With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

South West Yorkshire Partnership NHS Foundation Trust

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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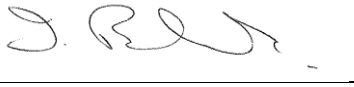
Date	**31/3/14**

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:

Ian Black *(Chair)*	

Approved on behalf of the Board of Directors by:

Steven Michael *(Chief Executive)*	

Approved on behalf of the Board of Directors by:

Alex Farrell *(Finance Director)*	

2014-16 2 Year Operational Plan - Table of Contents

Part One – Executive Summary and Overview of Strategic Direction

Part Two – The Short Term Challenge

Part Three – Operational Requirements and Capacity

Part Four – Productivity, Efficiency and CIPs

Part Five – Finance and Risk

Part One – Executive Summary and Overview of Strategic Direction

1.1 Our Mission and Goals

Our mission is to enable people to reach their potential and live well in their community. We will do this by:

- Doing the day job well, delivering quality and financial targets
- Delivering the service transformation programme
- Managing our partnerships

1.2 Our Values

- Honest, open and transparent
- Respectful
- Person first and in the centre
- Improve and be outstanding
- Relevant today, ready for tomorrow
- Families and carers matter

1.3 Our Key Strategic Objectives for 2014/15

- Develop integrated models of care with acute, community, third sector and local authority partners.
- Define the organisational form required to deliver sustainable services, including exploration of new strategic partnerships to create and utilise alternative capacity.
- Broaden clinical networks, specifically for forensic services.

1.4 Our Service Priorities for 2014/15

- Integration of urgent care pathway (whole system efficiency)
- Significant improvement in outcomes in Long Term Conditions (mental physical, social) – parity of esteem
- Health and Well Being – self care and prevention
- Recovery, self care and improved use of technology (people in control)
- Healthy communities / alternative capacity / social capital
- Specialist Services – critical mass

1.5 Our Operational Plan for 2014/15 and 2015/16

The next 2 years will place a significant level of service and financial challenge to the Trust in terms of:

- Sustaining a performance culture which delivers positive patient experience and continuous service improvement;
- Continuing to generate efficiencies and savings to maintain services;
- Implementing significant changes to workforce roles, skill mix and numbers as a key enabler of services redesign;
- Navigating the expected changes in service delivery and funds flow which are being driven by system wide integration and transformation schemes and national initiatives such as the Better Care Fund and Pioneer Status (Barnsley CCG).

The operational plan for the next two years therefore has the following key features:

- Continue the focus on organisational development – 2014 will be the "Year of Values" drawing on the work already undertaken to support staff in providing a good service.
- Focus on delivery by driving efficiencies using benchmarking against our quality priorities to identify the opportunities and Service Line Management and review of run rates to ensure delivery in year.
- Focus on service redesign in 2014/15 to deliver significant efficiencies in 2015/16 through the Transformation Programme. The Trust service redesign programme has been aligned to commissioner intentions through the inclusion of the work stream initiatives in the service development plan of the Contract.
- The Level of surplus and EBITDA is maintained at greater than 1% and 5% respectively
- The strong cash position supports the capital plan in development of community hubs and the redevelopment of our key inpatient site in Wakefield (Total investment £19m)
- The level of CIP delivery is significantly increased from 2013/14 – £12.9m and £11.8m in 2014/15 and 2015/16 respectively which is equivalent to 5.6%. This enables the Trust to manage cost pressures of around £4m per year.
- Income assumptions are prudent with downside scenario planning for those areas which are most likely to be tested competitively i.e. secure services psychological therapies and community services for dementia and long term conditions.

Key deliverables in the operational plan are

- Revision of the service offer at team level using the transformation work streams of Mental health, Learning disabilities, Secure services and General Community services;
- Review of workforce efficiency through for e.g. introduction of long shifts in inpatient wards; review of medical staff remuneration and productivity; management of vacancies (total savings £2.8m in 2014/15).
- Development of new workforce models which enable reduction in workforce capacity in statutory services by substitution with peer support workers. The model enables more people to access self-directed support and reduce crisis interventions and need for admission. This "Recovery "based model is a critical element in our transformation programme and is also reflected in the JSNA and commissioning strategies of our CCGs and Local Authorities.
- Implementation of a Leadership development programme which supports managers and staff at all levels to equip them with the skills and resilience to implement significant service and cultural change
- Roll out of different ways of working for example the use of technology and estate to support more efficient deployment of staff – agile working and expansion of tele health services; better sharing of information and communication with service users – development of web based portals and information sharing agreements with other providers
- Review of management structures and skills and focus on service line reporting to ensure managers have the right capacity, skills and tools to manage resources effectively.

- SWYPFT continues to play a key role in developing business cases and implementation of major service change at system level working in partnership with local providers and commissioners.

The main risks over the life of the plan are:

- Level of change and the pace of change required in workforce both internally and externally will impact negatively on team performance and potentially service quality.
- This is being mitigated through the investment in organisational development and leadership, practical schemes to support staff well-being and proactive engagement of staff representatives. The track record of the trust in this areas is a better than average performance in the staff survey in terms of workforce resilience; the Trust has innovative schemes to maintain staff well-being, some of which have been recognised by short listing for national awards; over the last 2 years the Trust has managed staff reduction of 26 w.t.e through the Mutually Agreed Resignation Scheme.
- The commissioning intentions of CCGs, Local authorities and specialist commissioners are not yet fully aligned with the Trust vision of the future of services. Therefore this increases the risk of decommissioning which could undermine service and financial viability of the Trust.
- This is being mitigated by maintaining positive working relationships with commissioners and proactive involvement in the system transformation projects across our footprint. Three areas where more work will be required in 2014/15 are ensuring the Trust is involved in the implementation of the Better Care Fund in all the local authority areas; development of a credible bid in the national procurement for secure services including working with other providers; and ensuring that the mental health currency is understood by commissioners and developed as a enabler of transformation. The Trust has a good track record in working with commissioners as evidenced by the success in negotiating 1.5% deflation with our CCGs in 2014/15. The political and financial imperatives in local health and social care economies mean that some organisational reconfiguration is likely and therefore the current organisational form will not be sustainable over the life of the 5 year plan. The preparation and planning for this challenge continues to be reviewed and considered by the Board .There is a risk that managing the transition to new structures will impact negatively on the services and outcomes achieved for service users. This is being mitigated by ensuring that the Trust is actively involved in influencing the future shape of health and social care economies across the geographical footprint.

Summary

The two year operational plan continues to build on the themes and work streams identified in the 2013/14 plan. The plan, both in terms of service delivery and finance is more challenging than previous plans but achievable. The focus on values and culture is important to support the changes in workforce which underpin the Transformation of services and financial savings in 2015/16.The ambition of the Trust in terms of the future of its services is aligned with commissioner intentions; but is an area for improvement in 2014/15 to ensure that the needs of its service users are well understood and reflected appropriately in system wide reconfiguration through, for example, the Better Care Fund.

Part Two – The Short Term Challenge

2 Our Local Health Economies – Epidemiology and Demography

Our main areas of business are Mental Health, Learning Disabilities, Secure Adult Services (Forensic), and General Community Physical Healthcare, including a significant focus on Health and Wellbeing services. The following demographic and epidemiological changes will impact on our business in the next five years.

2.1 Dementia

Growth in dementia prevalence will be a major cause of demand growth for South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) over the period of this Plan. This is primarily driven by growth in the older age population. Between ages 70 and 74 3.1% of the male population and 2.4% of the female population is expected to have dementia. By ages 85-89 this increases to 16.7% of men and 22.2% of women[1]. The table below shows where this growth will impact across our geography.

Locality	2020 prevalence (over 65's)	Increase from 2014
Barnsley	3,267	17.48%
Calderdale	2,894	18.51%
Kirklees	5,489	17.39%
Wakefield	4,813	19.25%
Trust total	16,463	18.14%

2.2 Functional Mental Illness

Prevalence of Mental illness in the adult (18-65) population is estimated by the PANSI database[2]. It indicates that for our localities we should expect steady growth over the period of this Plan. The table below highlights the impact in each locality.

Locality	2020 prevalence	Increase from 2014	'common conditions'	2 or more conditions
Barnsley	25,310	1.73%	23,555	10,522
Calderdale	22,304	1.73%	20,760	9,270
Kirklees	45,726	1.18%	42,544	19,036
Wakefield	35,834	1.61%	33,347	14,912
Trust total	129,174	1.5%	120,216	53,740

There are some notable gender differences within this data. Female rates of reporting common mental health conditions are a little higher than male; 94% of female mental illness compared to 91% of male. Also males are significantly more likely than females to have 2 or more conditions; 50% male / 36% female. Particularly of note is the significant proportion of those with common mental health conditions – which will require a different response from services to that which is required for those with severe and enduring, and multiple mental health co-morbidities.

[1] www.poppi.org.uk version 8.0
[2] www.pansi.org.uk version 7.0

2.3 Where We Operate

The Trust primarily operates in four geographical areas at present (Barnsley, Calderdale Kirklees and Wakefield), with the exception of the Forensic Business Delivery Unit (BDU) which primarily serves the wider Yorkshire and the Humber region.

Our local communities largely live in typical post-industrial towns and cities or in the extensive rural hinterland surrounding the main population centres. At one level our communities are well connected via the M1 and M62 motorways, with relative proximity to economic centres in Leeds, Sheffield and Manchester. However the hills and valleys of the region provide challenges to transport and connectivity. This impacts on the ways we work with our communities (increasing use of technology) and the physical locations we operate from (community hubs).

