

Summary Strategic Plan Document for 2014-19

Cornwall Partnership NHS Foundation Trust

Market analysis and context

A) Context

We are the principal provider of mental health, children's community and learning disability services to people living in Cornwall and the Isles of Scilly and have a strong record in providing integrated health and social care services. We have a strong ethos with the delivery of excellent, safe services which listen and respond to patients needs being at the core of everything we do.

We are the only foundation trust in Cornwall and the only foundation trust for mental health and learning disability services within the South West Peninsula.

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

Forecast health, demographic, and demand changes

Cornwall's population is growing and is estimated to reach 633,200 by 2030, an increase of 97,900 (18.3%). We therefore expect the demand for services to reflect this trend.

NHS Kernow's draft Integrated Plan identifies a number of population factors that impact significantly upon the planning and provision of health and care services for Cornwall and the Isles of Scilly:

- Increasing numbers of single person households will increase demand for care services. The number of single person household is expected to rise by 65% by 2033;
- Cornwall has the second weakest economy in the country and earnings were 19% below the national average in 2011;
- Some communities have high and persistent concentrations of people who are not in work with issues of deprivation, child poverty, health inequalities and community safety; and
- The proportion of older people in our population from 50 onwards is higher than nationally.

Our top health problems are hypertension, depression, obesity, and asthma. All but hypertension are more prevalent here than in England overall. Coronary heart disease, stroke, cancer, chronic obstructive pulmonary disease, heart failure, epilepsy and dementia are present in smaller numbers but are also more prevalent. By comparison with other areas we are also worse for disability free life expectancy and there is scope to improve quality of life for people with long-term conditions

The development of NHS Kernow's "Living Well" plans under the Integration Pioneer programme will drive change in the local health economy placing much greater emphasis on community care. CFT strongly believes that we can be an important part of the future provision landscape supporting delivery of the Local Health Economies (LHE) triple aims. We have extensive experience in delivering an integrated care model and delivering services from primary care (including psychological therapies) to specialist inpatient services. Our care pathways are rooted in community and primary care and are designed to support people in least intensive setting and to promote recovery and social inclusion.

It is within the context of this strategic environment that we have developed our five year strategic plan.

B) Trust vision and aims

Our vision is summed up in a statement that underlines the importance of Services and Patients to us- *"Passionate about our Services"*.

This vision is underpinned by 5 key strategic objectives driving the Business Plan and underpinning the development of future services:

- 1. To deliver high quality, safe and accessible services*
- 2. To maximise the potential of our workforce to deliver high quality patient care*
- 3. To achieve best value and ensure the Trust is sustainable and financially sound into the future*
- 4. To diversify and develop services that meet commissioner and service user needs and expectations*
- 5. To improve mental health and wellbeing by working in partnership to create life opportunities for clients*

Our vision and aims are embedded into the formulation and implementation of our plans.

C) Material challenges facing the Local Health Economy (LHE)

Service Challenges

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

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

- 10% of our population live in deprived communities
- 1 in 5 children live in poverty
- Over half our homes are not on mains gas and it costs more to stay warm and eat healthily

- Increasing technology and research supports the number of babies surviving longer with complex health needs and associated disabilities
- Increased prevalence of childhood obesity.
- Our 65+ population is more than the national average, expected to increase by 83% by 2031 and the number with a limiting long-term illness by 59%.
- For those 85+ we expect a 114% increase in the number with a limiting long term illness
- An estimated 9,089 people with dementia today will rise to 15,854
- Older people living alone or in care or ill or with a disability are more at risk of depression.
- People with long-term illnesses make up 80% of GP activity, 40% of out-patient activity and 80% of hospital in-patient bed days.

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

The commissioners have identified depression as one of the top four health problems in Cornwall, with it being more prevalent here than in England overall. Dementia is recognised as being more prevalent in Cornwall than England overall.

Financial challenge

The NHS is predicted to face a £30 billion funding gap by 2020/21 through increased demand and cost pressures if services were to remain unchanged. This challenge is reflected in the LHE. It is anticipated that should we not change service delivery there would be a funding gap rising from £15m in 2014/15 to £200m in 2018/19. As such the health community is required to deliver recurrent efficiencies of £200m by April 2018.

This financial challenge is also reflected in Council funded services with an anticipated funding gap of over £200m for the same period, driven by a mixture of both growth in activity and income reductions.

As such the health and social care economies are facing a joint financial challenge of a £400m funding gap over the next five years. This obviously places considerable pressure on commissioners to fund services and they have highlighted this financial challenge as a key driver in the requirement for commissioning and service delivery to be changed through the 'Living Well' programme.

D) Service Strategy

The Trust operates a range of mental health, learning disability and children’s services. These operate in the broad service strategies reflected below:

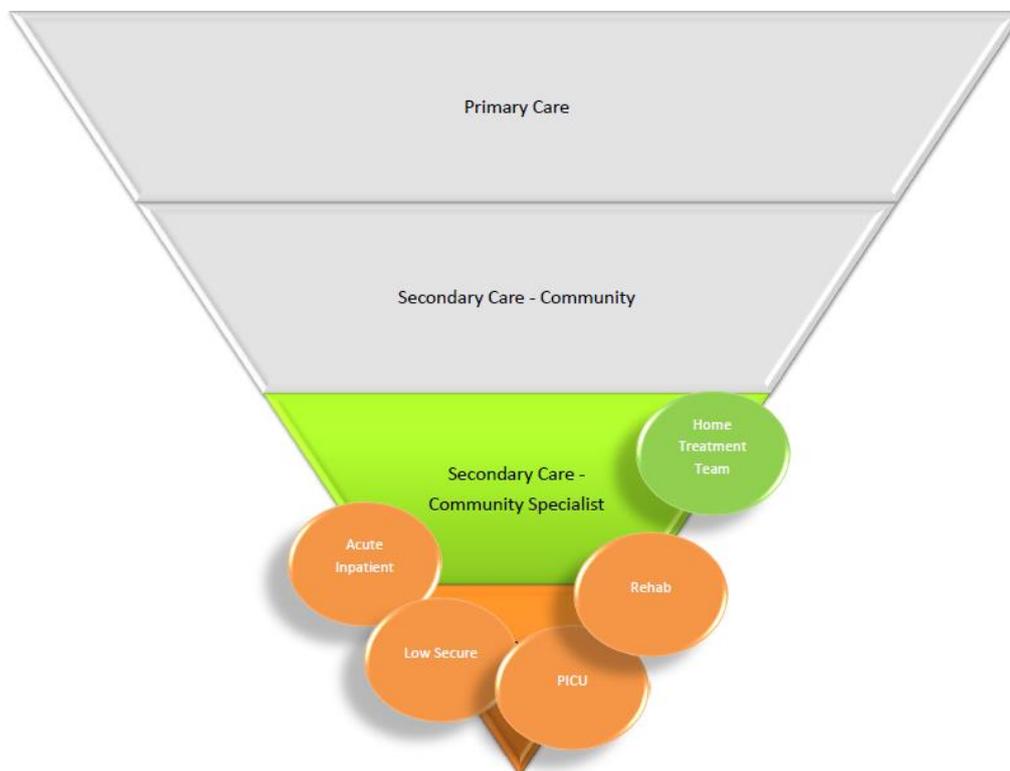
Service Strategy	Adult Mental Health		Children’s	Complex care	
Service Line	Inpatients	Community	Children’s	Complex Care & Dementia	Learning Disability

