Sussex Partnership NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Sussex Partnership NHS Foundation Trust

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

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

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Date	**2nd April 2014**

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

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	John Bacon

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Lisa Rodrigues

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Sally Flint

Signature

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1. EXECUTIVE SUMMARY

The 2014 to 2016 Operational Plan for Sussex Partnership NHS Foundation Trust is built on the successes of the Trust over a number of years.

However, the Trust recognises that times remain challenging and our staff are working very hard.

In the backdrop of the increasing competition, public scrutiny and the continuing financial pressures on the public sector, our Operating Plan for 2014-2016 sets out the Trust's plans for the next two years and describes how we intend to continue to deliver high quality, safe and sustainable services for the people we serve.

An overview of the Trust's financial projections for the next two years 2014/15 to 2015/16, compared to the expected performance for 2013/14, is set out in the table below.

	2013/14 Outturn	**2014/15 Plan**	**2015/16 Plan**
	£m	**£m**	**£m**
Turnover	240.3	231.3	227.4
Surplus	2.2	1.2	1.2
Capital Investment	5.2	13.2	12.3
Cash	37.5	35.4	32.5
Continuity of Services Rating	4	4	4

2 STRATEGIC CONTEXT, VISION AND PRIORITIES

2.1 Overview

Sussex Partnership NHS Trust started in April 2006 and became a Foundation Trust with teaching status in August 2008. Over the last six years as a foundation trust we have developed a strong national reputation through the development of leading-edge research programmes, innovative partnerships and excellent clinical practice. Since becoming a foundation trust we have sustained our income levels alongside achieving substantial new business growth and delivering internal cost improvement programmes, including service redesign. Delivering high quality, safe patient care remains our key purpose.

Our clinical and support staff have told us they are passionate about sustaining and developing NHS services free at the point of delivery for the people they serve. They also tell us they have never worked as hard as they are doing now. This is set against the pressure on health care services and linked to reducing resources, ageing populations and need rising in the areas we serve alongside some inefficient internal processes and ways of working.

The Board has listened to what our staff are telling us and considered the impact of growth through acquisition on the organisation and the impact on existing services, particularly in the context of the challenging financial and competitive environment NHS services are operating in. When agreeing to future growth opportunities we will use the learning we have gained from our acquisitions. Our guiding principle in all future growth opportunities will be our ability to add value to the person using the service without compromising our existing services. We have learnt through acquisitions that improving services and making the necessary changes takes time and we need to factor this in. Therefore using our learning we will ensure that when new services join us, there is a clear framework for culture, leadership, integration, safety and quality and that our infrastructure is able to support this.

The Board has acknowledged that continuing financial pressure and the on-going need to consider growth and diversification, could impact on quality. It is crucial our services can be both clinically and financially sustainable to secure our long term future. This will require us to think creatively at how we can transform the way we deliver care for people, building on developing new partnerships, exploring models of integrated delivery and the use of digital technology. We will also consider new opportunities to diversify our provision where we have core services and infrastructure established.

With the current and predicted rising demand for care, particularly for children, young people and older adults we will ensure we can provide the best value possible for what we do. This requires us to reduce and eliminate waste and where possible, through a model of earned autonomy, and to devolve decision making as close to the front line as possible. The model of earned autonomy will be developed this year and initially implemented across the Specialist Services Directorate.

A major change for us this year is that Lisa Rodrigues CBE, our Chief Executive, will retire. Her successor, Colm Donaghy, has been appointed and will start in July 2014. Our strategic priorities and financial plan remain ambitious during this period of transition in leadership but they also allow for an opportunity to review our five year vision and the supporting organisational development programme to deliver this building on our learning and success to date. The new organisational development programme will incorporate the work we will take forward from our recent staff engagement survey and is included in our business plan.

2.2 Organisational Priorities

Our organisational priorities in 2014/15 to 2015/16 take into account the opportunities available to grow our specialist services, consolidate our acquisitions and ensure our core services in Sussex realise the benefits of their new models of care and can prepare for the next stages of their development. The key features will be continuing to develop our existing services, expanding into new areas in a planned way, and stop doing those things that we are not best placed to do or cannot do safely within the resources available.

Our strategic approach is based on: developing and providing high quality, safe clinical services; ensuring quality through evidence-based care pathways, managing risk and safety, and patient experience; and further developing our teaching and research. We will continue to develop as a learning organisation, increasing our skills and continuing our excellent progress in equality, diversity and human rights and being ethical in the way we work.

Sussex Partnership remains a sustainable organisation in an external environment where commissioning NHS services is changing radically, and where the extended economic downturn continues. We will learn and respond creatively so that our services and our patients continue to thrive and we are clinically and financially sustainable.

Our Board and Council of Governors have agreed **four strategic priorities** to enable us to deliver these ambitions. They are as follows.

1. We will provide safe care based on the best available evidence to improve outcomes and patient experience.

2. We will secure our future by continuing to be clinically and financially sustainable.

3. We will shape a culture of openness and earned autonomy to deliver and govern our services.

4. We will develop and implement an organisational development strategy.

To deliver these four strategic priorities we are doing the following:

1. Continuing to implement the recommendations from the Francis Review.

2. Paying attention to our internal behaviours and culture to improve staff engagement and wellbeing.

3. Designing a development programme to progress towards a model of earned autonomy for operational and corporate services.

4. Ensuring every care group, division, team and individual has an agreed set of priorities and targets that are known and understood.

5. Making improvements to our process of strategic and service level planning.

6. Embedding our internal quality, safety and compliance inspection process across all our services.

7. Increasing our commercial skills in operational and corporate services. We have already started this but we have more to do.

8. Creating a clinical intelligence function to inform our planning and actions, both clinical and commercial. This will draw on our data, information and research.

9. Improving our internal and external communications.

10. Continuing to invest in our IT infrastructure, procuring and implementing a new clinical information system and exploring the use of digital technology.

11. Designing referral and demand management systems across all our services. Aligning our capacity to need.

12. Developing strength in depth and build our clinical leadership capacity for the future.

13. Developing and implementing an innovation strategy.

The remaining sections of the Operational Plan set out in detail how the Trust plans to meet the challenging and ambitious agenda for the next two years.

3. THE SHORT TERM CHALLENGE

3.1 The National Context

As the NHS enters the next planning round it continues to face financial pressures in the context of increasing demand for services and following the publication of the Francis and Keogh reports there has never been more focus on quality. There is therefore recognition that in order to meet this challenge health services must change fundamentally or the quality of care that patients receive will deteriorate.

The annual planning guidance from NHS England and Monitor provides guidance for both commissioners and foundation trusts on setting their plans for the coming years.

NHS England's planning guidance Everyone Counts: Planning for Patients 2014/15 to 2018/19 sets out their vision and purpose flow from the single idea that they exist to ensure ***high quality care for all, now and for future generations***. They want everyone to have greater control over their health and wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving.

It is recognised that significant advances have already been made as a consequence of last year's planning guidance. However, the next phase sets out how the how the NHS budget is invested so as to drive continuous improvement and to make ***high quality care for all, now and for future generations*** into a reality.

Collaboration between clinicians and staff at NHS England, CCGs and key stakeholders have translated into seven specific ambitions:

- **securing additional years of life** for people in England with treatable mental and physical health conditions
- **improving the health related quality of life** of the 15million+ people with one or more long term conditions, including mental health conditions
- **reducing the amount of time people spend in hospital** through better and more integrated care in the community and out of hospital
- **increasing the proportion of older people living independently at home** following discharge from hospital
- increasing the number of people with mental and physical health conditions having a **positive experience of hospital care**
- increasing the number of people with mental and physical health conditions having a **positive experience of care outside hospital**, in general practice and in the community
- making significant progress towards **eliminating avoidable deaths in our hospitals** caused by problems in care

In addition, there are three more key measures that are vitally important and on which there needs to be significant focus and rapid improvement. These are:-

- **improving health**, which must have as much focus as treating illness
- **reducing health inequalities,** by ensuring that the most vulnerable in our society get better care and services
- **parity of esteem**, by making sure that we are just as focused on improving mental as physical health and that patient's with mental health do not suffer inequalities, either because of the mental health problem itself or because they then don not get the best care for their physical health problems
- **No health without mental health,** fewer people will experience stigma and discrimination

In support of the government's ambition to drive parity of esteem there has never been more focus on mental health with mental health moving up the policy agenda across government. Whole-person Care: from rhetoric to reality (Achieving parity between mental and physical health) was published by Royal

Colleges of Psychiatrist in 2013 and supported by Norman Lamb, Minister for Care Services, sets out the governments committee to ensuring parity of esteem for mental health.

In January 2014 the Department of Health published "Closing the Gap: Priorities for essential changes in mental health", which builds on the government's mental health strategy of "No Health Without Mental Health". The Closing the Gap document sets out 25 areas where people can expect to see, and experience, the fastest changes in mental health services across a number of key themes:-

- increasing access to mental health services
- integrating physical and mental health
- starting early to promote mental wellbeing and prevent mental health problems
- improving the quality of life for people with mental health problems
- ensuring that mental health is everyone's business

These ambitions are set in the context of a continuing financial challenge for the NHS and wider public sector. It is recognised that for the decade ahead, the NHS budget is likely to remain flat in real terms or, at most, to increase in line with growth in the rest of the economy. Over the same period, demand for the NHS health care is expected to rise as people live longer, have more complex health problems and more advanced treatments are available.