Demographic changes in our communities will see growth over the period of this plan, particularly in the younger and older age ranges, placing increased demand on local health and social care provision, and changing the balance between working and non-working populations. Our communities are already ethnically diverse and becoming more so during the period of this plan. Kirklees is the most ethnically diverse of our local communities, with 1 in 5 (21%) giving their ethnicity as non-White in the 2011 Census.

Deprivation in our communities is higher than the England average, and the impact of poverty and lifestyle factors on the long term health of our populations is observable. In all our localities estimated levels of adult 'healthy eating', physical activity and obesity are worse than the England average. As are the rates of smoking related deaths and hospital stays for alcohol related harm. This leads to higher rates of Long Term Conditions. For example the percentage of Barnsley residents with a long-term illness or disability is 24.6%, higher than the national average of 17.3%. These factors mean that our Health and Wellbeing offer is key to addressing the needs of our local population.

What this means for us over the next 2 years:

- Our memory assessment services must meet growing demand for dementia diagnosis, and we must work with partners to ensure practical support is available to people living with dementia and their families. Our Transformation Programme includes a project focused on addressing this requirement (see section 5.1)
- Our mental health services must ensure there is a recovery focus that enables more people to self care and builds the capacity of communities to be supportive. Key initiatives include further development of Creative Minds, Recovery Colleges, and Peer Support. (See sections 5.2 - 5.4)
- Our health and wellbeing services will find new ways to reach more people than ever before using technology to support a multi-channel approach including 1:1 coaching, peer support, community champions, telehealth and on-line support networks. Our Transformation Programme includes a project focused on Health and Wellbeing Services. (see section 5.6)

2.4 Local Arrangements for Working Together

Partnership is essential to the vision and mission of SWYPFT. We are active across five local CCGs and four local authority areas, plus regionally across Yorkshire and the Humber with regard to Forensic services. The table below summarises the local partnership configuration and key initiatives within our local Units of Planning.

SWYPFT BDU	Local Authority	CCG	Initiatives
Calderdale	Calderdale	Calderdale	Strategic Review, and related OBC
Kirklees	Kirklees	Greater Huddersfield	
		North Kirklees	Meeting the Challenge Community Services improvement work
Wakefield	Wakefield	Wakefield	
Barnsley	Barnsley	Barnsley	Integration Pioneer CCG/ H&WB Programme Boards

2.4.1 Calderdale and Greater Huddersfield

Calderdale and Greater Huddersfield CCGs collaborate closely together on many issues affecting these neighbouring health and social care economies, which share a common acute trust, Calderdale and Huddersfield NHS Foundation Trust (CHFT). SWYPFT operates mental health and Learning disability services in both localities, plus a range of health and wellbeing services, and participates fully in the local Strategic Review.

Across these health and social care economies commissioners currently spend approximately £647m annually delivering services to a population of about 461,000 people. Of this, £514m is spent by the two CCGs and a further £133m is spent by Local Authorities on social care. The local multi-agency Strategic Review has identified the financial challenge facing the local health and social care economy as £163m over 5 years.

Calderdale and Huddersfield Strategic Review Vision

We want to improve the health wellbeing and safety of all our communities by supporting people to be independent, and to deliver the right care, in the right place, at the right time.

Future Care System

We have agreed upon a set of principles for our future care system in these localities which will focus on supporting individuals to stay in control. This will involve widespread use of technology, support to build resilient communities, and greater emphasis on self care.

Provider-led Outline Business Case

In pursuit of this vision SWYPFT and other local provider organisation's CHFT and Locala CIC have collaborated to develop a Strategic Outline Case (SOC) which offers local commissioners a description of integrated health and social care services built around primary care and locality teams, supporting individuals and communities in self care; delivering more specialist care in communities; and ensuring the quality and safety of local service provision within an affordable envelope. The SOC identifies recurrent gross benefits of £50m. The SOC has been received by local commissioners, who are currently discussing the solutions offered with local Health and Wellbeing Boards and Overview and Scrutiny Committees. It can be found on the SWYPFT website

at: http://nww.swyt.nhs.uk/transformation/partner-programmes/Pages/Calderdale-and-Huddersfield-strategic-review.aspxm. While opinions are being gauged, work continues on the further development of the ideas in the SOC to create an Outline Business Case (OBC), which will quantify the benefits available in more detail, and articulate a clear route map for implementation. Staff and the public will be engaged in the development of the OBC during 2014. This will be a key part of the work with partners in 14/15.

Better Care Fund
In Calderdale £4m will be available in 14/15 as part of the Better Care Fund. This is taken from existing NHS investment. In 15/16 this figure will increase to £15.4m, of which around £8m is yet to be identified from existing NHS expenditure. Four schemes have been proposed for investment of Better Care Fund in Calderdale:

- **Scheme 1 – Hospital Support Services** e.g. admission avoidance and complex discharge coordination
- **Scheme 2 – 7 Day Working** e.g. SPA for intermediate care, OOH emergency duty
- **Scheme 3 – Locality Co-ordinated Care** e.g. SPA, Supporting Independence Teams, locality action on dementia and mental health (amongst others)
- **Scheme 4 – Resilient Communities and Individuals** e.g. self care support including assistive technology and peer support networks, risk stratification and extra care hubs/ supported accommodation

2.4.2 Wakefield and North Kirklees

The Wakefield and North Kirklees CCG areas share a common acute provider Mid Yorkshire Hospitals NHS Trust (MYHT). During 2013 an Outline Business Case (OBC) was produced for the sustainable future of both health economies, based on integrated locality delivery and reconfiguration of MYHT's hospital provision. This work was developed by all local partners including SWYPFT working together within a programme called Meeting the Challenge.

Meeting the Challenge
The Programme is focused on the following four development areas;

- **Urgent Care**: An integrated 24/7 urgent care system, with faster access to the right quality of urgent care, and integrated alternatives to A&E and hospital admission
- **Care Closer to Home**: Integrated health and social care teams, including proactive care and crisis intervention at home or in the community, supporting an earlier discharge from hospital
- **Safe and Healthy Pregnancy**: A choice of high quality maternity services, improving biological, psychological, and social birth related outcomes
- **Mental Health**: a hospital based liaison psychiatry service, faster access to the right quality of mental health care, avoiding unnecessary admissions, delayed discharge, and integrating with ongoing mental health support

Key implications for SWYPFT include the development of integrated locality teams, which will include mental health provision; and also the development of 'RAID style' liaison services at local acute hospitals. Currently the Meeting the Challenge business case is with the Secretary of State for review, however we have already supported the implementation of an interim liaison psychiatry arrangement at Pinderfields hospital in Wakefield which has started to improve the quality of care and experience of mental health service users within the

general hospital setting. During the period covered by this Plan, the implementation of Meeting the Challenge will require significant change within this local health economy including in our organisation, and presents many opportunities to improve quality and efficiency.

Better Care Fund
Wakefield's proposals for the Better Care Fund will support the strategic direction towards closer integration which has been signalled by Meeting the Challenge and the Health and Wellbeing Board priorities. Specifically emphasis on:

- Early intervention and prevention
- Person centred care
- Integration, rather than fragmentation, including mental health
- Collaboration between services, rather than duplication
- Cost effective delivery

2.4.3 Barnsley

Stronger Barnsley Together
SWYPFT, BHNFT, BCCG and Barnsley MBC were successful in becoming one of only 14 Health and Social Care Integration Pioneer sites nationally. The aim of the Stronger Barnsley Together initiative is to make sure that the health and care needs of local people are met in the face of an increasingly difficult climate. It will achieve this through a focus on better information, advice and guidance, using technology and signposting to alternative services. Scaling up preventative services, providing early help, reablement and more self-management of long term conditions and will use an asset based approach to individual and families in need.

Joint Strategic Needs Assessment Priorities
During the period covered by this Plan Barnsley CCG and the Health and Wellbeing Board will focus on seven clinical priorities along with two cross cutting priority areas:

- Preventing People from Dying Prematurely – **Cancer, Cardiovascular disease**
- Enhancing Quality of Life for People with Long-term Conditions – **Long Term Conditions, Mental Health**
- Helping People to Recover from Episodes of Ill Health or Following Injury – **Unplanned Care, Planned Care, Maternity and Children**
- Ensuring that People have a Positive Experience of Care – **Patient and Public Engagement, Patient Experience**
- Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm – **Patient Safety**

Programme Boards
The CCG has developed a structure of Programme Boards aimed at developing a systematic approach to commissioning. The Programme Boards bring together key stakeholders including partners and providers with a common purpose of delivering improvement and transformation across the health and care sector. The key ones for this Trust are:

Ageing Well This Programme will address; dementia diagnosis and support, intermediate care services, and other services supporting the frail elderly.

Planned Care This Programme will lead to more people with long term illness accessing planned care support, enabling independence and avoiding unplanned activity.

Promoting Independence This Programme will develop a new, sustainable approach to delivering personalised care and support based on maximising inclusion, self-reliance and resilience and drawing on the strength of all of our community. It includes Personal Health Budgets and early intervention in Mental Health.

Think Family
The Think Family Programme aims to develop high quality services and support for families who need early help, and those who have significant multiple problems, so that they achieve positive outcomes and consequently place less demand on local services.

Unplanned Care
The aim of the Unplanned Care Improvement Programme Board is to deliver more efficient, effective and integrated unplanned healthcare services for the people of Barnsley, while addressing immediate pressures on Accident & Emergency services. In 2014 to 2016 of particular relevance to us:

- Care Co-ordination Centre
- Virtual Ward model for Community Nursing

Barnsley Better Care Fund
Barnsley CCG has committed £3.5m non-recurrently in 2014/15 to pump prime Better Care Fund Initiatives and is committing £18.4m recurrently from 2015/16. In Barnsley the Better Care Fund will be used to

- Provide joint assessments across health and care ensuring that, where funding is used for integrated packages of care, there will be an appropriate accountable lead professional.
- Protect vulnerable adults by ensuring those people who are in need of care and support are able to access that support in a way that best suits their needs and requirements.
- Establish stronger and more co-ordinated 7 day working across the sector including to reduce the levels of emergency admissions and to support timely discharge from Hospital, either to home or to an alternative, appropriate setting.
- Data sharing between agencies to facilitate a joined up approach to care planning and delivery. Sharing of information should also lead to longer term efficiencies and reductions in duplication.
- Provide information, advice and sign posting to support and promote self-management and self-care by enabling people to make better informed decisions in managing their own health and social care needs.