E) Market analysis at service line level

We are aware that differing factors impact upon the individual markets within which our service lines operate. We have therefore undertaken a review of these factors at a service line level to inform the development of our five year plans.

a) Adult mental health- Inpatients services

The diagram below shows the range of services currently delivered by the service line.



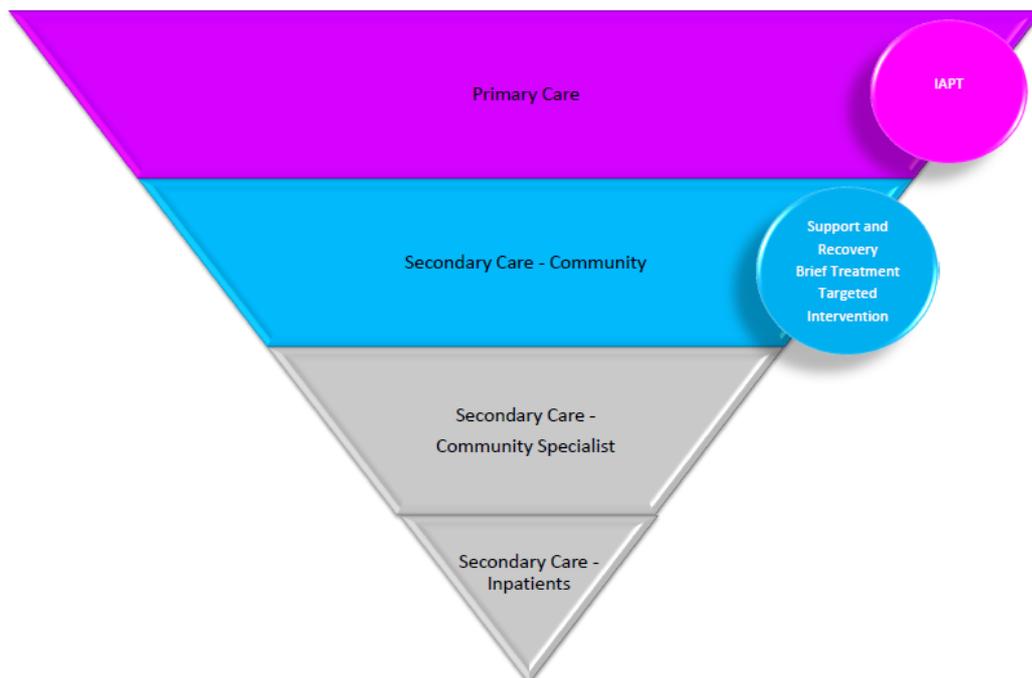
The service line operations range from the Home Treatment Team which supports acutely unwell people in the community to a Low Secure inpatient unit. With the exception of the Home Treatment Team, our inpatient service line manages hospital based services at Longreach Hospital, Redruth and Bodmin Community Hospital, Bodmin. We benefit from having modern, purpose built hospital facilities built and operated under the private finance initiative (PFI). We recognise that the successful operation of our PFI partnerships requires expert management and strong relationships.

The Inpatient Service has experienced an increase in demand over recent years in the volume of referrals and the complexity with which such referrals present.

We are committed to working with LHE partners to develop services in line with the intentions of the Crisis Care Concordat.

b) Adult mental health- Community services

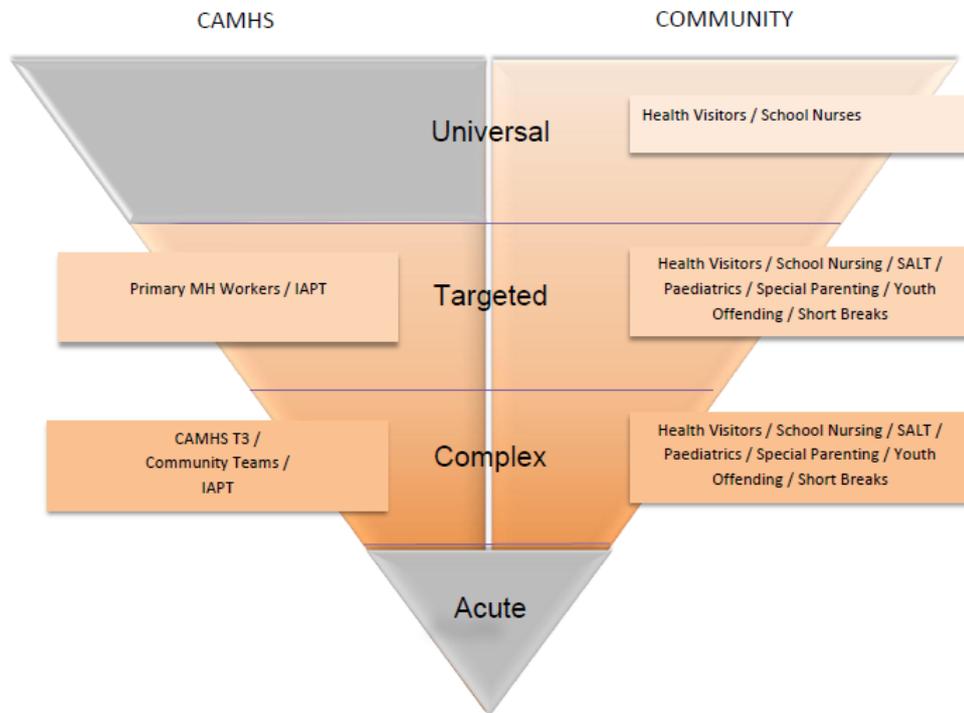
The service line provides services within both primary and secondary care. The diagram below reflects this range of services:



We provide an IAPT service across the whole county and have also redesigned our Community Mental Health Team and specialist team provision into the core areas of support and recovery, brief treatment and targeted intervention.

c) Children's services

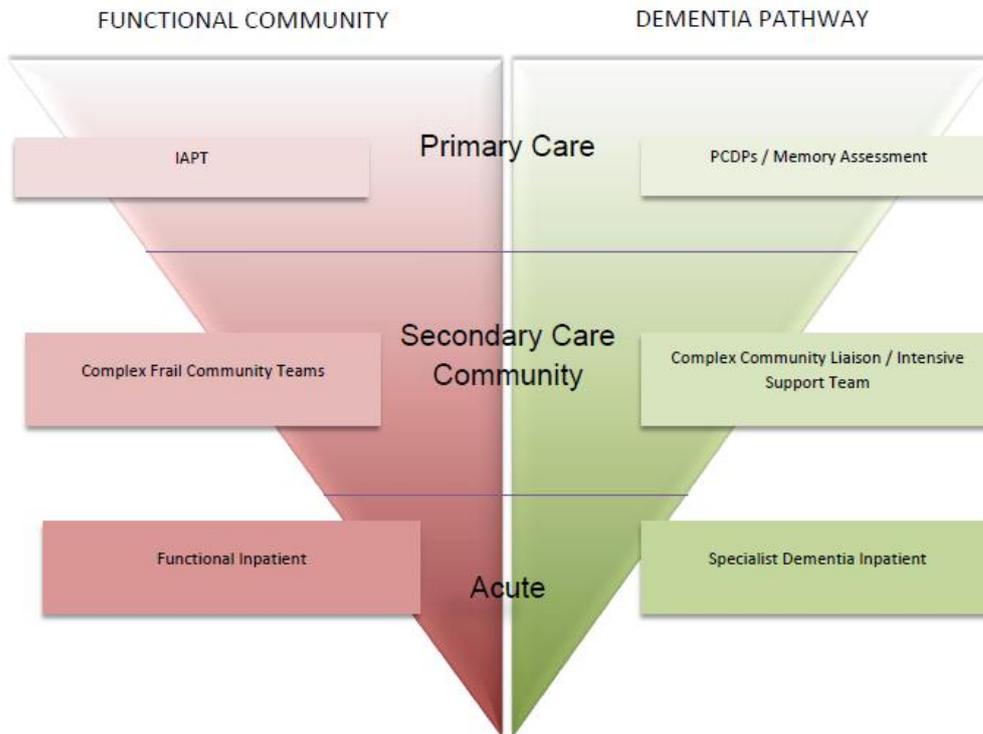
The service line delivers both Child and Adolescent Mental Health services and Children's Community Health services to the population of Cornwall and Isles of Scilly. The range of services is reflected in the diagram below:



All of the services we provide are delivered within the community. We have fully engaged in recent years in the Health Visitor programme, and have also embedded Improving Access to Psychological Therapies (IAPT) skills into our workforce. The provision therefore covers a wide breadth of community services.

d) Complex care- Complex care and dementia services

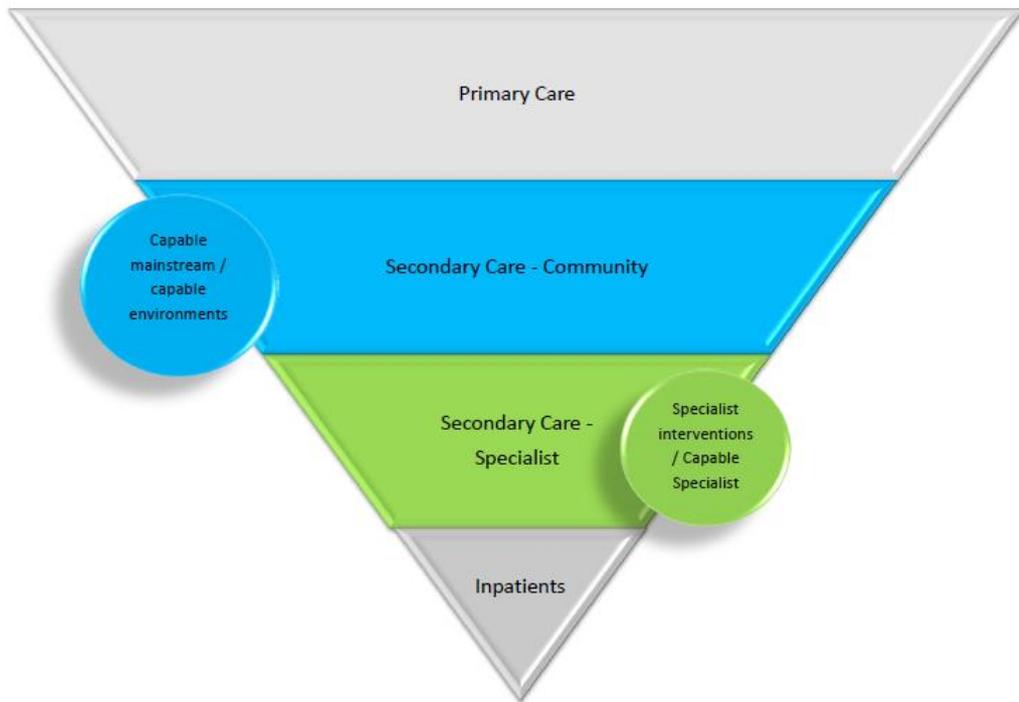
The service line currently covers a range of services from primary care through to acute care as represented in the diagram below:



The service line has engaged with commissioners in recent years to form a Primary Care Dementia Practitioners (PCDP) service which works within primary care. The service has also developed its inpatient facilities to concentrate its services into one ward.

e) Learning Disability health services

The service line operates secondary care services within the community as described in the diagram below:



Primary care services for Learning Disability services in Cornwall are provided by Primary Care Liaison nurses employed by Peninsula Community Health. There are no inpatient facilities for Learning Disability patients in Cornwall.

F) Market analysis at Trust-wide level

We have also considered our position within the market at an organisational level, and in particular how we fit into the KCCG's vision.

KCCG's vision to create a sustainable system of care is driven by the Triple Aim approach developed by the Institute for Improvement. The triple aims are; *Improve health and wellbeing, Improve people's experience of care, reduce the cost of care per capita*. We consider our vision and objectives to be consistent with the triple aims.