In October 2013 Monitor published a paper entitled "Closing the NHS funding gap: how to get better value health care for patients". The report is based on the notion that getting better "health value" for patients with each pound spent is a realistic prospect and by far the best strategy for closing the funding gap, and that getting better health value for patients means improving productivity. However, it is recognised that improving productivity does not mean working even longer and harder. It means:-

- Everyone working differently and smarter
- Altering or completely reshaping services, so they give patients the same or better quality and experience of care for less money
- Re-investing the money saved in more and better services and so extending access to NHS care

If everyone were to adopt this strategy across the NHS the outcomes will be a network of services designed to meet the challenging needs of patients in the 21st century within the limits of the NHS budget.

It is recognised that taking this approach will not be easy, historically improving productivity in the NHS has lagged behind productivity growth in the economy as a whole. It is also recognised that in order to prevent the funding gap from reopening after 2021, the NHS will need to continue improving productivity by at least the same rate as the rest of the economy, year on year. Only by keeping up a higher rate of productivity improvement can the NHS remain financially sustainable in the long term.

In order to help commissioners and providers with this challenge, Monitor has collected and reviewed the best available evidence on improving health care productivity, identified where the biggest opportunities lie and estimated the potential gains they offer. The available evidence indicates a range of opportunities to make significant recurrent productivity gains across the NHS by 2021 and beyond. These opportunities break down into four main headings, outlined below.

- Improving productivity within existing services
- Delivering the right care in the right setting
- Developing new ways of delivering care
- Allocating spending more rationally

3.2 The Local Picture

One year on from the changes in commissioning the Trust is working well with its local Clinical Commissioning Groups (CCGs) and NHS England. The Trust has seen increased support for mental health services and the part that our services can play in addressing pressures on the health economy. However, as the CCGs have started to become established there is greater scrutiny of our services and the need to provide better data, to inform commissioning and drive improved outcomes in mental health services.

As the Clinical Commissioning Groups have the opportunity to set their own ambitions and service strategy for the populations they serve it will be increasingly important for us to actively influence them in their agendas for mental health services. The Trust has welcomed these discussions during the year and will continue to development them through the next planning cycle. The Trust has also welcomed the production of mental health strategies by some its local CCGs.

Sussex continues to be one of the most financially challenged health economies in the country, with East Sussex now being identified as one of eleven financially challenged health economies in England that are to receive expert help with strategic planning in order to secure sustainable quality services for their local patients. As a consequence financial pressures have continued into the next planning round and it will therefore be essential that mental health, learning disability, substance misuse and offender health services are kept high on the CCGs agendas.

In terms of funding, given that there is a long way to go before mental health achieved parity with physical health, as borne out by the differential income deflator that it being challenged by the Trust. However, there is a strong argument for increases in this area and an opportunity for Sussex Partnership to demonstrate its overall contribution to the health economy. Both the NHS Mandate and now Everyone Counts have stressed the importance of mental health. Sussex Partnership will need to actively work with a broad coalition of interests to help make this a reality.

The Trust is already working on a number of initiatives to help reduce the number of admissions to acute general hospitals. There remain many opportunities for mental health, learning disability and substance misuse services to help improve outcomes for people while reducing reliance on hospital care. Sussex Partnership should continue its efforts to engage with a broad set of stakeholders to improve the integration of mental health, learning disability and substance misuse services with physical healthcare. The establishment of the Better Care Fund and shift of resources to local authorities will also help this agenda.

Use of information and technology will also become a key initiative. Allowing access to patient records across organisational boundaries and giving people electronic access to their own health records and making performance data, especially on outcomes public will become a necessity.

All of the work we have done so far, and propose for the future, in relation to the experience of people using our services will pay off. Payments will become linked to experience and mental health services are seen as an area where the Government would wish to prioritise introducing ‘choice’. Although, both the Trust and commissioners have agreed that they are not yet fully prepared for the implementation of payment by results as a method of contracting, in 2014/15 this will be operated in shadow form to provide the impetus for improving data quality and developing and recording clinical outcomes.

Above all else all services will need to evidence that they are delivering high quality care, treatment and support to the people they serve. That is, services must demonstrate they are safe, achieving good clinical outcomes and listening to the experience of people using the service and their families.

The Trust’s Operating Plan takes into account this external and local context.

4. QUALITY PLANS

4. 1 Quality and the Experience of Patients

Publication of the Francis Inquiry report has been the catalyst for a national discussion about the importance of combining compassion with care and treatment.

Amongst the many recommendations in the Francis report are two that have particular relevance to our patient experience strategy:

All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them effective real-time information, on the performance of each of their services against patient safety and quality standards;

Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near “real time” as possible.

Providing effective, evidence based safe treatment is of course essential, but as important is the care and compassion with which treatment is delivered. Sussex Partnership has always held as its central belief, that it is this combination of excellent treatment and caring staff that creates the environment for quality to flourish. This year, more than ever, we need to demonstrate that commitment to our patients.

Putting patients at the heart of all we do is our priority. Every member of Sussex Partnership staff recognises their role in ensuring that everyone who uses our services is welcomed, treated with dignity and respect and offered a package of care that is right for them.

Combining a compassionate and caring approach with a safe environment and the best treatment creates a high quality service, and one that our staff and our patients would recommend to their friends and family.

Each year, we set ourselves a list of detailed quality objectives, each with markers and measures. The Board of Directors reviews progress against each objective at every meeting. Where performance is not as expected, corrective action is taken.

Our quality priorities though are much more than a monthly report to the board and a summary dashboard that shows that the Trust is on target to meet its objectives.

Behind the dashboard sits the absolute commitment of everyone in the Trust to ensure that whatever their role, ultimately it is patients that come first. This commitment is reflected from recruitment and induction through to the annual appraisal programme and personal objective setting. It is reflected too in all our communication, from the Chief Executive’s weekly message to the Twitter conversations about the importance of compassionate care on our website.

4.2 Quality Priorities

The Trust has reviewed its work in 2013/14 and used the review to shape and inform the priorities for 2014/15. Our objectives are always shaped and informed by discussions with our patients, our people and our stakeholders. Many of them build on existing areas of focus, further sharpening areas that we have been working on, and taking us to the next level by setting standards of clinical care and patient experience.

We have to be open to what our data says and is showing us about the characteristics of the people who are accessing our services; and those that are not. We have to be open about how health outcomes may

differ for people with different characteristics. This can mean challenging ingrained and institutional processes and attitudes to lead to more open and transparent services; this is at the core of what we do and our commitment to equality and addressing inequalities experienced by those who access our services. This commitment runs throughout all our quality priorities.

4.2.1 Patient Experience

Building on our Better by Experience commitments we are committed to creating more opportunities for people to talk to us about how they have experienced their contact with us. We will use the National Institute of Clinical Excellence (NICE) Quality Standards for Patient Experience published in 2012 as the benchmark for developing our patient experience strategy across all services and care groups building on the values and commitments we've developed through our Better by Experience.

In addition we recognise that patient care is not only about clinical interventions but is about every aspect of patient experience, including how we welcome people, how we communicate with people and the information that we provide. These can have as much impact, positive or negative, as the treatment itself. We have begun work to build on the Better by Experience commitments to develop clear customer care standards and in this context we are looking at the reception function, starting in adult community mental health services. We are also exploring how support services like telephony can help to ensure high customer care standards in the future.

We are committed to co-production: involving patients and carers directly in feeding back on services and on helping to develop solutions as evidenced by the 15 Steps programme and the Triangle of Care. Looking forward we will be developing more approaches based on this model, prioritising the active engagement of patients and carers not just in feeding back their own experiences, but in determining how we define and measure quality.

We are committed to consistency: recognising that there are variations in the quality of some aspects of our services and that we need to take measures to address this.

We are committed to transparency and openness: all of the feedback we receive is placed in the public domain and even when we are doing well we will not be complacent – there is always the opportunity to do better.

It is also important that we are able to report patient experience in a way that identifies the most vulnerable and socially excluded groups in line with the Equality Act 2010. We have been able to do this for the first time this year with the analysis of data in the Patient Experience CQUIN and our aim is to ensure that future reporting is also able to address performance in this way, taking the protected characteristics in the Equality Act into account.

We recognise that we produce a vast amount of data about patient experience. We also receive information from complaints and plaudits, from serious incidents, from external inspections and from a diverse range of approaches to feedback developed in different care groups. Our commitment to gaining feedback from patients and carers and learning from this to improve our services is also well supported by our Equality Performance Scheme which will strengthen this commitment by the collection and analysis of our patients experience across the protected characteristics.

The challenge now is for us to be able to map patient experience data in an integrated way and to triangulate data to identify trends and common themes.

As part of our planning for the introduction of national Friends and Family Test across the NHS, we will be implementing a number of initiatives such as the 15 Step Challenge to enable us to understand better what is important to people who use our services, carers and families from there prospective.

We will recruit teams made up of people who use our services, carers and members of our Foundation Trust Governing Council to visit all of our units during 2013/14 using the principals of the fifteen step challenge. The key themes and learning from these visits will be used to inform our practice and lead to measurable service improvements.

We believe that if we work with people in a way that ensures they feel cared about then they will not only have a better experience of using our services but that their health will also improve. We continue to develop recovery orientated practice across the Trust in line with IMROC (implementing recovery through organisational change) recommendations. We have established a Sussex wide partnership with Third Sector Partners and local Education Providers to develop a number of Recovery Colleges. Service users and staff will be delivering educational programmes across Sussex to complement more formal interventions.

To this end we have set key Business Objectives for 2014/15 as follows:

•Establish with each Care Group clear metrics that enable them to improve patient experience evidencing improvements by triangulation with other performance information including complaints.

•Continue to implement the 15 Step Challenge programme across our inpatient and residential units and extend to all adult community mental health services.

•Implement the Triangle of Care programme across all services to support delivery of essential changes in mental health services highlighted in the national Closing the Gap Report.

•Develop a programme to ensure the implementation of feedback by patients through the Mental Health Friends and Family Test by 2015.