What this means for us over the next 2 years:

- Influence the development of integrated locality care models (Calderdale and Huddersfield OBC, Wakefield and North Kirklees Meeting the Challenge, and Barnsley Integration Pioneer. Ensure connectivity with models of care developed through our own Transformation Programme (see section 5)
- Roll out of RAID / Liaison services contributing to better whole system efficiency, and supporting Parity of Esteem – particularly for people in the general hospital setting.
- Develop business cases for Barnsley commissioners relating to Care Co-ordination Centre and Virtual Ward. Our Transformation Programme includes a project focused on Long Term Conditions and related services. (see section 5.6)

2.5 Commissioner's Perspective on the Short Term Challenge

Local commissioners face unprecedented challenges, especially when the combined social care and health impact is taken into account:

As previously referenced at section 2.4.1 the Calderdale and Huddersfield health and social care economy currently spends approximately £514m via two CCGs and a further £133m is spent on social care. The Strategic Review has identified the financial challenge facing the local health and social care economy as £163m over 5 years.

In 14/15 the Wakefield CCG programme allocation will be £457.5m and in 15/16 it is estimated to be £465.3m. The QIPP target is estimated to be £14m in 14/15 and £12m in 15/16. From 15/16 onwards the CCG will be required to make recurrent investment into the Better Care Fund of around £27m per annum. This will be partially off-set by additional investment into the CCG of £7.6m, which is currently paid direct to local authorities.

In 14/15 Barnsley CCG (BCCG) will have available £363.7m of which £10.6m is non-recurrent monies. In 15/16 this will be £367.7m of which £3.6m non-recurrent. 2014/15 BCCG intend to focus on understanding the baseline position with regard to activity, cost and efficiency. This will build the foundations for fundamental system reform in later years of the Plan. Therefore it is essential that in 2014/15 SWYPFT;

- Works with BCCG to re-set activity baselines aligned to actual practice
- Supports the BCCG development of community reference cost information
- Completes transformation 'discovery' and 'design' work, ready for 'delivery' (implementation) from 15/16 onwards. Where possible implementation should be accelerated in 14/15.

2.5.1 QIPP

Local commissioners have highlighted the extent of the QIPP challenge facing our local health economies and have translated that into a QIPP requirement to be met through changes to SWYPFT services. The table below indicates the scale of that challenge in each of our local commissioning areas. (note – where Greater Huddersfield and North Kirklees CCG appear, the combined total of these two is equivalent to the challenge facing our own internal Kirklees BDU).

Year	Greater Huddersfield CCG		North Kirklees CCG		Calderdale CCG		Wakefield CCG		Barnsley CCG	
	Cash £,000	Non-cash releasing £,000	Cash £,000	Non-cash releasing £,000	Cash £,000	Non-cash releasing £,000	Cash £,000	Non-cash releasing £,000	Cash £,000	Non-cash releasing £,000
14/15	£459	£196	£269	£116	£274	£117	£750	0	0	0
15/16	£443	£191	£265	£113	£296	£116	£500	0	tbc	tbc

In response to these requirements the Trust has identified a series of QIPP opportunities and discussed these with local CCGs. There is strong alignment with the stated quality priorities of each CCG and good correlation with the SWYPFT Transformation Programme and CIP Programme content. It has been possible to provide CCGs with locally meaningful yet consistent QIPP proposals. The table below provides a summary of the main QIPP proposals, their intended impact, and to which CCGs they will apply.

Scheme	Calderdale CCG	Greater Huddersfield CCG	North Kirklees CCG	Wakefield CCG	Barnsley CCG
Flat Cash reduction to contract baseline. Commissioners receive the current activity profile and service offer while reducing contract baseline payments by between 1.5% and 1.8%.	✓	✓	✓	✓	✓
Alignment of funding to service utilisation. Due to historical positions there is a differential level of contribution between West Yorkshire commissioners, compared to service usage. In 2013-14 the PICU contracts were successfully re-based and common prices agreed with each CCG. In 14/15 we plan to apply this methodology to Inpatient acute beds.	✓	✓	✓	✓	
Review of Model of Mental Health Rehabilitation and Recovery. Improve quality for service users – more people will have their own address. Fewer people will require Out Of Area Treatment placements. Anticipated QIPP gain for commissioner based on reducing Out of Area placement expenditure, less cost of local reprovision. Exact share between CIP and QIPP to be determined.	✓	✓	✓	✓	✓
Review of Model for Self Directed Support. Development of alternative capacity which will enable a cohort of people who are currently dependent upon statutory services to live well, maintaining their wellbeing through participation in Recovery Colleges, Creative Minds and other social support networks.	✓	✓	✓	✓	✓
Review of Model for Older Peoples Services. Productivity gains in the memory assessment pathway, so that demand for assessments is met using less resource. Resources freed up would be reinvested into post-diagnosis support leading to more people with dementia being sustained in the community for longer, thereby reducing Continuing Care expenditure.	✓	✓	✓	✓	✓
Review of Model of Learning Disabilities. Redesign referral pathway to facilitate early identification and rapid access to specialist consultancy support. Provide equity of access to all aspects of the SWYPFT service offer across all local CCGs, including access to inpatient beds. Work with social care to provide packages of care closer to home at less cost. Reduce the rate of people entering full time care, by sustaining more people in community based placements.	✓	✓	✓	✓	✓
CAMHS. Use critical mass of Trust-wide CAMHS to improve out of hour's responsiveness and Tier 3+ gate keeping, thereby reducing Tier 4 Out of Area admissions	✓	✓	✓	✓	✓
Adult Psychology Productivity Review. Wakefield clinical psychology services will be reviewed to ensure optimal productivity and efficiency is obtained. It is expected that this will lead to increased activity, reduced DNAs, and shorter waits within the existing resource envelope.				✓	

3 Quality Plans

3.1 Commissioning Priorities

National Quality Priorities

The NHS has organised itself around a single definition of quality: care that is effective, safe and provides as positive an experience as possible. Within each of our main service areas the national policy direction is aligned around this:

Parity of Esteem for people with mental health needs is key, as is the need to work with people in a holistic Recovery focused way, always being mindful that there is no Health without Mental Health.

Growing demand for early diagnosis of dementia and provision of compassionate care and support for people with dementia and their families is a major driver for our services, as is the need to ensure dignity for all including at the end of life.

Local Commissioning Quality Priorities

In addition to implementing commissioner's quality priorities via QIPP schemes (see section 2.5.1) we have worked together with our local CCGs to agree CQUIN incentives which are meaningful locally in the context of commissioner's quality priorities and relevant to our services and their current state of development.

CQUINs

CQUIN Goal	Description	Where applies
NHS Safety Thermometer	We will be early adopters of the NHS Safety Thermometer, focusing specifically on self harm, violence and aggression, falls, medication errors and pressure ulcers.	All local CCGs
Friends and Family Test	Staff FFT implemented by April 2014, Service User FFT implemented by October 2014, full implementation by January 2015	Trust-wide
Premature mortality of people with severe mental illness	Two indicators: 1) relates to the assessment of smoking, BMI, blood pressure etc, and delivery of appropriate interventions within care plans. 2) requires up to date care plans shared with GPs for people on CPA	Trust-wide
Improving physical health of people using LD services	Recording of outcome measures, timely medicines reconciliation for inpatients, access to cancer screening, service user feedback survey.	All local CCGs
Service User Experience Survey	Undertake surveys (inpatient and community) and demonstrate feedback acted upon.	
Improve access to Wakefield CAMHS	Routine access to CAMHS/ Access to autism diagnosis	Wakefield BDU
Dementia: prescribing of anti-psychotic drugs	Ensure that those people in care homes with dementia prescribed anti-psychotic drugs have a clear plan to reduce and stop their use within 4 weeks of commencing.	Calderdale, Kirklees and Wakefield BDUs
Dementia	Improving access to dementia diagnosis	Barnsley BDU
Antimicrobial Stewardship	Review of use of antimicrobial prescription of topical medicines – in line with specified indications, and with specified review/ stop dates.	Barnsley BDU

Collaborative Risk Assessments	Development of and delivery of an education and training package for staff and service users regarding collaborative risk assessment and management	Forensic BDU
Supporting Carer Involvement	Development and implementation of a strategy to engage and maintain relationships with carers for service users in secure services	Forensic BDU
Needs Formulation at Transition	Provide service users with information regarding current and future needs identified, and how proposed services might best meet them	Forensic BDU
Quality Dashboard	Embed and routinely use the clinical dashboards for specialised services	Forensic BDU

In total the Trust has agreed to CQUINs valued at £4.7m for 2014/15, of which the majority are RAG rated 'Green' for delivery. £0.4m (8.5%) are rated as 'Amber'. No CQUINs are rated as 'Red' for delivery. The greatest risk is in the Calderdale, Kirklees and Wakefield BDUs where CQUINs valued at £0.23m are rated 'Amber'.

3.2 Our Approach to Quality

Our approach to quality has been set out in our Quality Improvement Strategy and will be further developed and embedded during 2014/15. It is in line with essence of the Francis Inquiry reports and the Care Quality Commission's (CQC) Strategy for 2013-16 Raising Standards: Putting People First. Developing a culture that is dedicated to learning and improvement, and that continually strives to reduce avoidable harm is a top priority for us which is evident in our strategic goals.

