Cornwall Partnership NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Cornwall Partnership NHS Foundation Trust

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

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Date	4 April 2014

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Vicky Wood

Signature Vicky Wood

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Phillip Confue

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Sally May

Signature SAM

1.2 Executive Summary

The trust has a strong history of successful service and financial delivery, holding a commitment to the provision of the best possible care to its service users. As a responsive organisation, the trust recognises the challenging financial environment within both the local and national health economy. This operational plan has therefore been prepared in this context, and reflects the trust's intentions of meeting these challenges whilst securing on-going service improvement.

Strategic context:

The trust is a full and active participant in the local health community, contributing to the development of service provision across organisational boundaries. The trust was a partner organisation in the application for Cornwall to become a Pioneer site, with a clear focus and determination to achieve greater integration of service delivery. Cornwall was successful in obtaining Pioneer Status, though detailed delivery plans have yet to be finalised.

Financial challenge:

The trust acknowledges the financial pressures within the NHS and wider public sector both locally and nationally. Working collaboratively with its commissioners, the trust is close to finalising contractual terms for 2014/15 in line with national guidance. Though contract signature timescales have not been achieved we continue to work with commissioners, and our planning assumptions are consistent with the negotiated positions. These however result in a financial challenge to the trust with efficiency savings of over 6% being required in order to maintain the trust's current risk position. The annual plan for 2014/15 recognises the delivery of a planned surplus of £0.493m, having delivered 6.42% (percentage of operating expenditure less PFI) of cost efficiencies.

The trust's cost improvement programme has been developed by service lines and is tough but deliverable. Plans have been developed to deliver consolidated 4.37% cost efficiencies (percentage of operating expenditure less PFI) over the two years from April 2014 to March 2016. This is consistent with planning assumptions issued by Monitor and NHS England.

CFT continues to work with NHS Kernow and the wider health economy to support the development of the "Living Well" programme. This programme will need to mitigate excess demand for services or redirect resources into priority areas. Our Children's services provides vital early intervention and care services. Driving forward Parity of esteem and the Crisis Care Concordat will also need to be addressed as Living Well plans develop.

Focus on quality:

The trust remains committed to the delivery of good quality services and has strong governance and planning systems in place to achieve this aim. The trust has enhanced its planning processes for the delivery of more efficient services through its Bridging the Gap programme, with an assessment of the impact upon quality being a key determinant in the decision to proceed or otherwise with developments.

Commissioner Requested Services:

Schedule 2 (Mandatory Goods and Services Schedule, part of the Trust's old Authorisation) has been replaced by 'commissioner requested services' (CRS). For the purposes of continuity, Monitor grandfathered all of the services which were covered under schedule 2 for FTs to become CRS on 1 April 2013. Commissioners have a period of 3 years from 1 April 2013 to consider if the services now grandfathered as CRS should remain so. For CFT, the commissioner requested services schedule within our standard contracts states that all services are CRS. It is expected that, over time, this original 1 April 2013 grandfathered list will be reduced to a core of CRS services following active designation by

commissioners (overriding the grandfathering in an incremental manner). CFT will continue to work with commissioners in taking forward the designation process.

1.3 Operational Plan

Strategic Position

Cornwall Partnership NHS Foundation Trust (CFT) is the principal provider of mental health, children's community and learning disability services to people living in Cornwall and the Isles of Scilly. The trust has a strong record in providing integrated health and social care services.

CFT remains the only foundation trust in Cornwall and the only foundation trust for mental health and learning disability services within the South West Peninsula. Within Cornwall, community health services are provided by a community interest company (CIC), Peninsula Community Health (PCH). The Royal Cornwall Hospitals NHS Trust (RCHT) is the principal provider of acute and specialist care services in the county of Cornwall and is aiming to become a Foundation Trust in the near future. Within the peninsula, Plymouth Community Health (a CIC) provides community, physical and mental healthcare for around 270,000 people in Plymouth as well as some specialist services for those living in Devon and Cornwall. Devon Partnership Trust (DPT) provides mental health and learning disability services in Devon and is also aiming to achieve foundation trust status. In addition there are a range of voluntary and private providers who are potential competitors in some areas of service delivery

NHS Kernow Clinical Commissioning Group is the main commissioner of health services for Cornwall and the Isles of Scilly. And is responsible for commissioning the majority of the services provided by the trust. The trust also provides psychiatric intensive care services to Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group. Cornwall Council has taken on an increased role in commissioning our services and is responsible for commissioning children's public health nursing. The Devon and Cornwall Area team of NHS England leads the commissioning of the health visiting and family nurse partnership elements of children's public health nursing services. The commissioning of our low secure service is the responsibility of NHS England's specialised services team.

The development of NHS Kernow's "Living Well" plans under the Integration Pioneer programme will drive change in the local health economy and present both opportunities and threats to CFT's strategic position. CFT is engaged in the development of this emerging strategy with our CEO sitting on the Penwith Pilot Living Well Project Board.

Forecast health, demographic, and demand changes

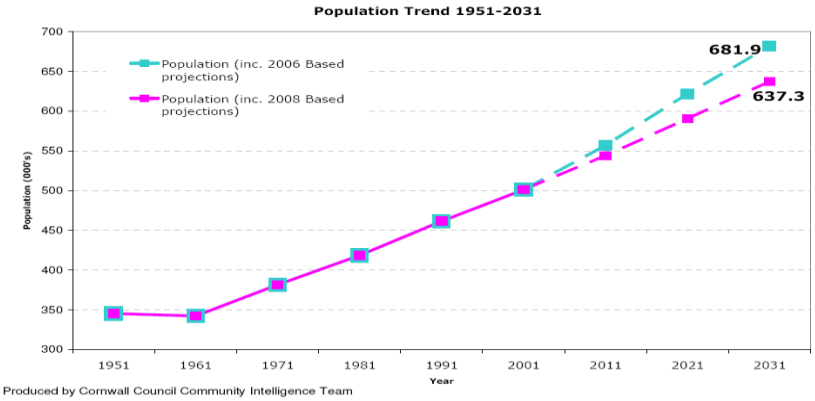


Figure 1: Population Trend 1951-2031

Source: 2008-based subnational population projections and Mid Year Population Estimates, Population Estimates Unit, ONS: Crown Copyright 2010.

Cornwall's population is estimated to reach 633,200 by 2030, an increase of 97,900 (18.3%). This growth is predicted to be driven by migration, largely due to more people moving into Cornwall but also, importantly, due to a decline in the number of people leaving the county. Contrary to common perceptions,

migration is predominantly persons of working age.

The population of Cornwall is gradually increasing and changing demographically. In line with national trends Cornwall's population is getting older as average life expectancy continues to rise. This has been bolstered by the cumulative effect of working age net migration over the last 30 years.

It is within the context of this strategic environment that the trust has developed its two year operational plan.

1.3.1 **The short term challenge**

The Local Health Economy (LHE) in Cornwall and the Isles of Scilly has demonstrable short- and longer-term challenges. In light of the challenges posed partners in the LHE came together to apply for the government's Integrated Pioneer Status in 2013. Partners were delighted to be successful in being one of 14 areas to achieve this status out of 111 applicants nationally.

