STRATEGIC PLAN DOCUMENT FOR 2013-14

SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

31 MAY 2013

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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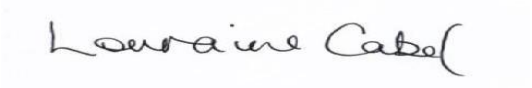
Date	**31 May 2013**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board. In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Lorraine Cabel**



Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Professor Patrick Geoghegan OBE**

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Ray Jennings**

Signature

Executive Summary

Consistent with the strategic outlook described in our Annual Plan 2012/13, health and social care service provision is now in the midst of radical structural change and is facing significant financial challenge. Our strategic position within this complex, new and potentially challenging context is less clear than that set out previously. Whilst SEPT is able to demonstrate a history of being able to effectively respond to changes around us; the scale of the changes and challenge is such that long term forward planning with any degree of certainty is not possible at this time.

As a result of the changes introduced by the Health and Social Care Act 2012, SEPT is operating in a new and complex commissioning environment. We are commissioned to deliver a diverse range of services in five separate geographic areas, working with 7 local clinical commissioning groups, NHS England and 6 local authorities.

The clinical priorities for the planning period set out by our commissioners do not represent any significant changes from those presented in previous years; the focus largely remains on providing more care closer to or at home; reducing admissions to acute hospitals and diverting attendance at A&E units. Whilst the clinical priorities have not changed, the commissioning intentions do however identify developments in strategy and contract intentions that introduce a greater level of risk to future contracts for existing services.

The strategic priorities that will provide the framework for responding to the challenges over the planning period based on what is known at this time are:

1: Delivering Quality Services That Are Safe and Effective
2: Workforce Culture and Capacity
3: Transforming Care
4: Clear Plans for Sustainable Services and Resources Used to Deliver Them

The Trust's financial plan for 2013/14 – 2017/18, is set against a background of continuing financial constraint within the public sector including the NHS. Services are facing a third year of significant efficiency measures and an expectation that this will continue over the planning period. The Trust's assumptions regarding the financial impact of commissioning intentions are taken into account in our financial strategy. Given the lack of formal notice at the point of preparation of this plan by commissioners that they intend market-testing our services, our base case assumption is that we retain existing contracts over the planning period.

The total planning shortfall facing the Trust over the planning period is £43 million. Although the Trust has an excellent track record of delivering CIPs, the level of efficiencies now required to be recurrently delivered year on year is significant and the risk associated with it is assessed as 'Extreme' and thus subject to further sensitivity testing.

In recognition of the significant pressures placed on both operational and support services to deliver cost reductions, the Board of Directors have agreed that the planned income and expenditure surplus for 2013/14 is reduced from the current £3.8 million to £3.3 million. The reduced surplus is the very minimum required to achieve a Monitor risk rating of 3. We have also taken into consideration Monitor's current consultation on a new Continuity of Service risk rating framework for Foundation Trusts. Assessing our financial plan against the draft Continuity of Service indicates a Monitor risk rating of 3 or 4.

In conclusion, this strategic plan confirms that the Board of Directors recognise the significant challenges faced by the Trust over the planning period and within the constraints identified, has a strategy to respond. We remain committed to ensuring that quality service provision is our priority and to taking action to minimise the impact of the challenges on frontline service provision wherever possible.

1.0 The Strategic Landscape

1.1 Complexity of Commissioning Arrangements

As a result of the changes introduced by the Health and Social Care Act 2012, SEPT is operating in a new and complex commissioning environment. We are commissioned to deliver a diverse range of services in five separate geographic areas (Bedfordshire, Luton, south Essex, west Essex and Suffolk); working with 7 local clinical commissioning groups (Basildon and Brentwood CCG, Bedfordshire CCG; Castle Point and Rochford CCG, Luton CCG, Southend CCG, Thurrock CCG and West Essex CCG), NHS England (for the provision of specialist forensic mental health services, in-patient child and adolescent mental health services and 0-5 children's services); have section 75 partnership agreements for the provision of mental health social care with 6 local authorities (Bedford Borough Council, Essex County Council, Central Bedfordshire Council, Luton Borough Council, Southend Borough Council and Thurrock Borough Council) and have new contracts with Southend and Essex Councils for the provision of public health related community services. In addition, SEPT (in partnership with SERCo) is the provider of specialist children's services in Suffolk.

Whilst each commissioning body has different challenges and commissioning priorities there are common themes; risks as well as opportunities; that the Trust will be required to respond to in its forward plan.

