

Tees, Esk and Wear Valleys 
NHS Foundation Trust

Business Plan Document for 2014-16

Tees, Esk and Wear Valleys NHS Foundation Trust

1. Executive Summary

This Business Plan sets out the key priorities identified by the Board of Directors and the plans to deliver them during the period 2014/15 to 2015/16 in light of its analysis of the external and internal environment. It has been developed following our robust Business Planning Framework which ensures the engagement of managerial and clinical leaders.

The Board have identified the following key challenges within the environment within which we operate:

- The increased requirements, driven by the Francis Report and Winterbourne Review to not only deliver high quality services but also to be able to demonstrate this to all stakeholders;
- The need to offer greater choice to our service users and enable them to co design and work with us in the delivery of care;
- The financial context of the local health economies, including the financial challenges facing our Local Authority partners;
- The growing population and the increasing demand this is expected to generate particularly in older peoples services, within a context of reductions in contract income through the tariff adjustor;
- The level of variation across our services in terms of the quality of the estate and service provision;
- The ageing demographics of our workforce.

Whilst the Board recognised the significant challenges in the environment that have, and will continue to take place over the life of this plan, it concluded that the current Strategic Direction of the Trust remains appropriate (as outlined in the diagram overleaf). The Board continues to remain committed to a focus on improving the quality of our services and increasing the value that we provide to commissioners. It believes that by doing this we will play our part in supporting the local health economies, and our partners within them, to address the challenges they face, whilst at the same time safeguarding our market position over the 2 year period of this plan.

In light of the above, the key themes that underpin this Business Plan are as follows:

- A continuing focus on improving the quality of our services;
- A continuing focus on adding value to commissioners, including supporting them in the delivery of national policy requirements, such as:
 - Improving access to mental health services;
 - Addressing the difference in the physical health of those who have a mental health condition or a learning disability compared to those who do not;
 - The prevention of mental ill health;
 - Promotion of recovery;
 - Addressing the requirements of the Winterbourne Review;

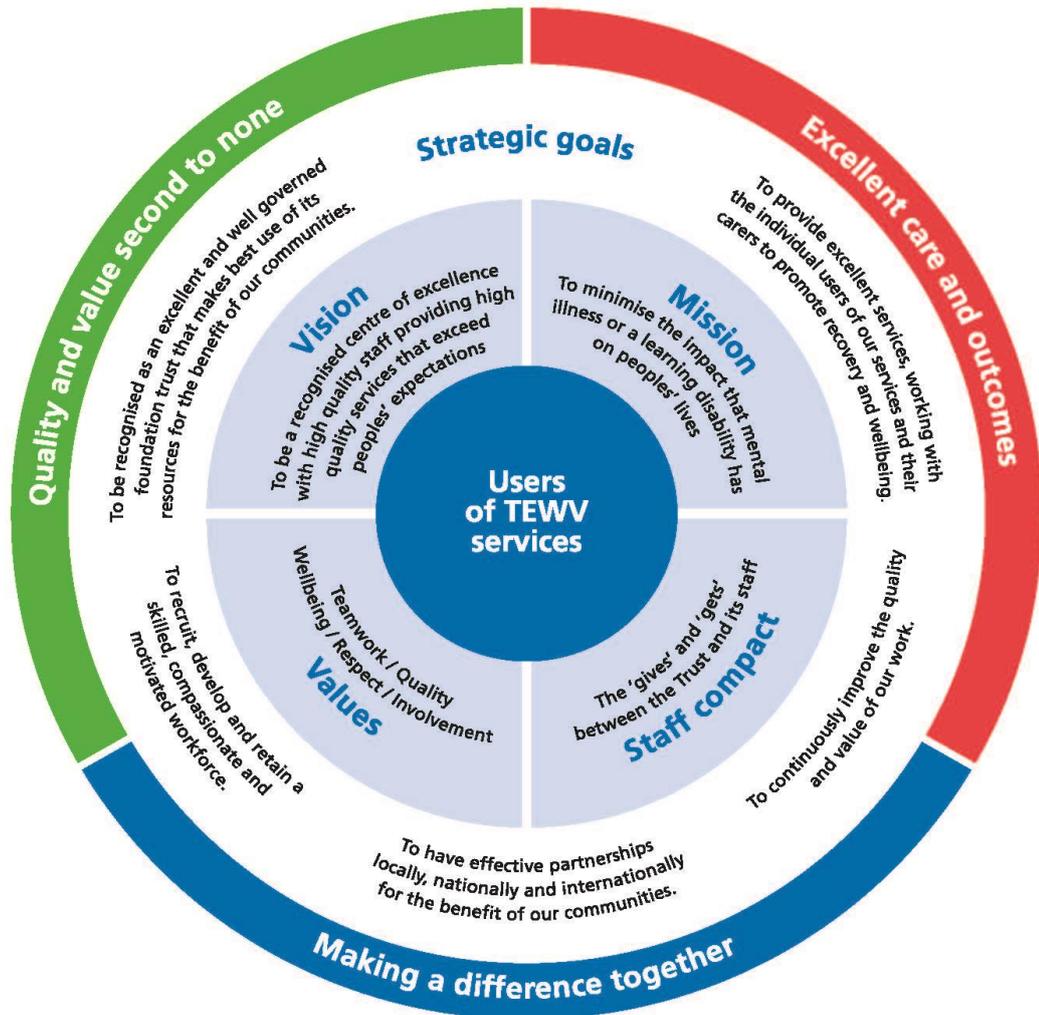
- Reinvesting surpluses to continue to make improvement to service provision and our estate.

The following sections set out the key priorities and plans in terms of quality, operational capacity and efficiency.

Finally the Business Plan has been developed on the back of a stable financial position that has been in place since the Trust became a Foundation Trust in 2008. The financial strategy of the Trust ensures we can continue to maintain this position by continuing to take a prudent approach to financial planning in order to ensure that the long term delivery of our clinical strategy is supported by a strong financial position.

Martin Barkley
Chief Executive,
Tees, Esk and Wear Valleys NHS Foundation Trust

The TEWV approach



2 The Short Term Challenge 2014/15 and 2015/16

2.1 Our Services

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provides a range of mental health, learning disability and substance misuse services for the 1.6 million people of all ages living in County Durham; Darlington; the four Teesside boroughs of Hartlepool, Stockton, Middlesbrough and Redcar and Cleveland; the Scarborough, Ryedale, Hambleton, Richmondshire and Harrogate districts of North Yorkshire and the Wetherby area of West Yorkshire. Our specialist services also serve patients from other local health economies, particularly Cumbria, Tyne and Wear and Northumberland.

The services we provide comprise inpatient and community services as follows:

- Children and Young People Mental Health Services (CAMHS), and Children and Young People Learning Disability services.
- Adult Mental Health Services (AMH), including Acute Liaison, Specialist Eating Disorder services; primary care psychological therapies, MoD / Veterans services and substance misuse.
- Adult Learning Disability Services (ALD).
- Mental Health Services for Older People (MHSOP), including Complex Care, Acute / Care Home Liaison, Memory Clinics.
- Forensic Services, including Forensic Learning Disability, Forensic Mental Health and Offender Health.

Services commissioned by Clinical Commissioning Groups (CCGs) are managed on a geographical basis in three Localities covering, Durham and Darlington; Teesside; and North Yorkshire. There is a Trust-wide Locality for Forensic Services. Each is led by a Director of Operations and a Deputy Medical Director who report to the Chief Operating Officer.

2.2 Our Local Health Economies' Stakeholders and Partners

These are shown in the table below.