•Ensure that our experience work is able to reflect patient experience across the protected characteristics and lead to measurable improvement (Equality Act 2010).

4.2.3 Safety

It is important that we ensure that not only do we investigate and respond to instances when things go wrong, but we share the learning right across the Trust as a whole. Through 2014/15 we will extend our new Report and Learn events for staff that enable clinicians to share the detail of their experience and learn from others. We consciously learn from any lapse of standards or clinical care and have mechanisms to ensure that any actions arising from serious incidents are reviewed.

We are continuing to place an emphasis on appraisal and supervision to ensure best and safe practice at individual practitioner and team level.

The Safety Thermometer is a national reporting and sharing tool, developed as a result of the Mid Staffordshire inquiry. It requires all NHS Trusts to record and return information to their SHA on key indicators of safety. For Sussex Partnership these are -

- Number of pressure ulcers
- Number of urinary tract infections in patients who have catheters.
- Venous thromboembolism (VTE)

The Trust has established a system for reporting, and has received positive feedback from the Strategic Health Authority (SHA) for its proactive approach. It is too early to determine (as the national data at this stage is not likely to be robust) whether the Trust is an outlier in any of the aspects it is reporting, but early discussions with other similar trusts suggest that is not.

We are progressing our training in clinical risk and care planning. Care planning is being revised to ensure that needs are met in this process. We will maintain a strong service user focus and ownership of plans, and ensure that risk is managed within and between service providers.

4.2.4 Effectiveness

Sussex Partnership continues to place significant emphasis on the effectiveness of clinical services. This is because effective services deliver better outcomes for patients. In 2014/15 we will continue to deliver our programme to develop the use of outcome measures so we can demonstrate the effectiveness of services. We will be able to improve the collection of clinical outcome information as we introduce a new clinical information system (planned to commence this year, delivered in stages).

Our clinical services are being aligned to care pathways which have been designed to account for best evidence and the recommendations by the National Institute of Clinical Excellence (NICE). This year we have implemented an audit of all the mental health NICE guidance published in 2012/13 related to psychosis and schizophrenia and have done a re-audit of back catalogue of publications and Trust audits for this condition. We are able to demonstrate a high standard of care which is compliant with these recommendations and the information helps us inform service gaps and improvements.

We are continuing to work closely with commissioners and partners to develop the Payment by Results (PbR) mechanism. We have developed packages of care across a number of clinical pathways. These packages describe choice centred on need and are in line with evidence based practice. We will work towards delivering these in shadow form.

For quality improvement CQUIN requires us to demonstrate quality improvements and this is linked to payment from our commissioners. Together with commissioners and clinicians we have established a number of quality projects which demonstrate improvements in safety, improved experience and continue our work with PbR.

4.3 CQC Compliance Actions

We currently have 2 minor impact compliance actions at Amberstone, East Sussex - Ouctome 10 and Outcome 14.

We currently have 2 minor impact compliance actions at The Chichester Centre, West Sussex - Outcome 13 and Outcome 14.

5. OPERATIONAL PLAN

5. 1 Introduction

In 2013/14 we introduced a new approach to leading our services with the creation of two new divisions led by their own Managing Directors– core services and specialist services. Core services provide primary care mental health, adult mental health and dementia services throughout West Sussex, Brighton and Hove and East Sussex. The Specialist Services Division includes a wide range of services delivered across the south east of England.

The core division is focusing on implementing a high quality and effective service model for local people working closely with commissioners and other stakeholders. The specialist division is enabling a very different set of services, some of which are small and highly specialised, to follow their own paths and to grow and thrive.

5.2 Core services – Adult Mental Health and Dementia

Adult Services is made up of our core mental health services serving the people of Sussex. This includes primary care mental health services, liaison, and dementia care. We work with seven Clinical Commissioning Groups, three Local Authorities and a wide range of other partners in the statutory and third sectors.

Following significant structural change over recent years, under the banner of the 'Under One Roof' programme, our focus now is on realising the benefits of the new model, and simultaneously exploring and articulating the next stage of our development.

The external environment within which we operate continues to change very rapidly. CCGs are now well established, new local commissioning strategies are being developed, and expectations of services to deliver 'more for less' continue. At a national level, the new 'Closing The Gap' document specifies priorities for pursuing implementation of the 'No Health Without Mental Health' strategy, and a new Crisis Care Concordat has recently been published. The Better Care Fund presents us with new opportunities for creative and flexible pathway solutions across local health and social care economies. In Adult Services we are building a proactive approach to engaging with the wider system, exploring the delivery of more integrated care and establishing a renewed profile with our partners.

Through an inclusive process with our local leaders, we have identified five priority areas for development in 2014/15:

1) Pathway for people with dementia
2) Pathway for people with significant rehabilitation needs
3) Pathway for people with an emotionally unstable personality disorder
4) Integrated care pathways which improve access to specialist help for people in urgent need
5) Closer joint working with primary care to ensure a smooth flow of care between care providers, according to clinical need

We have identified these areas because we are confident that there is scope for improving outcomes and experience, as well as better value for money. Limitations in current pathways are driving resource use which is not appropriately aligned to clinical need, thus inhibiting outcomes and driving up cost. In addition, we have expertise to offer to the wider health and care system in terms of delivering integrated provision. We will not be able to achieve these improvements in isolation so it is essential that we continue to work closely with partners to improve smooth patient flow.

We are in the process of identifying the actions which will enable these improvements, including:

•Roll out of demand and capacity analysis and process redesign
•Workforce review and redesign, including new roles (e.g. peer work, non-medical prescribers)

•Implementation of the new clinical pathways designed through the Payment by Results development work undertaken in 2013/14
•Development of a set of key performance indicators which are reliable in terms of measuring quality and safety in services
•Implementation of the new Clinical Information Strategy, and supporting infrastructure
•Development of Divisional service lines and a shift in the 'centre of gravity' towards local services, which are freed up to make decisions as close to the frontline as possible, alongside clearer lines of accountability
•A cultural shift towards mainstreaming the recovery approach, which is based on the strengths and assets of everyone involved (both people using and working in services)
•On-going engagement with partners in the wider health and social care economy, pushing the boundaries of traditional working and designing solutions which are based around the needs of the people who use services

These priorities will be interpreted for each local population area according to their specific needs, including by reference to equality and human rights impact assessments and to line up with commissioning expectations. It is important that we work towards consistency and standardisation in practice and outcomes, and make the most of our critical mass of services and expertise across Sussex. The models we put in place to deliver may differ between areas where there is clear rationale to do so e.g. differing local need. This does not amount to a substantial shift away from current structures, but rather a tailoring of those structures to achieve the best fit for local communities and circumstances.

In addition to the pan-Sussex priorities, each of the three core Divisions has specific initiatives to pursue.

5.2.1 West Sussex

The priorities for core services in West Sussex are:

•In April 2014 we will implement the new urgent care pathway, which will introduce a new access target of 5 days for urgent referrals. This is in addition to the existing targets of four hours for crisis referral, and four weeks for routine referral.

•Continue the rapid improvement work initiated in 2013/14 in Crawley, Horsham and Mid Sussex.

•Work proactively with commissioners towards delivery of their new Joint Commissioning Strategy.

•Commit to providing access to Recovery College services in 2014/15, with a view to developing more sustainable plans during the course of the year. We will do this in close partnership with people who use services and the organisations that represent them.

•Work to resolve the longstanding concerns about the quality of our community estate in Coastal West Sussex.

•Continue to engage in the proactive care developments across the health and social care economy and participate fully in the Better Care Fund developments.

•Look to piloting a joint initiative with South East Coast Ambulance Service which brings mental health skills closer to the frontline of mainstream emergency care.

5.2.2 Brighton and Hove

The priorities for core services in Brighton and Hove are:

•We will work with commissioners to fine-tune the Brighton Urgent Response Service (BURS) in line with their requirements. This will include full integration with the Assessment and Treatment Service.

•We will work closely with the new care home (Lindridge) to support its establishment alongside Brunswick ward.

•We will support the development of the shared care ward with Brighton and Sussex University Hospital

•We will undertake a review of our service provision on Caburn (women's) ward at Mill View Hospital, in recognition of the challenges associated with its current set-up.

•We will work closely with commissioners to identify the best options for reinvestment of funding released from acute bed closures, including crisis accommodation for people with a diagnosis of emotionally unstable personality disorder.

•We will engage fully in the Frailty Pathway development work co-ordinated by commissioners across the health and social care economy.

5.2.3 East Sussex

The priorities for core services in East Sussex are:

•Continue the national pilot in Eastbourne for 'street triage', in partnership with Sussex Police, building on the strong start in 2013/14 and ensuring evaluation and sustainability plans are developed.

•Continue to work closely with commissioners on a new solution for the delivery of dementia inpatient care, in line with the public consultation outcomes reached in 2013/14.

•Pursue an estates option appraisal for the future delivery of acute inpatient services in Eastbourne.

•Continue to participate in the strategic discussions about the potential options for closer integration of care in East Sussex, building on the momentum created in 13/14 as a result of the application to become a national pilot site for integrated care.

5.2.4 Primary Care Mental Health Services

Our primary care mental health services operate in a highly competitive market with the majority of services in a cycle of routine market testing. We have developed two innovative market solutions in Brighton and Hove and East Sussex developing tailored partnership arrangements with primary care services and the third sector.

The priorities for the year ahead are focused on three areas: quality, staff and growth.

1) **Quality** – improved GP engagement, clinical pathway efficiency, maintaining the high satisfaction rates and close working with commissioners.

2) **Staff** – The development of the 'mental health practitioner role', to continue to innovate around workforce planning and to emphasise staff wellbeing.

3) **Growth** – to develop our e-mental health support, to develop physical health support, employee assistance and medically unexplained symptoms.