1.2 Financial challenges facing our commissioners

All local health economies are facing significant financial pressures. In published strategic plans our local CCGs have identified the following forecast shortfalls between planned expenditure and income as follows:

	Forecast Shortfall 2013.14
Bedfordshire CCG	£25.4m
Luton CCG	£9.4m
Castle Point and Rochford CCG	£9.9m
Basildon and Brentwood CCG	£8.6m
Southend CCG	£7.8m
Thurrock CCG	£6m

In West Essex, the Commissioning Strategy 2012-2014, describes "a considerable financial challenge" and identifies that over the period 2012-2015, a total saving of £66m is required across health and social care systems.

NHS England has not published separate financial plans for the specialist mental health, offenders' health and public health services it commissions from SEPT but we understand that they face a similar range of financial challenges to CCGs.

The transfer of funding for public health and children's services to NHS England and Local Authorities has been based on a national funding formula, not necessarily on the actual cost of existing service provision. In some instances this has resulted in a financial shortfall.

The financial challenges being experienced by commissioners result in limited opportunities for growth funding , at least a 4% efficiency target being applied to SEPT's contract income and an expectation that the Trust will contribute to economy wide QIPP (Quality, Innovation, Productivity and Prevention) solutions.

The challenges being faced by the local government are similar to those faced by the NHS, financial constraints and increasing demand continues to add pressure to social care services. As a result, efficiency savings are being sort by a number of the local authorities with whom we hold section 75 Partnership Agreements.

1.3 Changing Role of Local Authorities

With the transfer of Public Health to the Local Authorities there has been a significant shift in commissioning responsibilities, and the local authorities have now become organisations who contribute more than in previous years to our annual income. These commissioning arrangements represent a changing role for our local authority partners and during 2013/14 we will work collaboratively with local authorities to ensure continuation of effective and safe delivery of the services commissioned. SEPT will also commence identification of new innovative models of care to ensure that in 2014/15 new models and service offerings can be presented to our commissioning colleagues.

1.4 Health, Demographic and Demand Changes

The population growth leading to increasing demand on NHS services has been well documented and identified as a driver for change by all our CCGs. Projected population changes from 2013 to 2018; based upon the 2011 census in the geographies in which we operate; indicate growth of between 3% (Southend and Castle Point) and 7% (Thurrock). The anticipated growth is a balance of natural growth and migration and in most areas is comparable to the estimated growth anticipated across England. However, it is noted that when reviewing population growth by age, the over 65's age group increase disproportionately in all the districts we provide services within. SEPT therefore predicts an increase in frail and vulnerable elderly patients accessing our services. With this comes the increase in specific conditions such as Dementia.

Whilst rising demand and inequalities do present challenges, the Trust's income is primarily generated from "block" contract arrangements, related to capacity levels in terms of beds and community contacts, and therefore any changes in demand or activity can be flagged with commissioners. However, from the Trust's perspective we have not been funded for demographic change, which has meant a larger level of efficiency savings than would otherwise have been the case.

1.5 Local QIPP (Quality, Innovation, Productivity and Prevention) Challenges

The financial, demographic and demand challenges being faced in the local health and social care economy is driving the initiatives identified through the CCGs QIPP plans which are largely focussed on managing acute hospital demand better through improved primary and community health service provision. SEPT is working closely with commissioners to support delivery of these initiatives and wants to continue to work collaboratively to effectively respond to these challenges. Based on previous experience, SEPT strongly believe we can be part of the solution, having identified initiatives in the past (e.g. Short Stay Medical Unit in Bedfordshire and Mountnessing Court in south Essex) to support local commissioners to deliver their ambitions and support the management pressures on other parts of the health and social care system. We are also working with South Essex commissioners to deliver a new model of care for a challenging behaviour dementia service.

1.6 NHS Providers

In Bedfordshire and Luton, there are two acute general hospital providers (Bedford Hospital and Luton and Dunstable Hospital NHS Foundation Trust (L&D), one provider of specialist mental health services (SEPT) and two providers of community health services (SEPT and Cambridge Community Services (CCS)).

- Bedford Hospital has not yet achieved NHSFT status, and in September 2012 they announced plans to test interest among NHS organisations in forming a partnership that would help them achieve NHSFT status by March 2014.
- L&D is a NHSFT with a Monitor governance risk rating of green and finance risk rating of 3 (as at December 2012).
- In October 2012 it was confirmed CCS (provider of community health services in Luton) would not progress its application to obtain NHSFT status. Luton CCG has commenced a market engagement exercise to determine the future provision options for these services from April 2014.