CCG	Social Care commissioner	Health and WB Board	Main NHS Acute provider	Specialist NHS contracting	Ambulance
North Durham	Durham County Council	Durham	CDDFT	CNTW	NEAS
Durham Dales, Easington and Sedgfield (DDES)	Durham County Council	Durham	CDDFT	CNTW	NEAS
Darlington	Darlington Borough Council	Darlington	CDDFT	CNTW	NEAS
Hartlepool and Stockton	Hartlepool Council / Stockton Council	Hartlepool / Stockton	North Tees and Hartlepool FT	CNTW	NEAS

CCG	Social Care commissioner	Health and WB Board	Main NHS Acute provider	Specialist NHS contracting	Ambulance
South Tees	Middlesbrough Council / Redcar & Cleveland Council	Middlesbrough / Redcar & Cleveland	South Tees FT	CNTW	NEAS
Hambleton, Richmondshire and Whitby	North Yorkshire County Council	North Yorkshire	South Tees FT	South Yorkshire and Bassetlaw	YAS
Scarborough and Ryedale	North Yorkshire County Council	North Yorkshire	York FT	South Yorkshire and Bassetlaw	YAS
Harrogate and Rural District (HaRD)	North Yorkshire County Council	North Yorkshire	Harrogate FT	South Yorkshire and Bassetlaw	YAS
Vale of York (Ryedale District patients)	North Yorkshire County Council	North Yorkshire	York FT	South Yorkshire and Bassetlaw	YAS
Leeds North CCG (Wetherby patients)	Leeds City Council	Leeds	Harrogate FT / Leeds Teaching Hospitals Trust	South Yorkshire and Bassetlaw	YAS

CDDFT – County Durham and Darlington Foundation Trust;
CNTW – Cumbria, Northumberland, Tyne and Wear NHS England Area Team
NEAS – North East Ambulance FT; YAS – Yorkshire Ambulance Service

2.3 Changing demand for our services

Over the next two years we expect the population served by TEWV's main locality services to increase by 0.97% (English average is 1.76%). However, the number of people 65 years old and over will increase by 4.5% which is 0.04 percentage points more than the English average. Our 0-17 year old population is expected to increase by 0.64% which is 0.35 percentage points above the English average. Our working age population is expected to decrease slightly by 0.06%.

This would suggest that we can expect increases in CYP and MHSOP referrals reflecting these demographic changes. Working age referrals will also be influenced by economic conditions given the correlation between economic deprivation and the prevalence of most working age psychiatric conditions. Our analysis shows that, even when the expansion of the Trust's area in June 2011 is taken into account, there was a significant rise of 13.8% in referrals between 2011 (82,422) and 2012 (93,818). In 2013 referrals stabilised at this new higher rate in Durham, Darlington and North Yorkshire but have increased further in Teesside.

Clearly, the ability of the Trust to deal effectively with referrals also depends on the extent to which TEWV can safely and successfully discharge patients from its care. In Adult services, despite the jump in referrals, caseload in 2013 is only 1.9% higher than in 2011 (this is partly due to substance misuse services in Redcar and Middlesbrough transferring to other providers during the year).

However, caseloads have significantly increased over this period for CAMHS (7.8%) and Older People's Services (23.8%).

Over the next two years our current forecast, based on demographic, economic, referral and discharge data is that the following changes will occur:

Service	Projected 2015 caseload (based on current services)	Increase / decrease from 2013 (number and %)	
Adult Mental Health	22,346	-14	-0.06%
CAMHS	9,350	60	+0.64%
Forensics	559	5	+0.97%
Older People (MHSOP)	14,939	1,292	+9.46%
Whole Trust	47,193	1,342	+2.93%

Based on this forecast, the Trust will need to:

- Improve the productivity of all of its services so that more patients can be treated within a reducing block contract cost envelope;
- Work with commissioners to understand the drivers for increased referrals and ensure appropriate services are available.

2.4 Resource Constraints in each Local Health Economy - CCGs

While the NHS has seen the value of its budget protected throughout the current austerity period, NHS England's *Everyone Counts: Planning for Patients 2014/15 – 2018/19* has highlighted that over the next few years a "gap" of £30bn could open up between the need / demand from the population and the resources available.

NHS allocation formula for the next two years includes a floor of 2.14% uplift (for 14/15) and 1.70% (for 15/16). The expected CCG payments into the Better Care Fund (BCF) have also been set. All of our core CCGs' current budgets are above what NHS England calculates would be their "correct" share of national resources. Therefore, they will receive increases at "floor" level.

CCG	13/14 £000s	14/15 £000s	15/16 £000s	BCF £000s
Darlington	130,681	133,478	135,747	7,175
Durham Dales, Easington and Sedgefield (DDES)	397,057	405,554	412,448	21,967
North Durham	306,409	312,966	318,286	17,226
Hartlepool and Stockton	357,996	365,657	371,874	19,533
South Tees	376,939	385,005	391,550	20,844
Hambleton, Richmondshire and Whitby (HRW)	169,403	173,028	175,969	9,152
Harrogate and Rural District (HaRD)	173,082	176,786	179,791	9,557
Scarborough and Ryedale	146,901	150,045	152,596	7,538
Vale of York	359,741	367,439	373,685	19,366

2.5 Resource Constraints in each Local Health Economy – Local Authorities

Budget and service changes at Local Authorities are important because of the impact that they can have on our patients and on the services that we provide to them. Some of these changes may increase TEWV caseload or costs. The table below summarises the changes being made by councils within our local health economies.

Local Authority	Expenditure reduction 13/14 to 15/16	Reduction in social care spending	Key proposals that could impact upon TEWV
Durham	£62.4m (7.6%)	To be determined	Review of all non-statutory services Review of in-house social care provision Eligibility criteria – consistent and effective use of existing criteria and re-ablement Review of Children's Care Services
Darlington	£7.269m (7.3%)	£4.75m (by 16/17)	Council / CCG single management team and fully integrated commissioning to accelerate transformational change.
Hartlepool	£4.724m (4.4%) in 2014/15 (15/16 to be determined)	£1.325m identified for 14/15 (15/16 to be determined)	£50k savings identified to cease commissioning of day opportunity support for people with mental health needs when the current contract ends September 2014. Full year effect to be achieved in 2015/16.
Stockton	£4.4m (14/15); £12.5m (15/16)	£600k efficiency target for 15/16	£365k reduction in mental health team staffing; Reconfiguration of LD provision.
Middlesbrough	£22m (14/15) with further £10m by 16/17.	To be determined	The Council plans to renegotiate management costs with TEWV to save them £100k. The introduction of a new operating model for Adult Social Care will reduce the work requiring fully qualified Social Workers, which will save £597k. Social workers will no longer be fully integrated part of TEWV teams but will be co-located.
Redcar and Cleveland	£0.6m (14/15) with further £10.2m in 15/16 (8.4% reduction)	£3.2m over the next 2 years.	Staff reductions in key teams – however, the Council has recognised the need to retain capacity to deal with DOLS and Safeguarding.
North Yorkshire	£47.1m (12.7%)	To be determined	Children's' social services focus will move from delivery of universal provision to targeting need whilst retaining the recognition of the importance of early intervention. There will be short term investment over the next 2 years of circa £1.3m. Adult Social will be move away from the council being a direct provider of services, commissioning new models of Extra Care Housing to replace residential care, integrated reablement to replace traditional care at home and digital and self help solutions to modernise assessment and care management. Pump priming will be sought from the Better Care Fund

2.6 NHS England Specialist Commissioning

Mental Health is one of the 5 areas covered by NHS England's specialist commissioning. Budgets for the totality of specialised commissioning will rise by 4.4% in 14/15 and a further 5.9% in 15/16, however there are also efficiency requirements of 6.2% and 3.1% respectively. This is likely to drive a reduction in the number of acute-sector specialist centres, but we do not expect there to be a direct impact on mental health specialist services which are already concentrated among a relatively small group of providers. We expect nevertheless to be required to deliver efficiencies of our own. NHS England is developing a new national strategy for all specialist services and supporting PbR / currency / tariff development for its directly commissioned mental health specialist services.

2.7 The Efficiency Challenge for Foundation Trusts

As part of the NHS Planning Guidance for 2014/15 there is a requirement for all NHS Trusts to deliver annual cost efficiency savings of at least 4%. TEWV has identified that cash releasing efficiency savings (CRES) of £16.7m must be delivered over the next two years. These savings are estimated to be sufficient to meet future cost pressures, provide a strategic change fund, and ensure medium term financial stability.

NHS England's tariff guidance states that the mental health "tariff adjuster" for 14/15 is 1.8%. This is less than the Acute Sector's 1.5% tariff reduction due to NHS England's contention that the recommendations of the Francis Report will not add to the costs of providers of Mental Health Services. Whilst the various mental health networks continue to lobby nationally on this issue as part of the parity of esteem for mental health services, the financial consequences for TEWV are around £0.8m p.a. of additional savings required.

2.8 Guidance for NHS Mental Health / Learning Disability Commissioners

There have been several policy and planning documents published by the Department of Health and NHS England which are likely to influence the commissioning intentions of CCGs and NHS England Specialist Commissioners.

