Camden and Islington NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Camden & Islington NHS Foundation Trust

Operational Plan for y/e 31 March 2015 and 2016

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EXECUTIVE SUMMARY

Introduction

This document sets out Camden and Islington NHS Foundation Trust's (C&I's) 2 year operational plan for the planning period 2014-16. It builds on the 2013/14 plan and takes particular account of the requirements and expectations set out in the Annual Planning Guidance. Following the publication of the planning guidance in December 2013, the Trust has worked closely with respective commissioners on planning assumptions and financial settlements to agree the Heads of Terms Agreement by 28 February 2014.

The Trust will continue to further embed its 'Changing Lives' values and behaviour standards, co-created with staff and service users during 2012/13 and the Board of Directors has agreed 7 high level corporate objectives, which will be a focus for this planning period and are designed to keep the Board focused on the continued provision of high quality and safe care, innovative and integrated care solutions and organisational resilience. The Board of Directors will continue to pursue its strategic objectives of Excellence, Innovation and Growth and will continue to focus on activities which will prepare for any potential merger opportunities should they arise during this planning period to ensure the long term sustainability and development of the Trust.

The executive management team has worked collaboratively with our local partners to identify the short term challenges within the Local Health Economy (LHE) of Camden, Islington and the North Central London sector. These challenges are detailed in section A and draws attention to the complex health economy in north central London. In particular, the financial challenges faced by the LHE as well as the gaps and service development opportunities to improve and integrate pathways of care are highlighted. A number of other challenges and uncertainties faced by providers are highlighted in this section including: the Mental Health Tariff; Implementing Choice; the Better Care Fund and the new regulation and inspection requirements of the Care Quality Commission.

The Trust's Clinical and Quality Strategy is summarised in section B and is designed to ensure continuous quality improvement is embedded into the Trust's culture, delivering high quality and safe health and social services, which place

service users at the centre of everything we do. The recommendations and learning from the Francis Inquiry, Keogh review and the Berwick report are incorporated into this strategy with regular progress reports scrutinised by the Quality Committee and at Board meetings. A summary of the Trust's clinical and quality priorities are provided in this section under the three domains of Safety, Effectiveness and Experience.

The Trust has carefully considered and analysed its operational requirements and capacity issues for this planning period, which is detailed in section C. The drivers and assumptions that have informed the Trust's activity planning are set out, along with the Trust's assumptions regarding activity across all divisional services and care clusters. A summary of the key service developments agreed with commissioners for 14/15 and the Trust's key workforce assumptions are also provided.

C&I has successfully implemented a number of major transformational schemes resulting in unprecedented levels of productivity and efficiency over the last three to four years. We recognise the need to continue to deliver improved value for money whilst retaining our focus on improving quality and outcomes. Looking forward, our major cost improvement programmes for the next two years 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.

The Trust's financial plan is summarised in section E and confirms that C&I is able to navigate 2014/15 and 2015/16 without having to apply unduly onerous QIPP targets to its services and is able to maintain a continuity of service rating of 4, with headroom because of its strong liquidity. With regards the Trust's capital programme, the Trust's approach is to employ capital investment in such a way as to directly support and enhance service delivery, efficiency and the patient environment.

Introduction

This document sets out Camden and Islington NHS Foundation Trust's (C&I's) 2 year operational plan for the planning period 2014-16. It builds on the 2013/14 plan and takes particular account of the requirements and expectations set out in the 2014 Annual Planning Guidance.

C&I's vision, values and strategic aims

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 (page 9) that are categorised under the headings 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.

C&I's shared values – Changing Lives

Our shared values were developed in 2012/13 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, compliment 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 continue to be embedded throughout the organisation as part of our continuous drive and commitment to a values-led culture. This work is now well established and referred to as 'Changing Lives'.

Our promises to service users and each other

Our strategic aims

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 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, together with the learning and recommendations of the Keogh review and Berwick report are now embedded within our plans and strategies to ensure the care we provide is safe and of the highest quality.

C&I's Principal Objectives for 2014-16

The Board of Directors has agreed the following principal objectives for 2014/16:

C&I's Principal Objectives for 2014-16

- We will provide service users with the highest quality and safest care possible within existing resources using the latest research and best practice.
- We will design, recruit, manage, and develop the best possible workforce for the future within existing resources, one that is competent to deliver the highest possible quality of care to our service users, now and in the future.
- We will keep to budget as part of our long term financial plan, while delivering value for money and efficiencies.
- We will continue to develop in partnership with others, accessible, innovative new services, which will enable the Trust to continue to grow.
- We will develop an Estates Strategy which will enable us to progress our plans and vision for the Trust's usage of the St Pancras Hospital site.
- We will increase the effectiveness of the Board of Directors and Council of Governors through improved governance systems, greater transparency and a programme of engagement.
- We will work in partnership with commissioners and providers to enable new integrated solutions, which will meet the mental health needs of the population.

Looking forward – organisational resilience and sustainability

Through 2014-16 we look forward to working closely with our Local Health Economy (LHE) partners to develop future service provision with a 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.

C&I is confident that the operational plans set out in this document are both resilient and support the challenges and priorities of the LHE. The Trust will continue to focus on activities which will prepare for any potential merger opportunities should they arise during this planning period – whether as a direct result of trusts failing to achieve Foundation Trust status or otherwise.

OPERATIONAL PLAN

SECTION A:
THE SHORT TERM CHALLENGE

The executive management team has worked collaboratively with our local partners to identify the short term challenges within the local health economy of Camden, Islington and the North Central London sector. These are summarised below.

LOCAL SYSTEM CHALLENGE

C&I is situated in a complex health economy in north central London. There are three acute care providers within Camden and Islington, including two large teaching hospitals and three mental health Trusts serving five boroughs. The Clinical Commissioning Groups (CCGs) in boroughs to the north of the Trust have been in significant financial difficulty, the analysis has shown they spend significantly more than comparator boroughs on acute care, with poor primary care and low spend in mental health.

Barnet and Chase Farm Hospitals NHS Trust has been in significant financial difficulty for several years, and a merger with the Royal Free London NHS Foundation Trust has now been agreed. The community services are a patchwork of four providers across the five boroughs, with two of these providers mainly based in north west London.

The Camden and Islington health economies are well integrated between mental health services and social care and between community services and social care, however, there remains many gaps in pathways of care in the health system. Much of the system demand management and diversion strategies required, create opportunities for a mental health Trust in terms of both the treatment of mental ill health in areas which have not previously been served, such as within acute and primary care, as well as potentially leading system change, drawing from some of the mental health experience.

The local system, like all the NHS, is facing increasing quality and governance challenges, with reduced tolerance of quality failures, increased inspection and improved skill mix and staff levels. These bring financial challenges as well as increased rigor in quality governance.

Both CCGs are committed to significant work in integrating care across the system and Islington is a pioneer site. It is a risk that critical mental ill health components may not be recognised in the integrated care work. However, the pace of change may not be enough to deliver the system changes required to mitigate the rise in health demand due to population growth and aging population. If the system changes do not yield anticipated efficacies at an adequate pace, the financial impacts will also be felt by the Trust.

THE FINANCIAL CHALLENGE

The scale of the short term financial challenge has been recognised in the Monitor planning guidance which is reproduced below:

	2014/15	2015/16
Total affordability challenge	3.1%	6.6%
Provider efficiency	2.0%	2.5%
System efficiency	1.0%	2.0%
Remaining challenge	0.1%	2.1%

Funding for NHS Commissioners nationally will rise from £96bn to £100bn over the next two years. Clinical Commissioning Groups (CCGs) control £63bn of this in 2013/14. In 2014/15 the average allocation uplift for CCGs will be +2.54% and in 2015/16 +2.09%, raising the 2015/16 allocation to £66bn.

Although the London regional team does best, with a +3.07% uplift in 2014/15 and a +2.62% uplift in 2015/16, Camden CCG and Islington CCG receive growth in 2014/15 and 2015/16 of +2.14% and +1.7% respectively, which is 0.4% per annum worse than original planning assumptions. On the face of it, the remaining challenge rises to 0.5% in 2014/15 and 2.5% in 2015/16.

2015/16 is a particularly critical year because of the relatively low uplift to CCG allocations, the impact of the Better Care Fund and the pressure felt on the provider side from increased pension costs, ICT investments and the Keogh and Francis agendas. Issues local to Camden CCG and Islington CCG have been the very strong growth in funding directed to the large local teaching hospitals, which may intensify in 2015/16 due to any funding required to support the merger of the Royal Free London NHS Foundation Trust with Barnet and Chase Farm Hospitals NHS Trust.

C&I suffered three years of negative cash and real terms funding reductions from its commissioners prior to 2013/14, when positive cash growth was again agreed, although not sufficient for the Trust to avoid a real terms funding reduction.

Indications for 2014/15 are that the Trust will be faced with a cash reduction of 0.3% (effectively "flat cash"), leaving it to make 4% efficiencies (a mix of provider and system efficiencies), with 2.3% inflation and 1.4% demographic growth being commissioner funded. An internal cost improvement programme has been developed to meet this.