3.2.1 Our Quality Priorities are:

Priority 1: Service users are central to what we do (Listen and act)

Priority 2: Timely access to services (Access)

Priority 3: Improve care planning (Care & care planning)

Priority 4: Improve recording and evaluation of care (Recording care)

Priority 5: Improve transfers of care by working in partnership across the care pathway (Care pathways)

Priority 6: Ensure that our staff are professionally, physically and mentally fit to undertake their duties (Fit and well to care)

Priority 7: Improve the safety of our service users, carers, staff and visitors (Safety)

During 2013 we have worked with our communities, key stakeholders, governors of member's council and commissioners to identify our key quality improvement areas for the coming year. We have also looked at feedback we have received from our national and local questionnaires and engagement events and taken direction from national policy to identify our quality plan for 2014-17.

3.2.2 Quality Plan for 2014 - 2017

In summary, the plan is aligned to published commissioning intentions through the CQUIN and Service Development Plan aspects of our CCG contracts and will include:

- Work streams associated with the quality priorities agreed by the Board of Directors (following consultation as outlined above).

- Strategic quality actions identified through the external environment e.g. Francis report & Hard Truths, CQC Strategy and revised commissioning and quality surveillance requirements
- Actions from patient, carer and public engagement and experience feedback
- CQUIN Schemes agreed with Commissioners
- Monitor Compliance Framework
- Quality improvement issues identified through clinical audit, incident analysis, external and internal inspections and visits

3.2.3 Response to Francis, Keogh, and Berwick reports

The Trust has undertaken a full review and where required has implemented action in response to Francis 2 (published February 2013) and the government's initial response 'Patients first and foremost' (published April 2013). The Trust has also reflected on the commissioned review reports including 'A Promise to learn (Berwick)', the review of the NHS Hospitals Complaints System (Clwyd and Hart) and the review into the quality of care and treatment provided by 14 hospital trusts in England (Keogh).

The challenges that the Trust is now addressing are those specified for providers in the government's full response to the Francis recommendations 'Hard Truths – the journey to putting the patients first' published in November 2013. The key actions we took during 2013 were;

- Specialist leads undertook an assurance review and gap analysis which was completed in May 2013.
- Organisational assurance level agreed in respect of each key action area.
- Recommendations placed with relevant groups within the Trust to ensure appropriate action is taken
- Established the 'Francis into Action' Steering Group to provide direction and oversight for the organisational response and ensure regular progress reporting to Trust Board.
- Reporting into the steering group is a 'Francis into Action' task-group which holds responsibility for collation and monitoring of the organisational action plan.
- Focused review at both Executive Management Team and Trust Board
- Facilitated discussion at Members Council about the role and responsibilities of governors

Using the processes set out above we have established a framework for action. A summary of our action plan and the current status of the actions being undertaken are set out below:

Action
Ensuring the service user voice influences all we do - listening events with service users, carers and members of the public linked to our mission and values and our service transformation programme. - re-framed our values, defined our 12 charter standards, completing our Carers Charter
Obtaining and acting on service user feedback about their experience of care - complaints processes and responses - use of technology to support real-time service user feedback well advanced with all in-patient areas completing regular surveys and the use of technology in community services progressing following completion of a successful pilot project
Introducing values based recruitment, induction and appraisal to support the fundamental requirement for compassionate care.
In 2014/15 planning a 'year of values' including rolling out more 'right first time' modules which will reach about 150 staff each month

Building on processes for developing skills in local resolution of concerns and staff being empowered to challenge poor behaviour
Staff workshops: cross section of staff from all services and in different roles - focused on recommendations related to: training and education; openness, transparency and candour; nursing (expanded to look across all professional groups); care for the elderly; information practices.
Specific task groups such as current group looking at requirements around staffing levels. Existing groups/bodies where elements of Francis placed reviewed and built into appropriate policy and procedure.
The Trust identified the need for a clear communication strategy so staff are aware and engaged in the organisational response. Holding further staff learning events in march 2014 to ensure that we maintain and build on the communication and feedback from the original workshops. Specific focus for the workshops being, compassionate care, staffing and openness, transparency and candour.

An internal audit of the impact of Francis II was completed in February 2014. This audit has concluded that there was 'substantial assurance' regarding the completed Gap Analysis and the ongoing Action Plan that is being implemented.

3.2.4 Quality Concerns

The Trust's Directorate of Nursing and Quality has analysed a variety of sources to identify quality concerns and has set out the plans to address each below. Quality concerns have been analysed against our stated Quality Priorities. The sources from which concerns have been identified include both internal mechanisms such as Internal Governance Reviews and external advisory visits such as CQC Mental Health Act Commission visits.

Quality Priority	Issue and Action Taken	Source	Services Affected
Access	Access and Flow in some services. Developing improved partnership with families and carers. Action Plan in place and shared with commissioners	Internal Governance Review	CAMHS
Access	Improvement of routine access (14 days) to adult mental health services.	Quality Account Indicator	Mental Health services
Care & Care Planning	Improvements regarding CPA review in last 12 months, % people offered copy of care plan, valid diagnosis at discharge	Quality Account Indicator	Mental Health services
Recording & Evaluating Care	Improvement of documentary evidence in care plans	CQC MHA Visit	Mental Health services
Fit & Well to Care	Areas for improvement from latest survey - Health & Safety Training, Diversity Training,	CQC national staff survey	Trust-wide
Safeguarding	Seclusion facilities requiring improvement. Trust-wide refurbishment plan to be completed in 14/15	CQC MHA Visit	Trust-wide MH inpatient facilities

At the end of 2013/14 the Trust had 2 minor/ moderate impact CQC compliance actions outstanding related to the design and layout of some seclusion rooms and the general décor and environment of Hepworth ward (within Newton Lodge). The Trust has submitted a detailed action plan which will be fully completed by 31st May 2014. The plan addresses environmental improvements and increased maintenance including Hepworth ward being fully refurbished and redeveloped. This is included in the 2014/15 Capital Programme. The Trust has no major CQC concerns at the current time.

3.2.5 Quality Risks

We have evidence of significant improvements made during 2013/14. External and internal inspections, reviews and visits to our clinical services have provided us with a range of feedback, both positive and negative, which will continue to focus our quality improvement work in 2014/15 as set out above. Areas of on-going concern for prioritised focus are:

1. Access to services
2. Record Keeping & Data Quality
3. Care Planning

We will continue to prioritise these areas to ensure we reduce any unnecessary harm and improve the experience of all those who require care from our services. Monitoring of the Quality Improvement Action Plan will be undertaken by the Clinical Governance & Clinical Safety Committee. We will use our annual clinical audit programme to make sure that improvements are implemented and sustained. A detailed table of Quality Risks is included as part of the Overall Risk section at the end of this document

3.3 Quality Assurance

3.3.1 Overview of Quality and Safety Board Assurance

During 2013/14 the Board worked with key stakeholders to revise our Mission (see page 1). During 2014/15 the Trust's revised Mission and Values will be embedded through an Organisational Development approach, the 'Year of Values' - How we do things is as equally important as what we do.

The Board and the Executive Management Team have established an organisational development approach to support the delivery of the Board assurance framework, which includes clear accountabilities for aspects of quality and safety in Director portfolios, with defined objectives and regular reviews. The Board is also supported by the committee structures covering Audit, Mental Health, Clinical Governance and Clinical Safety. The key strategy document which underpins our approach to quality is the Quality Improvement Strategy which sets out our 7 Quality Priorities.

The Board listens extensively to service users, carers and staff in order to develop a rounded view of quality and safety. Some of the various routes through which Board members are able to listen to gain assurance, include; Dialogue Groups, Members events, unannounced visits to services, Chief Executive 'drop in' sessions, the 'What Matters' report including 'you said – we did', staff wellbeing surveys, and via the Whistle Blowing policy.

The Board also has a programme of regular and exception based reporting including Quarterly Assurance Reports and BDU Level quality performance reports. There is an annual review of the Trust's compliance with the terms of its FT licence, an annual risk assessment against all national and local performance targets including CQUINs, and a CQC compliance self-assessment is undertaken twice yearly, the outputs and mitigating actions from the reviews feeding into the Annual Plan. The Board cycle of meetings includes a quarterly Business and Risk focused meeting, which includes a strategic review of serious incidents, complaints concerns and compliments, the Quality and Performance framework, review of the Trust Risk Register and Board Assurance Framework, allowing the Board to provide an evidenced based self-certification in line with Monitor's Compliance Framework.