5.2.5 Dementia and Later Life

The improvement of dementia services is a national priority and nowhere more so than in Sussex which has some of the highest prevalence of dementia in the country. The Trust is at the forefront of this challenge and is creating partnerships across the health and social care system to ensure an improved experience for people with dementia, their carers and families.

During this year we will review the effectiveness of our Assessment and Treatment model for people with mental health needs in later life. We will seek solutions which take account of local needs and commissioner expectations, as well as drive up consistently high standards across all areas. It is reasonable to anticipate that further change may lie ahead, in the context of the national strategic push towards integrated care across physical and mental health.

We will continue our work to consolidate the new innovations in dementia care that we have developed; memory assessment, dementia care home in-reach, dementia crisis services, and the dementia shared care ward. These services are part of a whole system model of care focused on supporting early diagnosis, providing early intervention, supporting people at home, and improving care in care homes and hospitals. As well as improving quality, they reduce in-patient admissions, length of stay, and the need for more costly care packages. We will develop the data systems to evidence the quality outcomes we are achieving and to enable us to set more challenge targets in the future. We also aim to design our approaches to include advance care planning for end of life within all trust dementia services.

5.3 Specialist Services

The Specialist Services Directorate is made up of four Care Groups providing specialist care across the south east of England, the Children and Young Peoples Division our Joint Venture with Care UK and the Lindridge care home development. The rationale for structuring our services in this way is that each specialist service will be enabled to take control of their own future and to act in a more responsive way to the need of the people they serve. Each specialist service is of a different size and operates in a different environment, with greater control of their destiny the assessment is that they will stand a greater chance of thriving in an increasingly competitive market place.

The care groups are substance misuse, specialist learning disability, prison health and secure and forensic services. Given the size of the services and geography covered the children and young people's services is a Division and provides services across Kent, Sussex and Hampshire. Our Care Groups and Division works closely with NHS England, sixteen Clinical Commissioning Groups, five Local Authorities and a wide range of other partners in the statutory and third sectors on the delivery of these services.

Specialist services will introduce a development programme that will support the services to progress towards a new model of earned autonomy. The trust will develop processes and criteria to grant autonomy and systems for assessing and monitoring quality, safety and performance. It is envisaged that the existing leadership team within specialist services will continue to work together to maximise the synergies and learning that emerges through the experiences of each component service. Detailed equality and human rights impact assessments will be completed for each specialist service, recognising the particular needs and disadvantages faced by protecting groups within specialist services.

The aim of the development programme is to develop senior leadership teams: strengthen leadership capability and make best use of the mature clinical/managerial relationships and expertise that exists within the directorate. Each care group and division will have a clear strategy focused on growth through clinical excellence: they will be enabled to develop and deliver their own annual business plan, supported by corporate business partners. Performance outcomes will determine the level of autonomy with which they are empowered.

This development programme will support greater flexibility to develop new ways of working in each services. For example through exploring alternative skill mix or extended roles that are transferable. It will be designed to create a platform to challenge traditional assumptions and behaviours; provide greater opportunities for engagement and encourage services that are confident, outward looking, and astute: pitched to enhance our reputation of delivering innovative treatment and care.

5.3.1 Substance Misuse Services

Our substance misuse services deliver a range of community, specialist and inpatient services throughout the south east. Substance misuse is the most competitive area of service delivery in which we operate with all services routinely put out to the market for tendering.

Our service model has been to offer a high level of clinical excellence whilst ensuring service user engagement and a focus on recovery. We work in close partnership with a range of third sector organisations in order to deliver integrated services. As we move forward we will seek to develop our service model further and prioritise partnership development and inpatient services in order to ensure the long term viability of the care group.

The aim is to be a provider of high quality specialist local community drug and alcohol services. This care group will work in partnership with proven third sector providers to develop future service models designed to continuously improve patient experience and clinical outcomes. There will be further work on specialist inpatient detoxification services, with the option for marketing the service regionally and exploring the potential for working with the private inpatient detoxification market.

Options for working more closely with Brighton and Sussex University Hospitals are being considered, with a view to developing a specialist provision for people requiring detoxification who have complex physical needs and provide local care to the most vulnerable service users.

Working in conjunction with the University of Sussex, substance misuse services will continue to maximise the opportunities to improve patient outcomes through research.

5.3.2 Specialist Learning Disabilities Services

The Learning Disability Services comprise of community teams, assessment and treatment inpatient service and a domiciliary care model of intensive specialist support services for people and inpatient services which enables people with complex and challenging needs to live safely and successfully in their local community.

The vision is to build on the community teams work in providing progressive specialist health interventions for people with a learning disability who have complex needs through developing care pathways. Wherever possible the service aims to enable people to use ordinary health provision, and give advice, support and training to other services to enable them to make reasonable adjustments. In addition to the Selden Centre, the model of care is being extended to provide a more comprehensive approach, working together with commissioning partners in reducing reliance on out of area placements. The supported living service being developed at Mayfield Court in East Sussex will complement our current supported living flats at Acorn House and enable a more creative approach to supporting people with complex needs to live in their local communities.

5.3.3 Prison Health

Prison health services aim to provide health services to offenders which enhance their overall wellbeing and are comparable to the level of care and support expected to be available to the wider population. As a relatively new entrant to the prison health market Sussex Partnership has begun a process of transformation and it has achieved positive reports from Her Majesty's Inspectorate of Prisons and the Care Quality Commission for our work at HMP Ford and HMP Lewes. The priorities will be to ensure that the service model is of best practice and consistently applied and that the service is financially viable for the long term.

Prison health services include the full range of physical, primary care, substance misuse and mental health services. It is noteworthy that this is the most integrated service the Trust provides in that the whole health needs (physical and mental health) of prisoners are met and general nurses are employed by the Trust. The service delivery works very well as the Trust is good at working with people who are vulnerable and with complex needs.

Healthcare at HMP Lewes serves an essential role in the offender care pathway across Sussex for men. The Trust currently manages this group of men from arrest through secure care and community outreach to the point of discharge from services. Retaining this contract, working in collaboration with prison staff and offender health commissioners will enable us to develop a high quality, fit for purpose service model with a focus on excellent clinical practice is the priority for this service over 2014/15.

HMP Ford and HMP Lewes health services aim to build on the positive inspection reports from both the Care Quality Commission and Her Majesty's Prison Inspectorate received in 2012. In particular there will be a focus on improving health and developing health promotion strategies, meeting the needs of an ageing prison population and developing the workforce to provide a holistic approach within this setting. 2014/15 will continue to provide an opportunity to progress governance across the prisons as the new prison leadership teams are established.

5.3.4 Secure and Forensic Services

Sussex Partnership is one of the market leaders in secure and forensic services with a wide range of low and medium secure services, community teams and court/criminal justice liaison services. Services are available and provided to Sussex, Kent, Surrey and Hampshire. The service model aspires to provide high quality, compassionate patient focused care with teams having a clear focus on evidenced based practice underpinned by a strong research base.

We are seeking to capitalise on our reputation of excellent clinical outcomes and high standards of accommodation by achieving efficiency and effectiveness targets including occupancy and throughput.

There are good opportunities for development including further inpatient services, support for probation services and court and police liaison services.

Secure and forensic services will focus on providing high quality, compassionate care. Services are provided from the point of arrest through into specialist inpatient care and in the community to those discharged from hospital. The combination of established clinical leadership and a mature senior leadership team ensures that care group maintains a clear focus on evidence based interventions and that a strong research base drives their practice. The team will strengthen clinical leadership by extending the practice of nurse-led clinical reviews and non-medical responsible clinician role and promote its work on restorative justice; adding to its research credentials by publishing articles on these achievements.

The service aims to work effectively with partners and other stakeholders to promote public protection, challenge stigma and achieve the best clinical outcomes for people who require this type of care. Building on the reputation of our high standard accommodation, care and patient engagement the service will continue to work with NHS England commissioning colleagues.

The police and court liaison and diversion service will work in partnership with Sussex Police, Surrey, Sussex Probation Trust, the youth offending service and offender health commissioners to maximise the benefits of the trust being a trial site for the new national operating model roll out.

The community Forensic Outreach service has developed a 3 year strategy that will guide its work and develop practice to enable the teams to support and sustain the benefits of inpatient secure care for those discharged into the community.

This provides the opportunity for growth through excellent clinical service at a range of points through the care pathway.

5.3.5 Children and Young People's Division

Sussex Partnership is one of the largest providers of mental health services to Children and Young People in the country. This means that we have a great deal of clinical leadership available to design and implement effective service models in the areas we serve. We currently provide community services to Kent, Medway, Sussex and Hampshire. We also deliver a very high quality inpatient service at Chalkhill in West Sussex.

The services aim to provide flexibility and choice, improve access, and maximise engagement of children, young people and families. Care pathways for eating disorder, developmental disorders and self-harm will be established in all areas and evaluated to ensure high quality consistent care. Our people will be committed to developing and sustaining strong relationships with our partners so young people quickly get the right help throughout a 24 hour period and where possible are supported to stay out of hospital.

There is feedback from most stakeholders of the need for Youth Services covering the 14 to 25 age range. Service users and carers talk about a mixed experience of transition from Children and Young People's Services to adult services. We are working with commissioners and third sector partners to improve this experience and are developing models of integrated healthcare that will improve outcomes and ensure smooth transfers between services.

With the largest geographical penetration of any division in the trust, the children and young people's service is in different phases of delivering the Right from the Start model of care to the populations it serves. Over the past year we have seen demand across the whole pathway increase, particularly in accessing tier 4 inpatient services and this subject to a national review. The increase in demand has placed additional pressure on the service. Therefore our main priority for the year ahead is in improving access to services and the timely delivery of treatment. Our service model is efficient and high quality but we need to ensure that rapid access is delivered consistently across all of the areas we serve. Good progress has been made but we need to sustain this effort to meet the expectation of children and young people, their families and commissioners. For instance, when we took on service for Kent and Medway in September 2012 there were waiting lists of 18 months, this has been reduced to six weeks but we need to keep improving and reduce the waiting times further.