Although both CCGs receive "minimum growth", this is better than Trust's original prudent planning assumptions, and represents reasonable growth when the scale of the two CCGs' current year underspends are accounted for. The local CCGs are committed to funding mental illness demographic growth at +1.4%, plus a range of positive full year effects from 2013/14 investments.

Position to date

Both Camden CCG and Islington CCG have offered C&I the 2013/14 financial baseline:

• PLUS	1.4% demographic growth
• PLUS	2.3% inflation
• LESS	-4% provider efficiency
• LESS	-1% extra commissioner QIPP
TOTAL	-1.3% (note that this is 1.3% worse than the offer to acute Trusts, before any QIPP activity targets)

However, the CCGs have offered a range of development schemes, full year effects of previous developments and incentives which move the Trust back to a flat cash position. Commissioners have committed to continue with this flat cash funding until 2015/16.

Substantial progress has been made in agreeing Mental Health payment systems, with the Memorandum of Understanding working in London in 2013/14 being extended and refined into 2014/15, with a shadow system in operation, with a movement to full cluster payments envisaged for 2015/16.

Local Authority Operating Context

Local Authorities are also facing a challenging financial outlook. Reductions in central government funding are expected to continue until at least 2017/18. Camden Local Authority, for example, is projecting a cumulative total savings

requirement of up to £163m between 2011/12 and 2017/18, from a 2014/15 budget of £857.9m. In terms of social services expenditure, there will be a significant impact from the 2013 Care Bill with a cap on care costs being introduced from 2016.

The current agreement is that there will be no funding reductions in 2014/15 which affect the Trust's delegated services under the Section 75 agreements with Camden and Islington Local Authorities. Budget reductions in 2015/16 are not finalised, and it's unclear what the impact will be.

The Trust is currently discussing with Local Authorities how integrated care solutions will be delivered in the area of primary care at a locality level. Both of our local Health and Wellbeing Boards have indicated that they will want to use the Better Care Fund to deliver integrated mental health services at locality primary care level.

Mental Health Tariff

So that there is a shared understanding of mental health tariff systems, C&I has signed a memorandum of understanding (MoU) with London CCGs, Commissioning Support Units (CSUs) and London Boroughs for 2014/15, with the intention that it will be reviewed and renegotiated, as appropriate, in December 2014 for contract negotiations for the financial year 2015/16.

All parties are working together to reach agreement on notional prices and activities so that 2014/15 can be operated as a 'shadow' tariff year, with the implementation of cluster-based commissioning for 2015/16, and with some form of risk share arrangement, subject to any overriding rules laid down by Monitor.
Contracts for 2014/15 relating to MH Tariff activity will be operated on a shadow basis. In the shadow year they will be stated either as a price per cluster per CCG (contract based prices) or as a single price per cluster for the Trust (single Trust prices). C&I will calculate prices based on its reference costs produced following national costing requirements, and will share and agree with the Commissioners, overriding principles for the division of costs between Tariff and non-Tariff services. C&I and Commissioners will agree separate contracting arrangements and prices for services that are excluded from the MH Tariff, where there will be

no change to the existing contracting arrangements for non-MH Tariff activity, unless previously agreed by all parties or directed by national policy.
The Commissioners will be open and explicit about services within the care pathways contracted from other providers and the impact of these services on the cluster prices and work with public health to understand the relationship between local demographic need and services provided.

C&I will supply the Commissioners with activity and price information on the basis of clusters within the MH Tariff based services and ensure that the key steps in the pathway process (assessment, cluster, review, (re-cluster), and discharge) are transparent and that cluster review intervals are applied properly. We will also agree with the Commissioners appropriate data quality improvement measures. We will also incorporate outcome reports as they are developed and mandated nationally and incorporate any additional reports that may be agreed locally.

Areas of mental health care that are currently excluded from the currency / care clusters will be dealt with under separate local block contract arrangements. For C&I these include:

- Discrete IAPT services
- Specialised addiction services
- Specialised Psychological Therapies – admitted patients and specialised out-patients
- Liaison psychiatry

SERVICE DELIVERY CHALLENGES AND OPPORTUNITIES

The Trust is actively engaged in discussions with commissioners to plan and take forward a number of service development priorities over the next two to five years. These are informed by, and respond to, the NHS Mandate and local Joint Strategic Needs Assessments. As mentioned above, the local system has identified gaps and opportunities for further care pathway development. The LHE priority areas for the next two years are briefly outlined below and are consistent with C&I's corporate principal objectives for this period. The key developments are summarised below:

Integrated mental health and physical health in the acute hospital

We are working with UCLPartners and the acute trusts to reduce the waiting times for assessment at A&Es for people experiencing a mental health crisis and to improve the quality of the experience. The integrated mental health and physical health model seeks to respond to the demand for urgent assessments in a timely manner working alongside the physicians where required, and to reduce duplication in assessment processes to deliver outcomes of the assessment more quickly. We are working with a neighbouring mental health trust to improve flows to their services following assessment in A&E.

The model also seeks to proactively diagnose depression and dementia in people on inpatient wards in the acute hospital. Diagnosis of dementia is variable and many people are not diagnosed. Frail people are more like to stay in hospital longer if suffering from dementia, which is unrecognised and more likely to be transferred to a nursing home rather than return home. Early diagnosis can improve outcomes for this group of people and provide savings for the LHE.

One in three people with Chronic Obstructive Pulmonary Disease (COPD), chronic heart disease and diabetes suffer from depression. Most of this is undiagnosed. If untreated this results in longer lengths of stay, relapse and further presentations to hospital due to poor self-care, non-compliance with treatment and early mortality for these people. The model seeks to provide education to key clinicians in the acute hospital and provide proactive early diagnosis and intervention. The service will also identify people with medically unexplained symptoms and refer to the IAPT service for these repeat attenders at the acute hospital to provide psychological intervention.

We are working with three acute trusts which requires significant enhancement of our current services in those trusts to provide 24 hour, seven day a week emergency services and the case finding approach.

Enhanced primary care provision to general practitioners

We will develop and implement a multi-disciplinary approach and primary care model to support GPs in managing service users with sub threshold for secondary care treatment mental health needs such as complex depression, anxiety, post-traumatic stress disorder, personality disorder and chaotic alcohol use.

Prior to full scale deployment of a Primary Care Mental Health Service, C&I proposes to undertake a one year trial to develop the evidence base to support the benefits of the service. The benefits would look at both financial and experiential measures including service user satisfaction, but in particular the trial will examine the following:

- **Savings achieved through reduction in the number of referrals to secondary care mental health service;**

Currently patients who are seen in psychological services need to be referred to secondary care assessment services to see a doctor. An integrated team approach would mean that these referrals are avoided. Advice and discussion with GPs currently prevents 25-30 referrals per week. We estimate there would be an increase in the avoidable referrals with this model as 75% of people seen in the assessment service do not require further intervention but are given advice and signposting to non-statutory services or other agencies.

- **Improvements in GP and primary care worker satisfaction;**

GPs currently see patients repeatedly who have personality difficulties or poor coping strategies without being able to provide containment or change their patterns of service usage. These same patients are often using A&E repeatedly and the integrated systemic management approach could prevent unhelpful and excess service usage and chaos.

The approach would enable patients who require a more coordinated proactive approach to be discharged from secondary mental health services; and who would relapse if discharged just to GPs. This will enable secondary care to concentrate on those with high need and prevent deterioration and relapse that might lead to use of crisis services or inpatient stays.

It is proposed that the team comprises a full time psychiatrist, three nurses, two psychologists, a social worker, service manager and administrator. The team would work within a single locality (12-15 GP Practices).

Improving access to services

Currently, following assessment within 10 days (for 95%) of people there can be a wait for specialist interventions due to inadequate capacity in services to meet the needs of the population. This has resulted in waiting lists. The national mental

health strategy argues for parity of esteem for mental health care and physical health care. Waiting lists are not acceptable and lead to potential deterioration before treatment is provided. Whilst we can manage immediate risks, we are negotiating funding to decrease waiting lists and provide earlier treatment by increasing capacity of our teams to provided treatment for complex depression, anxiety and trauma.

Physical Healthcare

We are working with the Whittington hospital to look at earlier smoking interventions and smoke free care. Forty two per cent (42%) of tobacco consumption in England is by people with mental health problems. The impact on mortality rates for people with schizophrenia and personality disorder is that on average they die 18 years prematurely. Physical health screening, diagnosis and intervention are required to reduce this premature mortality. There is a pilot project in Islington to do this with a community matron linked to mental health services. There is a smoking cessation service working across primary care and mental health services in Camden to provide assertive treatment and prevention. We are piloting physical health liaison clinics into the Highgate Mental Health Centre in order to intervene more quickly in the deteriorating patient and prevent deterioration and transfer to A&E. There is a national CQUIN for physical health. In London we have had incremental physical health CQUINs and smoking cessation CQUINs for some years now.

