dementia
 - **Priority 6:** Physical Health
 - **Priority 7:** Physical Environment and Sustainability
 - **Priority 8:** Dual Diagnosis – Improving our Responsiveness to Individuals with Problematic Substance Misuse and Mental Illness
 - **CQUIN** (Commissioning for Quality and Innovation) – delivering both our general mental health and specialist commissioning schemes. We have successfully achieved all CQUIN targets agreed over the last 3 years and used this income to support non-recurrent service developments.
 - **Care Quality Commission** – Continuing to monitor compliance with essential standards of quality and safety
 - **Delivering Contractual Key Performance Indicators (KPIs)**
 - **Data quality** – delivering improvements in data quality. We will be taking the following actions to deliver improvements in data quality in 2013/14 and onwards:
 - Developing an internal audit programme and undertaking regular audits and accuracy checks in line with Information Governance Toolkit requirements
 - Continuing to use the Trust-wide Performance Measures and Data Quality Group as a forum where data quality issues can be discussed and resolved
 - Liaising with, and providing training for, operational teams to drive improvements in data quality across all services
- Delivering continuous improvements by acting on patient experience feedback – this is identified as a key improvement priority for 2013/14 in our Quality Account. We will be looking to introduce different approaches to gathering service user feedback including, new technologies, service user-led initiatives and opportunities for more real-time feedback
- Promoting recovery through education –development of a Recovery, Health and Wellbeing Academy as described above
- Responding to tender opportunities (new and existing business)

- Delivering the financial plan – this includes delivering all planned efficiencies and using non-recurrent resources wisely to reduce revenue spend or increase income. We have consistently delivered our cost improvement programmes (CIPs) over the last five years and have constructive ‘buy-in’ from our clinical and corporate service leaders as to how future years’ planned efficiencies can similarly be achieved. Corporate services have been responsible for delivering a larger share of our efficiency savings over the last 3 years.
- Developing new strategic partnerships
- Strengthening existing relationships
- Reviewing and improving existing clinical services – see Appendix 1 to this strategic plan
- Proactive workforce planning, development and management – see Clinical Workforce Strategy below
- Strengthening our infrastructure:
 - Transition to/implementation of our new clinical information system – to ensure that our clinical information system best meets our needs, and delivers value for money, we have recently concluded a complex re-procurement process. The outcome of this process is a move to Civica’s Paris information system during the lifetime of this plan. Paris offers the best functionality, adaptability and cost and will enable us to operate and compete more effectively in the current challenging environment.
 - Review and expansion of pharmacy services in line with recommendations of pharmacy review – demands on our current pharmacy at Prestwich are increasing and facilities require improvement to ensure they remain fit for purpose. £450k has been identified to support this development in 2013/14.
 - Development of Trust-wide data warehouse and business intelligence solution - benefits of this development will include more timely reporting; improved data quality; triangulation of information between currently disparate systems; development of more robust performance reporting and monitoring mechanisms; and opportunity for more real-time reporting through the provision of local data dashboards. £300k has been identified to support this development.

Specific, key development plans for individual clinical service lines are summarised in the strategic development section of Appendix 1 to this Strategic Plan. Our development plans have been informed by:

- Analysis of the relevant markets and competition
- Intelligence or approaches from commissioners
- Assessment of our capability and capacity
- Robust risk analysis
- Benchmarking data, where available
- Assessment of financial viability

Clinical Workforce Strategy:

	<p>Our clinical workforce strategy is linked to our 5-year Strategic Workforce Plan. An annual workforce plan is also produced that is linked to the annual business planning cycle. All clinical directorates produce their own individual workforce plan which then forms the basis of the Trust's annual plan.</p> <p>The key service developments that are driving the key clinical workforce changes are:</p> <ul style="list-style-type: none"> • The development of RAID-type psychiatric liaison services across district services • The development of single points of access and new pathways of care in both District and Specialist services • The continued development of Memory Assessment Treatment services and dementia services • The on-going development of substance misuse services in response to service growth and commissioner expectations • The on-going development of community-based provision and a reducing bed base in District services <p>To support the above developments the following key clinical workforce developments are in place:</p> <ul style="list-style-type: none"> • The development of advanced and assistant practitioner roles to support the expansion of more specialist skills in non-medical roles e.g. non-medical prescribing • Additional Support Time and Recovery Workers based within the community supporting, for example, the development of Memory Assessment Services • Expansion of Foundation Year 2 doctors to support core service delivery
<p>Productivity & Efficiency</p>	<p>In terms of efficiency gains, we are working to the 4% efficiency target and have based our plans on a current reduction in costs of circa £5million per annum. Please see Appendices 1 and 2 of this Strategic Plan for further detail.</p> <p>Bank and agency spend will be monitored as part of our monthly budgetary control processes.</p> <p>CIP Governance:</p> <p>Our cost improvement schemes/targets have been developed as part of the Annual Business planning cycle, budget setting and financial planning processes. The CIPs have been developed at a strategic level after discussion with the Directorates and, where required, with Commissioners and other stakeholders. The Directorate Senior Management Teams (SMT, including Clinicians) and the Clinical leadership development group meetings have been involved in the CIP development process.</p> <p>We are planning to deliver CIPs of £5m in 2013-14 to 2015-16, in line with the 4% efficiency target, required by the Everyone Counts Planning Framework.</p> <p>Benchmarking information has been used to determine savings opportunities, along with review of existing service provision, rationalisation of services and service redesign.</p> <p>Plans are being developed for future years' CIP requirements and risks have been identified due to the impact on our services of being required to deliver cumulative</p>

	<p>savings whilst also continuing to deliver quality improvements.</p> <p>In order to address this, we are investigating ways of delivering Trust-wide CIPs, rather than Directorate-specific schemes, from 2015-16. This will involve potential rationalisation of sites, services and service delivery models.</p> <p>CIP Profile: See Appendix 2 of this Strategic Plan for an overview of our key CIP schemes for delivery over the lifetime of this plan. Our financial risk assessment in Appendix 1 assesses risks associated with our ability to deliver these savings and outlines actions, and monitoring procedures, to mitigate these risks.</p> <p>CIP Enablers:</p> <p>Our CIP for 2013-14 has been devolved to the Directorates as part of their annual budget. The CIP plan for 2013-14 will be monitored monthly, and routinely reported to the Executive Management Team and the Board of Directors. The CIP schemes have been RAG rated for risk to delivery and a CIP risk reserve has been identified as a contingency in case there is slippage on implementation of schemes.</p> <p>The Director of Finance and IM&T will oversee the delivery of CIPs as part of the financial performance of the Directorate budgets. Assistance where necessary, will be given to Directorates to enable CIPs to be achieved, without compromising quality.</p> <p>Quality Impact of CIPs:</p> <p>The Director of Nursing and Operations and the Medical Director have reviewed the CIP schemes and have evaluated the risks and impact on service delivery and quality. No concerns have been identified regarding the quality of service delivery and continuity.</p> <p>The CIP plan for 2013-14 will be monitored monthly, and routinely reported to the Executive Management Team; any concerns regarding the service delivery or quality of services are reviewed at these meetings, and addressed immediately to mitigate any potential risks.</p>
<p>Financial & Investment Strategy</p>	<p>Our financial outlook for 2013/14 – 2015/16 can be summarised as follows:</p> <ul style="list-style-type: none"> • We have a strong record of delivering on our performance and financial duties since inception and we are confident that we will continue to do so in the future. • This Strategic Plan has been developed in light of the challenging economic backdrop and a clear expectation that the funding provided to the National Health Service will need to be supplemented by making efficiencies to deal with the rising demand from an ageing population and the increased costs of new technology. • The main assumptions supporting the financial plan are based on the guidance in the Everyone Counts Planning Document 2013-14 (Section 3 Planning Assumptions) and the 2013/14 Payment by Results (PbR) Guidance. The national efficiency requirements of 4% and the reduction in tariff process of 1.3% have been factored into the 2013/14 plan. For 2014/15 and 2015/16 the efficiency challenge of circa 4% has been included with associated tariff reductions of - 1.3%. • The financial impact of Mental Health (MH) PbR for 2013/14 will be neutral. However, we have identified a number of risks, which are dependent on the future rollout and implementation plans for MH PbR. • The recent changes in the commissioning landscape with the change from PCTs to CCGs (Clinical Commissioning Groups), will provide a significant amount of

	<p>uncertainty and risk for the Trust in the forthcoming planning period/s.</p> <ul style="list-style-type: none">• With regard to drug and alcohol services, we have included a number of risks in 2013/14 as a result of services being subject to tendering processes and migration of services to Local Authorities. <p>We plan to deliver a higher level of surplus for the next 3 years to support the capital programme and to achieve a financial risk rating of 4 for 2013/14 – 2015/16.</p>
--	---