These documents include:

- Secretary of State's *Mandate* for the NHS;
- *No Health Without Mental Health* Strategy;
- *Closing the Gap: priorities for essential change in mental health policy*;
- *Everyone Counts: Planning for Patients 2014/15*;
- *Anytown* NHS England planning guidance for CCGs.

Interventions supported and recommended by these documents include expectations of improved or additional:

- integration between mental health, acute and primary care settings, including "adequate liaison psychiatry services" (RAID model);

- dealing with self-harm by Acute Hospital's Accident & Emergency departments;
- provision for crisis care, including street triage and access to "place of safety" / Section 136 suites and ensuring assessments commence quickly;
- access to Perinatal mental health services for pregnant and new mothers
- criminal justice Liaison and Diversion services with expansion to 50% of England by 15/16;
- multi-disciplinary case management for the frail elderly and those suffering with a long-term condition;
- use of dementia pathway fully integrated network model to improve health outcomes and achieve efficiencies in dementia care;
- promotion of the use of service user networks:- co-designed support services developed for and by people with emotional/behavioural problems;
- support for the Improving Access to Psychological Therapies (IAPT) programme, and extension of this to children and young people;
- commitment to the development of National access / waiting time standards for mental health services with implementation from April 2015;
- out-of-hospital provision Learning Disability patients;
- Joint commissioner-provider work to reduce suicides and incidents of serious self-harm or harm to others, including effective crisis response;
- government funding for new Care and Support housing;
- development of Payment by Results (PbR) for many mental health services;
- use of competition either "in the market" or "for the market" by commissioners where this will be beneficial to patient care.

This guidance is likely to influence commissioning intentions.

2.9 Local commissioning intentions

The table below summarises the proposed CCG commissioning intentions that are relevant for TEWV.

Proposed Service	North Durham	DDES	Darlington	H'pool & St'ton	South Tees	HRW	HaRD	Scar' & Ryedale
Acute Liaison (inc A&E / self-harm)	✓	✓	✓	Recurring funding already in place		✓	✓	✓
Care Home Liaison	✓	✓	✓					
Additional CAMHS	✓	✓		✓	✓			
LD – post Winterbourne change	✓	✓	✓	✓	✓	✓	✓	✓
Recovery college	✓	✓						
Community Rehab	✓	✓						
Dementia initiatives	✓	✓	✓	✓	✓	✓	✓	✓
Young Onset Dementia	✓	✓	✓					
IAPT (AMH)	✓	✓	✓			✓	✓	✓

There are also several Trust services which are commissioned by NHS England. Their intentions, or ongoing work to develop future commissioning intentions are summarised below:

Offender Health (Durham and Tees NHS Area Team) – Commissioners are about to hold a procurement process to appoint providers to run health services within North East England's 7 prisons. There is likely to be a specific mental health "Lot" within the overall procurement of services. The new contracts will commence in 2015 and run for 3-5 years. The Offender Health commissioners have also gained additional funding to extend criminal justice liaison and diversion work, though this is not sufficient to cover the whole Trust area.

Forensic Services / Eating Disorders inpatient and day services: NHS England is undertaking a strategic review of Specialist services.

Children and Young People's Secure (Tier 4) services: A national review of Tier 4 CAMHS services is being led by the Royal College of Psychiatrists. NHS England has announced that there will be a procurement exercise following the review. A market engagement event is taking place in April 2014.

3. Quality Plans

3.1 National and Local Priorities

The current national context within which the Trust operates has been significantly influenced by the major inquiries and reviews undertaken in the past twelve months, in response to failures in the quality of healthcare provision. Together with NHS England and the local Clinical Commissioning Groups we will be responding to priorities highlighted by the inquiries into the Mid Staffordshire Foundation Trust and Winterbourne View, as well as the further investigations and responses those initial findings generated. The overall recommendations from the Keogh reviews, the Berwick Report and the Department of Health 'Hard Truths' will set the key themes for the setting of quality standards in service delivery as well as driving the priorities for service development.

The key drivers within the environment within which the Trust has developed its plans with regard to quality are as follows:

- The need for the culture of organisations to be one based on compassion where the patient is the priority;
- The need for organisations to be focused on the quality of the services they deliver (or commission) and where improvements are needed to ensure that these are delivered;
- The need to ensure that the patient and carer voice is heard and that where patients and carers do raise concerns that organisations have mechanisms in place to hear those concerns, respond appropriately and learn lessons where applicable;
- The need to ensure patients are protected from avoidable harm and if mistakes are made organisations should be open and ensure any lessons are learnt in order to prevent such mistakes from reoccurring;
- The need for provider organisations to ensure appropriate staffing levels are in place, both in terms of numbers and skills;
- The need for organisations to be able to demonstrate the quality of services provided/commissioned using information on patient experience, patient reported outcomes, patient harms and clinical outcomes;
- The need for organisations to ensure there is parity of esteem in terms of the health and wellbeing of those people who suffer from mental ill health and those that do not;
- The need for organisations to ensure that the use of physical interventions to manage behaviours that challenge is appropriate;
- The need for organisation to ensure they have considered the impact of social changes and health demographics on suicide and homicide rates and identified plans to help reduce these impacts as far as possible;
- The need for organisations commissioning and providing mental health services to ensure those services are recovery focused and that service users and staff have a shared ambition of recovery.

3.2 Our Quality Goals

TEWV has a strong commitment to delivering high quality services as demonstrated by our second Strategic Goal: *To continuously improve the quality and value of our work*. Our starting point in delivering this Strategic Goal is to define what quality means to us. In order to be able to demonstrate that we are delivering quality we believe our services must:

- **Provide the perfect experience**- this means that the people who use our services consider that the way we worked with them ensured that they were listened to, engaged with and treated with compassion, respect and dignity.
- **Be appropriate** – this means that treatment and care should be safe, ‘do no harm’, be based on evidence and be relevant to the needs of the individual.
- **Be effective** – this means that what we do, delivers the outcomes that we expect and that makes a positive difference to people’s lives.
- **Reduce waste** – this means we should remove or minimise any activity that does not add value or is wasteful to people who use our services, our staff and our other stakeholders.
- **Be built upon** the standards set by the Care Quality Commission and the other regulators we are accountable to.

In order to deliver the above we have a Quality Strategy which sets out our vision for quality as follows:

To ensure safe, patient centred and effective high quality clinical care and treatment, delivered by valued individuals.

This vision is underpinned by 4 goals each with a number of objectives which clearly set out what we aim to achieve over the lifetime of the strategy.

In response to the key drivers in the external environment set out above and the goals and objectives we have set ourselves in our Quality Strategy we have identified a number of priorities to be addressed in the period 2014/15 to 2015/16. The table below highlights the key priorities identified by the Board and the key plans for 2014/15 and 15/16 in relation to these. The first four rows in this table (highlighted with an asterisk) are priorities included within our Quality Account.

Priority	2014/15	2015/16
<p>Review the Trust's Approach to suicide prevention and start the implementation of changes required to improve this approach*</p>	<p>Complete a review of current practice</p> <p>Develop a suicide prevention framework and training and implementation plan</p> <p>Develop a training needs assessment</p>	<p>Complete training of staff in response to training needs analysis</p>
<p>Embed the Recovery Approach*</p>	<p>Develop a programme of work to ensure the principles of recovery are embedded within all key programmes e.g. CPA, model lines, risk assessment & management.</p> <p>Establish the current position on recovery action planning and devise an implementation plan</p> <p>Increase the opportunities for volunteering.</p> <p>Establish a cohort of service user / carer trainers to co-design and co-deliver recovery training.</p> <p>Investigate the role of Peer Support Workers (staff with 'lived experience' providing care and support).</p> <p>Establish recovery leads in all localities, specialities and pilot teams</p> <p>Establish a recovery college and courses</p>	<p>Evaluate the amount of focus on recovery of services within TEWV.</p> <p>Roll out recovery training to staff across TEWV.</p> <p>Complete formal evaluation of the recovery college.</p> <p>Develop a plan to consider the sustainability of the initial recovery college and roll out to other geographical areas across TEWV.</p> <p>Review Recovery Project Action Plan and identify further future objectives and actions for implementation from 2015/16 onwards</p>
<p>Manage the pressure on inpatient beds in order to reduce the number of patients not admitted to their local hospital*</p>	<p>Reduce the percentage of people on Community Team caseloads that are admitted to inpatient care</p> <p>Reduce the readmission rates to inpatient care following discharge</p> <p>Continue to improve the skills and effectiveness of the crisis teams as gatekeepers to inpatient care.</p>	