KCCG and its partners have developed a pioneering approach to achieving its aims. KCCG are developing their strategic plan, "Starting well, Living well and Ageing well" which fully embraces the aims and vision of the pioneer status the Cornwall LHE has achieved. Referred to as the 'Living Well' programme its vision is;

Starting life well, living well and ageing well, people are supported to live the lives they want to the best of their ability in their communities.

Care and support is shaped around the needs of individuals and is clinically and financially sustainable for future generations.

It is joined up by a shared commissioning framework and local people and practitioners

Strategic options

A) Risks

We recognise that there are a number of local and national factors which present risks to our sustainability. As a general principle, the trust board recognises there are potential risks associated with retaining existing contracts, and therefore market share over the forthcoming planning period. The trust board appreciates that there would be a requirement for a varying range of mitigating actions dependent upon the contract lost to ensure the future continuity of services. In order to identify these risks, and to consider the options available to us to mitigate them, we have undertaken an assessment at service line and Trust level.

B) Strategic options

We have considered the strategic options at a service line level, however we recognise that each option can span across more than one service line. As such the following table reflects our ability to deliver the options.

Strategic Options					
Service Strategy	Service Line	Grow	Shrink	Merge/Collaborate	Reform
Trust wide	Trust wide	We will explore all opportunities in accordance with our growth strategy. Where opportunities align with our vision and goals we will pursue the development of existing markets as well as look to penetrate new markets. As the only foundation trust in Cornwall and the only mental health foundation trust within the peninsula we are well placed to exploit arising opportunities.	Should the risks attributed to the other strategic options escalate beyond our risk profile, we will consider concentrating upon our core business and consolidating our past achievements.	Given the current fluid state of the local health economy, and in particular the provider landscape we will consider all options for partnership opportunities carefully. Such collaborations may take many legal forms and we are well placed to optimise any such opportunities as a foundation trust.	We continuously evaluate the opportunities for reform via our business planning framework. The emergence of NHS Kernow's pioneer status will afford the possibility of further radical reforms that we will evaluate during the course of the forthcoming planning period.
Adult Mental Health	Inpatients	We see two key options for the growth of the service line. Growing the footprint of our current services and differentiation into specialist markets.	Should there be a need for us to shrink, we would look to differentiate our inpatient services as specialist within our core contracted terms.	Like our aspirations for growth within the service line, all opportunities for partnerships will be considered.	Opportunities for traditional and radical reform will be considered in-line with existing trust processes.
Adult Mental Health	Community	We will look to further develop opportunities in the primary care	Where market conditions dictate, we will concentrate our	We will look to maximise the opportunities afforded	Opportunities for traditional and radical reform will be

		markets. We will explore new markets that present as a result of fiscal uncertainties and events such as the expiration of original transforming community services contracts.	efforts upon our core contracted services.	via the living well agenda and other non-traditional opportunities that emerge as a result of our foundation trust status.	considered in-line with existing trust processes.
Children's	Children's	We will seek to provide new services both in existing and new markets.	Should our market analysis dictate, we will concentrate upon differentiating our existing children's services.	The integration agenda has highlighted great benefits for collaboration within children's services. We are open to reviewing the benefits of all partnership and alliance opportunities.	Opportunities for traditional and radical reform will be considered in-line with existing trust processes.
Complex Care	Complex Care and Dementia	Opportunities for expansion into emerging markets are being explored as healthcare is developed.	Should the provision of services become uneconomical we could evaluate the option to cease.	Opportunities for collaboration with the local authority, third sector and private partners are being explored.	Opportunities for traditional and radical reform will be considered in-line with existing trust processes.
Complex Care	Learning Disabilities Health Services	Growth into existing and new markets is currently being explored.	Should the service become uneconomical we would evaluate the benefits of specialist differentiation and cessation.	All opportunities for formalised partnerships would be considered.	Opportunities for traditional and radical reform will be considered in-line with existing trust processes.

Strategic plans

A) Our Strategic Plan

The NHS landscape is rapidly evolving, with substantial national, local and demographic changes presenting significant challenge in developing our strategic response. We recognise that we need to develop a strategy that is capable of constant evolution so that we are able to strategically position ourselves to successfully meet emerging opportunities and threats.

We recognise that the development of NHS Kernow's "Living Well" plans will drive change in the local health economy and that this presents both opportunities and threats to our strategic position. The focus of this emerging plan is "shaping care and support around the individual as part of the communities in which people live with better coordination of care provided by health, social care and the voluntary sector". This will build greater local social capital and community resilience which will decrease dependency on acute sectors. We believe that, as an established provider of community and acute services across a wide portfolio, we are well placed to support delivery this developing plan. The draft strategy proposes changes to the contractual framework under which providers are commissioned. We acknowledge that the Living Well plan signals an intention to examine innovative contracting models. We recognised that it is, therefore, vitally important that we are able to develop plans quickly and respond effectively to emergent commissioning intentions.

Our service and financial planning is reinforced by scenario planning and this is periodically reviewed by our board of directors. The board of directors has well established strategic development days which provide time and space to debate and make decisions on our future service configuration. These arrangements support us in ensuring that our strategy remains relevant to changing circumstances.

Through our service line management framework, we have embedded effective service delivery units with clear decision making and accountability and strong clinical leadership, ownership and engagement. Our strategic plan reflects a bottom up approach lead by the clinicians and managers best placed to understand their resources, costs, opportunities and threats. Our approach aims to empower clinicians and front line staff to own the development, performance and quality of their business plans in reshaping service delivery to meet direct patient needs.

We also recognise the importance of creating social capital and welcome the emphasis placed on this important issue within NHS Kernow's Living Well plans. Our ethos is to protect and enhance individual's rights, freedoms and responsibilities. We fully support the importance of involving people and communities in the delivery of healthcare. We have been fortunate to benefit from having a public membership since becoming a Foundation Trust that is interested and supportive of local health care services. We continue to develop volunteering opportunities

within the Trust, whilst also recognising the importance of educational opportunities to enable our clients feel able to contribute to society and gain independence.

There are a number of key enablers to our plans including:

- Continued development of our service business unit structure;
- Continued investment into our facilities;
- Continued investment in IM&T and mobile working technology to support integrated working;
- Partnership working across the LHE to deliver Living Well ambitions and the LHE's triple aims .