The application for Pioneer Status highlighted the significant financial challenges describing how it has been demonstrated "that across health and social care the gap between what's needed and what's currently paid for is £31 million now and will be £23 million every year over the next four years. As such the trust is working closely with LHE partners to identify the most efficient way of delivering the care required by our population."

The demographics of Cornwall and the Isles of Scilly also pose particular challenges. Issues include;

- 10% of our population live in deprived communities
- 1 in 5 children live in poverty
- Over half our homes are not on mains gas and it costs more to stay warm and eat healthily
- A rising birth rate with babies surviving with more complex health conditions and increasing child obesity.
- Our 65+ population is more than the national average, expected to increase by 83% by 2031 and the number with a limiting long-term illness by 59%.
- For those 85+ we expect a 114% increase in the number with a limiting long term illness
- An estimated 9,089 people with dementia today will rise to 15,854
- Older people living alone or in care or ill or with a disability are more at risk of depression.
- People with long-term illnesses make up 80% of GP activity, 40% of out-patient activity and 80% of hospital in-patient bed days.

Pioneer status is intended to provide the framework whereby the ambition of all the partners in the health and social care sector to 'seize a once in a lifetime opportunity' to improve health and well being' can be achieved. The intent is for people to be at the centre of the care and support system, and for it to be constructed in a way which is sustainable in the economic environment and in light of the population changes ahead. The aim is to move towards care which is provided through multi professional teams, across the County and across organisational boundaries to support people at home, intervene quickly and appropriately when necessary, thus reducing reliance on traditional hospital facilities.

However, in the short term, there remains a significant financial challenge within the health community. NHS Kernow continues to develop its change programme but there remains significant uncertainty in the delivery of its financial objectives.

1.3.2 **Quality plans**

1.3.2.1 National and local commissioning priorities

KCCG have issued draft contracting intentions to the trust which remain subject to change. KCCG's Integrated Plan is treated as a living document and is constantly refreshed and updated as plans are further developed. The application of the negotiated contractual terms results in a significant efficiency challenge of 6.42% for CFT in 2014/15. Although this exceeds 5%, we believe that this is tough but deliverable whilst maintained patient safety and quality.

1.3.2.2 The Trust's quality goals

The trust has implemented an improved patient safety strategy, which had been approved by the board of directors. Our aim remains to provide a positive safety culture that encourages and supports innovation in practice and enhances clinical service delivery by empowered, competent and safety conscious front line staff. Our strategy incorporates the elements of the successful productive series, providing an evidence-based approach to delivering efficient and effective working across our in-patient and community settings.

The trust's board of directors will formally review progress against our patient safety performance indicators each March, so that we are assured that we are doing all we can to maintain and improve the safety of our patients. We are targeting improvements in five key areas:

- Medicines management
- Safe and reliable care delivery
- Safe management of medical devices
- Prevention of slips, trips and falls
- Infection prevention and control.

Our approach to clinical effectiveness builds from the relevant NICE quality outcomes and strengthens the use of clinical audit to allow us to interpret and understand the effectiveness of our care. Our revised approach to clinical audit has aided us in identifying key areas for improvement and to also demonstrate where an effective improvement to care has been made. We recognise that it is important to understand our performance and effectiveness in comparison with other providers and the trust's strategy promotes participation in national audits to enable us to better understand our comparative effectiveness and improve our responsiveness.

Our patient experience strategy was approved by the trust's board of directors in the previous financial year. The aim of this strategy is to develop a culture throughout the trust that places the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm. As a trust, we care deeply about the quality of the care that our service users, their carers' and families receive from us. Whilst we know and accept that we do not always get it right, implementation of this strategy, has enabled us to embark on a cycle of continual listening, learning and service improvement; working together with our patients and partners in care, to ensure that important feedback from experience is routinely captured, and put to use most effectively.

The trust has identified key priorities by service line, these being;

CHILDREN'S SERVICE LINE:

To monitor and improve the experience of children, young people and their families who are either

referred to the new Care Management Centre or contact us for information to ensure that it is patient-centred and is a positive experience.

Why a priority?

The central Care Management Centre will process all referrals to children's services and has been designed to provide a consistent, equitable and reliable process for all children's services referrals and enquiries across the county. This will ensure that there will be a timely and appropriate response to all referrers or enquiries identifying a pathway of care and ensuring that patients experience a positive response that is patient/customer centred.

What actions are we planning to improve our performance?

We will design a process to capture the experience of those who are either making a referral to the centre or those who contact it with a query, whether they are professionals, other agencies, children, families or carers.

How will improvement be measured and monitored?

We will:

- Refine the survey that has been developed in the previous year following feedback from users.
- Demonstrate how feedback has influenced the service provided by the Care Management Centre with quarterly updates that will be presented to the Children's Trust.
- Work with the independent sector to develop an innovative process to further engage with users of our services.
- Ensure this is based on 100 surveys of users.

How will progress be reported?

Progress will be reported to our Performance Improvement Monitoring Meeting and to the Quality and Governance Committee. Final reporting to Governors in the Quality Report.

INPATIENT SERVICE LINE

To continue the 2013/14 priority of ongoing monitoring of compliance in delivery of the care pathway for people with a personality disorder. This will allow the service line to embed the changes made and continue to monitor process as a focused piece of work.

Why a priority?

Improvement in this area would enable us to deliver more timely care and treatment that support the client both in and transition out of hospital and minimises lengthy stays as per NICE guidelines.

What actions are we planning to improve our performance?

a)Target 95% of referrals to PD service within 3 days of admission

b) Monitoring of key points of pathway

c) Continued training in personality disorder awareness and compliancy targets against this

How will progress be reported?

Progress will be reported to our Performance Improvement Monitoring Meeting and to the Quality and Governance Committee. Final reporting to Governors in the Quality Report.

LEARNING DISABILITIES

To implement a Communication Charter

Why a priority?

The Adult Learning Disability Service Lead Speech and Language Therapist has taken the lead in developing a multi-agency Communication Charter which was formally launched in October 2013.

This includes communication charter training for all of the Adult Learning Disability staff. The Service Line will also identify Communication Charter implementation outcomes which would be assessed to demonstrate evidence of improved communication with service users.

What actions are we planning to improve our performance?

a. 95% of all Adult Learning Disability staff will have undergone training in using the Communication Charter.

b. Monitor key improvements/outcomes in communication within the Learning Disability Service line.

How will progress be reported?

Progress will be reported to our Performance Improvement Monitoring Meeting and to the Quality and Governance Committee. Final reporting to Governors in the Quality Report.

COMPLEX CARE AND DEMENTIA

Identified through the CCD leadership team's scrutiny of health records and the opportunity to listen to the voices of carers in the process of public consultation, a quality priority is to enhance the experience of carers of people receiving services from CCD.

Background

The NICE Quality Standard for Dementia describes clearly in quality statement 6 (Appendix A) the level of service provision carers should expect from service providers. Similarly an explicit expectation exists, first identified in the National Service Framework for Mental Health, that carers of people receiving care through the Care Programme Approach will have their needs assessed, a plan compiled to meet those needs and the effectiveness of the plan reviewed at least annually

Assessment of helpful approaches

A number of assessment tools exist to focus on and identify the needs of carers enabling services to deliver need meeting interventions.