In south Essex, there are two acute general hospital providers (Southend University Hospital (SUFT) and Basildon & Thurrock University Hospitals (BTUH)), one provider of specialist mental health services (SEPT) and two providers of community health services (SEPT and North East London NHS Foundation Trust (NELFT)).

- SUFT is a NHSFT with a Monitor governance risk rating of red and finance risk rating of 3 (as at December 2012).

- BTUH is a NHSFT with a Monitor governance risk rating of red and finance risk rating of 3 (as at December 2012).
- NELFT is a NHSFT with a governance risk rating of green and a finance risk rating of 3. It's community health service provision in south west Essex is a "hosting" arrangement, which commissioners had previously planned to market test however SEPT is not aware of any progress with these plans

In West Essex there is one acute general hospital provider (Princess Alexandra Hospital (PAH)), one provider of specialist mental health services (North Essex Partnership NHS Foundation Trust (NEPT)) and one provider of community health services (SEPT).

- Princess Alexandra Hospital has not achieved NHSFT status.
- NEPT is a NHSFT with a governance risk rating of green and finance risk rating of 4 (as at December 2012).

SEPT has significant experience of pro-active acquisition of diverse contracts for services. This has enabled the Trust to deliver efficiency savings that have minimised the impact on front line services and spread the risk associated with decommissioning and / or short term contracts. Other local providers have either not had to or not chosen to pursue this strategy to be sustainable but as the landscape changes all providers will need to consider different operating models; perhaps pursuing more opportunities for horizontal or vertical integration and as a result creating larger and more sustainable organisations.

1.7 Private and Third Sector Providers

There is increasing interest from the private sector in delivering community health and specialist mental health services. Our partnership with SERCo in Suffolk is providing us with greater understanding of the business model and approach used by the private sector which we will learn from and utilise as necessary.

The third sector still plays a relatively small part in local health care delivery. We believe that the sector has a great deal of expertise but needs further stimulation and development in order to play a significant role in care pathways of the future. We have developed partnerships in the past with local third sector organisations. The infrastructure and governance arrangements of most third sector organisations will impact on the sectors' ability to gain market share on their own. We are interested though in pursuing future partnerships with the third sector where we are able to support it appropriately to deliver parts of pathways where the sector has the expertise and experience and the ability to support people who we are not successful in engaging in traditional ways.

1.8 Commissioning Intentions and Associated Risks

The clinical priorities set out by our health commissioners do not represent any significant changes from those presented in previous years; the focus largely remains on providing more care closer to or at home; reducing admissions to acute hospitals and diverting attendance at A&E units. Other common themes within published commissioning intentions are identified as follows:

- Dementia
- Management of Long Term Conditions
- Prevention and Early Identification
- Development of tariff / payment by results
- Choice and Access

Any Qualified Provider (AQP), which had been identified in previous commissioning intentions, remains on the fringes whilst commissioners await further direction from the Department of Health.

Whilst the broad themes have not changed, the commissioning intentions do however identify developments in strategy and contract intentions that introduce a greater level of risk to future contracts for existing services.
As a focus continues on providing care closer to home and avoiding admissions, a reduction in existing hospital bed commissioning will take place during the planning period. Assumptions regarding the impact of these changes are incorporated within our productivity and efficiency plans.

Commissioners in Bedfordshire have confirmed plans to tender Musculoskeletal services under a prime vendor arrangement, and in West Essex notice has been served on provision of Endoscopy services. The risks associated with loss of these services are low, given the small financial value associated.

The commissioning intentions developed jointly between the 4 CCGs and the 3 Local Authorities in south Essex have identified that there may be some decommissioning of public health services that were transferred 1 April 2013. In 13/14 there is negligible impact arising but there is an increased risk associated with this over the planning period. However, as identified in section 3.0, SEPT is undertaking preparatory work to identify new service models and with expertise in this area feel equipped to respond effectively.

Health and Social Care commissioners in south Essex have recently launched a consultation on a revised Joint Mental Health Strategy. The proposals made would take place over the next 3-5 years, and indicate a potential transfer of a small amount of activity and income from our community mental health teams into Primary Care.