The model will be further refined and developed to create additional capacity and flexibility to meet an anticipated trend of increasing demand. The overarching aim is to be a force in young people's mental health that is more than the sum of its parts, and to achieve this by engaging with individuals, recognising their skills and experience, listening and planning creatively and with an open mind for the future. There is much to be achieved through the synergies of working this way. The appointment of an academic Chair for young people's services will build a strong voice in research and development and will work to ensure that a robust research and development agenda guides what we do and underpins our national profile

There is growing competition in the provision of Child and Adolescent Mental Health Services with a mixed range of organisations that includes acute and mental health trusts, the third sector and private companies. Sussex Partnership will work very closely with our third sector partners to ensure the overall service offer combines the best of clinical standards with sound user engagement and customer care.

The services will aim to provide flexibility and choice, improve access, and maximise engagement of children, young people and families. Care pathways for eating disorder, developmental disorders and self-harm will be established in all areas and evaluated to ensure high quality consistent care. Our people will be committed to developing and sustaining strong relationships with stakeholders and partners so young people quickly get the right help throughout a 24 hour period and where possible are supported to stay out of hospital.

Working with NHS England to find a solution to local pressures will be a focus for the coming year for all localities and exploiting any opportunities to increase our bed stock either through expansion of Chalkhill, development of high dependency or intensive care beds as well as acquisition of new contracts, particularly in Kent and Hampshire where we are the provider of community services.

In addition to the Division priorities, each of the three localities has specific initiatives to pursue.

- **Kent and Medway**

Here the focus will be on demonstrating quality and delivery of timely assessment and access to treatment. We will work with commissioners and partner providers to drive a more integrated approach across the whole system of care.

- **Hampshire**

Work with commissioners to meet the increased demand and improve service delivery will continue through the next year with a strong focus on relationship management and stakeholder involvement to prepare us for the impending procurement process which is scheduled to take place during the next year.

- **Sussex**

Across Sussex we will be working with commissioners and local stakeholders to ensure the whole emotional wellbeing pathway is delivered though an integrated working approach. New approaches will be explored through pilots such as planned for the Crawley area and developments in Brighton and Hove. The Early Intervention and Youth Mental Health Services across Sussex will develop a plan for the rollout of the evaluated Youth Mental Health service model across Sussex.

5.3.6 Complex care pathway

The Complex Care Pathways care group consists of a range of services including Personality Disorders, Eating Disorders, Peri-natal and Neuro-behavioural services. A market assessment has revealed there is a need to expand community and inpatient eating disorder services as demand for this service is increasing across Sussex. It has also been identified that there is additional needs and further development for community based personality disorder services.

5.3.7 Recovery and Rehabilitation Partnership Limited

Sussex Partnership has established a joint venture with Care UK to develop inpatient and high care rehabilitation services. This is being delivered by a new company called the Recovery and Rehabilitation Partnership and is jointly owned by both organisations. This has enabled us to develop new services that would not have been available without this new organisation. We currently operate a 32 bed service in Gosport and are opening a new 24 bed service in Horsham in 2014**.** The focus over this year will be on the opening of the Horsham service and continued work on the leadership, service model, governance and clinical outcomes across the partnership.

5.3.8 Lindridge Nursing Home Development

Lindridge is our care home development located in Hove, East Sussex. Lindridge will open in May 2014 for people with dementia and complex range of physical health needs This new service is undergoing significant expansion and redevelopment following our acquisition of The Downs Nursing Home from the Southern Cross Group. The Home is co-located in the same building as one of our specialist dementia inpatient wards and is undergoing extensive refurbishment resulting in the phased release of new capacity. The first 21 rooms and 4 flatlets will be available in May 2014, with 76 spaces for residents available from October 2014.

Based on a model of holistic, relationship-centred care Lindridge will meet the growing demand for care for people with increasingly complex health and dementia presentations and be marketed to a range of health, social care and private purchasers.

Working in partnership with multi-disciplinary colleagues, our team of staff are passionate about the rights of those within our care to experience “the best that life can be” within the challenges diminishing physical and mental health brings.

Our move into this market signals our desire to utilise our expertise as a Trust in the care of people with dementia and to grow our existing service to provide both transitional and home for life provision

6. PRODUCTIVITY, EFFICIENCY AND CIP's

6.1 Overview of Productivity and Efficiency Gains

In order to allow the Trust to continue to deliver a small surplus to invest in infrastructure and services, including improvements to information technology, and to maintain the Trust's Continuity of Services Rating as a 4, the Trust plans for another two years of significant cost improvement savings.

The Trust's financial plan for 2014/15 includes savings of £12.5m, and in 2015/16 includes savings of £13.6m, which we have allocated into the headings described in the 'Closing the Gap' report published by Monitor in the Autumn of 2013.

The major CIP projects, which are also described in the accompanying Financial Template, are listed below -

1) Improving Productivity within Existing Services

- Redesign of community services in line with Commissioner strategies on mental health, wellbeing work and outcomes from review of referral processes
- Reviewing our administrative systems and processes that support clinical and corporate service delivery
- Prescribe according to our own guidelines for use of generic drugs
- Review and redesign the clinical and operational leadership roles across the organisation

2) Delivering the Right Care in the Right Setting

- Ensure that our patients are admitted to our own beds within their local area wherever possible, to reduce Extra Contractual Referral costs
- Reduce our use of agency staffing to an average of 1% of the total annual pay budget
- Continue with our programme of estate rationalisation

3) Developing New Ways of Delivering Care

- Our Joint venture with Care UK: Nelson House and Horsham Rehabilitation Development
- Nursing Home Development at the Lindridge Centre in Brighton
- Redesign of adult rehabilitation pathway and service delivery
- Review of dementia care pathway, and inpatient and community service models

4) Allocating Spending More Rationally

- Reduce our spend on services provided by suppliers through more efficient procurement processes and contracts.
- Realise the benefits of the implementation of Agenda for Change
- Reduce spend across corporate functions
- Misc. saving programmes identified across all operational services

6.2 CIP Governance

Historically the Trust has been successful with its CIP delivery. In 2011/12 we delivered £10.4m, in 2012/13 we delivered £9.9m, and in 2013/14 we expect to deliver £10.6m.

Whilst not fully achieving the target in 2013/14, it was still a significant level of savings. The key learning from previous years was that the bottom up projects are the ones that deliver the most savings, and that stronger governance around delivery of the CIP was necessary, particularly in the context of being able to react quickly should it become apparent that a CIP project or projects are not going to deliver the necessary level of savings.

Both of these have been taken forward into CIP planning for 2014/15 and beyond.

6.3 CIP Process

All CIP projects are assigned to an Operational Division or Corporate Directorate, led by an Executive Director and Service Director. All of the CIP projects contained within each Division are then in turn led by a Project Manager.

All projects have been formally signed off by the Executive Director and Project Manager for each project, as well being collectively approved by the Trust's Executive Management Board, Finance and Performance Committee and the main Trust Board.

All projects have a detailed CIP Template containing a full analysis of the quality impact assessment. The delivery of all projects has been risk rated, with the risk adjusted savings being used to determine the expected savings values.

CIP Management

The ultimate accountability for CIP delivery is through the Trust Board. The Trust Board receive a monthly finance report regarding the progress of achievement of the CIP.

CIP is scrutinised in detail at the Executive Management Board, and also the Finance and Investment Committee, which is a subcommittee of the Board.

On a day to day basis, delivery of the CIP is managed by the Deputy Director of Finance. There are three CIP delivery groups, one with responsibility for the Adult Services Operational CIP, one with responsibility for the Specialist Services Operational CIP, with the other being responsible for Corporate CIP. Each delivery group is attended by the above leads, plus Service Directors and Corporate Directors. The groups meet on a monthly basis.

CIP is reported at a summary level within the Finance Board Report, with detailed project level reporting in place for the Executive Management Board, Finance and Investment Committee and the CIP Delivery Groups. In addition to this CIP is reported, and discussed, at all budget holder level meetings.

Delivery of the CIP is also now being supported by the Change Management Office, which was established at the beginning of 2013/14.

6.4 CIP Profile and Enablers

The Trust's CIP will be delivered through the Trust's Divisions and Directorates, with overarching CIP projects being managed on a Trustwide basis, although with individual targets relevant to each Division and Directorate.

Each Division or Directorate is led by an Executive Director, and comprises a number projects that are all related to that Division.

The individual projects that are contained within each Division or Directorate were generally established using a common approach, which was through a series of meetings and workshops with the Executive

Director and their deputies (who would then become the Project Leads). Scheme Leads and Project Leads were asked to identify savings projects in a bottom up approach, as based on previous experience those are the savings schemes that will always deliver savings.

CIP Risk Profile

All CIP projects have been risk rated, with the risk adjusted savings values being used to determine the predicted savings for each workstream. Therefore there is in built contingency within the CIP. The Trust is also maintaining a 1% contingency, held within the pay budgets, which will be used in part to off-set any underachieved CIP if necessary.

The detailed projects in place for 2014/15 have the following risk profile –

	CIP Target £K	Low £K	Medium £K	High £K
Adult Services	5,597	2,839	2,393	429
Specialist Services	3,929	1,623	987	1,256
Corporate Services	2,975	1,417	331	1,227
TOTAL	**12,501**	**5,878**	**3,711**	**2,911**

The risk profile of the CIP projects does indicate risks around the delivery of the CIP, with over half of the CIP being judged as medium to high risk.