One such tool, is the Carers' Checklist published by the Mental Health Foundation which provides an outcome measure for people with dementia and their carers

ADULT COMMUNITY MENTAL HEALTH SERVICES

The following were discussed and recommended by the service line clinical cabinet held on the 11th Sept 2013

1.To develop a programme of workshops for carers of people who use CFT's services

Background

The involvement and participation of carers is very often a key factor in supporting any service users treatment and recovery. It is incumbent on CFT to ensure that we identify the carers for any of our service users, carry out bespoke assessments of their needs and when needed facilitate them to receive the correct level of support. However many carers report that in the early stages of their contact with mental health services it can feel a bewildering and confusing system, that they struggle to understand and find their way through.

Proposal

That the service line will set up a system of Carers workshops which will enable carers to develop a greater understanding of the issues around mental health problems and the treatments and services available which support our service users. It would be designed to both provide knowledge and basic skills which will help carers to work alongside our staff as an integral part of the treatment delivered. It will be developed very much in the model of the service user recovery workshops which have successfully launched and which have been attended by some carers.

Implementation

The service will identify a pilot site from within the 6 district areas. A programme of sessions will be set up based on feedback from trust's carers committee. The workshops will be run over a fixed period and evaluated. This evaluation will be reviewed by the clinical cabinet and recommendations and expansion plans agreed. Once this has been done all 6 districts will implement the programme which will be run from our Day Resource Centres in line with the Recovery Workshop programme.

Pilot site to commence in June 2014, with:

- 2 further in September 2014
- 2 in December 2014
- 1 in February 2015
- 100% of programme implemented by March 2014

1.3.2.3 Existing quality concerns and plans to address them

The CQC have undertaken inspections in 2013/14 of the trust's Inpatient and Community services. As a result of the inspections the CQC issued a non-compliant action for the trust's Home Treatment Team and out-of-hours provision. The trust has developed an action plan to address these issues which pays regard to a business plan presented to commissioners concerning the Acute Care Pathway. [see confidential section 1.4.1 for updated position].

1.3.2.4 Key quality risks inherent in the plan and how these will be managed

Description of risk	Potential impact	Mitigating actions / contingency plans in place	Residual concerns	How Trust Board will monitor residual concerns
Population changes leading to increased demand on services, particularly dementia services	• Expectation to deliver activity beyond commissioned levels without additional resources, creating financial risk. • Increased demand on Dementia Services • Additional Resource implications of meeting complex mental and physical health needs • Increase in demand across the spectrum of mental health needs	• Implementation of new model of care for people with dementia • Redesigned services and workforce to meet population need • Close working with social care partners to deliver integrated care • Working with commissioners to develop service specifications to reflect changes in demand and model • Learning from national and international best practice. • Ensure emerging models meet GP needs within resources. • Working with commissioners to implement "No health without mental health" • Manage service delivery to commissioned levels of service	• Insufficient Commissioner focus on mental health, learning disability services and children's services • Availability of funding to commission services to meet increased demand	• Regular reporting to: Quality and Governance Committee • Performance, Finance and Investment Committee
Impaired reputation as a result of serious incidents or other quality failures	• Impact on reputation with the general public • Adverse impact on relationships with key parties including Monitor, CQC, coroner, police and commissioners.	• Patient Safety Strategy • Patient Experience Strategy • Lessons Learnt reviews • Governance and reporting of SIs • Quality Governance Committee oversight • Collaborative working with commissioners and key parties • Council of Governors engagement	• Ensuring that lessons learnt are embedded in practice across service lines	• Review of organisational learning reporting to: Quality and Governance Committee

		• Post Incident Review Panel and training for panel members • Thematic Review and action plans to mitigate • SI policy and procedures and external reporting to NPSA • CQC Relationship meetings		
Regulated practices are not maintained to compliance standards	• Regulatory action • Impact on reputation with the general public • Loss of relationship with key parties • Inability to develop new service developments	• Patient Safety Strategy • Patient Experience Strategy • Proactive compliance monitoring • Staff engagement and communication • Robust Board Assurance Framework • Engagement with regulators	• Ensuring a positive, open culture is embedded across all services	• Reports to: Board of directors Quality and Governance Committee Executive Management Group
The provision of safe and effective services is compromised during physical improvement works	• Regulatory action • Impact on reputation with the general public • Loss of relationship with key parties • Inability to develop new service developments	• Patient Safety Strategy • Patient Experience Strategy • Programme management arrangements • Robust governance and monitoring arrangements including clinical risk mitigation planning • Staff engagements • Management of contractors and PFI • Board and committee oversight	• Ensuring contractors meet planned timescales	• Regular reporting to: Quality and Governance Committee Performance, Finance and Investment Committee

CFT has a low bed base for adult acute mental health inpatients at 16 beds per 100,000 working age population. In 2013-14, approximately 70 adult patients have had to be transferred to out of county for inpatient admissions. The trust continues to work with KCCG to agree plans to increase capacity within Cornwall. The CQC has noted that the placement of patients away from their friends and family is distressing and may present a patient safety risk.

CFT is not currently commissioned to provide Tier 4 CAMHS and patients from Cornwall and Isles of Scilly should be accommodated at Plymbridge in Plymouth. Capacity constraints at Plymbridge have resulted in children being admitted to CAMHS inpatient beds far from Cornwall. Our local CAMHS team spends

significant time in managing this process and this places an additional pressure on our CAMHS tier 3 service. In 2013/14, our CAMHS services has seen referrals continue to rise and exceed the indicative activity plan by around 100%, impacting on referral to assessment times. The trust is developing a proposal for a Young People's Mental Health Unit for Cornwall and we continue to work with commissioners to take this forward. Cornwall Health and Social Care Scrutiny Committee have recently established a Select Committee to scrutinise the delivery of CAMHS services in Cornwall and the trust has provided a comprehensive information pack detailing demand and capacity issues.

1.3.2.5 Overview of how the board derives assurance on the quality of its services and safeguards patient safety

The trust has a Board Assurance Framework (BAF) in place which summarises the updated position for each Board agreed strategic objective and its associated principal risks and confirms that agreed actions are in place to address any gaps in control or assurance. This enables the Trust Board to review the evidence (assurance) in place to confirm that controls are working effectively to manage principal risks and to be assured that any deficiencies are identified and addressed. Each piece of assurance is given an adequacy rating to assist the Board in assessing the degree of reliance that can be placed on it.

A principal risk is defined as one that could prevent the achievement of one or more of the trust's strategic objectives, as recorded in the BAF, and where the risk rating exceeds the appetite score for the strategic objective in question. Any new principal risk will be considered and approved by the Board before being accepted as such and added to the BAF.

The BAF is discussed at Executive Management Group monthly to monitor progress. It is also presented to the Quality and Governance Committee, Performance, Finance and Investment and Audit Committees and to the Board.