The development of our strategic plan has been underpinned by a number of supporting strategies:

- Clinical Development Strategy
- Patient Safety Strategy
- Nursing Strategy
- People and Development Strategy
- Patient Experience Strategy
- User and Care Involvement Strategy
- Communication Strategy
- Productivity and Efficiency Strategy
- IMT Strategy
- Estate Strategy
- Growth Strategy

We are keen to explore opportunities to expand and strengthen our service delivery with our primary considerations being whether the potential opportunity would enable us to improve outcomes for patients and increase the quality and safety of our services. With these considerations in mind, we will prioritise investments that complement and strengthen our existing services by addressing acknowledged gaps, for example physical health care services, which extend our service offering along care pathways, for example primary care, or which improve resilience and efficiency through geographic expansion in core service lines. Our processes for rigorously assessing growth opportunities are set out with our growth strategy

We recognise the importance of effective communication in creating a positive working environment and establishing effective working relationships between organisations. We also recognise that good communication involves attitude and behaviour, as well as a clear identity which users will recognise. In assessing opportunities therefore we will take account of the need for effective marketing and branding of the service, and whether the opportunity fits with our identity of being "passionate about our services". Our communications strategy describes how we intend to communicate our plans to our key stakeholders, including our staff and patients.

Continuing to take forward our IMT and Estate strategies is recognised as being critical to our ongoing sustainability.

B) Strategic plans at service line level

We have developed business plans at a service line level through our established business planning process. These plans consider the aims and vision of each of our five service lines. We have grouped our service line plans into three service strategies for adult mental health services, children's services and complex care services.

An over-riding aim of the Trust is to ensure that individuals receive the right care at the right time from the right person. In recognition of this we will continue to promote the effective utilisation of the stepped care approach across our service lines.

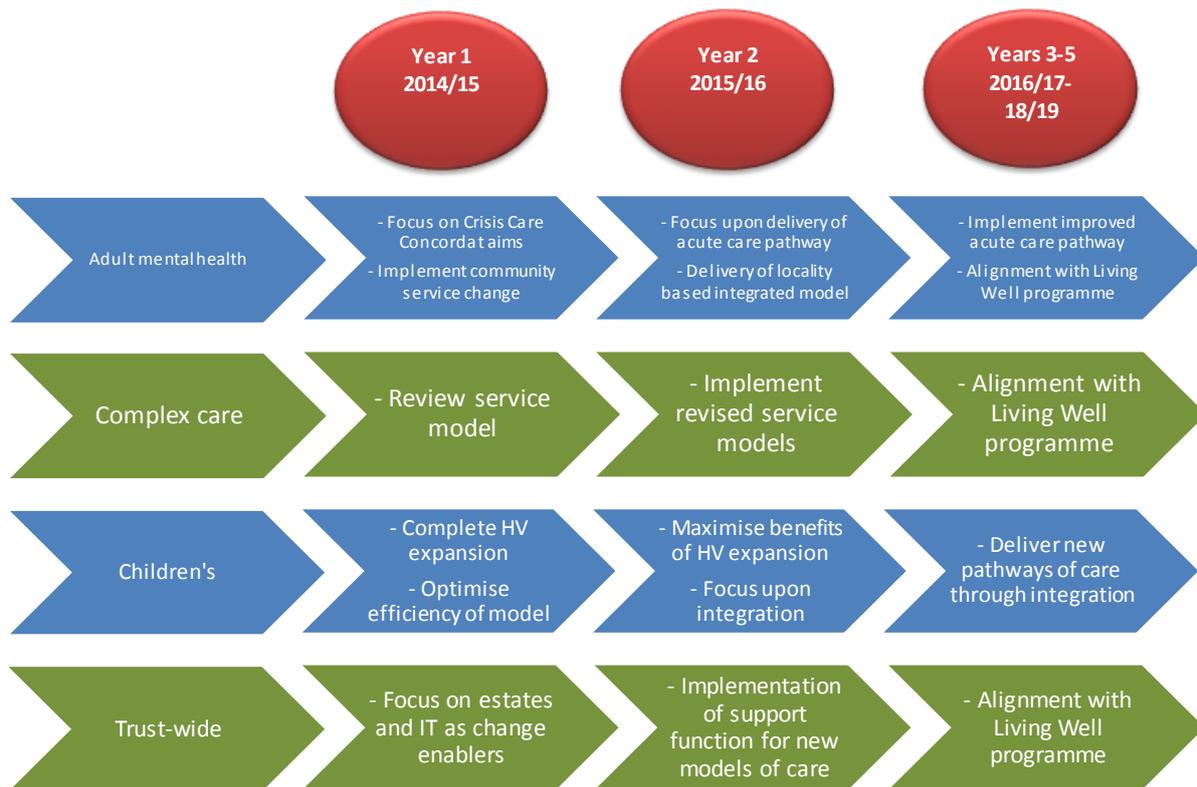
Our business planning process has enabled us to consider in detail the key initiatives that need to be taken forward over the planning period, with detailed operational plans developed covering the first two years of the plan and developments identified for implementation in the longer term, covering a further three years.

We are focused upon providing high quality, safe and sustainable services to our local population, and have a strong Quality Impact Assessment framework which we use when considering service changes.

We recognise the key areas of work to deliver this plan as being:

- Integration and collaboration with other providers (including Pioneer)
- Efficiency gains in service delivery structures
- Income generation
- Modernising our estate
- Harnessing technology

The following table summarises our focus of work over the five year plan for each service strategy:



Our service lines have well developed strategic business plans as follows.

a) Adult mental health- Inpatients services

i) Vision

Our Adult Mental Health Inpatient service line's vision is to be the preferred provider of acute mental health inpatient services in Cornwall. We aspire to be recognised as the best provider of mental health inpatient services across the South West Peninsula. To achieve this we will;

- Continue to ensure safe staffing on our wards, employing a well trained workforce who are highly motivated and committed to improving patient care.
- Ensure that the care we provide is evidence based and deliver improved patient outcomes using best practice ensuring that patients receive the right intervention (pathway) by the right person at the right time.
- Provide a service which meets the needs of acutely ill patients in the least-restrictive environment as close to their home as possible.
- Improve patient experience and staff satisfaction
- Introduce patterns of working for staff that aim to reduce their work-related stress and improve the safety and quality of the service delivery.