Demand and capacity

The Trust will continue to use productivity methods to work with clinicians and teams to identify the time required to implement the interventions they need to deliver for the patients using their services. This aims to prioritise face to face clinical work and reduce the time for other activities including administration. This leads to a sense of less pressure for staff and a method of allocating tasks to and managing activity. In turn, this enables a better understanding of demand and capacity for teams. The teams that have engaged in this work have found that staff satisfaction and the sense of pressure has reduced, patients are receiving the interventions identified according to their need based care plans and there is either opportunity for savings or an increase in the activity or intensity of interventions, where this may prevent an admission to hospital.

Implementing Choice in mental health

From 1st April 2014 service users will have the right to choose any clinically appropriate health service provider (whether a NHS mental health trust, a Foundation Trust or a mental health provider in the independent or voluntary sector) for the first outpatient appointment with a consultant or a consultant led team (or a health care professional or a team led by such a professional), as long as the provider has a contract with any CCG or with NHS England for the service required.

The challenges for C&I in the next two years will be to deliver systems for choose and book that connect to our current booking systems. The quality of service, including GP responsiveness, communication and patient experience will be paramount in increasing activity and becoming the provider of choice. Currently the assessment and advice team have improved their productivity to be able to assess 95% of patients referred within 10 days. Sustaining this performance and providing advice to GPs by phone to prevent unnecessary referrals will be a priority for the service and may require additional capacity in order to meet this standard. If the team does not manage to achieve this, this will lead to referrals for care to other providers.

C&I is further developing plans to offer choice of clinician for assessment. Where patients do not wish to see a certain clinician or consultant we already make arrangements for their care to transfer internally. The other services that will need to meet these challenges are the memory clinics, which will need to increase capacity to be able to meet increase demand. Demand has already exceeded commissioned capacity and we have successfully negotiated with commissioners to increase teams to meet this demand. We have high current detection of dementia in Islington at 78% and 56% in Camden. Barnet has a high prevalence of dementia and it's possible that we could attract referrals for dementia diagnosis and care from South Barnet.

We have a very high incidence of psychosis in Islington, second in London at 57.2 per 100K population and 49.4 per 100K in Camden. The range of incidence in London is 23.2 to 59 per 100K. Increase in referrals from neighbouring Hackney, Haringey, or Westminster who also have high incidence would require an increase

in team capacity to manage prompt and intensive assessment packages and ongoing care. A proportion of these people being assessed would require other packages of care and therefore may lead to referrals to other services for personality disorder, complex depression and anxiety and trauma. Invariably any increase in referrals for psychosis will require increased crisis and inpatient capacity. This will be a challenge due to the reduction in beds in the previous 6 years and the current high occupancy. However we plan to reduce use of long-term inpatient rehabilitation over 2 years with increased community rehabilitation in both boroughs, which may lead to increased space in inpatient units which may be able to deliver the increased need through choice if required. We also aim for 85% occupancy across the inpatient system.

The challenge will be to retain quality and responsiveness of service, and to respond quickly to increased demand so that this does not deteriorate and then lead to choice of competitors as providers.

Better Care Fund

The implementation of the Better Care Fund (BCF) in C&I will be underpinned by the Trust's long history and strong partnerships with local authorities and commissioners. BCF plans have been agreed by each local Health and Wellbeing Board, and the discussions with the Trust have been reflected in the submissions by the Health and Wellbeing Boards at a general level. The challenge for C&I will be to continue to work with partners to deliver transformational change in the local health and social care system, particularly in the area of integrated care. The main service development areas for the Trust, such as enhanced primary care provision to general practitioners and integrated mental health and physical health in the acute hospital will require funding to be allocated to these areas from budgets such as the BCF, and will require strong and enduring support from commissioners, primary care, acute hospitals and the Local Authority. In this context, the Trust will require a strong profile, clear proposition management, and strong relationships and governance structures with local partners. A challenge will be to retain a clear focus on outcomes for patients, and identify QIPP with strong mechanisms to count benefits achieved across organisations in the local health economy. Although the Trust has a good track record in delivering transformational change, the level of change across different partners that is required is exceptional, and will require exceptional levels of organisation and

commitment by health and social care leaders. The Trust will be a strong partner in this change process, and has excellent links with local organisations such as the integrated care Board in Islington and the Mental Health Partnership Review Group in Camden, which will help to formulate and agree cross organisational solutions.

The new Care Quality Commission Inspection Regime

C&I has been selected by the Care Quality Commission (CQC) for a full trust-wide inspection in the first quarter of 2014. Inevitably, this will have an impact on the resources of the Trust, and will require significant investment of time to ensure the inspection team is provided with all relevant information and support.

The new regulation and inspection regime requirements of the CQC, which were expected following the announcement of their transformed approach last Autumn, will present some challenge in terms of capacity to prepare for the inspection, as well as to work with the inspection team throughout their visit and then to respond rapidly to the action to reduce any risk of quality issue which is raised, following the quality and risk summit. The Trust's internal quality assurance processes have been carefully designed to meet the risk based approach to the quality standards, through strong performance monitoring of intelligence and information, the use of internal shadow reviews against the CQC's essential standards and stringent action plans to address identified weaknesses or hot spots.

We are preparing thoroughly for the management of the inspection, fully aware that the judgements applied to it, will produce the commission's rating of our services. We are mindful of the rating's impact on our reputation and on commissioning behaviour. Our mobilisation plan dedicates resources to run an effective programme, drawing on dedicated compliance officers and practice development support. We have adopted a stringent quality review group to prepare for the inspections, which is monitoring the action arising from the CQC's care pathway inspection of the Trust last summer, as well as other CQC inspections we have experienced. Where action is behind expectation or we judge that additional support is required, we use a rapid improvement methodology.

Against our internal monitoring using the above processes and systems we are optimistic that we know where our quality concerns lie and that we have appropriate action plans in place to address these, led by operational and corporate managers working in tandem.

SECTION B:
QUALITY PLANS

The Trust's Clinical and Quality Strategy and Quality Account reflects the national priorities as set out in the NHS Mandate 2014/15 and the priorities for essential change in mental health as set out in the recent Department of Health publication 'Closing the Gap'.

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 C&I's 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, driven by our co-created values and is fully embedded and aligned with divisional plans, team plans, individual objectives and delivered through an established performance management framework.

During the course of 2013, the board of directors considered the recommendations and themes of the Francis Inquiry, Keogh review, and the Berwick report into patient safety. This included a joint Board of Director and Council of Governor seminar specifically on the Francis recommendations. Associated action plans have been approved and are monitored by the Quality Committee with regular updates provided to the Board. The learning from these important inquiries and reviews is 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 and we intend to support our staff to improve service user outcomes even further. Through the Trust's clinical and quality strategy together with the 'Changing Lives' programme, we will continue our work to further embed a culture and climate that promotes positive attitudes

and behaviours and an excellent experience for everyone. The key aims of our clinical and quality strategy are set out below:

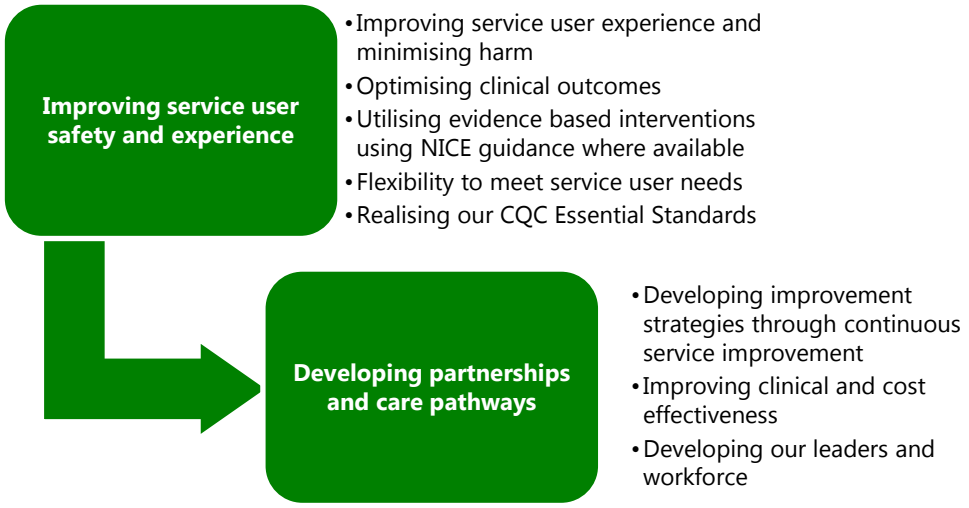
Our clinical and quality strategy aims to:

- 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.

An overview of C&I's clinical services and plans 2014-2016

In refreshing our clinical and quality strategy, we 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). 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 2014-2016.

The key principles which underpin the divisional clinical strategies are illustrated below:



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 and mental health services have 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'. 1 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 our operational services around the service user journey – or their care pathway. We provide a number of integrated health and social care pathways within each division. The implementation of care pathways will improve the quality of mental health services by focusing attention 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 continue to work closely with social care services, primary care and acute hospital services to further develop this approach.