Priority	2014/15	2015/16
<p>Implement recommendation of CPA review*: Improving Care Planning to:</p> <p>a) make it more focussed on individual patient needs</p> <p>b) Improve the communications between patient and staff</p>	<p>Redesign CPA processes and documentation to ensure they fulfil the following:</p> <ul style="list-style-type: none"> • meeting mandatory requirements whilst reducing unnecessary burden on staff • ensuring the requirements of the Mental Health Act are met whilst reducing unnecessary burden on staff • development of standard work regarding s117 after care <p>Implement actions relating to CPA from Model Lines Pilot Team</p> <p>Implement regular audit and case management/ supervision systems to include monitoring of transfer processes within PARIS (electronic patient record)</p>	<p>Implement core competency frameworks to identify the competencies needed by staff to implement the revised CPA processes and documentation</p> <p>Implement a work based competency tool to assess competency and appraises' / supervisors' performance of assessment and care planning skills.</p> <p>Implement systems and standards for training, supervision and case management of care co-ordinators and lead professionals</p> <p>Start the development of a revised Trust / multi-agency CPA policy</p>
<p>Review the current approach to the physical healthcare of our patient and develop and implement a framework for future delivery</p>	<p>Commence review across all services focusing on ongoing conditions, acute physical healthcare (including death prevention) and prevention and promotion (including smoking cessation, obesity, etc)</p>	<p>Complete review</p> <p>Commence development of physical healthcare framework, which will identify required workforce profile and competencies and a recording and reporting system</p>
<p>Review the current methodology for collecting and acting upon outcomes and experience information to ensure it is appropriate and standardised across services</p>	<p>Undertake a systematic review of current methodologies used for collecting patient experience information</p> <p>Agree standard methodologies to be used</p> <p>Develop and implement new framework for collection of patient experience information</p>	<p>Embed the new framework and methodologies</p>
<p>Develop the first model line to deliver clinical pathways and underpin service delivery and agree a programme of future model line development</p>	<p>Evaluate the initial psychosis pilot model developed in 2013/14</p> <p>Roll out the agreed model line for psychosis across Durham, Darlington and Teesside (subject to the evaluation)</p> <p>Commence development of the model line for affective disorders</p>	<p>Evaluate agreed pilot model line for affective disorders developed in 14/15</p> <p>Roll out agreed model line for affective disorders across Durham, Darlington and Teesside (subject to evaluation)</p> <p>Roll out agreed model lines for psychosis and affective disorders across North Yorkshire (subject to evaluations)</p> <p>Develop the plan for future model line development</p>

Priority	2014/15	2015/16
Implement the patient safety framework including the use of stop the line processes	Implement the revised patient safety framework (agreed by Board in March 2014) to include the Trust's response to the Berwick Report:	
Review the Trust's use and approach to the use of control and restraint and ensure this is appropriate across the organisation	<p>Review the use of control and restraint across the Trust to include an analysis of the type and frequency of use.</p> <p>Review the approaches used for the management of challenging behaviours.</p> <p>Develop and implement an action plan to address finding of the review</p>	Re audit the use of control and restraint to assess the impact of the action plan.
Implement the Trust response to the Francis Report and Hard Truths in line with the agreed action plans	Further implementation of the action plan developed in 2013/14	
Continue to implement the actions within the Deloitte review Action Plan	Further implementation of the action plan developed in 2013/14	

Other Plans set out within this document will also have a positive impact on Quality.

3.3 Existing Quality Concerns

In May 2013 following a re-inspection of our inpatient services at Auckland Park the CQC issued the Trust with a Warning Notice indicating that an enforcement action had been issued in respect of Outcome 1 (Respecting and Involving People who use services) and a moderate concern against Outcome 2 (Consent).

Whilst the CQC did not indicate that there were any issues in terms of the quality of the care provided at Auckland Park they did find that some processes on the ward were not tailored to meet individual assessments of the needs of the patients on the ward. In response to this warning notice the Trust developed an action plan to address the concerns of the CQC.

Following the issue of the warning notice Monitor launched a formal investigation regarding a potential breach the Trust's licence due to governance concerns highlighted by the CQC. In response the Trust commissioned Deloitte LLP to undertake a review of its quality governance arrangements. Whilst Deloitte identified a number of strengths in the Trust's governance arrangements it also identified some areas where improvements could be made. In response the

Trust developed an action plan, which would ensure the majority of the issues identified in the review would be addressed by the end of 2013/14.

Following a re-inspection of Auckland Park in August 2013 the CQC lifted its warning notice and in January 2014 Monitor advised the Trust that its investigation had been completed and there would be no further action taken.

Whilst the governance rating of the Trust has returned to green there are actions in response to the Deloitte review that are planned to take place in 2014/15, not least the further review of the quality governance arrangements by Deloitte LLP in April 2014.

Further to the above there were 13 additional CQC compliance inspections during 2013/14 including the Dental Suite at Roseberry Park whose dental services are provided by an external dentist. We have received 11 reports which stated we were fully compliant against the outcomes inspected. The Trust is awaiting feedback on two inspections which took place during March 2014.

The Trust has not had any requests for information from the CQC under Section 64(2) of the Health and Social Care Act during 2013/14

The Trust was visited on 38 occasions by the CQC Mental Health Act commissioners. There were no concerns on four of the wards visited, where full implementation of the Act and the Code of Practice were demonstrated. The issues identified by the CQC on other wards were included in action plans completed with an appropriate response and all returned by the specified dates.

The collated themes, of the main issues identified, are listed below.

Themes of issues and concerns	Action the Trust took
<p>Purpose, Respect, Participation and Least Restriction Locked areas – the communal bathroom and toilet areas (although patients had access to en suite facilities in their bedrooms); the relaxation room; quiet / telephone room; garden doors; were all kept locked and the staff could give no reason why these areas were kept locked.</p>	<ul style="list-style-type: none"> • Individual and environmental risk assessments were reviewed to reflect any potential rationale for restricted access to these areas. Risk management plans were put in place for all the other areas. • All communal areas were unlocked. • The communal assisted bathroom has been kept locked due to the hazards, electronic equipment risks, and potential ligature points that were identified.
<p>Purpose, Respect, Participation and Least Restriction Mobile telephones and internet access were not allowed on the ward. Patients were allowed mobile telephones while on leave but these were limited to basic phones. The internet could be accessed supervised by staff in the activity centre. This was despite some patients having unescorted leave which provided the opportunity to access internet and smart phones whilst out.</p>	<ul style="list-style-type: none"> • Internet access on the ward will be provided as part of the roll out of the PATTI project. • The security differentiation work includes piloting open mobile phone access in low secure and locked rehabilitation services.

Themes of issues and concerns	Action the Trust took
<p>Consent to Treatment Issues</p> <p>There was no entry from the responsible clinician (RC) regarding capacity or consent at most recent authorisation of medication.</p> <p>There was no RC entry following the second opinion appointed doctor (SOAD) visit and there was no entry from the consultees.</p> <p>Medication had been administered but not authorised on either a T2 or T3 form.</p>	<ul style="list-style-type: none"> • Medical Director wrote to RC cited to remind of the requirements to record capacity and consent issues. • All named nurses and RCs reminded of the need to record SOAD involvement in the PARIS records. • Medical Director sent out reminder regarding use of T2 and T3
<p>Leave of Absence</p> <p>There were old expired section 17 leave forms in patient's files. Code of Practice recommends all old forms to be either destroyed or scored through</p>	<ul style="list-style-type: none"> • Teams were reminded of the procedures for management of Section 17 leave and the associated administration.
<p>Admission to the Ward</p> <p>Patients' rights had not been revisited on the date entered on the Trust's 132A form.</p> <p>Copies of the original section papers were not available for inspection as they had been archived.</p>	<ul style="list-style-type: none"> • Teams reminded of the Section 132 policy and recording requirements. • Archive records were retrieved and originals filed as per policy in the secondary paper file.