3.3.2 Self Assessment against Quality Governance Framework

The Trust Board regularly use the Monitor Quality Governance Framework as a tool for self assessment and improvement of assurance on quality. In 2013, following discussion at the Clinical Governance and Clinical Safety Committee the Directors of Nursing and Corporate Development commissioned a review, using Monitor's guidance, of the evidence against the Framework. An assurance report was presented at Trust Board in December 2013 which concluded that the Trust is meeting the requirements of the Framework. It also identified the following areas for further development;

Area for development	Current status and plan for 14/15
A Trust Board development programme was developed as part of the Trust's application for Foundation Trust status, there is a need for a full review of this programme in view of changes to the Board composition and the changing regulatory frameworks and requirements.	• Co-production of Trust Board development programme, including review of required skills and competencies. • Succession planning programme in place re NED recruitments.
Need to embed annual planning at team level with evidence to support the seven quality priorities.	• Annual planning 14/15 focused around service lines supporting the delivery of the Trusts 7 quality priorities.
Continued action to address Francis development areas, particularly Trust response to service user and staff feedback	• Clearer link between Quality Accounts and the organisational risk register • Further work to ensure learning from clinical audits is communicated and acted upon • Implementation of Friends and Family test for service users and staff and responding to issues raided "you said, we did".
Using service user and carer feedback to improve services and maintaining the impact of service user input	• Ensure feedback from engagement and consultation events is integral to the visions for transformational service change
Increased emphasis on understanding the cost base of services linked to refinement of service line reporting and development of the Quality Academy approach as a support function for BDUs.	• Supported by an external review of the Quality Academy commissioned by the Chief Executive • Increased utilisation of benchmarking, both internally and externally

Part Three – Operational Requirements and Capacity

4.1 Activity Projections

In previous years the Trust has operated fixed value contracts with activity baselines based on contacts and occupied bed days and for mental health services the cluster information for adult and older people's services. The activity baseline in this plan has therefore been calculated on the basis of contract expectations. Future year's activity utilises the baseline activity plus the impact on demand of demographic changes on our services. Specifically:-

Activity Baseline 2014/15 the key changes from 2013-14 out turn relate to the increase in mental health contacts based on a full year impact of RAID within Calderdale and Huddersfield. (14,617 mental health contacts split between adult and older people 8,653 and 5,964 respectively).

Activity Baseline 2015/16 the activity baseline has been adjusted for the estimated impact of the cost improvement and transformation programmes as follows:-

- Rehabilitation bed reduction = 39 beds and 9,965 bed days; but corresponding increase in mental health rehabilitation community contacts: 31,558 contacts estimated delivery for 31 w.t.e.
- Older People's bed reduction = 16 beds and 4,964 bed days; but corresponding increase in community contacts of 17,520 based on ratio of 1:3 bed days to contacts.
- If we are successful in the national procurement exercise for secure services there will be a predicted increase in bed days for forensic services of 3,294 occupied bed days. This is not reflected in the current Plan.

Activity Baseline 2016-17 the activity baseline has been adjusted for the further estimated impact of the transformation and cost improvement programmes as follows:-

- Acute Bed reduction = 16 beds and 4,964 days; but corresponding realignment of Crisis and Home Based Treatment activity to support alternatives to admission following review and redesign in 2014/15.

4.2 Workforce

In 2014/15 and 2015/16 the change to our workforce numbers in w.t.e. terms is as follows:

	2014/15	**2015/16**
Opening w.t.e.	4,259	4,148
Service Developments	54	77
CIP	(132)	(143)
Other	(33)	
Closing w.t.e.	4,148	4,081

In addition during the next two years the Workforce Programme will increasingly align with the Transformation Programme. A summary of the key workforce schemes that contribute towards our Transformation and the change in w.t.e. is set out in the table below:

Change	Impact	Quality	Efficiency	Trans formation
Changes to ward based shift patterns will reduce handovers and better align staff numbers to service user needs	£1.5m saving in 14/15, equivalent to 58wte	✓	✓	
Vacancy Control Panel – leading to reduced use of agency and locum staff, and driving adherence to an increased vacancy factor in budgets. Particular focus on medical locums	£4.3m saving in 14/15, equivalent to 143wte from vacancy factor		✓	
Medical Staff Review – including consideration of appropriate time for Supporting Professional Activities in job plans – will free up time for clinical leadership of transformation projects	£500k identified, plus possible reduction in w.t.e required tbc		✓	✓
Reform of Reward and T's & C's – including AfC reform in 15/16 and local performance related pay arrangements for senior managers, mileage rates, study leave allowances etc	£850k from Ts & Cs, further work will quantify 15/16 impact of AfC reform	✓	✓	
Continued emphasis on sickness absence – internal benchmarking, focus on support to reduce stress related absence – e.g. rapid staff support service and engagement forums linked to staff survey results	£590k during 14/15	✓	✓	
Implementation of clinical and management leadership arrangements in BDUs, and review of wider management and administration arrangements, including consolidation within some trust-wide specialist services, and via implementation of community hubs	£650k, equivalent to 25wte identified, further opportunity to be quantified	✓	✓	
Development of the clinical support workforce including clinical apprenticeships - clearer career paths and better skill mixing	Quality & compassion in care. Efficiency gain to be quantified	✓	✓	✓
Development of Peer Support workforce as part of emphasis on Recovery including Recovery Colleges. Enabling subsequent re-focusing of traditional professional roles and w.t.e reduction in community teams (mental health and physical health)	Improved alignment with service user expectations, improved recovery outcomes, efficiency gain to be quantified	✓	✓	✓

4.3 Bed Base

Mental Health Bed Capacity
Our local CCGs commission capacity from the Trust to provide just less than 100,000 mental health bed days per annum. This covers Adult Acute Mental Health, Adult PICU, Mental Health Rehabilitation, and Older Peoples Mental Health, including Rehabilitation. The split between our commissioners is broadly 1/3 each for Kirklees and Wakefield and 1/6 each for Calderdale and Barnsley.

In 2014/15 one of the key areas of transformation activity will be to extend the Patient Flow Co-ordination work that has been tested in the Kirklees BDU during 2013/14 in order to reduce the use of Out of Area placements. This, coupled with the review and realignment of Crisis and Home Based Treatment, will impact on the overall number of occasions when an out of area placement is required and also on the length of stay within out of area placements.

Forensic Bed Capacity
We are commissioned to provide capacity for around 50,000 forensic bed days per annum serving the Yorkshire and Humber region. This covers both Medium and Low secure environments and a range of sub-specialisms within the Forensic field. In 2014/15 we expect significant changes to the Forensic commissioning framework, driven by a national tender for centres of excellence and full pathway provision. In preparation for this development the Forensic BDU is refining pathways for key sub-specialisms following a thorough evaluation of the market and opportunities in 2013/14.

Physical Health Bed Capacity
In Barnsley we provide capacity for 24,500 bed days addressing the local need for older people's sub-acute rehabilitation, neurological rehabilitation, and stroke rehabilitation. In addition we operate an 8 bedded substance misuse inpatient detoxification unit focused on complex cases. In 2014/15 we will develop a commercial approach to evaluate and exploit the potential of this facility.

4.4 Capital Plan

The Estates Strategy previously approved by the Trust Board remains the strategic framework for the capital plan in 14/15 and 15/16. Specifically this strategy is focused on:

- Development of Community Infrastructure
- Development of Inpatient Estate linked to Acute Care Pathway
- Ensuring Compliance with national standards and the regulators
- Disposal of Surplus Estate

The capital programme is aligned to the Long Term Financial Plan and is as per the submission made to Monitor in January 2014. It provides for capital expenditure of £11.8m in 2014/15 and £7.4m in 2015/16. The approach adopted is that all new capital developments will be designed to support service transformation and will be based on agile working principles supported by greater use of IM&T. All new capital developments will be subject to the approval of business cases that clearly set out the service and financial impact.

Summary of Capital Plan Expenditure in 2014/15 and 2015/16

Development	2014/2015	2015/2016	Description
Community Hub Development	£6.6m	£1.5m	Programme of reconfiguration of community estate to invest in smaller number of community hubs which are multi-disciplinary, create potential for co location with partners and reduce the overall space requirement by incorporating impact of agile working
Main inpatient site master plan	£2.4m	£3.4.m	Reconfiguration of main site at Fieldhead to incorporate a decant facility and rationalise and refurbish inpatient accommodation and create a support service hub.
IM & T	£0.5m	£0.2m	Capital investment has reduced from 2014/15 due to outsourcing of IT services for services and networks. The capital spend is linked to the continued development of clinical systems and software to facilitate agile working and promotion of web portals and reduce reliance on paper records
Maintenance and minor capital	£2.3m	£2.3m	reflects 2 year rolling programme for estate maintenance and compliance plus allocation of £1m for Service specific bids linked to service quality improvements
Total	**£11.8m**	**£7.4m**	

Capital Receipts
In 2014/15 the Plan forecasts £1.3m receipts from disposal of surplus investment property. Future capital expenditure post 2016-17 is dependent on generating capital receipts from the disposal of surplus estate. This represents a critical risk to the overall estates strategy as any slippage in disposal will create increased revenue running costs from 2016-17 and deferring of capital investment.

An additional risk is the assumption regarding the share of the capital receipt from CHFT on the disposal of the St Luke's site. The Trust has taken independent advice on the most likely outcome of valuation with planning permission; worst case scenario would be a share worth £800k which will be realised in 2016-17.

Enabling Transformation and Delivery
The focus of the schemes above is to support integrated team working closer to communities – in line with the transformation vision of the Trust and of our partners. In addition opportunities to consolidate sites from which support services are provided enable the Trust to deliver further efficiencies, while minimising impact on front-line clinical delivery.

Cash Balance
The cash balance at the end of 2 years is £29.4m with an EBITDA of 5.6%. Assuming the plan is delivered to target this does create potential for additional capital investment using

historical cash reserves to support the Estate Strategy without compromising the EBITDA position

4.5 IM&T Plan

The aim for 2014/15 and 2015/16 is to use IM&T to facilitate:

- Transformation of services both within the Trust and more widely in conjunction with partners
- Staff being able to work in an agile fashion without being tied to fixed locations
- Integration of key clinical systems with partners including between health and social care

Once we have delivered this plan the following benefits will be achieved:

- Services will be able to deliver care where and when it is required
- Clinical systems will enable not limit the integration of care
- Service users will use technology to access our services in the same ways that they use technology in other aspects of their lives
- People will have access to relevant activity data when and where it is required
- Information will be shared across health economies and used to support improvement
- Resilient and robust infrastructure will underpin the consistent achievement of these goals

Our priorities for delivery in 2014/15 and 2015/16 are:

2014/15	2015/16 and beyond
Transfer to new IT Support Provider (July – Nov 2014)	Continued support to the Transformation Agenda & Estates Strategy
Facilitate the Transformation Agenda & Estates Strategy	Implementation of Trusts revised Telecoms provision
Roll-out plan Lync/agile working/comms	Continued development & optimisation of key clinical system to meet service needs
Clinical System optimisation and development (RiO & SystmOne) / Route map	Partnership working to develop Clinical Portals for staff and clients
Core assessment April / Specialist / E-discharge	Development and enhancement of the Performance Framework & information provision
In Q1 Integration / Interoperability of clinical systems within the Trust and with partners to improve accessibility and sharing of data	
In Q1 SystmOne and Rio sharing information – RAID	
Self care hub: clinical portals	

Operational risks in the delivery of this Plan are included in the combined Risks section at the end of this document.