Recent service changes – responding to feedback and the evidence base

In the last three 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.

[1] Department of Health Mental Health Clustering Booklet (V3.0) 2013/14

- 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. 70% of people being assessed do not require a further service. 25 to 30 phone calls a week by GPs to the lead consultant for advice and discussion do not result in further referral.
- Responsiveness to non-urgent referral. Assessment and advice team now see 95% of referrals within 10 days.
- Clear understanding of the evidence base for effective treatments will lead to fewer people receiving interventions that do not improve outcomes.
- Care Packages for MH tariff are now defined and agreed with GPs and CCGs.
- 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 and 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 experience[2].
- 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.

[2] 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 satisfaction[3]
- 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. The primary care SMI register shows Islington as having highest prevalence for schizophrenia in London and Camden the third highest.
- 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 caseloads[4].
- 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.[5]
- 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.

[3] Nelson, T, Johnson S and Bebbiington, P (2009) Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health teams

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

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

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.
- For non-psychotic disorders there are very clear NICE guidelines for interventions that are proven to work. These form the basis of the agreed care packages. Ongoing training is required to ensure that staff have the skills and knowledge to deliver the interventions in their service for the needs of their patient group.
- 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 considers the skills and expertise required in each division and ensures 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 teams[6]. 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.

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

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.
- Working with the teams to understand the interventions they need to deliver, how long they take, the levels of activity required and to prioritise face to face clinical work, has led to a management system of being able to allocate work. Staff are more productive and feel less stressed and more in control.
- Patients are receiving and increased level of intervention as set out by their care plans.

INTELLEGENT USE OF INFORMATION & DATA TO PLAN SERVICES

- We have carried out an analysis of our caseload data and diagnosis using the Mental Health Clustering tool to identify the care packages that we need to deliver.
- We are in the process of working with teams on productivity and identifying the time required for activities and allocating the right time for the number of activities they have. This means that staff spend more time on clinical interventions and patients are receiving the interventions with the frequency determined by their need.
- We have used incidence and prevalence data for disorders in order to identify the likely capacity required of services. This has led to a case for increasing the capacity in early intervention services for psychosis, increase in services for complex depression and identification of services specific for neurodevelopmental disorder.
- We are working with UCLPartners and our commissioners to develop sets of value based outcomes for psychosis and depression and anxiety and dementia and frailty.
- We are working with commissioners in Camden to improve transition into service for adolescents and becoming involved in earlier prevention.
- We are working with the acute trusts to develop enhanced integrated models of mental health and physical health to proactively identify the 1 in 3 people with diabetes, chronic heart disease and COPD who have increased mortality rates and longer lengths of stay due to depression.
- We are also working with the acute trusts to increase dementia awareness and to increase diagnosis of dementia in frail populations to reduce lengths of stay and treat more people at home and reduce transfers to nursing homes.
- We are working with the community providers to provide integrated solutions for mental health and physical health for frail populations.

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 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;
- We have introduced a new Quality Assurance Framework which allows quality assurance processes to be determined, maintained, measured, monitored, reported and continually improved. This includes:
    - An integrated quality assurance dashboard;
    - An internal inspection programme led by internal developmental inspectors;
    - Rapid improvement teams who will provide short term intervention and support to services identified as requiring urgent improvement.
- The Quality Committee reviews each domain of the Monitor Quality Governance Framework annually and provides assurance on this to the Board of Directors as part of the Annual Governance Statement.

Board Assurance Framework key quality risks

As part of the Trust's Board Assurance Framework, a number of high level quality-related risks have been identified. Each of these risks is 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 provide service users with the highest quality and safest care possible within existing resources using the latest research and best practice.	Risk that high staff vacancies in divisions' impacts negatively on delivery of patient outcomes and quality improvements to expected timeframe.	3	4	12	Paul Calaminus
	Risk that failure to develop and implement divisional service plans which embed a co-ordinated, recovery focused, integrated, tariff 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.	3	4	12	Paul Calaminus

	Risk that if productive methods of working are not effectively implemented, do not focus sufficiently on achieving outcomes and are not properly supported by a well-developed dashboard, quality and safety of care are affected.	4	4	16	Paul Calaminus
	Risk that pressure and demand on acute beds impacts negatively on the quality of care.	5	4	20	Paul Calaminus
	Risk that failure to meet fundamental standards for acceptable levels of care leads to service user safety failure.	2	5	10	Claire Johnston
	Risk of clinical and patient safety risks, missed information, and potentially serious incidents as a result of the Trust not having a common computerised information system which covers all aspects of its services. (The RiO system does not link in real time to the two psychology systems, nor with local authority systems and there is no common patient master index.	3	5	15	Paul Calaminus / Dave Wragg
	Risk that failure of the system to be able to recognise, identify and carry out corrective action plans where standards are not being met leads to reduced standards of care for patients	3	4	12	Claire Johnston
PRINCIPAL OBJECTIVE 2	**HIGH LEVEL RISKS**	**L**	**C**	**SCORE**	**DIRECTOR LEAD**
We will design, recruit, manage and develop the best possible workforce for the future, one that is competent to deliver the highest possible quality of care to our service users now and in the future.	Risk that failure to build and sustain a culture of candour, compassion and safe practice leads to regulatory action.	3	4	12	Claire Johnston
	Risk that non-compliance with mandatory training for all Trust staff could result in staff or service user injury, poor quality of clinical care and financial claims.	3	4	12	Claire Johnston
	Risk that weak clinical and operational management results in failure to deliver the high quality and safe care.	3	4	12	Claire Johnston
	Risk to patient safety and poor quality care results from a lack of trust and confidence by staff in raising concerns.	3	4	12	Claire Johnston
	Risk that staff not having skills and competencies that are needed results in failure to deliver interventions that work.	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 provides 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. Disclosure and Barring Service 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 commitment to safeguarding children, young people and adults at risk. A corporate statement is included in new and updated policies and job descriptions. These 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

The Trust registers all of its services under two main locations

- St Pancras Hospital; and
- Highgate Mental Health Centre.

All Trust services are then listed as subsidiaries of either of these two locations for which we are registered to provide a number of regulated activities.

As at the end of 2013/14, eleven Trust services have been reviewed as part of the CQC formal Compliance Inspection programme; the CQC carried out an inspection of the trust's services in Camden across a care pathway. The new model of inspection was used, which involves desk top scrutiny, front line visits and interviews with staff and service users. The team of nine inspectors between them visited the following services:

- North and South Camden Crisis Resolution Teams
- Clozapine Clinic at the Hoo;
- Medication clinic at the Peckwater Centre;
- North and South Camden Recovery teams;
- Assessment service;
- Wards at the Huntley Centre; and
- Community team of the Service for Ageing and Mental Health.

The Trust has implemented a robust action plan to ensure compliance with every element of each outcome that has led to the two moderate concerns associated with two standards (Outcome 2: Consent to Care and Outcome 4: Care and Welfare of People who use services). This is being monitored jointly with divisional managers at a weekly Quality Review Group, which is chaired by the, Executive Director of Nursing & People.

In addition to a Camden Care Pathway inspection, which saw 9 discrete services inspected the commission also undertook two further compliance inspections of the Camden Specialist Alcohol Service and Stacey Street nursing home. The CQC provided extremely positive assessment reports and found us compliant with all quality standards at Camden Specialist Alcohol Service. There is one moderate

concern in regards to a service provided at Stacey Street, but the CQC found positive improvement in 5 of the 6 essential standards including 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), which during the last CQC inspection in February 2013 had been judged to be non-compliant. This demonstrates that the action plan which was implemented to ensure compliance by 20th May 2013 has been achieved.

Notwithstanding the positive improvements, the draft report indicates areas of non-compliance in regards to Outcome 9: Medicines Management. An action plan has been implemented to ensure compliance by 31st May 2014. The specific actions being taken are detailed in an action plan which has been reviewed and signed off by Trust's Quality Review Group, which includes senior C&I staff and local commissioners.

The Quality Committee has an important role in overseeing the response to CQC inspections and monitoring progress against associated action plans and to provide assurance to the Board.

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 2014/15 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; and
- Smoking cessation.

The Trust has a wide range of clinical and quality priorities set out in its Clinical Strategy, Quality Account and CQUIN plan and the Trust has also implemented an Outcomes Framework for each of the five divisions with each division having a service improvement plan and a clinical audit plan in place.