We aim to provide people with a positive experience of the care and support. We will actively engage with patients and carers in all aspects of service delivery and service development. The information and feedback obtained from local and national surveys, complaints and incidents will be used to embed learning and deliver improved services.

ii) Service line initiatives

Our acute inpatient service has experienced significant pressures over recent years with bed occupancy in excess of 97% (excluding leave) and patients regularly needing to be placed out of county. The Royal College of Psychiatrists occasional paper (June 2011) "Do the right thing: how to judge a good ward" sets out ten standards for adult inpatient mental healthcare. Bed occupancy rates are identified as a main driver of inpatient care standards with a bed occupancy rate of 85% is seen as optimal. This enables individuals to be admitted in a timely fashion to a local bed, thereby retaining links with their social support network, and allows them to take leave without the risk of losing a place in the same ward should that be needed. Delays in admission, which result from higher rates of bed occupancy, may cause a person's illness to worsen and may be detrimental to their long-term health. The importance of a resilient acute care pathway is reinforced in the Mental Health Crisis Care Concordat¹ which sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

Having carefully considered demand patterns and capacity within our acute care pathway, we have developed plans to increase local provision by expanding our bed numbers from 54 to 66 to provide sufficient inpatient provision in county, whilst enhancing Home Treatment Team support in people's own homes to reduce the need for an inpatient episode. We submitted a business case to KCCG in July 2013 detailing proposed improvements to the pathway

The key elements of this initiative are summarised as:

- Continued investment to sustain safe staffing levels to enable additional observations
- Provision of a 12 bedded Extra Care Inpatient Unit to provide care for our most vulnerable patients
- Strengthening of our Home Treatment Team
- Provision of an Alternative Provision Fund for use by the HTT to provide alternatives to admission and enablers for discharge

iii) Key milestones, resource requirements, dependencies and risk mitigations

¹ Mental Health Crisis Care Concordat, Improving outcomes for people experiencing mental health crisis, HM Government, February 2014

We have agreed to work with NHS Kernow throughout the 2014/15 financial year to enable the acute care pathway business case to be further developed clinically. We have identified the funding requirements which will need to be addressed by commissioners.

Our service line plan includes health and well being initiatives which aim to reduce sickness absence and a skill mix review to ensure that our wards are able to deliver a range of therapeutic activities to promote recovery through increased productivity.

iv) Communications

Our staff have been fully engaged in the development of the service line business plans.

Programmes of work that impact upon external organisations are discussed with those organisations.

b) Adult mental health- Community services

i) Service line vision

Over the forthcoming years our intention is to reorganise our method of operating to ensure that we makes optimum use of mobile technology, plans staff activity in a methodical and logical manner, increases our ability to deliver psychological therapies, and ensures patient care is planned in line with recognised best practice and agreed pathways. We recognise that these aims need to be achieved whilst ensuring value for money and the achievement of all savings targets. The ability to plan and manage activity will require a trust-wide review and approach which will build on pilot activities that have already been commenced within this service line and others. The work on increasing our delivery of psychological therapies has commenced and is being piloted within one of the services existing teams. This approach will require a substantial training element but more fundamentally will require clinical staff to move away from a focus on their care co-ordination role to their professional ability to provide treatment. The aim is to ensure that the service is able to address issues raised from external surveys which have indicated that there are challenges relating to access to psychological therapies and in the way people are involved in the planning and review of their care. These are so fundamental to the work that we do and our reputation in doing so, that these activities will be a priority for the service line over the next three years. We will work alongside the wider corporate services to ensure that the changes and developments in how our staff work are informed by the clinical and operational imperatives. This will include work on the working environment, transportation, electronic records and smart use of IT.

ii) Service line initiatives

Our main initiative is the redesign of the functional community mental health services. It will create a service model that dispenses with the current CMHT model and instigates a service that focuses on care cluster pathways. This aims to ensure greater efficiency in service delivery through correct skill mixes and resource allocation. The scheme will be enhanced by becoming part of the strategic vision for mental health services, providing a layer of service under the primary care services that are provided by BeMe. The expectation is that by targeting and focussing staff activity within specific areas of the function we will be able to ensure efficiencies within our service delivery. This will also support a cultural change within the service moving from a focus on care co-ordination activity to a focus on treatment. This will be supported by the wider trust programmes to reduce travel and rationalise the estate. These elements are a constant theme throughout all of the schemes within this plan and whilst they will not be explicitly outlined again they will form a central core of the plan. The scheme is rolling together a number of existing programmes that have been developed over the last few years, including the Integration of Assertive Outreach, Community Management Restructure and Admin Review. This will ensure that a full programme of change is implemented rather than smaller disjointed plans are undertaken. The intention is to provide sustainable change that will meet the needs of the service line for the next 3 years. It will create 4 areas of service across the county:



iii) Key milestones, resource requirements, dependencies and risk mitigations

We have commenced the delivery of the redesign which is reported to the Trust executives on a regular basis.

iv) Communications

Our staff have been fully engaged in the development of the service line business plans.

Programmes of work that impact upon external organisations are discussed with those organisations.

c) Children's services

i) Service line vision

The vision for Children's Services in Cornwall and the Isles of Scilly is to strengthen partnership delivery and alignment of provision moving towards full integration, with practitioners focused on children's health and wellbeing.

"Getting it right for children and young people: overcoming cultural barriers in the NHS" (Professor Sir Ian Kennedy, 16 September 2010) emphasises the need to review and improve children's services in order to provide services that are integrated and child focussed. This document describes the importance of services being developed with children at the heart of our delivery; the creation of a single point of access; focus on prevention, early intervention and wider well-being; and improved information sharing to inform improved outcomes of young people.

This is a shared vision of the Children's Trust with an aim to deliver high quality, safe, evidence based and accessible services to all children, young people and their families equitably across the county.

The deliverables planned over the next 3 years are:

- Workforce demand and capacity analysis and pathways documentation to provide will allow the service to make efficiencies through reduced duplication, focusing the right skills and interventions at the right time.
- Estates review work continues with the objective to identify options for co-location with our partners to improve partnership working and communication and reduce financial overheads
- Review of contracts management and all procurements processes, identifying and implementing any efficiencies
- Information Management and Technology deliverables to support our vision are:
 - Child Health migration onto KITS RIO
 - Migration of CAMHS and ASD from BT RIO onto KITS RIO
 - Other service providers use of KITS RIO to improve information sharing and inform improved outcomes for young people.
- Integration service delivery with the Council to further reduce duplication of management, accommodation, processes, systems and provide a combined service delivery with the child at the heart of our joint delivery.

ii) Service line initiatives

Our key priority is to pursue closer working with the council, with the aim of the provision of a fully integrated service.

We are also exploring proposals to provide a Young person's Integrated Mental Health Unit. This would ensure that we provide services throughout the entirety of the stepped care model.

We have a fully configurable digital patient record and a pioneering programme regarding the inclusion of iPads and associated technologies.

iii) Key milestones, resource requirements, dependencies and risk mitigations

The benefits from closer working with the council are anticipated to begin to be realised in this financial year.

iv) Communications

Our staff have been fully engaged in the development of the service line business plans.