Should any CIP projects not deliver savings to the necessary level, it is understood that alternative projects will need to be established immediately to mitigate any income shortfalls.

The projects within the workstreams are a combination of transformational themes, as well as more stand-alone projects.

To mitigate against the risk profile of the cost improvement plan additional controls have been put into place, particularly in the first quarter of 2014/15 to ensure that the financial plan is delivered.

6.5 Quality Impact of CIPs

All projects have a detailed CIP Template containing a full analysis of the quality impact assessment, which is approved by one of the Trust's Quality Directors.

The Executive Director of Finance and Performance also presents the Cost Improvement Programme to the Quality Committee, which is a subcommittee of the Board.

The on-going impact on quality of the CIP schemes is picked up as part of the on-going review of performance, for example through the monthly Quality performance review meeting that is held in Operational services.

7. FINANCIAL PLAN

7.1 Financial and Operating Environment

The financial plan for 2014/15 to 2015/16 is set in the context of a period of unprecedented financial challenge.

The National Tariff Guidance for the NHS was published in December 2013. The key highlight of the guidance is that there will be income deflation of 1.8% for non-acute provider organisations. This is calculated as 2.5% price inflation less 4.3% provider efficiency.

This section and following appendices of the plan sets out the Trust's financial plans for next two years as well as the investment the Trust plans to make in its capital programme.

7.2 Financial Strategy

The main focus of the Trust's overarching strategy is to provide services that are Better by Design in terms of their provision, the estate and the skills of our workforce. The Trust's financial strategy is therefore focused on:

- the delivery of the high quality services that provide value for money through optimum and consistent service models
- maximising the skills of our workforce and the utilisation of technology to enable this
- rationalisation of our estate to provide fewer better buildings from which to deliver our services and accommodate our staff

The Trust will also continue to pursue new business opportunities. However, these will only be taken forward if they align with the Trust's vision and provide the required rate of return.

7.3 Financial planning process

The two year plan takes account of the following:

- assumptions as set out in the NHS Tariff Guidance for 2014/15
- changes in commissioning intentions and contract negotiations with Clinical Commissioning Groups
- changes in service delivery and redesign
- changes due to cost pressures and cost improvement plans

These changes have been discussed through a number of meetings with Divisional and Executive Directors to ensure that the financial plans are owned and embedded across the organisation.

7.4 Key financial assumptions

It is assumed that the income deflation of 1.8% in 2014/15 will revert to a 1.5% deflator in 2015/16.

It should be noted that from 2015/16 it is expected that we will be commissioned or part commissioned based on a local Payment by Results tariff rather than our existing block contract, although for the purposes of planning at this stage it is expected that this will be cost neutral.

With regards to pay, the Trust has reflected the Government's decision not to accept the recommendation from the pay review bodies for a 1% uplift to all pay scales from April 2014, and for it only to be applied to staff at the top of the pay scale. Staff who are entitled to incremental progression will continue to receive this.

This change will affect around half of the staff in the Trust, and it is estimated that the financial impact of this decision will be a saving of around £850K in 2014/15, which has been used to increase the contingency element within the pay budgets.

We have assumed that the same principles will apply in 2015/16, although we are aware that the exact details of the pay awards are still to be negotiated. We have also assumed there will be no further amendments to National Insurance over next two years.

The Trust has assumed that non pay inflation will be 2% per annum over the period, which is consistent with the current CPI index, and cost pressures of 0.5% per annum.

A summary of the inflationary assumptions that are included in our two year plan are set out in the table below.

Category	**2014/15**	**2015/16**
Income deflation	-1.80%	-1.50%
Pay inflation	0.50%	0.50%
Pay increments and other pay uplifts	1.00%	1.00%
Non pay inflation	2.00%	2.00%
Non pay pressures	0.50%	0.50%

7.5 Overview

An overview of the Trust's financial projections for the next two years 2014/15 to 2015/16 compared to the previous year's performance are set out in the table below.

	2013/14 Outturn	**2014/15 Plan**	**2015/16 Plan**
	£m	**£m**	**£m**
Turnover	240.3	231.3	227.4
Surplus	2.2	1.2	1.2
Capital Investment	5.2	13.2	12.3
Cash	37.5	35.4	32.5
Continuity of Services Rating	4	4	4

The impact of the key assumptions and service developments that underpin these projections are set out in Appendix 1 below.

7.6 Summary

The Trust's financial plan is set in the context of more challenging times for the NHS, as public sector funding is squeezed in order to address the economic downturn.

The Trust will need to be flexible in meeting these challenges in order to mitigate against these risks over the next three years in order to maintain its financial stability. However, the Trust's track record of delivering financial performance puts it in a favourable position to tackle the challenges ahead.

A full analysis of the financial plan is included in Appendix 1 below.

8. APPENDIX 1 – FINANCIAL COMMENTARY

8.1 Income

Overall the Trust's turnover will reduce over the next two years, from £240.3m in 2013/14 to £231.3m in 2014/15 and £227.4m expected by 2015/16.

The major reason for this is a reduction in clinical income, which is expected to reduce from £228.2m in 2013/14 to £218.9m in 2014/15, and £215.4m in 2015/16. The key movements are described in Table 1 below.

The main income movements in 2014/15 include 1.8% income deflation which was announced in the NHS Tariff Guidance in December 2013, which applies to all non-tariff NHS services. This accounts for £3.8m of the reduction.

The Trust can expect to receive additional income relating to new service developments which will be effective from April 2014, the main one being the Lindridge Centre nursing home development, with additional clinical income of £1.1m expected in 2014/15, as well as an additional £0.4m of private patient revenue. In addition to this we have been successful in securing an additional £0.7m of new income relating to our Hampshire CAMHS service.

There are large income reductions relating to the decommissioning or re-tendering of services, which are outlined in Table 2 below. It should be noted that there will be cost reduction to off-set most of this reduction, with the expected margin loss to be around £0.8m.

It is expected that the current income deflation level of 1.8% will revert to 1.5% deflator in 2015/16. This has been applied to all of our large block contract agreements.

The value of CQUIN remains at 2.5% of our main contracts, which is equivalent to around £4m per annum. However, we have assumed that we will not deliver all of the potential income, due to concerns about our ability to achieve some of the targets.

Table 1 - Movements in Clinical Income 2013/14 to 2014/15

Description	**Value £m**
Closing Value at March 2014	228.2
Plus	
Additional Income from Service Developments	1.8
Less	
1.8% Income Deflation	(3.8)
Decommissioning of Existing Services	(7.3)
Opening Clinical Income 2014/15	**218.9**

Table 2- Service Decommissioning – 2014/15 Income Impact

Service	Location	Income Value £m
Lavender Lodge	East Sussex	0.6
Substance Misuse Services	East Sussex	2.3
Community Learning Disability	East Sussex	0.4
Recovery Houses	Brighton	1.0
The Cottages	West Sussex	0.6
Section 75 Budget Transfer	Brighton	2.4
Total		**7.3**

The major risks to our planned income are those outlined in the Financial Risk section below.

It is important to note that during 2014/15 we are in a shadow year for PBR for our Working Age and Older Adult services. We have developed prices for cluster review periods, which we will be using to model our activity against throughout the year. It is envisaged that 2015/16 will be a further shadow year as we continue to refine our understanding of cluster activity, with 2016/17 being the earliest that we expect we will move to being commissioned on a full PBR basis. However, for the purposes of this plan we have assumed that there will be zero financial impact of the move to full PBR.

8.2 Strategic Developments

In November 2011, the Trust took over the Downs Nursing Home, which was located within one of our rental properties in Brighton. The home is a 25 bedded nursing home.

We are aiming to expand this service by developing a more premium nursing home service located within the existing property, to exploit opportunities in the market place.

Work commenced in 2013/14 to increase the number of beds in the unit, and when the development is complete we will have a total of 76 beds at the unit, which we are renaming Lindridge..

The beds will be opened on a phased basis over the course of 2014/15, with all beds available during 2015/16.

The main customers are CCG's, County Councils, and private patients.

During 2014/15 the development is expected to be revenue and cost neutral, as the beds are being open on a phased basis, with costs being more linear. However, in 2015/16, when all beds will be available from the start of the year, we expect to make an overall contribution of £755K.

The incremental financials relevant to the development are described in the table below –

	14/15 £K	15/16 £K
Priate Patient Revenue	381	239
Cost and Volume Revenue	1,144	863
Total Revenue	***1,525***	***1,102***
Pay and Non Pay	- 1,389	- 217
Capital Charges and Depreciation	- 136	- 130
Total Costs	***- 1,525***	***- 347***
Net Contribution of Development	**-**	**755**
CAPEX	2,320	-
WTE	25	6

The other major strategic development is our Joint Venture with Care UK Ltd, which is outlined in more detail in Section 9 below.

8.3 Transactions

At this point in time the Trust is not planning on undertaking any significant transactions during the planning period, with the exception of the potential expansion into providing Muscular Skeletal (MSK) services, which is being delivered through the Sussex MSK Partnership and is explained in further detail in Section 9 below.

8.4 Activity

The Trust's activity is described in terms of occupied bed days for inpatient facilities and caseload for the community services.

The Trust is operating Payment By Results in shadow form in 2014/15 ahead of the planned implementation for adult mental health services in 2016/17. The Trust will be monitoring the Payment By Results activity monthly in 2014/15 as part of the contracted activity plan being agreed with Commissioners.

The Trust was contracted to provide 631 inpatient beds at the end of 2013/14, which is expected to remain constant over the period, subject to any changes to inpatient provision that may arise through the cost improvement programmes relating to changes in the Dementia and Rehab pathways.