A summary of our key priorities which are linked to the quality domains of safety, effectiveness and experience are provided below:

Clinical/Quality goals	Key actions required	Risks to delivery	Key milestones 2014-2016
SAFETY			
Reduce the level of violence and aggression on inpatient units (Quality Account)	Implement the Safewards programme and associated interventions Review plans for Trust wide implementation at the Acute Care Forum	The programme does not result in a reduction of violence and aggression	January 2014 Implemented Safewards on Rosewood at Huntley Centre Phased rollout will be completed by 2016
To achieve an improvement on 2013/14 rates of reporting incidents and publish figures monthly. (Quality Account)	Engaging staff at team level through the circulation of educational material and attendance at team meetings in order to promote a better reporting culture. Trust's incident reporting system upgraded to enable more robust reporting, and enhanced control and restraint Datix modules. Redesigned online incident reporting forms. This new form will ensure that the system is more robust and efficient at gathering incident data whilst at the	Staff not using system to record all incidents Technical faults with the online system	Publish monthly incident data via Division Performance Publish control and restraint data monthly to allow services to make reasonable adjustments to service provision to meet people's needs (for example transfer to a psychiatric intensive care unit) can be considered in a timely manner.

	same time supporting operational services to effectively manage and track incidents. Guidance developed for staff on how to complete incident forms and for managers and specialists to sign-off incident reports.		
Improve the physical health of our service users (Quality Account)	Implement a 'track and trace system in accordance with NICE guidelines. Introduce a 'Modified Early Warning System' (MEWS). Improve physical health diagnoses in hospital & community settings.	Poor training provision and take up. Absence of practice development nurse for Acute division who has been leading this work	80% of staff on each ward to be trained.
Publish Ratio of qualified staff to patients is a good marker across all three domains. (Francis Rec)	In light of the Francis Report findings and in being transparent the Trust should publish ratio of qualified staff to patients as this is a good marker of all three of the governance domains covered by the Quality Accounts.	Lack of consistency or problems in maintaining a systematic approach results in this information not being published.	Published Ratio of qualified staff to patients from 1st April 2014
Define and implement optimum ward staffing levels (Francis Rec/Quality Account)	Review of skill mix and staff ratios; Publish ratio of qualified staff to patients	The review of skill mix and staff ratios recommends optimum staffing levels in excess of current funded establishments	Review of staffing levels to take place by June 2014

Clinical/Quality priorities	Key actions required	Risks to delivery	Key milestones 2014-2016
EFFECTIVENESS			
Recovery-orientated practice - clinical services working collaboratively with service users in setting meaningful goals to promote recovery, increase the quality of life and reduce possible relapse. (CQUIN)	Completion of a quality audit of recovery-orientated practice in the Trust using The Quality Indicator for Rehabilitative Care (QuIRC) ; Audit of care plans to provide assurance that care plans show evidence of collaborative planning of care between service user and clinician and contain at least two personal recovery goals. Facilitating a patient experience forum to provide the opportunity for the Trust to gain rich and useful feedback from Service Users.		Completion of a quality audit of recovery-orientated practice in the Trust; using QuIRC across all Inpatient and Community Rehab services in Q2 and Q4 2014/15 Key themes which emerge from the group to be summarised and published on Trust website detailing actions the Trust is taking to improve its quality of services and the experience of users.
To achieve an improvement in the number of people who are moving to recovery in Trust IAPT services (Quality Account)	Actively investigate all reduction in recovery rates Monitor average number of treatment sessions and to offer extra follow-up sessions for those discharged to ensure that recovery has continued	Failure to achieve the recovery rates.	Review position and progress quarterly
To achieve an improvement in the Average length of stay for PICU (Quality Account)	Monitor PICU average length of stay for inpatient care spells to ensure that there is effective provision of care across inpatient and community-based services. Benchmark PICU models of care	Failure to achieve a reduced length of stay and an increasing use of private PICU beds Adult acute bed pressures resulting in patients remaining in a PICU bed longer than is clinically required.	Implement RAG rated Zoning system by April 2014
To develop and implement a Recovery College model (Clinical Strategy)	To produce a Trust model for the Recovery College.	Failure to identify suitable premises Failure to develop effective links with educational providers.	To implement and begin courses during Q3 2014/15

Clinical/Quality priorities	Key actions required	Risks to delivery	Key milestones 2014-2016
EXPERIENCE			
Increase the scores and ratings from the Friends & Family Test and Staff Survey to within the national average. (Quality Account)	Regular staff surveys; Improved communication and engagement; Focused work-programme of the Staff & Service User Experience Board sub-committee	Failure to achieve the positive improvements.	Re- Launch monthly staff morale surveys by July 2014
Increase the amount of feedback being received from patients and carers to enable staff to be able to reflect on their practice based on direct feedback from patients. To support the triangulation of data – in order to highlight more quickly any Service with compromised levels of quality (Quality Account)	Implement the Meridian Real Time Patient Experience and Clinical Audit Tool Rationalise the survey work that is currently being undertaken into a standardised approach across the Trust. To reduce the manual inputting and analysis that current Patient Experience (PE) and Clinical Audit (CA) programme incurs Triangulate data – in order to highlight more quickly any Service with compromised levels of quality Embed the internal Quality Assurance Framework	Feedback from service users and carers does not result in changes to service delivery or practice.	Develop implementation project plan for go live on 1st June 2014 Promote continuous reflection and improvement on practice through regular patient feedback mechanisms Consolidate the use of the Friends and Family Test in services across the organisation Introduce a patient and carer feedback and reporting system (including the NHS Friends and Family Test) across the organisation, enabling staff to receive regular commentary on their service from an end user perspective.
Friends and Family Test – Implementation of staff FFT (CQUIN)	Implementation of staff FFT as per guidance, according to the national timetable	None identified	Trust to demonstrate to commissioners that staff FFT has been delivered across all staff groups as outlined in guidance
Thematic review of responses via focus groups asking if carers felt supported by C&I(Q4) (Quality Account)	Facilitate focus groups with carers to understand how the Trust could better support carers, and what support they feel they need. The Trust also want	Feedback from carers does not result in changes to service delivery or practice.	The Trust will hold focus groups with different carer groups, such as young carers, carers from black and minority ethnic (BME) communities, carers of older adults and people with learning

	to assess what information carers want, and if they have the information to access services in a crisis.		disabilities, and carers supporting someone accessing community recovery services. The key themes which emerge from the focus groups will be summarised and published on Trust website detailing actions the Trust is taking to improve its quality of services and the experience of carers.

Clinical workforce plans

The Divisional services, Human Resources (HR) and Finance will work together to finalise the medium-term workforce plans for the next two years. The plans will take into account the QIPP plans, new business and any Organisational Development and workforce issues each Division and the Trust as a whole may be facing over the next 2 years. The plans help identify priorities for the coming years in order to support the Trust to recruit, retain, manage, develop and design the best possible workforce, one that is competent to deliver the highest possible quality of care.

It should be noted that these workforce plans are dynamic documents, which are reviewed and updated as appropriate to reflect changes in services. Moreover, in keeping with the HR Business Partnering model that is used in the Trust, it is recognised that workforce planning is oftentimes undertaken on a slightly shorter cycle in response to changing organisational or commercial expectations.

Strategically, however, and in broad outline, the workforce priorities for the next two years at C&I include:

- Recruiting to vacancies (singly and as part of larger recruitment exercises in the divisions) as quickly as possible and in accordance with the HR Key Performance Indicators that form part of the corporate performance framework, whilst ensuring a high quality workforce is attracted through values-based recruitment and the wider use of subtler selection instruments such as assessment centres;
- Acknowledging and addressing the difficulties within inner London and in the mental health sector with recruiting qualified nurses and Occupational Therapists (OTs) through a focus on C&I's employer brand and the more

regular use of assessment centres. On a practical level, this will involve promoting the Trust as a place to work that potential applicants actively choose and also building the relationship with the universities and the Local Education and Training Board (LETB now NECL HEL(L)) to manage the issues longer term. In recent recruitment cycles the Trust has advertised for nursing posts within national and local newspapers as well as on NHS Jobs;

- Embedding the Trusts new Recruitment Policy, revised in July 2013, so that every job has both an assessment and an interview as part of the competency based selection process;
- Embedding the Trust values by using 'Values Based' recruitment to ensure that the successful candidate will uphold the values of the Trust;
- Actively addressing the areas within the 2013 staff survey where improvement is required, which will include working with colleagues in Estates & Facilities looking at the provision of hot water in the Trust to address concerns around hand washing and exploring in far greater detail, through proper engagement with staff, the matters concerning violence, bullying and discrimination that are flagged in broad outline therein. This will be the work of the Staff Survey Action Group, which from 2014 will report directly to the Service User & Staff Experience Committee, a crucial sub-group of the Board that is chaired by the Senior Independent Director. This is a significant recognition of the impact that staff, who feel well supported and cared about, as well as being performance focused, then in turn have on patient experience;
- Effective implementation of the 'Friends and Family Test' to ensure that we are monitoring staff and Service User experience effectively and actively using this data to inform work on staff engagement, enhancing morale and delivering the best possible quality of care;
- Meeting the requirements in regards to 'Total Reward Statements' as per recent guidelines so that all NHS employees will receive a summary notifying them of the benefits they are currently in receipt of including pensions. The Trust is scheduled to produce their Total Reward Statements in October 2014;
- Working with senior management in divisions and corporate directorates to manage sickness absence; identifying underlying causes and working to

reduce absence rates, particularly in inpatient areas, in line with the Trust's target of less than 3%;