PART FOUR – PRODUCTIVITY, EFFICIENCY AND CIPs

5. Our Transformation and CIP Programmes

In 2014/15 our overall cost improvement requirement is £12.9m, and in 15/16 it is 11.8m. To reduce recurrent expenditure in line with this we have both a CIP and a Transformation Programme

In 2014/15 £500,000 of the overall cost improvement requirement will be met through the Transformation Programme, and in 2015/16 at least £4.85m (41%) will be achieved via Transformation. The main transformation projects that will contribute to this are:

- Transformation of Dementia / Memory Assessment
- Transformation of Mental Health Rehabilitation and Recovery
- Transformation of Adult Acute and Community Mental Health
- Transformation of General Community (physical health)
- Transformation of Learning Disabilities
- Transformation of Forensic mental health

A summary of the hypothesis underpinning each of these major schemes and the key milestones for each is set out below:

5.1 Dementia

The issue is that the current service model is resource intensive in diagnosis and prescribing, and less effective in carer support and enabling people to live independently for longer

Change	Impact	Timescale
Quicker Memory Assessment process which is less resources intensive. This work will improve the quality and efficiency of memory assessment processes to meet growing demand. The project will aim to do this with fewer resources, to enable investment of efficiency savings into post-diagnosis support for people with dementia and their families. Increased rate of discharge will support this change.	• Free up £1.1m from 15/16 enabling some reinvestment in post-diagnostic support (differential opportunity between BDUs) • Improve service user experience by reducing end to end time from referral to diagnosis and prescribing commencement from current delivery of 3 - 9 months • Increase capacity of memory assessment process to meet demand. (23% growth in prevalence by 2020).	• Complete understanding of demand, activity, workforce numbers, waiting times, capacity etc by end April • Complete redesign of pathway by end Q1 • Complete implementation by end Q2
Discovery College will provide support for families and individuals to help them stay independent longer. This programme of activities delivered as part of a "Recovery College" will improve quality of service for service users and their families.	• Improve service user and carer experience by enabling access to community support and Discovery College content following diagnosis • Increase the number of people supported to remain in their own homes for longer, delaying entry into institutional residential care by	• Complete development of Discovery Colleges by end Q3 • Link to community hubs and GP practice development with CCGs by end Q4

This will result in more people being supported to remain in their own homes for longer	approximately 12 months for 50 people per annum. This will generate a saving for commissioners of Continuing Care of approximately £200k per annum per person	

5.2 Mental Health Rehabilitation & Recovery

The issue is that we have an institutionalised model of care for people with long term mental health problems, focused on maintenance rather than recovery.

Change	Impact	Timescale
More people with severe and enduring mental health problems have their own address and live in the community with support rather than in secure rehabilitation. This will improve the quality of experience and outcomes achieved for people needing longer term rehabilitation from mental ill health, and improve value for commissioners and providers. Savings will be realised due to the difference in costs between inpatient care and packages of support provided in the community. SWYPFT have commissioned a third sector provider to review current service provision and recommend an alternative model	• Annual recurrent savings for the Trust (compared to current spend) of £1.35m from 15/16. • Additional QIPP benefit for commissioners based on reduction in out of area placements • More people supported to live independently in their own homes in their communities, instead of living in institutional settings, both within the Trust and in private sector placements, which are often Out of Area	• Review external service review work early Q1 • Define community aspects of future model by end Q1 • Review and agree functions of key inpatient units by end Q2 • Determine role of housing providers and how we will work with them by end Q2 • Determine role and functioning of Recovery Colleges and link to Peer Support by end Q2 • implementation plan by end Q2

5.3 Acute Mental Health

The issue is that there is increasing pressure on inpatient beds due to ineffective case management in community services with sub optimal management of “crisis”

Change	Impact	Timescale
The Crisis resolution and Home Based Treatment Team (CRHBT) will provide comprehensive assessment, preferably face to face, for	• In combination with Community Mental Health transformation free up £1.1m resources recurrently from 15/16	• Understand the profile of the bed base – for example occupancy, length of stay, beds per 100,000 of population –

service users presenting with very urgent high risk and complex needs within 4 hours. It will focus on intensive home based treatment to reduce pressure on beds as well as increasing capacity of CRHBT to support timely discharge from wards Introduction of lean principles to wards e.g. early discharge planning More active management of Out of Area placements by care coordinators and patient flow coordinators Initial Assessment undertaken by experienced clinician to ensure that right care package implemented first time.	• More admissions gate-kept by Crisis • Improved quality of experience and outcome for service users through reduced hospitalisation and increased community treatment. • Reduced use of Out of Area placements (both frequency of use and length of stay). Leading to savings for the Trust • Impact on acute general hospital experience and usage – through RAID / Liaison service roll-out	linked to clustering by end Q1 • Understand the proportion of beds used for sub- acute/ step down activity at, (for example at Enfield Down) by end Q1 • Understand the spend on, and extent of, out of area activity linked to acute provision by end Q1 • Understand the split of Crisis work – gate-keeping, home-based treatment, any evidence of taking on complex CMHT cases by end Q1 • Agree revised thresholds between CRHBT and Community functions in support of more home based treatment and gate keeping by end Q2 • RAID / Liaison evaluation underway in Q1 – continues throughout 14/15 • Separation of SPA and CRHBT resources by Q3

5.4 Community Mental Health

The issue is variation in caseload and outcomes between community mental health teams due to insufficient clarity of focus and understanding of "what good looks like". Transformed services will include more substitute activity, and better case management using MH currency

Change	Impact	Timescale
This work will develop substitute recovery focused service provision which will enable savings to be realised within existing community services It will refocus community teams on care coordination and the provision of a responsive service including urgent response which will reduce demand on the acute pathway. Access to services through efficient SPA offering triage assessment and signposting. Plus rapid re-entry to services (not via SPA) for those recently discharged	• see acute MH transformation above for savings • More people supported via peer support and recovery colleges/ fewer on CMHT caseloads • Greater GP satisfaction through rapid access to guidance and advice • Greater service user satisfaction through more responsive and flexible service	• Clear definition of pathway by end Q1 • Understand current team composition incl. discipline for all CMHT, EIP, and AOT teams by end Q1 • Caseload activity profiles, CPA performance by team by end Q1 • InPAC mapping of current and future service models, incl. links to primary care and acute by end Q2 • Development of Recovery Colleges supported by Peer Workers: plan by end Q2, implementation by end Q3 • Transfer of CMHT activity into Recovery Colleges and Peer

	Support Networks by end Q3 • Linkages with primary care to agree shared care model by end Q3 • Agree and determine configuration for larger integrated CMHTs by end Q2 • Review need for realignment of APTS by end Q1 • Agree function of AoT by end Q2 • 1st stage of movement into community hubs by Q4

5.5 Learning Disabilities

The issue is a need to improve outcomes and service by standardising the offer across commissioners and clarifying the consultancy role of these services in support of whole system efficiency.

Change	Impact	Timescale
This work will drive efficiency and quality improvement across the whole LD system locally – not just in Trust provided services. We will aim to consolidate specialist LD beds onto a centre of excellence and support the flow of service users through consultancy and advice. We will drive operating efficiency through a Trust-wide LD service management approach and movement of more activity into the community	• Saving £220,000 by 15/16 • Reduction in management cost • Estate rationalisation • Increased control and independence for service users	• Consultation Q1 14/15 • Consultancy and Advice business model defined Q1 • FBC for centre of excellence Q2 • Trust-wide staffing model published Q2 • Implementation begins Q3 14/15

5.6 General Community

The issue is a lack of clarity on service definitions and how this meets peoples' needs. Transformed services will be more integrated, have improved productivity and help meet demographic and service pressures

Change	Impact	Timescale
This work will improve quality and access through the establishment of a central care coordination centre handling referrals. It will drive efficiency and enhance service user experience through staff multi-skilling in LTCs and the deployment of virtual ward approaches. It will build on	• Saving £250k in 14/15 and £1.1m by 15/16 • Reduction in management and administration costs • Estate rationalisation • Increased use of technology to access services	• Review of LTC demand and capacity Q1-2 • Deployment of Health and Wellbeing hub from Q2 • Care coordination centre business case to commissioners in Q2

existing strength in tele-coaching to develop a telephone and web access hub supporting delivery of health and well being services at scale	• Increased integration of services – care coordination centre/ virtual ward etc	• Roll out of LTC model from Q3

5.7 Forensic Services

The issue is the need to be competitive on price but also demonstrate value through achieving faster progression for individuals through pathway from medium to low secure and beyond.

Change	Impact	Timescale
In 2014/15 we anticipate a national tender for secure mental health services. The direction of travel indicates full pathway provision and centres of excellence will be at the heart of the requirement. We will develop sub-specialised pathway offers and develop clinical networks in readiness for this development	• Enables better patient flow and care closer to home • Maximised contribution from secure services through sub-specialisation strategy • Effective pathway working through clinical networks	• Q1 refinement of sub specialist pathway offers and development of clinical networks • Q2 bid preparation and submission • Q3 commence mobilisation

5.8 Transformation Programme Delivery and Assurance

Including those schemes described above, the Transformation Programme is made up of four delivery work streams (Mental Health, Learning Disabilities, General Community and Forensic) which contain 12 projects. Some of these projects are specifically focused on quality enhancement and productivity, but most will generate a balance of quality improvement and efficiency savings.