In addition to the CQC Compliance Inspections against the 16 Essential Standards in Quality and Safety and Mental Health Act Commissioners monitoring inspections, the Trust have also been inspected by CQC as set out below:-

- A review of health services for Children Looked After and Safeguarding in Stockton on Tees was carried out, and the Trust was recommended to:
 - ensure that practitioners are assessing and describing the risk to children and families when making referrals to children's social care to enable social workers to make informed decisions; and,
 - assess the training requirements of practitioners working in a supporting role to ensure that they are accessing safeguarding training at a level commensurate with their duties.
- The CQC MHA Commissioners undertook a two day inspection in September 2013 to look at the arrangements for assessment and application for detention that operated in County Durham and Darlington. The primary action was for the two local authorities to address conveyance / transport issues. However the Trust was requested to identify and progress action to reduce the time that police are waiting at S136 suites.

We received three whistle blowing reports in 2013/14: - all were initially anonymous but the author of the first issue made themselves known through a trade union representative.

The first case related to concerns about night duty staffing levels in an MHSOP unit where the whistle blower thought a risk to patient care may develop. A full investigation was agreed with the author and their trade union representative.

The reviewer was independent from the service cited and the issues identified in the review upheld a number of the concerns alleged by the author. No harm to patients was found to have occurred but there were examples where additional staff would be required. The service addressed these findings by increasing the nurse staffing levels at night. The author and the trade union representative were issued with a copy of the report and were satisfied with the outcome.

The second case was about standards of care for elderly patients in another MHSOP unit. A full safeguarding adult investigation was undertaken into the standards of care on the ward. This included observation of care delivery and feedback was sought from carers and relatives of current in-patients. There were no concerns identified, nor history or trend of previous concerns and other quality data indicated positive experience and care delivery provided by the ward.

The third case focussed on staff employment issues following the closure of a unit. An independent review is currently taking place of the organisational change processes that was implemented as a result of the closure.

3.4 Quality Assurance

We have developed a Clinical Assurance Framework to summarise how we assure the Board of Directors and our stakeholders about the quality of our services. The Framework outlines the two sources of assurance:

- the clinical governance systems and process;
- the Trustwide governance infrastructure.

The Quality and Assurance Committee (QuAC), as a subcommittee of the Board of Directors, oversees the clinical governance systems and processes and the Trust wide governance infrastructure. The QuAC reports to the Board of Directors monthly and provides assurance on the quality of services by monitoring regulatory compliance, and service and clinical outcomes.

Clinical Governance Systems and Processes

The clinical governance systems are aligned to the operational management structure and are illustrated in the diagram below:



Within each of our four Localities there is a Locality Management and Governance Board (LMGB) which receives monthly assurance on the quality of services from the Directorate Quality Assurance Groups (QuAGs) which are in place for each of the functional service directorates based within the locality. The LMGBs then provide monthly assurance reports to QuAC.

The Directorate QuAGs receive monthly information reports on a range of quality metrics and indicators including patient safety, safeguarding, patient experience and clinical effectiveness data. The analysis of this governance data is triangulated with the operational contextual information to provide the reports up to the LMGBs.

The monthly reports from the LMGBs to the QuAC include trend analysis of incidents and complaints as well as workforce data that includes training compliance data, staff and patient satisfaction feedback. Audit reports and clinical outcome data are presented with evidence of compliance with best practice such as NICE guidance. These reports are presented to the QuAC for debate and challenge each month.

These clinical governance systems and processes also include:

- The performance management of progress with action plans, which includes the signing off of action plans from incident reviews, complaints investigations, regulator inspections, risk assessment and analysis and critical patient experience reports. Escalation arrangements exist for action plans which are not completed in line with the agreed timeframes.
- The Risk Management and Escalation processes. Each Directorate QuAG holds their risk register capturing issues escalated from the direct care delivery teams. Risk mitigation plans are created and the evidence of the plan delivery together with the monitoring reports of the risk levels are reported up to the LMGBs as part of the assurance data flows.

In addition to the above there are Speciality Development Groups, which ensure consistency of clinical care standards across the functional specialities, for example Mental Health Services for Older People. These groups manage clinical development, the clinical audit programme and monitoring of implementation of standard practice across geographical areas. The groups focus on relevant national audits for their clinical speciality and then identify local audits linked to risk or improvement issues. The groups receive governance data to inform the local audit priorities. These groups also report into the QuAC.

[Trust wide governance infrastructure](#)

In addition to the above there are twelve Trust wide governance groups that also regularly report to the QuAC. These represent key elements of quality and are supported by corporate governance teams that manage the policy and systems that enable the control of risks to clinical delivery. These groups monitor the Trust wide assurance information to highlight risks and best practice as well as

scrutinising the standards of the systems being implemented. The groups also check the progress of related quality development projects and workstreams.



The Trust-wide governance groups have a planned reporting schedule to the QuAC but the key metrics are reported on a monthly scorecard to ensure there is a snapshot of the Trust wide position and an opportunity to escalate any risks within this framework.

3.5 Implications for our Workforce

To deliver the plans set out above, and in Section 4, we will need to:

- Ensure our staff have the appropriate skills and competencies to deliver our aspirations in terms of quality whilst also meeting appropriate national standards;
- Ensure we have a positive organisational culture that is focused on providing the perfect experience to every patient;
- Ensure we have robust leadership at all levels throughout the organisation
- Ensure that our staff feel supported in delivering their roles.

In order to address the above we have identified a number of priorities which we will deliver in 2014/15 and 2015/16 as follows:

Priority	2014/15	2015/16
Redesign the Trust's approach to appraisal to increase clarity of objectives, how they are to be achieved and feedback about individual performance.	<p>Pilot a revised appraisal process amongst a key section of the workforce and evaluate the outcomes</p> <p>Refine the approach in light of the evaluation of the pilot and agree an implementation plan.</p>	Implement the revised appraisal process across all non-medical staff groups (taking into consideration any impact upon appraisal of nurse revalidation)
Ensure that the Trust's Healthcare Assistant Career Framework meets future national standards.	<p>Extend the application of the current inpatient HCA Career Framework to include the 260 HCAs working in community teams.</p> <p>Map the Trust career framework standards to emerging national standards.</p>	Evaluate the impact of the Trust career framework on inpatient and community staff, using information from three years of the frameworks local operation.
Produce and roll-out a Trust Talent Management Plan.	<p>Capture information on aspirations and readiness for development from leaders and managers</p> <p>Complete a gap analysis to identify oversupply or undersupply of workforce within and across Directorates.</p> <p>Agree an action plan extending the talent management approach to the whole Trust workforce</p>	Plans developed to address any gaps or oversupply.
Further development of the TEWV Culture metrics to help create a positive organisational culture.	Consider the introduction of weighted future culture metrics factors and scores and undertake a review of the information sources used.	Undertake a comparison of the Trust's culture metrics with other emerging culture metrics, within and outside the NHS, and consider whether to engage with local universities to refine our future approach further.
Introduce an improved process for conducting the Trust Training Needs Analysis	<p>Implement the new process for producing the TNA plan as part of the business planning cycle</p> <p>Undertake a review of the TNA and amend process for future as appropriate.</p>	
Respond to the Nursing and Midwifery Council commitment to develop and implement an effective system of revalidation for nurses.	<p>Framework agreed in response to national requirements</p> <p>Develop implementation plan for roll out of revalidation across the Trust.</p>	Deliver the implementation plan.

3.6 Risks to Plans

The organisation has identified a number of risks to the delivery of the plans above in addition to the risk that our plans may have a negative impact on the quality of services we deliver. These risks and how we will mitigate them are outlined in Section 6 of this plan.

4. Operational Requirements and Capacity

4.1 Introduction

The analysis of the environment outlined in Section 2 together with the Strategic Direction of the Trust highlights that the future operational requirements and capacity will need to address the following:

- Changes in the general population;
- Increase in the older people's population;
- Potential increase in demand/referrals;
- Providing more care closer to home and reducing the reliance on inpatient beds;
- Improvement in the quality of services delivered;
- A reduced financial envelope with which to deliver services;
- A requirement to increase productivity.

The following sections provide our key plans in terms of ensuring that we have sufficient capacity to address the above.

4.2 Inpatient Services

In line with our strategic direction of travel to reduce reliance on inpatient beds our plans over the next two years are designed to ensure that we have the appropriate number of beds for the populations we serve. Whilst the table below provide the key priorities we have identified relating to inpatient services these cannot be divorced from the plans for community services as the two are inexplicitly linked.