- Ensuring that all staff are regularly trained and confident in carrying out therapeutic management of violence and aggression particularly within inpatient areas;
- Working with senior managers in divisions and corporate directorates to reduce bank and agency use with no diminution of quality of care with the aim of improving continuity of care and service user experience. It is anticipated that as we reduce our vacancy rate we will no longer require Bank and Agency use at current levels. This will be done in a considered manner to ensure patient safety;
- Continuing to support the Trust to manage employee relation issues effectively through robust policy, partnership working and dedicated training and coaching of line managers. To work with local authority HR teams to expand the scope of training and support available to Trust managers who manage staff working across organisations and within integrated care models;
- Engaging in a partnership approach with senior service managers and other corporate directorates (crucially Finance) in order to support effective organisation design to deliver the services that are required to a high quality but with a clear commitment to cost effectiveness. This approach is consistent with our productivity analysis programme to increase face to face clinical time;
- Altering the skill mix as determined as part of the efficiency programme, with a clear recognition that C&I has very effectively incorporated an expanded support workforce to compliment the excellence and ability of the professional groups that we employ – and that C&I's commitment to ensuring that these staff are appropriately inducted and trained before taking up their roles in the workplace reflects the sorts of recommendations in this area that were subsequently seen in both the Cavendish and Berwick reports;
- Within services where we have completed productivity assessment projects in 2013/14, support delivery of sustained productivity gains by supporting workforce review and re-profiling and ensuring that changes are managed effectively and in consultation with staff.

Organisational Development

In respect to organisational development (OD) in the Trust, the following deliverables will be at the forefront of our work:

- Work to incorporate seamlessly into the very warp and weft of the organisation our Changing Lives values including the amendment of the Appraisal Policy to include assessment against Trust Values;
- Provide appropriate organisational development interventions around care pathways in projects identified in partnership with senior management in service divisions and corporate directorates;
- Provide appropriate organisational development interventions in support of productivity activity undertaken in the Trust by managers, staff and acknowledged external partners; and
- Work with all five service divisions to draft and deliver a local OD action plan to support the seamless and effective embedding of the Trust's model of care into everyday practice across the whole organisation.

Moreover, the Trust's organisational resilience will be enhanced through our work in regard to the staff survey, staff engagement (with the launch of a substantially revised strategy in this area), and our on-going commitment to the "professionalisation of management", which involves management and leadership development opportunities for all, including the Band 6 Leadership Development Programme, our First Line Manager Programme (for all ward managers and team leaders at Band 7) and a new development programme called "Quality Every Day" (QED). The latter will support our managers to think positively about the impact and practice of good quality care through the prism of clinical leadership and active innovation.

In relation to the Trust's important partnership with Camden and Islington Local Authorities, the Trust is refreshing its partnership approach using a London wide Section 75 Quality Assurance Framework. One of the quality assurance domains will be workforce development, and the Trust will improve its social work workforce strategy through this project.

SECTION C:
OPERATIONAL REQUIREMENTS AND CAPACITY

The Trust's current service profile comprises 273 inpatient beds, of which 159 are acute inpatient beds. This includes 26 crisis beds and 12 male Psychiatric Intensive Care Unit (PICU) beds. In addition, approximately 2,300 bed days have been outsourced to the private sector annually including female PICU, which we do not provide in C&I. The remaining are adult acute admissions and male PICU as a result in fluctuations in demand at points during the year. Other than flexibility afforded by private sector placements, the Trust does not envisage significant change in the acute bed space demand in 2014/15. However, in 2015/16, we are planning to substitute beds for older adults with increased community services and we will reduce the number of inpatient rehabilitation beds through the move on of more patients through the accommodation pathway.

Drivers and assumptions informing activity planning

The demographic, macroeconomic and local health economy trends apparent in the boroughs of Camden and Islington are summarised for the respective services in the Table below. The net effect of the factors is applied to the 2013/14 activity volumes to provide the forecast activity for the full years 14/15 and 15/16.

Services & Care Clusters	Demographic growth	Specific service targets	Population need changes	Changes in commissioning as a result of LHE	Choice in MH	Net Effect
Acute (in-patient) 5-8, 15 & 19-21 Acute (non-inpatient services)	Forecast annual growth of 0.7% p.a.		No forecast impact in 14/15 & 15/16	No forecast impact in 14/15 & 15/16	Negligible impact in 14/15 & 15/16	0.7% p.a.
Substance Misuse & Forensic Non-clustered	Forecast growth of 0.7% p.a.		Likely detectable impact	Possible impact in 14/15 & 15/16	Possible impact in 14/15 & 15/16	1.0% p.a.

Services & Care Clusters	Demographic growth	Specific service targets	Population need changes	Changes in commissioning as a result of LHE	Choice in MH	Net Effect
IAPT/iCOPE – Community 1-4 (but do not cluster)	Forecast growth of 0.7% p.a.	Refreshed model, effect on target & commissioned population indicates mixed effect	Likely detectable impact	Likely detectable impact	Possible impact in 14/15 & 15/16	1.3% p.a.
Rehabilitation & Recovery 11-13	Forecast growth of 0.7% p.a.		Possible impact in 14/15 & 15/16	Possible impact in 14/15 & 15/16	Possible impact in 14/15 & 15/16	0.9% p.a.
Rehabilitation & Recovery (Psychosis outreach) 10, 16 & 17	Forecast growth of 0.7% p.a.		No forecast impact in 14/15 & 15/16	No forecast impact in 14/15 & 15/16	Possible impact in 14/15 & 15/16	0.8% p.a.
Services for Ageing & Mental Health Mixed but predominately 4-7, 11 & 10-21	Forecast growth of 3% p.a.	c5%; Widened public awareness is contributing to increased detection & diagnosis	No forecast impact in 14/15 & 15/16	Likely detectable impact	Possible impact in 14/15 & 15/16	8.5% p.a.
Community MH (Non-psychosis service, including the Assessment & Advice Team – non- clustered) 5-7	Forecast growth of 0.7% p.a.		Likely detectable impact	Likely detectable impact	Possible impact in 14/15 & 15/16	1.3% p.a.
Non-contracted activity	Forecast growth of 0.7% p.a.		Likely detectable impact	Likely detectable impact	Possible impact in 14/15 & 15/16	1.2% p.a.

Current and forward planning activity assumptions

Based on the analysis above, C&I''s best estimate of activity over the next two years is provided below set against the divisional services and related care clusters:

Services	Activity Information	Care Clusters	2013/14[7] Activity[8]	2014/15 Activity	2015/16 Activity	Comments
Acute	Bed days (incl PICU)	5-8, 14, 15 & 19-21	64,496	64,490	64,490	Current bed capacity fully used. No new capacity planned.
	Clusters in year		13,701	13,790	13,880	
Substance Misuse & Forensic	Contacts	Non-clustered	3,333	3,360	3,390	
IAPT/iCOPE – Community	Contacts	1-4 (but do not cluster)	66,900	67,700	68,500	
Rehabilitation & Recovery (R&R)	Clusters in year	11-13	10,740	10,830	10,920	
Rehabilitation & Recovery (Psychosis outreach)	Clusters in year	10, 16 & 17	2,154	2,170	2,180	
Services for Ageing & Mental Health	Clusters in year	4-7, 11 & 18-21	8,235	8,930	9,680	
	Assessment Contacts		1,381	1,490	1,610	
Community MH (Non-psychosis service) Assessment & Advice Contacts apportioned across other Services)	Clusters in year	5-7	13,208	13,380	13,550	
	Assessment Contacts		4,781	4,840	4,900	
	IAPT Contacts			Leave Blank	Leave Blank	Activity TBA

[7] The 11-Month from PLICS has been uplifted to 12-months by adding 1/11th of the sum of months 1 to 11.

[8] P99 (Un-clustered) and P00 have been apportioned, pro-rata, into the clusters on the respective service line.

Services	Activity Information	Care Clusters	2013/14[7] Activity[8]	2014/15 Activity	2015/16 Activity	Comments
Non-contracted activity (active episodes)	Contacts	Non-clustered	153,709	155,550	157,410	

Service developments

For this planning period, the Trust has attracted support and planned investment from local commissioners for a number of service developments, which will further increase quality and service user experience; benefit the LHE; and enhance both the effectiveness and efficiency of systems of care delivery. These developments together with other local reconfiguration schemes are detailed below.

Additional service capacity will be found from more efficient working and productivity measures. These will include a planned reduction in the number of community sites, and through smarter working methods and reduced travelling time, this will lead to increased productivity per staff member. This is now underpinned by improving activity recording and capacity utilisation. To deal with the expected increase in activity in some of the divisions and care clusters, we will use our productivity work to either achieve greater outputs for each member of staff and/or to enable the redistribution of resources in order to meet demand.