Occupied bed days reduced in 2013/14 compared to our previous plan, mainly due to a reduction in bed numbers in the year.

Community activity and caseload in the Trust has remained fairly constant in the past year and is expected to remain constant going forward.

In 2014/15 the Trust will continue to monitor performance information through monthly reporting at team level.

This information is scrutinised through a monthly operational review meeting chaired by the two Managing Directors, through monthly contract monitoring meetings with our Commissioners and through the monthly Finance & Performance Committee, chaired by one of the Trusts Non-Executive Directors.

8.5 Workforce

Our aim is to be the employer of empowered, engaged, well trained and highly motivated staff and to be valued as an outstanding employer. We have continued to deliver against quality and financial indicators and have continued to attract excellent people into posts across Hampshire, Sussex and Kent. In particular, the growth of our research and teaching base and development of new opportunities has led to a strong recruitment field for consultant psychiatrist and psychologist posts. However, we have not achieved similar positive improvement in our measures of staff engagement, including the NHS staff survey, which we recognise we need to improve on.

During 2014/15 our goal is to increase focus and investment on organisational development ensuring that we support our people to be compassionate, values driven and engaged in debate and decision making at all levels. This will be crucial over the next two years to support our plan to reduce pay costs by £10.6m in 2014/15 and £11.9m in 2015/16.

The workforce plan for the years 2014 to 2016 is an ambitious programme designed to meet the economic challenges and support service re-design.

Plans have been developed to achieve a net reduction of 149 whole time equivalent posts (wte) at the end of the first year 2014/15 and will continue with a further 187 wte reduction in 2015/16. Effective planning and robust vacancy management has helped to ensure a significant number of posts are available for redeployment opportunities.

8.5.1 Workforce Redesign 2014/15

The next stage of service re-design in Adult services commenced in 2013/14 and this work will continue in the first part of the 2014/15 with full implementation continuing into 2015/16. The challenge of delivering good quality services for patients at a time of rising demand and reducing resources requires a transformational change to the way in which we deliver care. The redesign will focus on ensuring our staff can intervene at the places where patients present with mental health needs, including accident and emergency departments, GP surgeries, police cells and ambulances. This will improve outcomes and should help better manage demands on specialist care. In terms of the workforce this will require a re-design of patterns of working, including shift patterns and seven day working where they are not currently available and new role designs. We also anticipate more co-location of our people with other providers of health and care services to meet the requirements being driven through greater integration for people with complex needs. This will require detailed workforce plans for the next two years and a detailed supporting resourcing plan with an associated equality and human rights impact assessment.

The level of acuity on inpatient wards, both for dementia services and acute adult services has resulted in a requirement to review skill mix and levels of staffing across all wards. As alternative support is being made available in patients own homes and other community settings, the acuity of patients on wards is presenting a higher level of need. This will be another key objective in 2014/15 and additional investment in staffing on dementia wards will feature as a part of the workforce plan, together with additional investment in training and developing staff to care for patients with significantly more challenging behaviours.

Specialist services models have been designed over the past two years but some service models such as Children and Young Peoples services will be reviewed in the light of significantly increased demand for services and the need to review, with commissioners, a change in service models across all tiers of service delivery in order to meet this increase in work.

The acquisition of Children and Young Peoples services in Hampshire and Kent have required significant focus over the past 2-3 years changing service models, introducing more consistent performance

management and recruiting to vacancies. The practice of tendering services for three years has a significant impact on staff engagement and requires additional clinical and managerial leadership capacity to manage the change whilst improving the quality of services offered. Our process for acquisitions will be reviewed to ensure we have a particular focus on the staff engagement and cultural change process.

More significant workforce developments for 2014/15 will be the opening of our new care home and the new rehabilitation and recovery unit in partnership with Care UK in Horsham. The development of the nursing home services requires a significant recruitment drive for staff with a different skill set and terms and conditions more applicable to the private sector nursing home market. A key requirement for 2014/15 will be the development of expertise in the workforce required for these new ventures.

In 2014/15 we will implement a Mutually Agreed Resignation Scheme (MARS). This scheme will have defined eligibility criteria and will be time limited. For the purposes of the plan the scheme has been assumed to be cost neutral.

8.5.2 Pay Policy and Terms and Conditions

While continuing to support the principles of the national terms and conditions of service, offered under Agenda for Change, we have removed some of the local and discretionary payments and flexibilities currently in place which has contributed to our cost improvement programme over 2013/14 and will continue to deliver an £800K saving in 2014/15.

8.5.3 Workforce Plan 2014/15

Our plan will address the cultural issues arising from the staff survey results and focus groups feedback with regular feedback from staff on progress. This will include the design and delivery of a leadership development programme, including management skills. In recognition of the work pressures experiences by staff there will be a new goal to give time back to clinical staff through improved IT and streamlining clinical and support service processes.

- Reduction of time to hire target to average of 15 weeks with a review of the target in September 2014.

- Achieving consistent 95% completion of appraisals (90% achieved in 2013/14) and improving the reported quality of those appraisals from 40% in the NHS staff survey 2012 to 50% by 2015. Appraisals and supervision is a key route to improving staff engagement and ensuring that each individual feels supported to deliver the best possible performance.

- Achieving the re-validation of doctors' target through the consultant revalidation process. This has commenced and we are on target to achieve the re-validation of the majority of doctors for the first time by 2016. The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practice.

- Reduction in sickness absence to average of 3.5%.

- Delivering essential training in the most effective time and cost efficient way. The focus in 2014/15 will be increasing the number of staff undertaking essential training. Shift patterns and staffing levels are the priority for the next 12 months. There will be a review of the methods of delivery of essential training. We will find the optimum combination of e-learning modules, web ex and classroom based sessions whilst recognising the benefits of staff engagement in face to face learning sessions and managing the delivery of service. In particular the recent introduction of 12.5 hour shifts will be reviewed to assess the impact on meeting essential training requirements and solutions found to mitigate any actual reduction in our ability to deliver essential training.

- Reduction in use of agency to 1% of monthly pay bill and delivering most cost effective and efficient solution for temporary staffing will remain a key objective.

- Continuing our focus on developing good relationships with Health Education, Kent, Surrey and Sussex and the Local Education Board to ensure that funding allocations for continuing professional development ensure the future supply of professionally registered staff meets our needs.

8.5.4 Improving Health and Wellbeing

There will be continued focus on managing sickness absence with our ambition to achieve the target of 3.5% and specifically focussing on the development of improved care pathways and early intervention for people who have more complex mental health issues. There will also be a key focus on improving support for people experiencing stress and anxiety as a result of change in the workplace and workload with an increase in our range of supporting tools and mindfulness groups.

We have recently held a Health and Wellbeing Conference for our staff and we will publish the new strategy in autumn 2014. This will continue our work on measuring and improving staff health and wellbeing. We will continue our programme of improving staff rooms; increasing cycle to work support and maintaining investment in employee assistance programmes and occupational health services.

We will also continue to improve the care and treatment of our staff with stress, anxiety and more complex mental health problems through timely and effective assessment and treatment interventions and the expansion of mindfulness based support. The focus will be on evidence based interventions reflecting NICE guidance and through regularly seeking feedback on the effectiveness of our programme. The Occupational Health and Employee Assistance Services will be key to helping us achieve this.

8.6 Capital Expenditure and Estates Strategy

Sussex Partnership is refreshing its estates strategy with the aim of maximising the value derived from its investment in assets to create a sustainable estate. The programme will also seek to maximise the benefits of new technology on working practices to focus investment in patient facing facilities. The programme will continue to ensure investment in the refurbishment and replacement of existing buildings to improve functionality and accessibility. The strategy will also focus on ensuring optimum use of the building assets by the Trust and others exploring new way in which the assets can be utilised to support the Trust's business.

The estates and facilities strategy will complement and enable the delivery of our improved clinical services including more flexible and team working practices. This focus will continue to cover new business acquisitions both in Sussex and further afield over the coming years.

8.6.1 Key Priorities

- Secure and forensic service developments
- Re-alignment of the rehabilitation/recovery estate to meet the future needs of the service
- The effective use and deployment of assets and resources
- Completion of the community estate rationalisation and addressing poor working environments e.g. Arun.
- Improving compliance and maintenance backlog risk management

- Carbon reduction by increasing the utilisation of the estate, making savings on energy use and travel impacts and broadening the influence of sustainable decision making across the organisation
- Using the operational capital programme to improve current environments and continued programme of reducing ligature risks
- Implementation of business information and intelligence systems and processes to enable better informed demand and capacity management, risk management and sustainable interventions
- Food service, food quality and personalisation
- Compliance, resilience and risk management
- Within the context of the overall trust workforce development strategy improve skills development and succession planning

8.6.2 Capital Programme Summary

The Lindridge Centre
The Trust Board approved the development of the Lindridge nursing home on the Neville Hospital site in Hove, East Sussex. We will refurbish the Neville Hospital to create a nursing home with 72 new en-suite bedrooms, and 4 small flats and ancillary facilities. The project commenced in October 2013 and is planned to complete in October 2014.

Catering Central Production Unit (CPU)
The geographical location of the CPU has still to be finalised. Subject to the approval of a revised business case the new unit will come on stream in late 2014 / early 2015 providing a highly valued and sustainably sourced food service to multiple Trust and potentially other locations.

Secure and Forensic Development
Hellingly phase 2, Elm Ward. We will construct a replacement 15 bed medium secure unit by May 2015. A supply chain has been appointed to undertake extensive enabling works from February to August 2014 with the main construction works commencing in August 2014 and completing in August 2015. Planning permission for a further 15 bed ward in the same location has been secured.

Clinical Information System
During 2014 the Trust will be procuring a new clinical information system, which will be part funded through a contribution from the Safer Hospital Fund. For the purposes of the plan the net capital expenditure has been included in the Capital plan, with the contribution from the Safer Hospital Fund being accounted for as a PDC receipt.