Programmes of work that impact upon external organisations are discussed with those organisations.

d) Complex care- Complex care and dementia services

i) Service line vision

We believe passionately that collaboration with all partners is critical to the provision of the best quality of care for clients. We will deliver excellent and accessible services and maximise the potential of all our staff and resources. We will act with respect and integrity and show compassion in all our work. We will assist the people referred to us to improve their well-being and will be forward looking in the service we provide.

The approach to treatment is mindful of the need to balance risk and independence, have contingencies in place to prevent crisis, and build the resilience of the person and their supporters to enable the recovery of well-being. This is done effectively through a "formulation based approach" identifying the bio psychosocial factors that need to be addressed through an agreed plan of care which is co-ordinated and reviewed regularly.

The service is not a "stand alone" service and works closely with all other teams within the Cornwall and IoS health community engaging with local populations in developing dementia friendly communities, to provide a whole systems approach to comprehensively meet the local and individual needs of people with dementia and their carers. In doing so it will meet the NIHCE Dementia quality statements, the four key priorities of the National Dementia Strategy 2009, fulfil the intentions of commissioners, partner agencies, General Practitioners, clients, carers and staff.

A partnership of fifteen organisations, including CFT, in Cornwall and Isles of Scilly was recently awarded Pioneer status by the Government in recognition of its plans to integrate services. An integral part of the Pioneer plan is the coproduction of a frailty pathway that will support individuals who are frail, including people with a diagnosis of dementia and mental health difficulties. This pathway will identify people who are at risk at an early stage in primary care and help plan for their care by targeting interventions in a timely way to promote health, wellbeing and self-management. CFT has responded to this strategic intention by remodelling the service delivery to target frailty for people with dementia or mental health needs across this pathway. Work will continue over the next three years to deliver against this vision working closely with primary care.

ii) Service line initiatives

The service line needs to continue to develop the service delivery model to meet the capacity and challenges and will review the service in the following ways:

- Primary Care Dementia Practitioners (PCDP) – this initiative is currently funded non-recurrently by NHS Kernow and it is imperative that we secure recurrent funding as it forms the gateway to secondary services. The service meets a range of important needs including increasing early detection and memory assessment screening, developing the dementia register and promoting carers' health checks.
- IAPT Benefit Review - we will review dementia services in terms of IAPT research and evidence (Realising the Benefits - IAPT at Full Roll Out, February 2010)
- Memory Assessment Service (MAS) - we will review MAS to ensure it is delivering complex diagnosis and ensuring people with early onset dementia are diagnosed early. We will learn from the outcomes of the East memory clinic model to review practice in the rest of the county. The resulting model may result in the reduction in the number of memory clinics offered across the county but an increase in their specialism in diagnosis with more screening and diagnostic requests being carried out within primary care through the PCDP, releasing resources.
- Complex Community – we will develop the Complex community teams through a focused approach to respond to people with moderate – severe dementia utilising a 'behaviours that challenge care givers' model. We will remodel our health care assistant role with our teams in response to the development of alternatives such as Changing Lives and Newquay Pathfinder.
- Dementia Liaison Service – we will focus the delivery of dementia liaison to meet the changing demand and support delivery of end of life pathway and focused delivery of interventions to targeted care homes working closely with GP's in primary care who support care homes.

- Dementia Inpatient Unit – we will undertake a further review the required number of specialist dementia inpatient beds, to optimise bed numbers, in response to the change in the delivery of the community services. We will look to ensure that our Dementia Inpatient unit environment provides an appropriately designed, modern environment to support best practice, building from significant investment over the last two years.
- Develop a 7 day a week Intensive Treatment Service, subject to agreement by NHS Kernow, that will outreach providing rapid intervention, delivering intensive support to people known to the CCD community services who are most at risk of needing an unscheduled stay in hospital as a result of unmet mental health needs or unresolved crisis in the support structure and an intensive approach to maintain their place of residence. We will review the impact of this approach on the workload and capacity within CCD complex teams to sustain change.
- Functional patients - we will consider the delivery of services to functional frail elderly to provide a stepped approach linking primary care (BeMe) through to specialist services including the use of computerised CBT for people with dementia.
- Assess functional services in terms of IAPT research and evidence (Realising the Benefits - IAPT at Full Roll Out, February 2010)

iii) Key milestones, resource requirements, dependencies and risk mitigations

The changes identified in the plan are scheduled to occur within the 2014/15 and 2015/16 financial years.

iv) Communications

Our staff have been fully engaged in the development of the service line business plans.

Programmes of work that impact upon external organisations are discussed with those organisations.

e) Complex care- Learning Disability services

i) Service line vision

Over the forthcoming years we will develop as a specialist Learning Disability Health Provider which is aligned with and works closely with the developing health and social care services in Cornwall. We aim to deliver a single pathway for people with learning disabilities in Cornwall which prevents relapse and crisis, ensures appropriate access to physical health care and promotes healthy lifestyles and access to mainstream services.

We will provide a consultative model enabling community providers to manage challenging behaviour effectively.

We are committed to implementing service developments and cost improvements aimed at improving efficiency which will result in productivity gains whilst maintaining and improving the quality of the service. Our prioritised schemes are Video Conferencing, Prescribing, Memory Service Development and Service Redesign.

The most significant scheme is the Service Redesign. The Service Redesign Scheme provides the opportunity for us to deliver services which have the potential to be at the forefront of NHS Specialist Learning Disability Service provision that maximise the resources in supporting clients to realise specialist health outcomes. The success of the Service Redesign Scheme will enable maximum value to be realised from the other prioritised schemes. The Service Redesign Scheme will include a review of funding responsibilities for input into residential care homes by practitioners for out of county clients.

The Service Redesign Scheme will be underpinned by the development of a core pathway which will ensure commissioned service provision results in effective, efficient and affordable specialist health outcomes for clients. The pathway will include the key components of eligibility, initial screening, assessment, intervention, review and discharge. It is acknowledged the core pathway will be complimented by targeted specialist pathways to include psychological, physical, mental health and other specialist provision.

We will continue to work with Cornwall Council, Adult Care Health and Wellbeing to ensure there is a joint focus on Building Better Futures Together, the Single Pathway and joint assessment to include on-going support and complex support requirements.