1.3.2.6 What the quality plans mean for the Trust's workforce

1.3.2.6.1 Background to Plans

The Trust has established detailed business plans covering the next two years which have fed Service workforce plans for the same period, with higher-level strategic overview for years three – five. All workforce plans have incorporated:

- Changes in service provision / delivery
- Skill mix review across all service areas to enhance efficiency, streamline and ensure highest capacity in the right places
- Development of Leadership and Management skills
- Development of succession planning models to mitigate risks inherent within age profile
- New service delivery models and methodology incorporating new ways of working
- Reduction in agency use with a corresponding increase in flexible use of trust's own staff
- Increased use of technology and systems with an associated decrease in travel time and costs
- Review of administrative support and estates trust-wide covering all services rather than in separate plans

1.3.2.6.2 Key Points in Planning

- A strategic re-focussing of the directly employed skill mix increasing the proportion of qualified staff to unqualified staff to align with the wider goal of differentiating the trust's service offering
- Develop robust succession planning particularly in areas of leadership and management / higher-banded clinicians
- Develop student numbers across the services to help ensure succession planning
- Develop Preceptee placements across the services to help ensure succession planning
- Further development re: potential for Apprenticeship roles in clinical areas including Adult Inpatient – to go alongside reduction in band 3 HCA roles
- Development of key skills including customer care, communication techniques, leadership & management, enhanced psychological therapies and care co-ordination
- Trust-wide development of specific clinical IT systems and non-clinical IT packages (e.g., RiO, KITS RiO and Windows 7 upgrade) assisting with capacity through reducing clinical time spent on non-clinical activities
- Reduction in agency usage specifically and aiming for reduction in bank use through increased flexible use of substantive workforce, particularly in Inpatient units – this is facilitated through centralised eRostering

1.3.2.6.3 Key Assumptions supporting Plans

- Realisation of CIP through streamlining processes and working practices as well as planned reduction in headcount / FTE
- Reduction of inefficiencies through improved use of technology
- Implementing demand and capacity mapping to establish service-led workforce need
- Development of culture open to change through communication and involvement in Business Planning cycle

1.3.2.6.4 Service Plans – Key Points Overview

Functional Community Services:

- Job role redesign leading to reduction in band 3 HCA posts and introduction of more specialist posts whether via redeployments or recruitment
- Skill mix change – replace some band 6 Practitioners with band 5 practitioners
- CMHTs, Assertive Outreach and Supported Housing teams to be re-aligned into geographical teams comprising Brief Treatment and Support and Recovery pathways
- Change focus of secondary care from assessment to treatment
- Skills development required in treatment area including Cognitive Analytic Therapy and EMDR
- Reduction in band 7 Manager posts as consequence of service re-alignment
- Need to standardise training of team managers to ensure consistency
- Care co-ordination to be embedded within job plans
- Primary Mental Health provision expansion – aim for unnecessary / inappropriate referrals into secondary care to reduce in line with increase in primary care delivery

- Succession planning into band 6/7 – need to work with enthusiastic band 5s to put in place development and progression routes for example leading project workstreams.
- Development of Therapy skills required – internal training programme, 12 months
- Customer care training required for administrative staff
- Base IT skills required for clinical staff who are struggling with technology demands

Children's Services:

- Focus on integration / service alignment with Council – not merger but working practices / service provision / locations
- Creation of more generic roles as a result of above – leading to working practices changing
- Streamlining and centralising administration processes and ensuring consistency through development of Children's Management Centre (CMC)
- Need to go further down centralisation route as next step
- Reduction in FTE of two band 2 and six band 5 over two years
- Band 2 reduction achieved through ending fixed term uplifts in hours and reducing bank / agency usage
- Band 5 reduction to be addressed through workforce re-aligning across services, reviewing potential for other efficiencies work and grade shift down in vacancies where appropriate
- Aiming to reduce numbers of part time workers who work in total less than 22.5 hours per week (equivalent of three days)
- Ensuring development of specialist services where appropriate e.g., Paediatrics, LD
- Build robust succession planning through intelligent use of student placements and also development of Apprenticeship roles
- Development of Band 7s in areas such as change management, understanding place within management hierarchy and being able to delegate
- Require leadership and management training for lower-level managers
- Streamlining and reducing travel through use of videoconferencing and how can be used to engage with young people

Functional Inpatient Service

- Job role redesign leading to reduction in band 3 HCA posts and introduction of band 2 HCA posts whether via redeployments or recruitment
- Development of band 2 clinical Apprenticeship programme to support this
- Skill mix change – replacement of Home Treatment band 6 practitioners with band 5 practitioners through turnover
- Focusing on recruitment and retention – turnover to internal trust services is high and the service is high-impact / high-stress
- Bid to develop specialist 12-bed unit under Acute Care Pathway – would necessitate recruitment but would also mean income generation
- Development of customer care and communication skills in bands 2 and 3 HCAs
- Development of assessment skills in band 5s; leadership and management in band 6 and 7s

- Embedding of clinical risk training (STORM) theory into practice – essential development to improve quality and provision
- Development of succession planning of bands 5 into 6; plus band 6 Development Days – need to increase knowledge in band 6s of HR issues – links to leadership and management training
- Building mentoring into job descriptions of qualified staff to maximise numbers of students – this will help with future-proofing the service and retention of staff
- Potential to include a Developmental band 6 role which could be rotated into; need to focus on development of less experienced staff to ensure succession planning

Learning Disabilities Service

- Focus on creation of sustainable, specialist service
- Increasing numbers of older people with learning disabilities and with dementia – service plans focused on building clinical resources and skills in that area
- Development of psychological therapies, diagnostic processes and screening, new Memory Service
- Succession planning key – Nursing workforce managers / senior practitioners will be hit hard by retirement profile in 5 years
- Service keen to advance use of technology to help engage with younger client group and development of skills in this area – Service User Advisory Group engaged
- Aim to increase capacity and reduce travel through this work
- Leadership and management review – informed by consolidation of services and age profile. Management responsibilities moving away from professional leads back to team managers
- Development of primary care relationships and link into IAPT for appropriate service users
- Development of relationship with University of West of England (UWE) – Education provider for Learning Disability Nurse placements – to build better communication and aim for higher numbers of LD Students coming on placement
- Developing a sustainable workforce and delivering quality services key themes

Complex Care and Dementia Service

- Job role redesign leading to reduction in band 3 HCA posts and introduction of more specialist posts whether via redeployments or recruitment
- Strengthening primary care relationships through band 5 Primary Care Dementia Liaison Practitioners
- reduce PCDPs through funding pressures by 5 FTE
- Inpatient unit to remain high numbers band 3 support staff with band 5 practitioners and band 6 shift managers
- Activity levels are projected to change as dementia and early-onset diagnoses increase. Activity commissioned does not currently meet need
- Potential to bring in Apprentices to clinical roles but this needs to be offset against reduction in posts of community HCAs
- Recruitment pressures at band 6 level and others not wanting to progress – development needed at band 5 / 6 in areas of leadership and management

- Develop use of students and preceptees to help with service demand and also to help integrate prospective new starters into service
- Increase numbers of mentors across service – mentoring being built into job descriptions of qualified staff to support this
- Potential future income generation through working closely with dementia care homes – consultancy model (not training delivery) and / or rescue package and strategy when homes start to fail

1.3.2.6.5 Delivering the Plans

Each service is responsible for developing actions to support and deliver their business plan and associated workforce plan. Fundamentally, the business and workforce plans impact on the workforce through planned reduction in headcount of band 3 HCAs – the trust is forecast to reduce FTE in this area by 50%. This will be offset by an increase in band 2 HCAs working in inpatient areas. Other areas of reduction include skill mix changes from band 6 practitioners with a corresponding rise in band 5 practitioners offset by a slight reduction in band 5 Primary Care Dementia Practitioners in Complex Care.