Operational Capital Programme

1) **Compliance, Health, Safety & Environmental**

The budget has been developed in consultation with the Estates & Facilities Area Managers, Facilities Managers, staff and services and has considered Small Works Requests, Estates and Facilities intelligence, Patient-led Assessment of the Care Environment Reports and Care Quality Commission mock and actual inspections. Within this year's proposal is a significant allowance for statutory compliance including a substantial volume of backlog maintenance relating to electrical safety, water management, asbestos containment / removal and upgrading of security, fire and life safety systems. A substantial programme of ligature reduction works has been developed with the Risk and Safety Team to ensure that all high level risks are dealt with promptly and efficiently.

2) Quality / Patient Experience

Within this year's proposal are substantial programmes for furniture replacement and internal/external redecoration. Following last years prolonged period of high temperatures we have identified simple low energy solutions to reduce a recurrence of similar issues at a number of sites and identified 'better use of space' opportunities at a number of locations also.

East Sussex Inpatient and CAMHS Development (2015/16 projects)

At this stage these plans are not fully defined and have not been approved by the Trust Board, but have been included in the plan to represent the likely expenditure on these two major schemes.

Rehabilitation and Recovery Services

Through our joint venture with Care UK we will complete the development of the Martyn Long Centre site in Horsham this year. The new high quality rehabilitation and recovery centre will have 20 bungalows and 8 en-suite bedrooms on 2 floors with ancillary, therapy and social space. Note this is not included in the capital plan as it is accounted as an investment in the joint venture.

The major capital projects for 2014 to 2016 are outlined in the table below.

Project Name	2014/15 £M	2015/16 £M	Total £M
Lindridge Nursing Home Development	2.3	0	**2.3**
Catering Production Unit	2.2	0.9	**3.1**
Secure and Forensic Elm Ward Redevelopment	3.8	1.5	**5.3**
Community Improvements and Rationalisation	1.5	0	**1.5**
Operational Capital Programme - Maintenance	1.9	1.5	**3.4**
Clinical Information System	1.6	1.6	**3.2**
East Sussex Inpatient Reprovision	0	4.3	**4.3**
CAMHS Development	0	2.5	**2.5**
Planned Expenditure	**13.3**	**12.3**	**25.6**
Disposals	-4.8	-2.8	**-7.6**
Net Expenditure	**8.5**	**9.5**	**18**

8.6.3 Disposals

The Trust will continue to disinvest in surplus of non-strategic property not forming part of the longer term requirements of the Trust. The property disposal programme is aligned with the Trust's planned capital expenditure for the period to (2014/16). The Cash Plan identifies how the expected timing and value of capital receipts, together with asset depreciation, will enable the Trust's capital investment plans for this period without the need for external finance borrowing.

In order to maximise the prospects of sale and to minimise risks, considerable planning promotion and preparation work is underway to prepare some of the Trust's larger sites for disposal. Professional valuation and agency advice is obtained as required in order to identify the risks and opportunities posed by the current property market.

All disposal opportunities arising from current phases of the site rationalisation programme have been either realised, or identified. Further actions focused on scope for asset utilisation improvement will be identified from space utilisation reviews, including future use of the Private Finance Estate (PFI), opportunities for shared occupation with other agencies and the post investment evaluations of completed projects.

The Trust owns a number of residential buildings. The outcome of the rehabilitation service review that will consider the optimum model of service and housing management arrangements going forward. There is potential for partnerships with housing providers to be explored as part of the new model.

8.6.7 Asset Revaluation

We expect there to be some amendments to the value of our asset base as a result of a recent valuation exercise, although because of timing this has not been reflected in our plan.

8.6.8 Cash

The Trust expects to have an opening cash balance of £37.4m, which will reduce to £35.4m at the end of 2014/15, and £32.5m in 2015/16. The cash balance reduces because of the investment in our capital programme described above.

It should be noted that the opening cash balance contains a receipt of £10.5m relating to the sale of our Graylingwell site in Chichester, which completed on 31st March 2014.

However, we will also be reporting a contingent liability of an equivalent value in our 2013/14 annual accounts, as the sale will only be guaranteed in December 2014, when conditions relating to the sale have been met. Therefore for the purposes of cash planning we are not assuming that this cash is available until that time.

The Trust is also exploring the possibility of buying out some of our PFI liabilities in order to utilise our cash reserves and to deliver recurrent savings regarding our interest and maintenance payments, although at the time of writing these are not developed enough to include in the two year plan.

8.7 Costs

8.7.1 Overall Expenditure

In order to deliver the level of efficiency savings as set out in the NHS Tariff Guidance there will be even closer scrutiny of the cost base of NHS organisations to ensure that the tax payer is getting value for money and that resources are being focused on service delivery and quality, rather than management costs and corporate overheads.

During 2013/14 the Trust has made significant progress in reducing costs through the delivery of a £10.6m cost improvement programme. Moving into the next two years the Trust's efficiency savings will be driven through optimising service models, maximising the skills of our workforce and rationalisation of our estate.

The detailed assumptions underpinning pay and non-pay expenditure and the Trust's cost improvement programme are set out in the sections below.

The table below sets out the Trust's expected operating costs for the next three years.

Operating Expenditure	**Forecast**	**Plan**	
	2013/14 £M	**2014/15 £M**	**2015/16 £M**
	£m	**£m**	**£m**
Pay	179.2	174.2	169.4
Non Pay	47.4	44.7	45.6
Total Operating Expenditure	**226.6**	**218.9**	**215.0**

8.7.2 Pay

The projections for pay costs over the next two years are aligned to the Trust's workforce plan as set out in Section 8.5. As pay costs form a significant percentage of operating expenditure, there will also be continued focus on pay costs over the two years in order to make efficiency savings.

The main areas of focus will be:

- Use of the rostering system to deliver efficiencies
- A drive to reduce sickness absence
- Continued focus on bank and agency usage
- Development of new strategies to reduce pay and the introduction of further controls around pay expenditure
- Removal of non-agenda for change pay allowances

The Trust has reflected the Government's decision not to accept the recommendation from the pay review bodies for a 1% uplift to all pay scales from April 2014, and for it only to be applied to staff at the top of the pay scale. Staff who are entitled to incremental progression will continue to receive this.

We have assumed that the same principles will apply in 2015/16, although we are aware that the exact details of the pay awards are still to be negotiated. We have also assumed there will be no further amendments to National Insurance over next two years.

8.7.2 Non-Pay

During 2013/14 the Trust has seen significant pressures on non-pay expenditure, with most areas overspending against budget.

The main areas of overspend will be the focus of the Trust's cost improvement programme over the next two years years.

In the next two years the Trust is also going to experience a step up in non-pay costs associated with Information Technology and the Clinical Information System, with an increase of £2.3m of costs in 2014/15, and then a further increase of £1.1m in 2015/16.

For 2014/15 onwards the Trust has assumed a 2.5% uplift to non-pay budgets to cover the main cost pressures and inflationary pressures. This leaves the Trust with a significant cost improvement plan to be delivered for non-pay over the next two years. This is detailed in the cost improvement section.

8.7.3 Service Developments and Changes

The impacts of service developments and changes that have been set out in the plan have been reflected in the Trust's operating costs and income. The main service changes relate to the decommissioning of services, as well as new services that will be in place from April 2014.

8.7.4 Cost Improvement Plans

The Trust is planning to achieve an operating surplus of £1.2m, with a Continuity of Services rating of 4, in 2014/15 and 2015/16.

The Trust has to self-fund the impact of income deflation, pay inflation and pressures, non-pay inflation and pressures, and service developments, by identifying appropriate cost improvements. In addition, a number of cost improvement schemes agreed in 2013/14 failed to deliver the planned level of recurrent savings.

Taking all of these factors into account, the cost improvement target for 2014/15 is £12.5m, and £13.6m in 2015/16.

Through a number of meetings with the divisions and corporate departments, detailed cost improvement plans for 2014/15 onwards have been identified.

The plan also assumes that the majority of CIP from 2014/15, and then going forward, will be achieved recurrently. Should this not be the case, the cost improvement programme would increase accordingly.

8.8 Sensitivity, Risks and Mitigation

8.8.1 Contingency

The Trust has a 1% contingency (£2.3m) in its financial plan for each year of the planning period, which is included within pay costs.

It is envisaged that the contingency will be necessary to cover any shortfall on the CIP, particularly the challenging pay reductions.

8.8.2 Sensitivity

Within the sensitivity section of the plan we have included risks to Clinical Income, Employee Expenses, Cost Improvement Programmes, and Capital Expenditure.

The Clinical Income risk relates to potential undelivered CQUIN in 2014/15, and in 2015/16 unknown service decommissioning. This would be mitigated by increased CIP savings.

The Employee Expenses risk relates to potential shortfalls on CIP projects. It is recognised that if this did happen the Trust would have to find alternative savings.

The Cost Improvement risk relates to potential shortfalls on CIP projects, as above.

The Capital Expenditure risk relates to potential underspends on our Capital programme, which may arise due to slippage on projects.

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8.8.3 Key Financial Risks

As the Trust enters a period of unprecedented financial challenge the risks to maintaining a sound financial position have never been greater.

In addition to the risks outlined above, the Trust recognises that there are a number of financial risks to delivering its financial plans over the next three years. The main risks are set out below -

- New national and local commissioning arrangements
- Financial position of local health economy
- Introduction of Payment by Results
- Tendering and re-tendering of services
- Ability to deliver the Cost Improvement Programme
- Organisational capacity to manage change

The impact and mitigation of these risks are currently being addressed by the Trust, and have been reflected in the planning assumptions.