Service	2014/15	2015/16
Acute Adult Mental Health Assessment and Treatment	<p>Identify and agree with stakeholders the preferred option for the development of the best affordable plan for the provision of modern inpatient facilities for Harrogate, Hambleton and Richmondshire patients.</p> <p>Develop a business case for Section 136 suite Harrogate and Rural District and implement if supported</p> <p>Implement Section 136 suite for Hambleton, Richmondshire</p> <p>Develop and implement inpatient services for people with Personality Disorders in response to commissioning intentions</p>	<p>Commence implementation of agreed option for the provision of modern inpatient facilities for Harrogate, Hambleton and Richmondshire patients</p> <p>Continue to embed the inpatient services for people with a Personality Disorder</p>
Crisis Beds	<p>Embed the Durham and Darlington Crisis and Recovery House</p>	<p>Review provision of crisis beds across the Trust and identify future model</p>

Service	2014/15	2015/16
Adult Mental Health Rehabilitation	<p>Implement the recommendations of the review of rehabilitation beds in Durham and Darlington</p> <p>Implement the recommendations of the review of rehabilitation beds in Teesside</p> <p>Reprovide rehabilitation beds within North Yorkshire at Orchard House.</p>	<p>Further review the inpatient rehabilitation pathways and implement recommendations in Durham and Darlington</p> <p>Implement the recommendations of the review of rehabilitation beds in Teesside</p>
MHSOP Assessment and Treatment	<p>Identify and agree with stakeholders the preferred option for the development of the best affordable plan for the provision of modern inpatient facilities for Harrogate, Hambleton and Richmondshire patients.</p> <p>Implement the recommendations of the review of MHSOP inpatient services in Durham and Darlington and Teesside</p>	<p>Implementation of agreed option for the provision of modern inpatient facilities for Harrogate, Hambleton and Richmondshire patients</p>
Learning Disability Assessment and Treatment	<p>Reconfigure beds at Lanchester Road Hospital in Durham and Darlington in line with recommendations from the Winterbourne Concordat</p> <p>Rationalise beds on Bankfields site in Teesside in line with recommendations from Winterbourne concordat</p>	<p>Identify alternative uses for vacant beds at Lanchester Road Hospital.</p> <p>Identify alternative uses for vacant beds at The Dales.</p>
Children and Young People	<p>Completion of West Lane Westwood refurbishment (Low Secure Assessment and Treatment)</p> <p>Embed additional capacity within Westwood Centre (Low Secure)</p>	<p>New build Eating Disorders facility opens at West Lane, with patients and staff moving from current Newberry unit at West Lane.</p>
Forensic Services	<p>Implement the reconfiguration of inpatient beds agreed with commissioners</p> <p>Increase number of non-forensic locked rehabilitation beds (Female)</p>	

4.3 Community Services

Our priorities in terms of community services (see table below) have been identified to respond to the increased demand we expect to see in 2014/15 and 2015/16 driven by demographic changes, our focus on providing more services in the community, the need to increase productivity and the development of services that will support the wider health economy to manage demand across other parts of the system.

Service	2014/15	2015/16
Adult Mental Health	<p>Review and reconfigure community services throughout the Trust incorporating Model Line work as appropriate</p> <p>Establish community rehabilitation service in Durham and Darlington</p> <p>Transfer of IAPT service in NY from current provider in line with commissioning intentions</p> <p>Develop and implement a proposal to implement a peri-natal community services in response to commissioning intentions</p>	<p>Review and reconfigure community services to improve productivity throughout the Trust incorporating Model Line work as appropriate</p>
MHSOP	<p>Review and reconfigure community services to improve productivity across the Trust</p> <p>Embed Care Home Liaison service in Durham and Darlington (Better Care Fund)</p> <p>Embed Acute Hospital Liaison Service in Durham and Darlington</p> <p>Develop Acute Hospital liaison services at Harrogate General Hospital and Friarage Hospital, Hambleton</p>	<p>Review and reconfigure community services to improve productivity across the Trust</p>
Children and Young People	<p>Implement the agreed workforce model across all community teams in Durham and Darlington</p> <p>Pilot provision of a crisis service in Durham and Darlington</p> <p>Review Tier 3 services within North Yorkshire</p> <p>Continue to implement revised service model in response to new specification agreed with commissioners</p>	
Forensic Services	<p>Review and reconfigure community services in response to new service specification issued by commissioners</p>	
Learning Disabilities	<p>Review and reconfigure community teams to ensure sufficient capacity to support transfer of patients from inpatient assessment and treatment beds (in line with recommendations from Winterbourne Concordat throughout the Trust</p> <p>Implement specialist assessment service for epilepsy utilising telemetry equipment in Teesside</p>	<p>Review and reconfigure community teams to ensure sufficient capacity to support transfer of patients from inpatient assessment and treatment beds (in line with recommendations from Winterbourne Concordat throughout the Trust</p>

In line with our Business Development Strategy we will also continue to submit responses to any tenders of services we currently provide and where we consider the service being tendered to be core services within our current geographical footprint.

4.4 Key Enabling Priorities

In addition to the priorities highlighted above there are a number of priorities that the organisation has identified for 2014/15 and 2015/16 which will underpin the delivery of the service changes we are planning as follows:

- Undertake a systematic review of current levels of community team productivity across the Trust to inform the ongoing review and reconfiguration of community teams;
- Further development of Model Lines (see Section 3);
- Further development of a recovery approach across the organisation (see Section 3);
- Implementation of the recommendations of the CPA review (see Section 3)
- Reduce the number of patients that cannot access their local inpatient unit (see Section 3);
- Continue the development of robust care pathways across all services
- Ensure the electronic clinical records and data systems support the implementation of the developed pathways of care;
- Implement Payment by Results (or its successor) within the national timescales.

4.5 Workforce Development Priorities

The plans highlighted above will have a considerable impact on the workforce in terms of skills and competencies that the organisation will require of its staff and the numbers of staff employed. The organisation has identified a number of priorities to support the development of the workforce in order to deliver the service changes outlined above as follows:

- Review the role of Ward and Team managers and implement a training programme to ensure all ward and team managers are supported in delivering that role in the future;
- Develop and implement a system that evaluates and governs standard work and embed it across the organisation;
- Implement an improved process for conducting the Trust training need analysis (utilising the skills / competences included in the developed care pathways);
- Introduce the behaviours / beliefs and practical changes required to bring about a waste reduction culture at all levels within the organisation;
- Improve the health and well being of our staff leading to absence rates of 3.9% by 2015/16;
- Implementation of a new Occupational Health contract which has a greater focus on managing mental ill health and improving access to services

throughout the Trust whilst also being clear about how we will monitor the impact and outcomes of the occupational health interventions;

- Develop and commence implementation of a framework to support the extension of working lives.

4.6 Information Technology Priorities

The current Information Strategy contains a number of key priorities which will support the delivery of the high quality care and workforce changes over the life time of this plan in addition to being particularly critical to the delivery of increased productivity. The key priorities are as follows:

- Further implementation of the Integrated Information Centre to support robust performance management and decision making at service, team and individual levels;
- Implementation of the upgrade of the Electronic Patient Record (PARIS) which will support improvements in the quality of care and productivity of staff by for example introducing:
 - A revised interface that will support touch screens and tablets which will support mobile working;
 - Inclusion of a staff diary which will enable clinical staff to arrange appointments more efficiently, and will support the implementation of Choose and Book;
 - The medication drop down being a copy of the British National Formula with all dosage and contra-indications thus supporting safer prescribing;
 - Interoperability with NHS mail allowing us to share patient information with GP systems electronically.
- Further roll out of the Electronic Staff record, including the roll out of E rostering to community teams;
- Implementation of digital dictation and other digital input devices;
- Development of a Trust wide knowledge management system.

4.7 Priorities for Improving the Estate

The Trust's Capital Expenditure Plan is set out in Section 7. The £19.9 million programme over the next two years is a result of agreed and planned investments. Subject to ongoing affordability the strategic programme will continue to improve the quality of inpatient and community accommodation which will support the delivery of high quality and productive care.