A summary of the planned service developments and associated workforce changes over the next 2 years are summarised below:

Service development	How this will improve quality and benefit the LHE	Income	Direct Cost	Risks	Resourcing requirements (workforce & estates)
Locality based enhanced primary care provision to GPs (1 year pilot proposal for Camden and Islington Boroughs)	This model will provide improved holistic care and improve access and capacity within primary care to increase confidence in managing mental ill health within primary care and improve the effectiveness and efficiency of the local healthcare system.	£700k in 14/15	£504k in 14/15	Model doesn't work, or pilot is not extended or funded recurrently Staff in unfunded posts	9 WTE in 14/15 Staff will be co-located within GP practices. 6 staff will be new posts, 3 from redeployment

New contract mobilisation for South Barnet Primary Care provision to GPs	As above for the residents of South Barnet	£250k in 14/15	£197k 14/15		3 WTE Staff will be co-located within GP practices
Waiting list schemes	These schemes will target waiting times in 4 specific service areas and will improve access, quality and experience of care and lead to better outcomes.	£925k in 14/15	£667k 14/15	There is a risk that targets are missed and that planned costs are understated	8 WTE in 14/15
New Dementia Navigator Service in Islington	Ongoing support and care management for those with Dementia so that people are better able to access other parts of the health service	£135k 14/15 £180k 15/16	£97k 14/15 £130k 15/16	Minimal risks involved in delivering service	4 WTE

Only the direct costs are shown in the table above. The trust, in calculating the pricing for services, also includes overheads at the rate of 36% for contracts where estates costs are not included within direct costs and 24% where they are known and included in direct costs. The overhead costs are in addition to the direct costs shown in the table above.

The Trust aims to generate a contribution to overheads of £0.7M in 2014/15 from primary care provision and to this end will be bidding for funding of £1.4M from CCGs. We would expect further savings from budgets in 2015/16 if the schemes are successful, as the requirement for community clinical staff ought to fall.

The costs of the waiting list schemes represent an escalation of £250K to £300K in 2014/15 compared to 2013/14. We aim to manage the impact of this cost escalation against plan by developing robust plans for delivery of primary care enhancements, at least cost, through delivery of sound waiting list targets, through contributions to overheads from better integration of liaison psychiatry at the three local acute Trusts, and emerging bids for improved early intervention, perinatal and dementia services.

Workforce assumptions

The Trust budgeted FTE posts are detailed in the table below:

Staff Group	Budgeted FTE posts (February 2014)
Additional Professional Scientific and Technical	189.48
Additional Clinical Services	386.11
Administrative and Management	304.10
Allied Health Professionals	50.61
Estates and Ancillary	5.00
Medical	124.17
Nursing and Midwifery Registered	491.95
Local Authority seconded staff	166.22
Other	6
Total	**1723.64**

The Trust currently has a thirteen percent (13%) vacancy factor and as explained in the clinical workforce plans section, the Trust is working to fill the vacancies and is using bank, locum and agency staff where required to ensure patient safety and high quality care is maintained. It is anticipated that 2% of the budgeted FTE posts will form part of the Trust QIPP plans. The narrative below explains in further detail the known changes to the workforce and the current recruitment. The known changes that the Trust will see in the workforce in the next 2 years include:

- Reduction of 42.46 FTE posts in 14/15 due to the loss of the Pentonville contract, and the 30.64 FTE staff will be TUPE transferring to the new providers on 1 May 2014;
- Increase of 16.81 FTE posts (of which 3 are vacant) in 14/15 due to Pharmacy staff TUPE transferring in from the Whittington to the Trust on 1 April 2014;
- Increase of 21 FTE posts in 14/15 as outlined in the service development table;
- As part of the QIPP plans the budgets will be adjusted to reflect posts that will not be required in the upcoming period and this will reduce the vacancy rate (based upon the budgeted FTE minus the actual FTE). It is anticipated that the Trust will see a 2% reduction in budgeted staffing

levels in both 14/15 and 15/16 whilst the actual permanent staff in post will see increases in order to fill vacancies. As outlined in the LETB education commissioning return there will be an increase in nursing levels in order to fill vacancies but once this is complete the staffing levels will remain relatively stable depending on future changes to services such as new business.;

- Increase in permanent nursing levels across the Trust through targeted recruitment campaigns;
- It is anticipated that by filling the vacancies and altering the skill mix the Trust will have less need for bank and agency use and will therefore see savings. From the 1 May 2014, the Trust will no longer have the bank and agency costs associated with Pentonville due to the Service being moved to new providers (an average of 14.12 FTE per month.
- The following posts are currently in different stages of the recruitment cycle as at March 2014:

Staff Group	FTE
Additional Clinical Services	49.4
Additional Professional Scientific and Technical	10.6
Administrative and Management	17.2
Allied Health Professionals	1.4
Nursing and Midwifery Registered	29.8
Total	**108.4**

Risk Analysis

An analysis of the risks associated with activity and demand and planned service developments are considered below:

Risk Area	Commentary	Mitigation
Move to tariff based contract	There are risks associated with currency activity and prices which are not yet accurate.	Memorandum of Understanding with price guarantee; Funding for 1 extra female PICU bed; plus 1.4% extra growth funding agreed, and funding for waiting list pressures.
Incentive schemes	C&I has the opportunity to earn additional revenue through CCG incentive schemes. The value of C&I's incentive schemes is £925,000 in 2014/15. There is a risk of not	C&I has a good track record of delivering against incentive scheme targets.

	achieving the full value of these schemes.	
Implementation of Choice in Mental Health	C&I will need to deliver systems for choose & book that connect to our current booking systems, are responsive to GPs, are timely, offer choice of clinician for assessment and provide a positive experience for service users. Failure to deliver and sustain this may result in referrals for care to other providers.	Our assessment services have demonstrated increased productivity. Choice of clinician is already an established practice for service users who do not wish to see a certain clinician or consultant.
Service developments	The Trust has developed plans with commissioners to take forward service developments including some pilot schemes. There is a risk that the pilot schemes such as the Primary Care Mental Health pilot may not be successful or funded recurrently.	The Trust has provided robust business development proposals and evidenced based models of care that provide an opportunity to realise significant efficiencies for the LHE and system improvements that will increase quality and experience of care.
St Pancras Hospital site development	The practicalities of re-developing the SPH site, while remaining in occupation of significant areas and buildings. The development and assured delivery of the SPH site decant plan is a risk for this planning period. Getting collective agreement and synergy from potential multiple stakeholders.	These risks are addressed through clear decision making responsibilities and structures with comprehensive project management and governance systems.

SECTION D:
PRODUCTIVITY, EFFICIENCY AND COST IMPROVEMENT PROGRAMMES

C&I has successfully implemented a number of major transformational schemes resulting in unprecedented levels of productivity and efficiency over the last three to four years. We recognise the need to continue to deliver improved value for money whilst retaining our focus on improving quality and outcomes.

Looking forward, our plans for the next two years 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 and other productivity tools to build further capacity to embed 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 E rostering 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;
- The other priority is the C&I Clinical & Patient Portal which has a number of key objectives:
    - Facilitates longitudinal care pathways involving multiple organisations within the care community;
    - Supports an approach that puts the service user/patient at the centre of their own care and provides a patient sub-portal providing access, and input, into key elements of their care (i.e. care plans, medications etc);
    - Supports Trust working outside geographical boundaries, extending service reach;

  - Provides fallback contingency of patient information access during EPR migration.
- Further expand mobile and flexible working linked to changing Estate locations and operational and service priorities;
- Further deploy electronic information sharing with GP's to new practices and areas;
- Improved scope and analysis of data, reporting and dashboards;
- 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 due to administration of 2E2 UK Ltd.

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 and £5m in 2013/14. Combined, this level of savings equates to circa 18% 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.

In the 2013/14 financial year, CIP delivery has been ahead of requirements. Both community and in-patient schemes have delivered above plan savings. The current financial year has required fewer transformational savings than previously, due to the NHS "normal" 4% level of CIP required, and significant full year effects from 2012/13 contributing to scheme delivery. The Project Management Office has been run down in size to an extent, with corporate projects targeted towards mental health payment system improvement and developing options for the future shape of St Pancras Hospital. Delegated CIP schemes in clinical services have been 100% achieved, and shortfalls on Estates and Corporate areas have been well within headroom.

CIP governance will be delivered through an approach embedded at service level, 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. A revised version of this framework has been recently approved by the Board (January 2014), and it reflects continued development of the divisional 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 where the scheme justifies this level of investment. 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 Foundation Trust Executive (FTE) Committee, which doubles as the CIP Board, and to the Board of Directors and Finance Committee. Progress to the Foundation Trust Executive Management 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 and received large reductions in funding, followed by a more stable year of flat cash in 2013/14, we had initially expected 2014/15 and 2015/16 to present the Trust with particularly severe challenges and pressures. We expected that these pressures would return in future years following the introduction of new payments systems and AQP (Any Qualified Provider) which will provide greater transparency of pricing and benchmarking between providers.