Development of leadership and management skills in middle managers are identified as essential if the trust is to continue delivering focused and quality services – funded options for developing these skills through Higher Apprenticeships have been developed by HEESW although release time from service is an issue.

Development of customer care and communication skills in support staff is also fundamental to delivery of quality services – again funded options via Apprenticeships have been developed by HEESW and are available to the trust to take up. Release time is an issue – for both developments the trust needs to weigh positive future benefits against immediate productivity cost.

Development of succession planning in the context of overall workforce numbers reducing and pressure to find quality new starters has been identified as essential in all Services. This is supported by the corresponding plan in all services to increase student placements, numbers of mentors and where possible numbers of Preceptees. Integration of students and Preceptees in the workforce with quality mentor support assists succession planning by developing a pool of prospective new starters who have knowledge and understanding of the trust and trust practices.

Delivery of quality services also depends on the ways of working; plans addressing use of technology, increased clinical capacity from reduction in travel and other non-clinical activities as well as reductions in unnecessary secondary care referrals will help ensure services remain focused, streamlined and targeting the appropriate service users with the most appropriate care packages.

Service developments:

The table below reflects the service developments included in the plan:

Development	Amount
Health visitor final year investment	2014/15 £440,000
CQUIN's	2014/15

	Community block (children's) £329,000 MH block £1,191,000 PCDP (six month extension) £180,000 2015/16 Community block (children's) £325,000 MH block £1,351,000

Capital:

The key capital priorities are reflected in the table below;

Development	Amount
Safe and sustainable estate	2014/15 £437,000 2015/16 £510,000
Harnessing technology	2014/15 £1,348,000 2015/16 £984,000
Improving clinical services	2014/15 £2,305,000 2015/16 £500,000

1.3.2.7 The Trust's response to Francis, Berwick and Keogh

Francis

The trust's Medical Director has undertaken a review of the 290 actions identified in the report to identify those which it has the ability to impact upon. The trust finance department has captured the financial implications of Francis and submitted this information to commissioners. The national tariff guidance signalled a higher tariff deflator for mental health and community services on the assumption that there were no financial implications associated to this. NHS Kernow CCG has acknowledged this submission

and agreed to adjust the tariff deflator to 1.5%.

Berwick/ Keogh

The outline review revealed clear implications to the trust and further work will be undertaken to develop costed implementation plans in the financial year ahead.

1.3.2.8 Risks to delivery of key plans

The trust has worked to enhance the business planning process to ensure it operates as a continual cycle throughout the financial year. This programme is called Bridging the Gap and provides the opportunity for clinical and non-clinical staff across the organisation to propose and help deliver schemes of change. The trust continually reviews risks inherent in its plan to manage and monitor delivery. For each of the principal risks the Board sets out a number of key controls that are in place. The trust adopts a planning process which ensures financial and quality risks are assessed through conception to their implementation. Measures include Quality Impact Assessments which are taken through clinical cabinets within each service line before being signed off by the trust's Caldicott Guardian and Lead Nurse.

1.3.2.9 Contingency built into the plan

The trust has developed a downside case and mitigation plan to provide a contingency in our plans should the expected position not be delivered. This plan has been reviewed and accepted by the trust's board of directors.

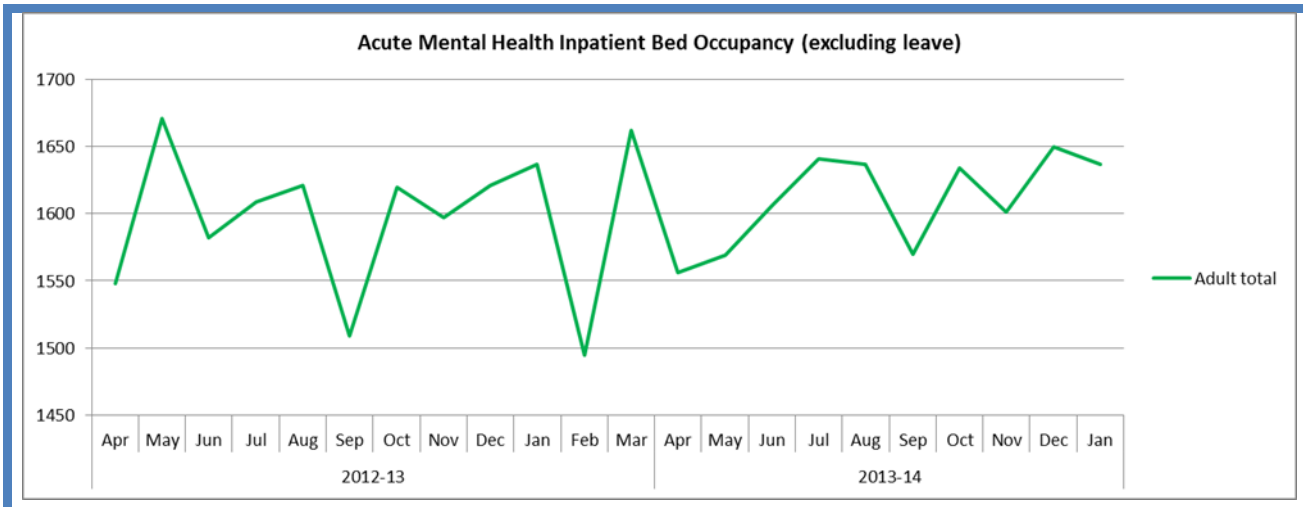
We have strengthened our in-year monitoring and developed a process to enable senior level consideration and adoption of revised plans throughout the year. The strengthened planning process, and the greater flexibility of our in-year planning arrangements, mean that we are confident the trust is in a strong position to deliver contingency plans should the need arise.

1.3.3 **Operational requirements and capacity**

The current block contract arrangement requires the trust to deliver activity that meets the mental health, learning disability and children's health needs for the population of Cornwall and Isles of Scilly. The trust continually analyses level of demand and efficiency on the range of services provided. Annual business planning ensures that the services respond appropriately to existing demand variations.

The demand for acute mental health inpatient beds continues to increase and the trust has maintained occupancy levels of in excess of 97%. This high level of demand and shortage of in county inpatients has resulted in patients being accommodated out of county.

In order to meet the current and predicted future levels of demand the inputs required over the next two years are an increase to the acute mental health inpatient bed stock from 54 (92% occupancy) to 66 beds (85% occupancy) and an increase in the staffing establishment of the Home Treatment Team from 29.33 wte to 45.8 wte. A business case has been submitted to KCCG.