To support the delivery of the Transformation Programme the Trust has established a programme infrastructure whereby:

- Every work stream has an accountable lead Director, supported by a programme manager
- Every project has a project manager to drive delivery and a clinical lead to safeguard quality and ensure change is embedded
- Every work stream has a monthly Transformation Board that checks progress on all projects and supports Directors reporting each month to the Executive Management Team
- All of the above is supported by a Programme Management Office that provides the framework and assurance
- All projects move through a three phase development process ‘Discover, Design and Deliver’ with gateway reviews between each phase.
- All projects utilise a co-production approach with service users and other stakeholders

In 13/14 progress with the delivery of the Transformation Programme has been slower than planned. In 14/15 the following changes will accelerate progress:

- Chief Executive review of all Work streams with Director leads;
- Each work stream has plan with key deliverables to be actioned each quarter as a "critical path" which will be monitored during the year;
- Each work stream has developed a "vision" statement which has a communication and engagement plan.
- Developed rationale for service model and associated savings which is reflected in the 2015/16 plans.
- Made QIPP proposals to our commissioners in each District which link to the Transformation themes so that our transformation programme is aligned with commissioner intentions and the wider system transformation programmes.
- The completion of operational Deputy Director and Clinical Lead recruitment processes (in Q1) will ensure better connectivity with operational teams for implementation and embedding of changes
- The transformation tool kit has been completed in year and training rolled out to ensure consistency in delivery of product , monitoring of progress and governance;
- Resources in place in the Programme Management Office to support the work and monies set aside in the Innovation Fund to support the engagement of external expertise and secondment of internal staff where this is appropriate;
- Internal Audit report commissioned on Transformation Programme which is due to report to Audit Committee in April.

5.9 Our Approach to the Cost Improvement Programme

5.9.1 Generation of CIP proposals

The Trust Annual Planning process operates at Team, Service Line, and BDU (or Quality Academy Directorate) level prior to being combined into the overall Trust Plan. Within this process BDUs and Quality Academy Directorates generate opportunities for CIP. These are all quality impact assessed in line with the process set out below. In addition to team generated CIPs the Quality Academy undertakes exercises to help identify further opportunities. This includes scenario planning – e.g. HR provision of shift pattern analysis, Finance providing benchmarks and analysis of under-spends against budget etc.

5.9.2 Quality Impact Assessment

The Trust operates a robust Quality Impact Assessment (QIA) process which is applied to all CIP and transformation programme changes prior to implementation. In 13/14 the challenge process has been improved to include wider input from the Trust's Quality Academy (corporate support directorates) and more challenge between operational BDUs. This has ensured that safety and quality are safeguarded, and where possible additional opportunities to realise efficiencies have been identified.

The QIA process involves a high level review by EMT to identify areas that require further scrutiny and indicate key lines of inquiry for the review. A quality impact rating process is

completed by BDUs for each identified CIP utilising a standard QIA tool. Initial assessments are then reviewed at joint BDU/Quality Academy challenge events where the relevant BDU/Quality Academy Directorate general manager and clinical lead review the cost improvements with matched quality academy/specialist clinician/ personnel, basing discussion around the key lines of inquiry. A desk top review follows, which is undertaken by Nursing, Medical and Workforce Directors, before EMT approve.

5.9.3 Summary of CIP Programme

		Workforce Productivity	Workforce Redesign	Service Redesign	Estates & non pay	Income CIP	Total
2014/15	w.t.e	58	74	-	-	-	132
	Pay	£2,588,000	£5,424,000	£500,000	-	-	£8,512,000
	Non-pay	-	-	-	£4,386,000	-	£4,386,000
	Total	**£2,588,000**	**£5,424,000**	**£500,000**	**£4,386,000**	**-**	**£12,898,000**
2015/16	w.t.e	-	37	106	-	-	143
	Pay	£500,000	£3,450,000	£3,395,000	£2,200,000	-	£9,545,000
	Non-pay	-	-	£1,455,000	-	£800,000	£2,255,000
	Total	**£500,000**	**£3,450,000**	**£4,850,000**	**£2,200,000**	**-**	**£11,800,000**
2 Year Plan	w.t.e	58	111	106	-	-	275
	Pay	£3,088,000	£8,874,000	£3,895,000	£2,200,000	-	£18,057,000
	Non-pay	-	-	£1,455,000	£4,386,000	£800,000	£6,641,000
	Total	**£3,088,000**	**£8,874,000**	**£5,350,000**	**£6,586,000**	**£800,000**	**£24,698,000**

Workforce productivity includes changes to shift patterns, and improved recruitment management processes.

Workforce redesign includes clinical roles review, effective alignment of mandatory training requirements with service needs for 2014/15. In 2015/16 it additionally includes review and harmonisation of terms and conditions.

Service redesign is focused on the Transformation Programme as outlined at section 6.

Estates and Non Pay includes savings identified through efficient procurement, improved budgetary management and review, and estates rationalisation.

Cost Improvement Programme Assessment

All of our CIP initiatives for the 2 years of this plan have been identified and scale of opportunity has been assessed. Based on initial Quality Impact Assessment these plans are realistic and achievable. For 2014/15 £9.6m (c. 75%) of the total £12.9m has a detailed plan effective from 1st April 2014. Plans are being worked up for the remaining 25% with a phased implementation throughout 2014/15.

PART FIVE – FINANCE AND RISK

6.1 Financial Performance

The next two years will continue to be challenging for the Trust due to the ongoing requirement for efficiency; and expected changes in service provision anticipated to meet the need for the development of more integration of services. The latter is likely to lead to significant organisational restructure within 5 year period.

The financial and clinical strategy for the Trust therefore needs to put the organisation in the position where it can

- Capitalise on its strengths – Continue to do the "day job" well and maintain quality of services and market share;
- Align achieving quality with the use of resources to generate areas of improvement and cost reduction.
- Drive productivity and efficiency so that existing services are competitive;
- Drive service improvement and innovation so that existing services can be redesigned to be more integrated with physical and social care in order to meet demographic need within reduced resources
- Identify opportunities for new business through expansion and growth in services;
- Create the right conditions externally in terms of managing stakeholders and internally in terms of having the right capacity and skills to realise those opportunities.

This is consistent with the Trust's mission:

Enabling people to reach their potential and live well in their community

6.2 Assumptions

In setting the financial plan the LTFM reflects the key principles agreed by the Board in the financial strategy.

- The drive in determining the use of resources is the link to quality. International evidence has shown that improving quality also reduces costs and therefore the financial plan and strategy is predicated on quality being the key driver.
- Maintain a normalised EBITDA of 5%
- Maintain a recurrent underlying surplus of 1% to 1.5% which is increased non-recurrently to fund the capital programme.
- Generate cash reserves through surplus to fund a significant capital investment programme to 2016/17 to support and enable redesign of services and reduce estate running costs;
- Achieve a Continuity of Service FRR of 4 based on the 2013/14 risk rating which is more focused on demonstrating strength of liquidity and going concern position.
- Demonstrate efficiency meeting nationally recognised efficiency requirements of between 4% to 5.5% (dependent also on local service investment requirements) through the quality and efficiency savings Programme.
- Have effective contingency planning for downside scenarios due to changes in providers, outcomes of tenders and future commissioning intentions.
- The plan also reflects the requirement for providers to create efficiencies across health and social care pathways through better integration of services. This is particularly pertinent in year 2 of the Plan.

6.3 Income, Activity and Demand Management

The assumptions for income are summarised below:

- Between 1.5% and 1.8% deflation in contract income for 2014/15 and 2% deflation in 2015/16 to reflect tariff deflation and decommissioning costs which is assumed to continue through the life of the plan.
- 2.5% of income for 2012-15 linked to achievement of quality targets (CQUINS). This reflects the continued focus on quality and outcomes and linking financial reward to quality. The plan assumes that the Trust is able to meet these requirements and secure this income on an on-going basis.
- Impact of mental health tariff. The trust has agreed a Memorandum of Understanding with its commissioners for 2013/14 and set up a joint Steering Group and work programme. The purpose of the group is to understand the current position in terms of service model and quality expressed by the mental health currency; and agree a transition to a "tariff" model which complies with national requirements and meets local commissioning needs. The Trust shared baseline information on costs and activity in 2013/14 and there is an agreed programme of rebasing between the west Yorkshire commissioners so that the same price can be charged for the same activity. This will continue in 2014/15. The contract risk management arrangements continue to be fixed price contract with monitoring of activity and quality metrics and application of contract penalties for failure to achieve key performance indicators e.g. IAPT.
- Additional investment from Commissioners has been included in the plan from 2014/15 onwards.
- Revenue generation development schemes have been included for 2015/16. Providing an additional contribution (c. £800k) anticipated from additional forensics activity; additional income stream from Creative Minds, alternative therapies and training; additional income from liaison psychiatry and tender opportunities.

6.4 Costs

The table below highlights the key incremental investments within the Trust expenditure plan. These represent the areas in which the Trust has to invest e.g. pay awards and those in which it has prioritised for investment, particularly in ward staffing, and for example VAT guideline changes. These cost pressures and investment requirements have led to a corresponding increase in the Trust Cost Improvement Programme above the national 4% efficiency requirement.