Key elements of the Capital Expenditure Plan, which support the planned changes to inpatient and community services set out in sections 4.2 and 4.3 are:

- CAMHS Tier 4 / Eating Disorders inpatient facilities improvement (West Lane Hospital)
- North Yorkshire – Harrogate, Hambleton and Richmondshire Inpatient reconfiguration
- North Yorkshire – development of Community Mental Health team bases / resource centres

- North Yorkshire – Rehabilitation (move to fit for purpose facility)
- Durham and Darlington – Community Mental Health Team Refurbishments
- Durham and Darlington - LD Beds review
- Eating Disorder Day Services improvements (Imperial Avenue)
- Trustwide – works to facilitate inpatient reconfiguration

4.8 Risks to Plans

The organisation has identified a number of risks to the delivery of the plans above. These risks and how we will mitigate them are outlined in Section 6 of this plan.

5. Productivity, Efficiency and Cost Improvement Programmes

5.1 The Efficiency Challenge

As stated in Section 2, the Trust efficiency programme requires an annual efficiency of 4%. Based on this, CRES (CIPs) plans have been identified by the Trust. These savings are estimated to be sufficient to meet future cost pressures, provide a strategic change fund, and ensure medium term financial stability.

Monitor separates cost improvements into “traditional” and “transformational” schemes. We regard “transformational” as relating to whole-system redesign, which improves patient outcomes but reduces cost across the Health Economy. In general, schemes which are transformational at the health economy level often involve additional investment in mental health services. Psychiatric Liaison services within Acute hospitals (RAID) is an example. Therefore, commissioners’ transformation schemes may increase or maintain rather than decrease our income. In the table below, our cost saving initiatives consequently all fall within the “traditional” definition.

Scheme	2014/15 £000	2015/16 £000	Total £000
TRADITIONAL			
Bed Reconfiguration	2,720	2,396	5,116
Community Productivity	1,982	1,432	3,414
Skill Mix	803	1,408	2,211
Non pay review	1,538	2,108	3,646
Review of Management and Corporate Structures	591	248	839
Income Generation	818	100	918
TRANSFORMATIONAL	0	0	0
Total Identified	8,452	7,692	16,144
CIP plans under development	0	0	0
Total CRES required	7,678	8,243	15,921

The Trust’s CRES schemes are evaluated both financially and clinically with a Quality Impact Assessment process undertaken by the Executive Management Team. The process led by the Director of Nursing and Medical Director provides assurance from each lead Director that efficiency plans do not have an unacceptable impact upon the quality of patient care.

TEWV’s Quality Improvement System is a key enabler that helps us identify sustainable cost improvements. This is because it helps us to redesign systems and eliminate waste.

6. Identification and Management of Risks to Plans

The risks to the plans identified in the previous section can broadly be described as:

- Risks to the quality of services delivered;
- Risks that the plans will not be delivered as expected.

6.1 Identification of Risk

In terms of risks the Trust has a robust planning process that involves the Board and the senior operational and clinical leaders in the organisation. Risks are identified through a number of ways:

- Risk to the organisation identified via the internal and external environmental analysis (this then leads to the identification of priorities within the plan to mitigate those risks);
- As each service develops its plans to address the priorities identified they highlight the risks to delivery;
- Quality Impact Assessments of the plans are undertaken to assess any risks the plans may have to the quality of services delivered.

Once identified there are a number of opportunities within the planning process where the plans developed by our clinical services and any associated risks can be identified and challenged by:

- The Board;
- The Council of Governors;
- Executive Management Team members;
- Senior clinical and operational leaders.

Furthermore all our Cost Improvement / Cash Releasing Efficiency Schemes are subject to a process of Quality Impact Assessment (QIA), using the framework issued by Monitor. The completed assessments are considered by the Director of Nursing and Governance and the Medical Director to ensure that no relevant CRES schemes significantly impact on the quality of patient care. Therefore any proposals for cost improvement that carry with them unacceptably high levels of risk are not approved. In addition, during March 2014 we have also presented the evidence of our QIAs to our commissioners in contract meetings who acknowledge the robust process that we have in place for developing our business plan and the CRES schemes within it. Furthermore through our governance arrangements, described in Section 3, any adverse impact on quality indicators would be identified by the appropriate Directorate Quality and Assurance Group and escalated if necessary to the Locality Management and Governance Board and the Quality and Assurance Committee of the Board.

The key risks that have been identified and the corresponding mitigating actions are described in the table below.

Risk	Mitigation
Assumptions underpinning the plans are incorrect e.g. demand for services is greater than anticipated	<ul style="list-style-type: none"> • Regular monitoring of referrals into the service • Regular dialogue with CCGs, GPs, H&WBB, LAs and other partners • Implementation of stakeholder engagement plan • Implementation of care pathways • Use of proof of concepts before roll out
Inability of community services to manage people in their own home environment	<ul style="list-style-type: none"> • Implementation of care pathways • Review of community services based on the delivery of the care pathways • Development of standard work • Identification of skills gaps and skill development in community teams
Inability to deliver the levels of productivity increases required	<ul style="list-style-type: none"> • Further use of QIS to drive out waste and develop standard processes • Further development of model lines • Increase organisational development resource to those teams identified as requiring additional support • Regular monitoring and reporting of productivity levels being achieved of each team
Reduction in morale/motivation of the workforce	<ul style="list-style-type: none"> • Increased communication with staff to increase understanding of the plans • Use of QIS (which engages front line staff in identifying and making changes) • Use of Project Management Framework to ensure engagement of staff is part of project plans for delivery of the changes • Collection of feedback from staff • Use of Local Consultative Committees and Joint Consultative Committees to gather feedback
Reduction in patient experience e.g. due to additional travel, changes in staffing	<ul style="list-style-type: none"> • Increase communication with patients about any proposed changes • Engagement of patients in delivering the changes • Regular monitoring by the Board and EMT via formal reports and visits to the services • Further embedding of patient experience trackers to allow for routine collection of patient experience.
Unintended consequences of plans	<ul style="list-style-type: none"> • Regular reviews of quality indicators and activity via Directorate QuAGs and Local Governance and Management Boards with escalation as appropriate • Use of QIS including 'Stop the Line' • Use of Project Management Framework
Lack of support for changes	<ul style="list-style-type: none"> • Clear identification of key stakeholders for each plan using Project Management Framework • Continued engagement of stakeholders in delivery of the plan
Unintended consequences of changes made by other partners in the health economy	<ul style="list-style-type: none"> • Regular dialogue with CCGs, GPs, H&WBB, LAs and other partners • Regular monitoring of referrals into the service
Inability to manage the workforce changes	<ul style="list-style-type: none"> • Continued use of organisational change policy

6.2 Managing the Risk

The Trust defines risk as *“an uncertain event or set of events which, should it / they occur, will have an effect on the achievement of objectives.”*

Once the risks have been identified through the annual business planning process a formal review is undertaken. The management of the identified risks is integrated into the Trust’s governance structure as follows:

- At the Board and Locality / Corporate Directorate levels the risk registers are integrated with the Assurance Framework. These are based on the concept of a book with the Board and each Locality Management and Governance Board (LMGB) having their own chapters.
- The Board Chapter, the “executive summary”, contains:
 - Strategic Risks to achievement of the Business Plan.;
 - Cross Locality and “very high” scoring quality risks;
 - Other very high scoring risks;
 - Significant risks to Level 1 projects (as identified via our Project Management Framework).
- The Locality / Corporate Directorate Chapters contain:
 - Risks to the achievement of the Service Plan;
 - Cross Directorate and “high” scoring quality risks;
 - Other high scoring risks;
 - Significant risks to Level 2 projects (as identified via our Project Management Framework).

All risks contained within the chapters of the Integrated Assurance Framework and Risk Register are scored for consequence and likelihood against a 5 point scale based on those published by the National Patient Safety Agency (NPSA). The scale for consequence is based on odd numbers to provide higher scores (and visibility) for those risks which would have a catastrophic impact on the Trust.

Monthly reports are provided to both the Board and the Locality Governance and Management Boards on their Chapters of the Integrated Assurance Framework and Risk Register. These provide assurance on the progress of planned actions to mitigate risks whilst also allowing for the identification and consideration of new risks in year.

Exception reports are also provided to the Quality and Assurance Committee by the LGMBs as part of their monthly assurance reports. This allows the escalation of risks to the Board as required.

In addition locality Directorate Quality and Assurance Groups (QuAGs) oversee their own risk registers. These contain:

- Risks to the achievement of the Directorate’s priorities in the service plan;
- Risks to quality identified by wards and community teams;
- Low/medium risks e.g. those with risk scores of <18;
- Risks to Level 3 projects.