Key Risks

The risks associated with meeting the increasing levels of demand for acute mental health provision are:

- Population changes leading to increased demand on services, particularly dementia and acute mental health services
- Expectation to deliver activity beyond commissioned levels without additional resources, creating financial risk.
- Commissioned service insufficient to meet local population demand
- Recruitment of staff
- Additional Resource implications of meeting complex mental and physical health needs

Risk management

- Implementation of new model of care for people with dementia and acute mental health needs
- Redesigned services and workforce to meet population need
- Close working with social care partners to deliver integrated care
- Working with commissioners to develop service specifications to reflect changes in demand and model NHS Kernow commissioning intentions to support the Acute Care Pathway Business Case
- Learning from national and international best practice.
- Ensure emerging models meet GP needs within resources.
- Working with commissioners to implement “No health without mental health”
- Manage service delivery to commissioned levels of service

1.3.4 Productivity, efficiency and CIPs

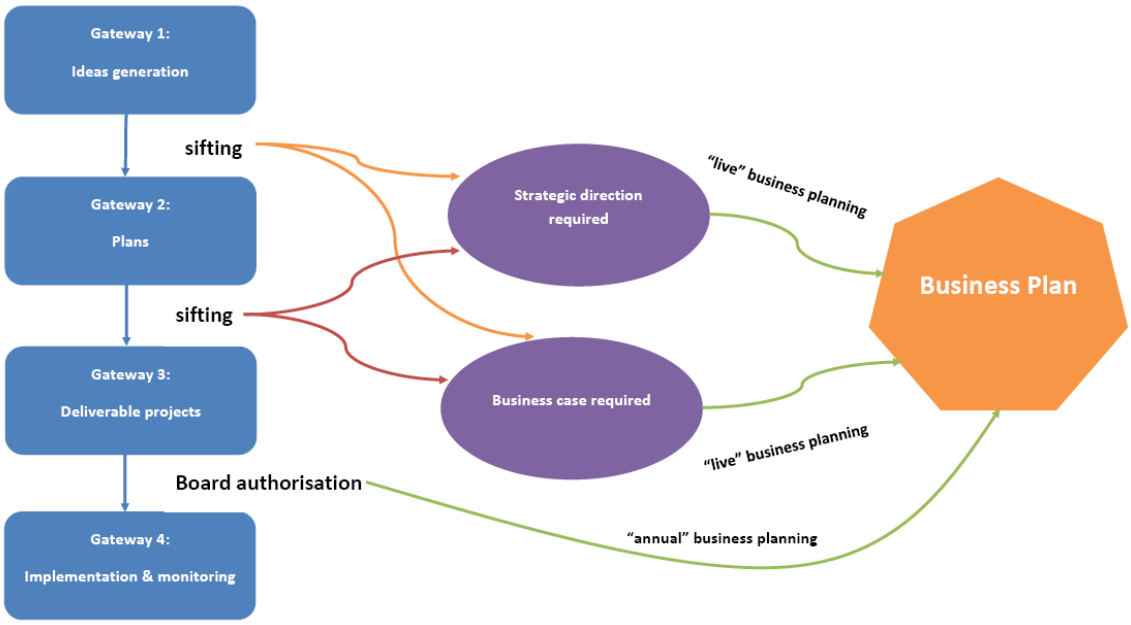
1.3.4.1 Process followed by the Trust

The trust recognises that in order to remain financially sustainable it must ensure that it has plans to deliver the services it is commissioned to provide in each year. Moreover as service pressures and opportunities evolve over time it is important that we continually review our position, and develop services to meet the relevant requirements upon us. As such the trust has implemented a revised process, named 'Bridging the Gap', which is focussed upon efficiency development.

Bridging the Gap follows a Monitor recommended Gateway process for the planning and implementation of effective CIP schemes. The Gateways are;

Gateway 1	**Ideas generation**
Gateway 2	Development of ideas into plans
Gateway 3	Development of plans into deliverable projects
Gateway 4	Implementation and monitoring of projects

At each stage of the CIP planning process CFT will document the ideas generated and the decisions made on how to progress. At each Gateway a decision will be made by Executives on whether and how to proceed. This process is reflected in the diagram below;



The CIP Gateways sit within the wider business planning process and are designed to ensure support for individual service lines and corporate functions' business plans.

1.3.4.2 Cost Improvement Plans

PROGRAMME	TRADITIONAL/ TRANSFORMATIONAL CIP	DESCRIPTION

Programme A – Children	Transformational 2014/15 £421,000 2015/16 £543,000	
Programme B – Clinical and Business Intelligence Systems	Transformational- enabling Strategic programme intended to deliver benefits in 2016/17 onwards and will be aligned to Programme F for reporting purposes	Information systems are to be used more effectively to transform service delivery
Programme C - Health and Well Being Policies	Traditional Strategic programme intended to deliver benefits in 2016/17 onwards and will be aligned to Programme X for reporting purposes	Workforce measures are to be implemented in order to drive efficiencies.
Programme D - Adult Learning Disabilities Service Redesign	Transformational 2014/15 £188,000 2015/16 £71,000	Efficiencies are to be delivered through skill mix changes within the LD service line.
Programme E – Pharmacy	Traditional 2014/15 £105,000 2015/16 £-	Efficiencies are to be delivered through review of existing operations.
Programme F - Infrastructure	Transformational- enabling 2014/15 £1,207,000 2015/16 £366,000	Efficiencies are to be driven from existing areas of spend such as travel, training and meeting technology
Programme G - Management Review	Traditional 2014/15 £238,000 2015/16 £195,000	Efficiencies are to be delivered through skill mix changes within management.
Programme H - Consumables	Traditional 2014/15 £123,000 2015/16 £-	Efficiencies are to be driven through more effective purchasing and use of consumables.
Programme K – Income	Income generation	The trust is continuing to pursue

	2014/15 £202,000 2015/16 £-	additional funding streams
Programme L - CCD Service Transformations	Transformational 2014/15 £278,000 2015/16 £155,000	
Programme M - Community Service Transformation	Transformational 2014/15 £1,555,000 2015/16 £217,000	
Programme U – Contract management	Traditional 2014/15 £120,000 2015/16 £-	The trust continues to monitor the appropriateness and cost of services purchased from other trusts
Programme X- Governance, Legal and Human Resources	Traditional 2014/15 £249,000 2015/16 £59,000	On-going review of services provided and purchased
Programme Y- Business process redesign	Traditional 2014/15 £37,000 2015/16 £41,000	On-going review of services provided
Single Schemes	Traditional 2014/15 £214,000 2015/16 £205,000	
	Total value of CIP schemes: 2014/15 £4,735,000 (cost efficiencies) 2014/15 £202,000 (revenue generation) 2014/15 TOTAL £4,937,000 2015/16 £1,852,000	

1.3.4.3 State of development of Transformational CIP's

Each of the transformational CIP programmes relate to fundamental development in the design of service

delivery models. The services which are impacted by transformational CIP's are Community, Complex Care and Dementia and Children's.

In order to deliver transformational changes in service delivery there is a significant reliance upon the key enablers of Estates and Clinical and Business Intelligence Systems.

1.3.5 **Supporting financial information**

1.3.5.1 Summary

The trust has utilised the latest forecast outturn position available (Month 11 plus known movements as at 31st March 2014) as a basis for the submitted plan. The planning assumptions and key projections for 2014/15 and 2015/16 adopted in the trust's financial strategy are set out as follows:

	2014/15	2015/16
Net Tariff reduction of	-1.5%	-1.9%
Cost inflation at	+2.5%	+2.6%
Cash releasing savings, min % pa	4%	4.5%
Quality achievement % - non recurrent allocation	2.5%	2.5%

In the next two years the national tariff inflationary uplift is 2.5% (2014/15) and 2.6% (2015/16), against which there is a 4% (2014/15) and 4.5% (2015/16) cash releasing efficiency requirement, thus resulting in a net deflator of 1.5% for 2014/15 and 1.9% for 2015/16.