Because our two local CCGs have for 2014/15 opted to pay the Trust for past and expected demographic growth (at +1.4% of allocation), have invested recurrently in a number of service improvement schemes, and are actively partnering with C&I to develop mental health services in primary care, integrated A&E liaison

emergency care and innovative ways of deploying Better Care Funding, the income position represents one that is somewhat better than "flat cash". Our real level of CIP requirement will be around 4%, with some full year effects of previous years' CIP and recurring CIP headroom reducing the scale of front line financial pressure.

2015/16 is also likely to be a "flat cash" year, as commissioners pursue similar commissioning intentions to 2014/15.

CIP Profile

The CIP programme for 2014/16 builds on the plans achieved in previous years. 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. Thirteen per cent (13%) 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 Trust's CIP schemes fall into three broad categories. The first is continuing to exploit the productivity improvements available as a result of the substantial reorganisation of clinical services implemented in 2012/13 by using quite simple work study techniques to improve the ratio of service attendances per member of staff, supported by new rostering information systems. A second set of schemes are focused on improving the efficiency of the estate by improving space utilisation and working with key partners to achieve cost reductions in estates and facilities. The final set are clinically led and are transformational in nature, focusing as they do on realising the benefits of new clinical pathways.

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 Foundation Trust Executive 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.

Our Cost Improvement Plans

The Trust's major specific CIP schemes for 2014/15 are set out below:

1.	**Scheme description**	Using productivity tools to increase community teams' and crisis teams' efficiency		
	How the scheme will reduce costs	Increasing number of contacts per team member enables staffing reductions, better management of patients and fewer unnecessary admissions to hospital		
	Total savings £m(full year)	£1,350K	2014/15	£950K
			2015/16	£1,350K
	Key measure of quality for the scheme	Increasing the number of community contacts per service user and per member of staff		
	Executive Director Lead	Paul Calaminus, Chief Operating Officer		

2.	**Scheme description**	Effective movement of patients through the secure accommodation pathway		
	How the scheme will reduce costs	NHS England hold funding for a budget underspending recurrently in the Trust		
	Total savings £ (Full year value)	£800K	2014/15	£800K
			2015/16	£0
	Key measure of quality for the scheme	NHS England maintains volume, quality and appropriateness of placements		
	Executive Director Lead	Paul Calaminus, Chief Operating Officer		

3.	**Scheme description**	Community Mental Health & Substance Misuse staffing and skill mix review		
	How the scheme will reduce costs	Allow posts vacant to be made recurrently so		
	Total savings £ (Full year value)	£699K	2014/15	£699K
			2015/16	£0
	Key measure of quality for the scheme	Ensuring teams are adequately reviewed and monitored for presence of key skills and staff numbers		
	Executive Director Lead	Paul Calaminus, Chief Operating Officer		

4.	**Scheme description**	Corporate Efficiency Schemes (e.g. Finance, ICT, Estates, HR core teams and contracts, including facilities management and occupational health)		
	How the scheme will reduce costs	Benchmarking and reviewing back office services to ensure service model is economical, cost effective and high quality		
	Total savings £ (Full year value)	£980K	2014/15	£875K
			2015/16	£980K
	Key measure of quality for the scheme	Maintenance of service quality and response times whilst removing significant costs		
	Executive Director Lead	David Wragg, Director of Finance		

5.	**Scheme description**	Energy Management		
	How the scheme will reduce costs	Use of CCS frameworks contract for electricity and gas, plus active monitoring of usage		
	Total savings £m	£260K	2014/15	£218K
			2015/16	£260K
	Key measure of quality for the scheme	Appropriately lit and heated premises, with ability to recharge other users of our sites accurately.		
	Executive Director Lead	David Wragg, Director of Finance		

SECTION E:
FINANCIAL PLAN

The Trust is able to navigate 2014/15 and 2015/16 without having to apply unduly onerous QIPP targets to its services, as the table below demonstrates. The Trust is also able to maintain a continuity of service rating of 4, with headroom because of its strong liquidity:

	2013/14 £'000 Actual	2014/15 £'000 Plan	2015/16 £'000 Plan
Income	**136,886**	**132,149**	**130,002**
Pay	*-87,485*	*-85,320*	*-81,729*
Non-Pay	*-40,263*	*-36,790*	*-37,711*
Expenditure	**-127,748**	**-122,110**	**-119,440**
EBITDA	**9,138**	**10,039**	**10,562**
Depreciation	-4,124	-4,423	-4,813
Dividends	-2,440	-3,720	-3,853
Interest Paid	-6	-6	-6
Interest Rec	180	110	110
Profit on Sale	1,621	0	0
Normalised/Restructuring Costs	0	0	0
Normalised Surplus /(Deficit)	**4,369**	**2,000**	**2,000**
Impairments	0	-897	0
Normalised Surplus / (Deficit)	2,748	1,103	2,000
Indicitive Continuity of Service Risk Rating	**4**	**4**	**4**
EBITDA margin	6.68%	7.60%	8.12%
Planned CIP	4,900	4,000	6,000

Continuity of Service Risk Rating

The Trust will continue to maintain a top rating on the Continuity of Service (COS) Risk Rating. Liquidity days are planned to remain at more than 100 comfortably scoring a 4 (with the threshold of -2.0 days being when a 3 would be scored). The capital service ratio again scores a 4 but has less headroom within it, standing at 2.7 (the threshold for a 3 is 2.5). Overall, the Trust will score a 4.

Continuity of Service Risk Rating (CoSRR)						
	13/14		14/15		15/16	
	Plan	Rating	Plan	Rating	Plan	Rating
Liquidity (days)	94.3	4	91.2	4	89.75	4
Capital service capacity ratio (times)	3.81	4	2.72	4	2.77	4
Overall Rating		**4**		**4**		**4**

Moving from 2013/14 to 2014/15, the Trust in real terms has secured "flat cash" with the drop in income of circa £4m being primarily due to a £2.2m reduction from the withdrawal of funding for the Pentonville Prison Healthcare service, £0.5m from the DeNDroN R&D project funding costs being re-routed,£0.3m from the new direct billing arrangements from our facilities management provider to one of our tenants at St Pancras Hospital, and £1.2m due to reduced cohort funding on the education contract with Health Education England. The Trust will reduce its expenditure by a similar amount. The Trust therefore achieves its required £3.2m cost reduction (in addition to creating pay, non-pay and specific reserves for 2014/15 of £3.7m); by identifying a QIPP of £4.0m and letting its surplus fall by £0.8m on top of the removal of Pentonville costs.

In 2015/16 the Trust expects its downside case to involve a loss of income of £2.8m (before any service withdrawals). Inflation reserves of a further £2.8 will be needed, meaning a QIPP of around £5.6m in that year. A flat cash position envisaged by CCGs would reduce QIPP requirements by £1.0m, but has yet to be confirmed, and increased risks (see below) to 2015/16 make it prudent to model on the downside case.

The Trust will continue to maintain a contingency reserve of just over 1.5% (£2M) in both 2014/15 and 2015/16, which is set aside to cover the following risks:

- Income losses from new mental health payment systems (which may be material in 2015/16);
- The need to increase the size of the provision for doubtful debt (again more an issue in 2015/16, with mental health tariff and patient choice becoming more established); and
- Some uncertainty on the Learning and Development Agreement income.

Capital Programme

The Trust's approach is to employ capital investment in such a way as to directly support and enhance service delivery, efficiency and the patient environment. The Strategic direction is to continue to focus on reducing the estate footprint through consolidation and improved space utilisation.

Projects/Schemes	£000	£000
ICT	2014/15	2015/16
Hardware refresh schemes	188	188
Network components refresh	145	145
Servers and storage	108	108
EPR system/application	974	2,126
EPR hardware	200	-
Implementation	574	-
C&I Portal	145	95
Other projects	200	200
Sub-Total ICT	2,534	2,862
Estates		
St Pancras backlog and compliance works	2,341	1,250
St Pancras – Huntley Centre	1,500	2,000

Highgate backlog and compliance works	693	750
Community properties	1,616	1,100
Recovery College	250	
Sub-Total Estates	6,400	5,100
Total Capital Programme	**8,934**	**7,962**

The capital programme for both 2014/15 and 2015/16 are in excess of the level of 2013/14. The major reasons for this is the strategic investment in an electronic patient record system (EPR), to replace the Trust's current NPfIT supplied RiO system.

On the Estates side of the programme, capital is allocated to:

- Continued remedial works addressing significant backlog maintenance issues, particularly at St Pancras Hospital. Works are required to mechanical, electrical and water services to remove health and safety risks, ensure statutory compliance and service resilience pending commencement of redevelopment plans;
- Within St Pancras Hospital, the refurbishment of the Huntley Centre. This building accommodates in-patient services and significant refurbishment is required to address issues around both patient safety and providing a suitable environment for service user treatment and recovery;
- At Highgate Mental Health Unit, cyclical programmes of in-patient ward refurbishment and redecoration;
- The establishment of a 'Recovery College'; and
- Across the Trust's community estate, a number of smaller refurbishment projects to improve service user accommodation and or building service improvements such as replacement of ageing or efficient boilers.