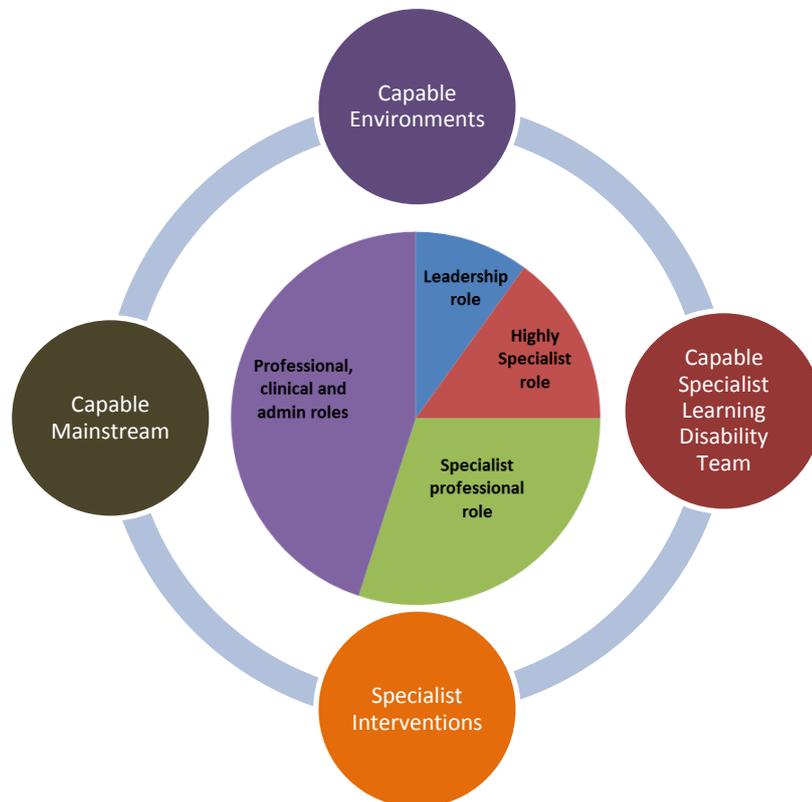
The Service Redesign will be developed ensuring best practice is evidenced to include the learning from Winterbourne View, alongside compliance with the Health Equalities Framework and the Department of Health Learning Disabilities Good Practice Project November 2013.

ii) Service line initiatives

The proposed Service Redesign will be informed by the Service Line Service Model which was agreed by the February 2014 Learning Disability Service Line Clinical Cabinet. The Service Model includes Specialist Invention, Capable Mainstream, Capable Environments and Capable Specialist Learning Disability Team components. The Model also includes the recognition of roles to include the Leadership Role, the Highly Specialist Role, the Specialist Professional Role, the Professional Clinical and Administration Role.

The Tiered Model of Health and Social Care Services, Department of Health Commissioning Guidance and the Position Paper from the Royal College of Speech and Language Therapists informed the development of the Service Line Service Model.

Learning Disability Service Line Service Model



iii) Key milestones, resource requirements, dependencies and risk mitigations

The service line has begun to deliver the changes required, and will continue to report progress to the Trust’s executives.

iv) Communications

Our staff have been fully engaged in the development of the service line business plans.

Programmes of work that impact upon external organisations are discussed with those organisations.

Overview of financial projections

We have continued to develop our strategic plan and associated financial model since the submission of our two year operational plan and model on 4th April 2014. As part of this work, we have continued to develop our “Bridging the Gap” programmes to deliver more efficient provision and clinically designed transformation schemes. We have decided that, at this time, it is unrealistic to plan for further significant savings from our inpatient service line given current levels of demand and safe staffing requirements excepting a contribution to the trust-wide programme (health and well-being) to target sickness absence levels. We will continue to review our inpatient service model over the life of the plan to test this decision and develop more radical options.

The planning assumptions and key projections adopted in our financial strategy are set out as follows:

	2014/15	2015/16	2016/17	2017/18	2018/19
Net Tariff reduction of %	-1.50%	-1.60%	0.40%	-0.60%	-0.70%
Cost inflation at %	2.50%	2.40%	4.40%	3.40%	3.30%
Cash releasing savings, min % pa	4.00%	4.50%	4.00%	4.00%	4.00%
Indicative Implied Efficiency modelled %	3.60%	3.60%	2.22%	2.73%	2.80%
Quality achievement % - non recurrent allocation	2.50%	2.50%	2.50%	2.50%	2.50%
Cost Improvement Programmes - £'000s	4,735	2,262	1,055	1,161	4,905
CIP% of Operating Exp less PFI Costs.	5.80%	2.80%	1.30%	1.40%	6.00%

Our income assumptions within the submitted plan are consistent with published tariff assumptions and the limited financial information made available by NHS Kernow.

Our planned year two position has improved by around £800k as a result of our refinement and development of our “Bridging the Gap” schemes. We have carefully considered our potential to deliver efficiencies and transformational change against the absolute requirement to maintain safe services. We believe that our submitted plan is challenging but realistic. As a consequence, there is a weakening of our financial performance over the period of the plan. We will deliver a deficit on operations in years two, three and four of the plan before returning to financial balance in year five. This return to financial balance will depend upon successful delivery of the programme of radical transformation across the LHE.

Our plan maintains a continuity of service risk rating (COSRR) of 3 in each of the five years.

	2014/15		2015/16		2016/17		2017/18		2018/19	
	Rating	Metric								
Continuity of service risk rating										
Liquidity ratio (days)	4	34 days	4	28 days	4	22 days	4	13 days	4	16 days
Debt Service cover (times)	3	1.84 cover	1	1.15 cover	1	1.24 cover	1	0.93 cover	2	1.52 cover
Overall CoSSR	4		3		3		3		3	

Bridging the Gap

We have established a process, Bridging the Gap, to support the transformation of services to be more effective and deliver required cost improvements with significant ownership by our clinical leaders. The cost improvement plans have been risk assessed so that mitigating actions can be identified where required.

Capital

The financing of capital investment over the period of the plan will be from trust cash balances, thus mitigating the need to borrow. However, this level of capital investment does introduce the risk of over-run should actual costs prove more than planned. Mitigation of these risks will be achieved through effective design and procurement of the schemes.

Workforce

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

Estate

We have developed an Estate Strategy covering the period to 2018. This strategy is intrinsic to the delivery of our strategic objectives and, in particular, supports the objectives of promoting green working and reducing travel, carbon and waste and of providing services from high quality facilities. We have considerable flexibility in our strategic options as there are no critical investment issues which cannot be absorbed from internal resources. There are however, substantial opportunities in relation to the modernisation of the Estate.