Risks are escalated to the LMGBs, QuAC and Board as appropriate. Finally the clinical specialties have a key role in the Trust’s risk management processes by both identifying new clinical risks (e.g. those arising from new national requirements/guidance or from clinical audits) and advising on appropriate mitigating actions. However acceptance of a risk is a matter for the LMGB / QuAG recognising variation across the Trust’s area.

7. Supporting Financial Information

7.1 Statement of Comprehensive Income

The following table shows the planned Statement of Comprehensive Income for 2014/15 and a further one year forecast position. This is based on agreed commissioner contracts and other income assumptions and is reflective of the current economic position and inflationary pressures.

	2014/15	2015/16
	£m	£m
Clinical Income	268.7	264.0
Other income		
Education and Training	6.4	6.4
Other income	2.8	2.8
Total income	277.9	273.2
Pay Costs	-214.0	-210.6
Drug costs	-3.6	-3.6
Clinical supplies and services	-1.6	-1.7
Research & Development	-0.2	-0.3
Education and Training	-1.0	-1.0
PFI Operating Expenses	-2.4	-2.5
Other Costs	-33.9	-32.0
Total costs	-256.7	-251.7
EBITDA	21.2	21.5
Fixed Asset impairments	-3.0	-2.0
Depreciation & Amortisation	-4.0	-4.1
Interest receivable	0.1	0.1
Interest (payable)	-5.4	-5.4
PDC Dividend	-4.3	-4.4
Net Surplus	4.6	5.7

Key points to note are:

- Pay costs fall in the 2015/16 in line with the Trust's CRES programme and reduced non recurrent investment in the Information Strategy and strategic change enabling schemes;
- The Trust anticipates an impairment of £3m in 2014/15 following the completion of The Orchards and phase 2 of West Lane, and £2m in 2015/16 following completion of phase 3 West Lane and other capital schemes;
- Planned non recurrent investment in the Information Strategy and Strategic Change is £5.4m in 2014/15 and £4.2m in 2015/16.

The technical assumptions included in the table are as follows:

		2014/15	2015/16
Inflation	Income Inflation	-1.8%	-1.8%
	Pay Inflation	0.41%	0.52%
	Drug Inflation	2.0%	2.0%
	Clinical Supplies	1.6%	1.6%
	Non Clinical Supplies	1.6%	1.6%

Keys points to note are

- Income inflation in 2014/15 is in line with agreed commissioner contracts at - 1.8%; with the exception of North Yorkshire, who following the decision not to tender for those services provided to Harrogate, Hambleton and Richmondshire have agreed a nil cash decrease on the contracts. The following year takes account of the Planning Guidance, the current economic position and other inflationary pressures borne out within the model;
- Pay inflation is set at 0.41% in 2014/15 and a net 0.52% in 2015/16. This takes account of the Agenda for Change pay award, i.e. 1% non-consolidated payment in 2014/15 and 2% in 2015/16. This award is non recurrent each year and applicable only to those staff at the top of their payscale. Incremental drift is assumed to be offset by staff turnover;
- Non pay inflation has been assessed and profiled in accordance with the latest estimates for the economy.

7.2 Sensitivity Analysis

The following Sensitivity Analysis tables show a number of potential downside risks that have been identified whilst carrying out the completion of the Forward Plan and how those risks could be mitigated:

Risks	Year 1	Year 2
	£000	£000
Under occupancy of non contracted HCLV Beds		
- Forensic – 25%	232	230
- CAMHS Low Secure – 50%	112	110
Reduced activity of Non contracted - other cost and volume		
- Tees IAPT (AQP) -30%	490	446
- North Yorkshire non contracted beds	106	212
Delays in delivery of CRES		
- plans in development (Red) -50%	362	1,018
- plans requiring approval (Amber) -25%	861	1,116
Total	2,163	3,132

Mitigations		
Reduction in discretionary spend e.g. strategic change fund	-1,057	-1,570
Reduction in Tees IAPT Staff	-245	-446
Plan B CRES Schemes	-861	-1,116
Total	-2,163	-3,132

7.3 Cash Releasing Efficiency Savings (CRES)

Given the current economic climate and in order to operate within the national and local financial frameworks the Trust is planning to deliver cash releasing efficiency savings (CRES) of £15.9m over the next two years. The following table summarises the CRES programme targets for the Trust by Locality / Directorate:

Locality / Directorate	2014/15 £000	2015/16 £000	Total £000
Durham and Darlington	3,064	1,623	4,687
Teesside	1,805	1,489	3,294
North Yorkshire	881	1,042	1,923
Forensic	859	852	1,711
Chief Operating Officer Inc Pharmacy	478	148	626
Estates and Facilities	638	632	1,270
Corporate	227	559	786
Trustwide Schemes	-154	1,899	1,591
Target	7,798	8,244	15,888
Identified Schemes	8,453	7,692	16,145
CRES to identify (-) denotes ahead of target	-655	552	-103

The following table summarises the current position for Locality / Directorate CRES plans against target. (-) denotes ahead of target.

Locality / Directorate	2014/15 £000	2015/16 £000
Durham and Darlington	231	18
Teesside	3	296
North Yorkshire	97	139
Forensic	-384	-138
Chief Operating Officer (including Pharmacy)	272	420
Estates and Facilities	0	0
Corporate	-235	186
Trustwide Schemes	-638	461
Schemes in development		-1,485
CRES to identify	-655	-103

Schemes in development are digital dictation, the travel reduction scheme and the lease car salary sacrifice scheme.

7.4 Capital Expenditure

The following table summarises the Trust's capital expenditure plans for the next two years:

Description of Scheme	2014/15 £000	2015/16 £000	Total £000
North Yorkshire - HHR Inpatient reconfiguration	0	1,000	1,000
North Yorkshire - CMHT	218	1,182	1,400
North Yorkshire - Rehabilitation	3,321		3,321
North Yorkshire - Child & YP - WLH	2,343	3,270	5,613
Durham and Darlington - CMHT Refurbishments	861	1,405	2,266
Durham and Darlington - LD Beds review		350	350
Teesside - Imperial Avenue	50		50
Trustwide - Inpatient reconfiguration	400		400
Life Cycle Maintenance (Trust wide)	1,201	1,117	2,318
SISUP (service improvement & space utilisation)	952	1,396	2,348
Equipment (Inc. Business cases & IT)	100	100	200
Estate Rationalisation & Efficiency (Trustwide)	275	250	525
Salaries	420	370	790
Total	10,141	10,440	20,581

The capital expenditure profile remains significant and as such will be regularly reviewed to ensure ongoing affordability in the short to medium term.

The Trust is currently holding one property for disposal which has been released from operational requirements as part of the estate rationalisation plan. This property will be sold in 2014/15 quarter 1, and receipt of sale proceeds is included in the plan.

7.5 Statement of Financial Position

A summary of the Trust's Statement of Financial Position is shown below. The main movement in cash from 2014/15 to 2015/16 is investment in the capital programme.

	2014/15	2015/16
	£m	£m
Property Plant and Equipment	237.1	241.5
Receivables Non current	0.1	0.1
Current Assets	5.4	4.4
Cash at bank and in hand	24.1	22.5
Current Liabilities	-17.6	-16.1
Non Current Liabilities	-1.0	-0.9
PFI Finance Lease < 1 year	-2.3	-2.4
PFI Finance Lease > 1 year	-79.6	-77.2
Total assets employed	166.2	172.0
Taxpayers Equity		
Public Dividend Capital	144.7	144.7
Retained Earnings	-9.7	-3.9
Revaluation Reserve	31.2	31.2
Total assets employed	166.2	172.0

7.6 Continuity of services risk rating (CoSRR)

The following table summarises the planned continuity of services risk rating (CoSRR) for the Trust:

Monitor Rating Guide	2014/15	2015/16
Debt cover service	3	3
Liquidity (days)	4	4
CoSRR (maximum 4)	4	4

The margins on CoSRR risk ratings are as follows:

- Debt service cover - to reduce to a 2 a surplus reduction of £0.7m is required in 2014/15 and, £0.4m in 2015/16.
- Liquidity - to reduce to a 3 a working capital reduction of £16.6m is required in 2014/15 and, £15.3m in 2015/16.

The current results demonstrate that the Trust Financial Risk Rating will not drop below a 3 over the next 12 months.