Heading	Description
Pay Award, Incremental & Pension Changes	In line with nationally issued guidelines additional pay expenditure has been planned to cover National pay awards, Incremental impacts under Agenda for Change and proposed pension changes from 2015/16 and beyond. As pay represents approximately 75% of all Trust expenses increases in this area give a material impact on the Trust position.
Non Pay Inflation & VAT	Increased expenditure has been included as a result of non-pay inflation assumptions. For 2014/15 a recurrent pressure has also been factored for the VAT changes expected to be implemented from 1st April 2014.
Tariff Deflation	The Trust has been able to negotiate with local Commissioners to secure agreeable rates of Tariff deflation. Within the various contracts different rates exist due to the nature of the Trust service offer which includes both inpatient and community services.
Cost Pressures &	As noted below the Trust has identified significant levels of cost pressures

Developments	and developments. For 2014/15 this has included recurrent funding, as below, but also a material level of non-recurrent investment. Trust Business Delivery Units will continue to work and mitigate these costs.
Depreciation / PDC	The Trust undertook an Estates Transfer on 1st April 2013 and the increased PDC impact of this has been included in the plan for 2014/15. (as originally planned)
Estates	In line with the Trust Capital Programme, 2 main Estates impacts have been included for 2014/15. These costs are for the revaluation of 2 Trust assets, one of which is planned to be sold in 2015/16.
Restructuring	As identified previously the Trust will be undertaking a Transformation Programme during 2014/15 and 2015/16. As such an estimation of the restructuring costs associated with this major change has been included within the plan.

As noted above the Trust has identified a significant level of development funding in 2014/15. The key recurrent areas are:

Description	Pay	Non Pay	Total
Investment in Inpatient Services	£600,000	-	£600,000
Investment in Governance	£511,000	£36,000	£547,000
Investment in IT & Technology	-	£466,000	£466,000
Transformational Investment	-	£500,000	£500,000
Non Pay investment above inflationary	-	£460,000	£460,000
Total	£1,111,000	£1,463,000	£2,574,000

Additionally a further £1.8m has been included non-recurrently. This includes staffing support and additional investment in projects such as the roll out of Agile Working.

6.5 Key Actions to Support the Delivery of the Financial Strategy

The key actions to support the financial strategy are summarised below:

- Completion of the internal transformation plan for incorporation into revised Integrated Business Plan which is due to be presented to the Board in June 2014. This involves completion of the plans for the 4 transformation schemes – Mental Health; Learning Disabilities; General Community Services and Forensic Services – and the contribution of enabling strategies, workforce, estates and IM & T. The Transformational Service Redesign programme will define a clear vision for the future and articulate the service offer; using innovative practice and partnership working to sustain the quality of services in a resource constrained environment
- Application of the “Recovery model” concept to the redesign of services which will require investment of time in staff training and development and engagement with service users and carers.
- Maintenance of good working relationships with local provider partners and local health and social care commissioners to ensure that the purpose and value added of the internal transformation programme is understood and supported; and the Trust is able to play a role in shaping the integration of services in the future.
- Manage the transition to a currency model for Mental Health services both internally and externally to minimise the risk of reduced contribution.

- Utilisation of Service Line Reporting through the Business Delivery Units to ensure that all service lines have a sustainable baseline in terms of activity, workforce and resources and to identify opportunities for creating efficiencies.
- Deliver a substantial Cost Improvement Programme from the management of expenditure on current services and redesign of the service offer through the planned Transformational Service Programme.
- Implement the Estates strategy and manage the Capital Programme to support the service redesign and optimise the estate footprint and costs.
- Implement the IT strategy to ensure that robust infrastructure is in place to support innovative use of technology in delivering the revised service offer
- Implement the workforce strategy to drive workforce productivity and support the development, skills and well-being of our staff so they can enable service users to "achieve their potential."

6.6 Downside Scenario and Risks

The Trust has agreed contracts for 2014/15 which are in the fixed price contracts. Therefore the financial risk associated with fluctuations in activity is relatively low.
However the Trust does recognise the risk that may present in future years as commissioners retender services and increase the services which they commission through any other provider.

There are three areas where there is likelihood that commissioners will wish to test the market

- Intermediate care services in general Community Barnsley
- Specialist services – IAPT and health and well being services
- National procurement for forensic services

The Trust believes that it would be successful with the majority of services in any such re-tendering exercise with one possible exception in respect of IAPT. The Trust deliver IAPT Services within Barnsley and Kirklees and these services are potentially services where commissioners may want to retender. The investment in these services is £5.0m which is approximately 2% of the Trust clinical income.
If the service were retendered and the Trust was only partially successful then assuming income loss of £2.2m, that staff would TUPE and majority of non pay costs could be released, however there would be potentially up to 20% in relation to fixed costs which couldn't be released in the short term. This amount would be c. £0.4m

Mitigating Actions – Short Term

- Utilisation of recurrent contingency £0.5m from 2014/15
- Utilise element of Innovation Fund reserve £1m

Mitigating Actions – Medium Term

- Develop additional recurrent savings and/or increased revenue to cover loss of contribution and un-releasable fixed costs

Risks to the Delivery of the Plan

	Risk	Controls
Quality Risks	Risk that implementation of transformational change will result in an imbalance of staff skills and capacity between the day job and the change job	• Clear and regular monitoring of quality indicators reported to EMT and the Board to ensure day to day operational performance maintained • Clear accountabilities for both operational delivery and transformational change. Including clinical leaders empowered to highlight issues and act upon them • Robust process in rollout of corporate objectives there is focus and clarity on priority areas; • Good staff support and programme management through the delivery of the Transformation Programme
	Risk that service users and carers perceive a diminution in quality as our clinical approach transitions from a professional expert approach to a co-production/ empowered service user model	• Tracked through service user experience measures and listening mechanisms. • Proposals are consistent with feedback from service users from widely attended engagement events
	Risk that the skills and competencies of our workforce do not match our future operating model, which is based on recovery principles and co-production	• The workforce plan will build confidence and capacity in areas such as negotiation skills, informed risk taking, and partnership working
Operational and Transformational Risks	Commissioners do not have any significant decommissioning plans to implement in 2014/15 However there are a number of service reviews being undertaken and it is likely that there will be more de-commissioning challenge for 2015/16. In addition a number of services will be going out to tender in 2014/15 including IAPT in Calderdale, Health and Well being services in Wakefield and Barnsley. Therefore our focus on Service Line Management and Commercial Development is key.	• stakeholder engagement with CCGs; • using the development of mental health currency to work with commissioners to increase understanding of the service model and make the case for value for money • Using the Recovery and Creative Minds work to develop alternative models of self- directed support to demonstrate how our pathways meet service user expectations , improve outcomes and deliver value • Completion of work on 3 key themes in 2014 • Development of Forensic service offer ready for procurement in QTR 3 2014 • Using the Care Packages and mental health currency development to drive service improvement • Clarify the model for “integrated service” provision for mental health,
	Local health economy transformation programmes lead to reconfiguration, which could feasibly lead to some Trust	• Full and active engagement with all local health economy transformation programmes. Offering innovation and partnership based solutions for commissioners. Sub-specialisation and

	services being decommissioned	diversification strategies
	Management of reputation and service issues in CAMHS service in Calderdale and Kirklees	• Action plan developed and shared with commissioners to address concerns re access and quality of service • Action plan monitored at EMT • Additional resources procured to ensure action plan is sufficiently resourced to meet address most serious issues quickly.
	Trust has sufficient capacity and skills in place to achieve challenging targets. Risk of losing focus and grip on core services due to need to support change and development.	• Robust process in rollout of corporate objectives there is focus and clarity on priority areas; • Good staff support and programme management through the delivery of the Transformation Programme
Financial Risks	Failure to meet CQUIN and performance targets results in loss of income which compromises surplus and EBITDA achievement	• Negotiation and design of CQUINs and performance targets in 2014/15 should reduce risk of non-compliance. • Review of contract and compliance risk paper to Board April 2014 • Contingency of £1m held centrally can be deployed to offset reduction in income plus reviews of any discretionary spend to reduce costs. • Communications and data quality plan to ensure all relevant information is captured on the clinical system;
	Cost pressures exceed planned levels	• Only cost pressures which cannot reasonably be expected to be managed within existing budgets have been funded through detailed agreement and negotiation with Directors; • Annual planning process has reviewed all budgets to gather intelligence on cost pressures to reduce risk of unforeseen cost pressures; • Contingency funds to manage risk of unplanned cost pressures in year to allow recurrent solution to be worked through for following year. • Quality impact assessment process undertaken by Director of Nursing and Medical Director to give Board and BDUs assurance that proposed CIPs and cost pressures can be managed without adversely affecting quality of service delivery.
	Savings on back office and sustainability can be delivered	• This risk has been mitigated through Director sign-off of CIP plans to confirm they are achievable
	CIPs from transformation change to services can yield between £3 - £4m annually from 2015/16 onwards	• In 2013-14 progress has been made in developing the infrastructure and vision for the Transformation Work Streams. See Transformation programme section for further details • This work is underpinned by the development and implementation of the enabling strategies for workforce, IM & T and Estates

		• Redesign of corporate systems over next two years
	Introduction of mental health currency destabilises safe provision of services.	• Agreement of memorandum of understanding with Commissioners to manage implementation process and risk to both parties. • Creation of joint currency steering group to oversee the implementation of mental health currency. The steering group has agreed terms of reference, work programme and commitment of senior staff from commissioner and provider organisations
	The Trust will be unable to convert key opportunities to increase in market share and contribution – with potential detrimental impact on future viability e.g. forensics sub specialisation; use of telehealth and telecare	• Trust has identified integrated care development and forensic market offer as key priorities in 2014/15 and commissioned specialist consultancy to ensure that models are robust and produced in required timescale. • Trust has good stakeholder engagement with commissioners as a platform for strategic discussions/

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