The trust's financial plan for 2014/15 is to achieve a net surplus of £0.5m, with a deficit of £2.6m projected for 2015/16. An important factor in meeting these plans is our cost improvement plan of £6.6m plus revenue income generation of £0.2m over the two year period (giving a total efficiency of £6.8m, split as £4.9m in 2014/15, £1.8m in 2015/16).

Assumptions which under pin the plan include:

- Income and activity targets will be met;
- Pay and non-pay inflation will be contained in planned budgets;
- Future service transfers will be, as a minimum, cost neutral and TUPE will apply to any staff affected; and
- Outstanding risks will be mitigated through management action

Key highlights for 2014/15 include the following:

- Securing additional resources to improve patient safety and maintain safe quality services;
- Potential to achieve payment of up to 2.5% of contact income to reward quality improvements by delivering on Commissioning for Quality and Innovation (CQUIN) targets; and
- Plans in place to deliver efficiency savings of 6.42% (£4.9 million) with many schemes in place and delivering from the start of the year.

The trust has established a process, Bridging the Gap, to support the transformation of services to be more effective and deliver required cost improvements with significant ownership by the trust's clinical leaders. The cost improvement plans in each of the two years has been risk assessed so that mitigating actions can be identified where required.

The financing of capital investment over the period of the plan (valued at £6.1m in total from 2014/15 to 2015/16) will be from trust cash balances, thus mitigating the need to borrow. However, this level of capital investment does introduce the risk of over-run should actual costs prove more than planned. Mitigation of these risks will be achieved through effective design and procurement of the schemes.

The Chief Operating Officer holds accountability to the board of directors for the achievement of cost improvement plans. Accountability to the board of directors for the achievement of capital expenditure plans, agreement of contract income, on-going monitoring of financial performance and financial standing is via the Director of Finance, Performance and Information.

The board of directors reviews the trust's financial standing and performance monthly to ensure proactive mitigation of any financial risks as they emerge. Our financial plans reflect national planning assumptions regarding income inflation plus appropriate quality developments (-1.5%) and cost inflation (2.5%). With these base case assumptions the trust's cost improvements are 6.42% and 2.36% of operating costs (excluding PFI) in 2014/15 and 2015/16 in order to maintain a Continuity of Service Risk Ratings (CoSRR) of level 4 in 2014/15 and level 3 in 2015/16.

1.3.5.2 Underlying Assumptions and Efficiency for 2014/15 – 2015/16

1.3.5.2.1 Income changes

The income budget baseline has been set to reflect the current position of contract negotiations and the impacts from service developments for NHS clinical activities and educational and training funding.

Achievement of the full 2.5% CQUIN income has been assumed with an appropriate provision has been made for costs to achieve the quality improvements and/or incomplete compliance. There remains an inherent risk if costs are incurred in the pursuit of quality improvements but then targets are not fully achieved.

The baseline funding included in the plan therefore reflects;

- The continued demand for inpatient services in 2014/15;
- Baseline corrections for safe staffing levels for enhanced observations;
- Commissioner changes; and
- CQUIN schemes including six months funding for the primary care dementia pathway

2014/15 NHS contracted income has been set to the current commissioner alignment. There are further commissioner changes expecting in 2015/16 around specialist services, Children's FNP and risks associated the development of Better Care Fund in 2015/16.

1.3.5.2.2 Income assumptions

Our financial templates have been completed using the following income assumptions:

Block and Clinical Partnerships – The net deflators recognised in the plans in line with the national tariff are -1.5% and -1.9% in 2014/15 and 2015/16 respectively. CQUIN funding calculated at 2.5% of contract value is also included.

Cost & Volume Income - The Improving Access to Psychological Therapy (IAPT) service development is reflected within the Community service line. It has a revised income profile from 2013/14 following an increase in provision, and thus provides this element of the service line with a trading budget. This allows the reporting for each service to reflect a true position for expenditure budgets, whilst also highlighting in year when additional savings or alternative income is required should there be variances to planned NHS activity.

Other Clinical Income - Income from local authorities and other health bodies matches expected costs, as has been the practice in recent years. Assumptions are in line with national planning guidance across the life of the plan.

Education and Training - Funding streams supporting educational activities are being revised to bring in a tariff structure and proposed Education Resource Groups (ERGs) following a national costing exercise. A transitional funding agreement has still to be agreed with NHS Heath Education (South West), but for planning purposes has been assumed for 2014/15 to remain at the same level as 2013/14 for all medical and other training placements. In additional the trust's estimate includes the additional investment in Health Visitors in 2014/15 in line with the final year of the business case agreed with commissioners.

Other Income - Income is forecast to remain relatively flat for all years of the forecasting period. The trust has assumed a zero tariff deflator/ flat cash scenario in areas such as Shared Services (for example CHESS). The established practice through the appropriate contractual framework is to manage pay uplifts, inflationary and other cost pressures and any risk share around variance to plan. If this were to become a risk to the trust in the future, the trust would not accept such on-going arrangements and manage the risk through partnership board.

CQUIN Income - 2.5% of the opening baseline of relevant contracts is assumed to be received for the two years of the plan as a quality payment. The plan assumes a 50% benefit to net surplus (therefore is matched by 50% cost of scheme delivery). Therefore £1.7m is assumed as income against which £0.84m of costs are reflected (split 70% pay / 30% non-pay costs), resulting in a benefit in the model of £0.84m.

1.3.5.2.3 Expenditure assumptions

Inflationary impacts on expenditure have been calculated using local information of specific cost increases, an allowance for pay, non-pay & prices, and the actual increase in capital charges arising from our programme of capital investment.

An inflation budget will initially be established with funding then being distributed to appropriate budgets as required. Provision has been made for funding for cost pressures and agreed developments in line with the assumptions made in the Annual Plan

Pay inflation - The plan assumes an increase in expenditure of 1.7% (1.00% pay uplift, 0.7% incremental progression) for 2014/15 & 2015/16. Local calculations for costs pressures arising from Agenda for Change, Consultants' Contracts and clinical excellence awards (CEA) payments have also been included within the plan for 2014/15. In addition to the above assumptions the

NHS employer pension changes reflecting increase by 0.3% from 2015/16, according to March 2014 Budget has been incorporated.

Non-Pay Inflation - National inflation and tariff assumptions have been applied, resulting in a 2.5% and 2.6% in 2014/15 and 2015/16. The trust's non pay profile does not include any unique, complex or high risk items which might create risk of inflation above the national average. Indeed experience is that many cost rises are below levels expected within the national tariff. The most volatile area relates to utilities, where additional allowance has been made. Specific non-pay assumptions are:

Drugs - Drugs have been increased by 3% based on an analysis of historic expenditure which has consistently increased on a steady basis.

Utilities - These elements are combined in the assessment of overall uplift

PFI Unitary Charges (Operating Revenue Cost element) - The trust has assumed inflation of 2.5% per annum for the period of the plan, as reflected within the IFRS PFI model. Risk if RPI is higher than 2.5% in March 2014 (currently 2.67% as at December 2013)

Other Costs - The trust has assumed inflation of 2.5% and 2.6% per annum for clinical supplies and services for period of the plan.

Additional costs also included in the plan are:

- CQUIN (as above)
- Inpatient re-investment for three shift rotas on PICU (Harvest) and short-term provisions managing complex staff changes.
- Restructuring costs (as detailed)

1.3.5.2.4 Workforce

The development of our workforce is essential to enable the trust continue to deliver a high quality service, its contractual obligations and continue to achieve its financial success. The projections for staff numbers are driven by the changes to establishment arising from the CIPs, offset by new posts, which will be generated through the new developments. The above are underpinned by the People and Organisational Development Strategy and a Workforce Management Group is in place to enable Business Units / Service lines to maximise opportunities for workforce change.

1.3.5.2.5 Capital

The trust has developed an Estate Strategy covering the period to 2018. This strategy is intrinsic to the delivery of our strategic objectives and, in particular, supports the objectives of promoting green working and reducing travel, carbon and waste and of providing services from high quality facilities. The revised Estates Strategy 'Creating a Property Portfolio Strategy' was refreshed in November 2013 and present to PFI Committee / Board.

The trust will generate c £2.7m pa from depreciation. This resource combined with cash from disposals (£3.0m Housing Communities Agency (HCA) deal planned in 2014/15) and prior year accumulated revenue cash reserves generated through surplus will be sufficient to resource the planned improvements. The trust has considerable flexibility in its strategic options as there are no critical investment issues which cannot be absorbed from internal resources. There are

however, substantial opportunities in relation to the modernisation of the Estate and the trust is therefore keen to progress whilst being mindful of the current property market conditions.

1.3.5.2.6 Key Financial Risks 2014/15

Key financial risks for 2014/15 can be summarised as:

- Finalising contractual negotiations with all commissioners
- The target level of savings which will require significant changes in clinical pathways.
- CQUIN delivery given local CQUIN schemes have not been finalised
- Cost shifts due to changes in policy and/or underlying agreements (for example patient choice)
- Financial instability within the local health economy

1.3.5.2.7 Risks

Risks, which are not provided for, include

- Slippage or failure of CIP delivery and service transformation;
- Excessive, unexpected cost pressures e.g. agency;
- Specialist commissioning and local authority commissioned contractual changes;
- Keogh, Berwick report recommendations, financial implications;
- Projections for further growth in demand and increasing and changing demographics;
- Changes in ‘market share’; and
- Effect of Young Persons Mental Health Unit, financial implications (capex); and
- PFI re-financing of Longreach; and
- Discontinuation of Estates management and support services.
- Impacts of financial failure within the local health economy

1.3.5.2.8 Base Case Metrics

The FT risk ratings scores generated through the annual plan review are shown in the table below:

Finance Risk Rating

	2014/15		2015/16	
	Rating	Metric	Rating	Metric
Continuity of service risk rating				
Liquidity ratio (days)	4	34 days	4	24.1 days
Debt Service cover (times)	3	1.84 cover	1	1.01 cover
Overall CoSSR	**4**		**3**	

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The continuity of services risk rating incorporates two common measures of financial robustness;

(i) liquidity: days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown; and
(ii) capital servicing capacity: the degree to which the organisation's generated income covers its financing obligations.

The liquidity ratio as a result of the above measures will reduce from 47 days in 2013/14 (forecast March '14 position) to 24 days by 2015/16 with cash at bank reducing from £12.6m to £10.7m respectively.

1.3.5.2.9 Potential Downside Risks and Mitigations

We have recognised the increased risks presented by the economic climate and the board has debated and agreed contingency plans to address this.

The board has considered a range of income (including reductions in specialist services and social care funding alongside CQUIN non-achievement) and expenditure downside risks (including CIP non-delivery. The value of the risk is reflected in the assessed moved in the net surplus (deficit) over the period and is £3.2m for 2014/15 and £1.8m for 2015/16.

The value of the downside results in an impact to cash (liquidity) of £3.1m for 2014/15 and £4.5m cumulatively at the end of 2015/15. This results in a CoSSR of 3 unmitigated as at March 2016.

Application of the identified mitigations results in £0.9m for 2014/15 and £2.2m for 2015/16 in

order to maintain a CoSSR of 3 in each year. This is equivalent to an additional cost improvement level of +1.11% in 2014/15 (rising to 7.53%) and +2.77% in 2015/16 (rising to 5.13%) or an amalgamated 6.32% over the two year period.

1.4 Appendices: commercial or other confidential matters

1.4.1 Reference 1.3.2.3 - The trust was re-inspected at the start of March 2014 and a draft report issued by CQC confirms that the trust is now compliant.

1.4.2 References 1.3.5.2.6 and 1.3.5.2.7 - Within the local health economy, it appears that the financial position of Peninsula Community Health CIC, the provider of community services, is under significant pressure. The impact of failure in the wider health community would be significant in terms of service delivery and in terms of cross-organisational support services (financial services, IT etc) and shared premises.

1.4.3 **CCG Financial Position**- The financial position of the Cornwall Health Economy is becoming increasingly strained. The 'Living Well' programme is developing but does not yet have sufficient granularity of detail to provide assurance that financial efficiency will be delivered.

1.4.4 Following discussion with Steve Atkins at Monitor we have agreed that the following wording will be included within the template. As we have been unable to include the information in the submitted template we have included this information as an appendix. The current membership position is therefore reflected in the following table;

Membership return for Cornwall Partnership NHS Foundation Trust

This is your 2013/14 annual membership report and forms part of your membership plan for 2014/15

Membership size and movements			Actual	Plan
Public constituency			**2013/14**	**2014/15 (estimated)**
	At year start (April 1)	+ve	8,313	8,831
	New members	+ve	701	600
	Members leaving	+ve	183	100
	At year end (31 March)		8,831	9,331
Staff constituency			**2013/14**	**2014/15 (estimated)**
	At year start (April 1)	+ve	1,763	1,636
	New members	+ve	143	100
	Members leaving	+ve	270	200
	At year end (31 March)		1,636	1,536
Patient constituency			**2013/14**	**2014/15 (estimated)**
	At year start (April 1)	+ve		0
	New members	+ve		
	Members leaving	+ve		
	At year end (31 March)		0	0

Analysis of membership		31 Mar 2014 Actual members	31 Mar 2014 Eligible membership
Public constituency			
	Age (years):		
	0-16	8	11,036,997
	17-21	921	3,606,915
	22+	7902	40,633,475
	Unknown	0	
			55,277,387
	Ethnicity		
	White	8,599	48,624,857
	Mixed	36	1008519
	Asian or Asian British	12	3,118,480
	Black or Black British	19	1601599
	Other	109	923932
	Unknown	56	0
	Socio-economic groupings*:		
	AB	4,769	20,299,684
	C1	1,767	7,470,881
	C2	1766	5,550,261
	DE	529	1,908,455
	Unknown	0	20,048,106
	Gender:		
	Male	6,408	27,245,473
	Female	2,423	28,031,914
	Unknown	0	0
Patient Constituency		**31 Mar 2014 members**	**Eligible membership**
	Age (years):		
	0-16		
	17-21		
	22+	0	
Staff Constituency		**31 Mar 2014 members**	**Eligible membership**
	Members	1,636	1646

Note:
Socio-economic data should be completed using profiling techniques (eg: post codes) or other recognised methods. To the

NOTE: The Trust's Membership database is currently being updated. As part of this process consideration will be given to determine the costs associated with amending socio economic groupings (purchased by the Trusts).