The three year contract for mental health services in Bedfordshire and Luton came to an end in March 2013 and has been extended for 1 year to March 2014. Luton CCG is currently seeking suitably qualified service providers to engage in a market engagement exercise for a range of Community and Mental Health services from April 2014. The community services are currently provided by Cambridgeshire Community Service but a new provider is required from April 2014. Through these discussions, suitably qualified providers like SEPT will have the opportunity to articulate how our organisations can add value to these services and to what extent they can enable more effective integration. This exercise poses a risk that SEPT will not successfully retain the mental health contract but also offers an opportunity to acquire an additional contract for community services. The Trust believes it is in a strong position to mitigate the potential risk because it is able to demonstrate that it has successfully managed service transition and transformation in the locality and elsewhere. Bedford CCG has confirmed that due to the synergies associated with the provision of mental health services across Bedfordshire and Luton that they will be joining Luton CCG in the market engagement exercise for Mental Health services only. Overall this could result in a loss of contracts worth circa £70million in 14/15 if we were not to retain the contracts, although the net impact of this would be considerable less once the associated costs transferred to new providers.

Contracts for existing community health services in Bedfordshire, south east Essex and west Essex will end in 2014. Commissioners have not shared any plans for further formal market testing at this stage; however SEPT is supporting commissioners with a number of services reviews. Whilst SEPT does not underestimate the risk of any potential decommissioning decisions or further market testing, commissioners have not indicated any concerns in respect of current provision.

The Trust's assumptions regarding the financial impact of commissioning intentions are taken into account in our financial strategy (set out in section 4.0 and Appendix 1). Given the lack of formal notice at the point of preparation of this plan by commissioners that they intend market-testing our services, our base case assumption is that we retain these contracts over the planning period.

1.9 SEPT market share

SEPT has proven itself to be a proactive organisation responding effectively to the income growth opportunities that have presented themselves in the past three years as a result of the competitive tendering of services that were not able to achieve NHSFT status or were subject to the community service transformation agenda. As a well established NHSFT, the organisation attributes its successes to strong governance arrangements, effective management of operations and the taking of well considered opportunities. Over the past 3 years the market share held by SEPT has grown significantly through the acquisition of a range of services across multiple geographies.

Going forward, we will make every effort to retain existing contracts (as long as they remain clinically sustainable in the form they are commissioned and generate a contribution to overhead). Whilst further growth is not the immediate main strategic focus, the Trust has expressed interest in participating in the market engagement exercise being undertaken by Luton CCG to seek a suitable qualified provider for both mental health and community health services from April 2014 because we believe that the acquisition of community health services in Luton will provide

benefits to patients, commissioners and the Trust as we are providing the mental health services in Luton and community services in Bedfordshire already.

The Trust recognises that there is a potential risk associated with retaining existing contracts for services (and therefore market share) over the planning period. We recognise that the loss of existing contracts would require varying levels of mitigation dependent on the contract lost in order to ensure the future continuity of services.

2.0 Our Strategic Response and Priorities

2.1 Overview

Consistent with the strategic outlook described in our Annual Plan 2012/13, health and social care service provision is now in the midst of radical structural change and is facing significant financial challenge. Quality and delivering a values based service has always been a priority for SEPT, but the increased explicit focus on quality in light of the findings and recommendations of the Francis Inquiry has added a further dimension. Our strategic position within this complex, new and potentially challenging context is less clear than that set out previously.

Whilst SEPT is able to demonstrate a history of being able to effectively respond to changes around us; the scale of the changes and challenge is such that long term forward planning with any degree of certainty is not possible at this time.

Four years ago SEPT was a provider of specialist mental health services in Essex and was faced with a growing level of efficiency measures as the scale of the period of austerity started to become visible. In 2011, the Board of Directors approved a revised strategic direction for the Trust that recognised these financial challenges and developed an overarching strategy that was designed to ensure that the Trust was both clinically and financially sustainable in the long term. The Board recognised that doing nothing was not an option and the Trust therefore pursued a strategy of growth to offset the implications of efficiency savings on front-line mental health services in Essex that were required at that time. The Trust subsequently acquired additional contracts that increased the Trust income from £130 million to circa £300million. This has enabled the overhead costs of delivering clinical services to be spread across a greater quantum of service provision through creating efficiencies in management and back office functions. This strategy was right at the time, but we are now facing new challenges that may require a very different response in order for the Trust to ensure the continuity of the services for the future. During 2013/14 we will be undertaking a full review of our strategic direction. The Board of Directors has however undertaken its usual comprehensive annual review of the strategic landscape and determined the strategic priorities that will provide the framework for service delivery over the planning period based on what is known at this time. In light of the challenges faced and based on the feedback we have received as a result of engaging with approximately 900 staff, patients, governors, members and partners, we have to be absolutely focussed on a smaller number of priorities (4) underpinned by far fewer corporate aims (12) going forward compared to those in the past.

Our strategic priorities are:

1: Delivering Quality Services That Are Safe and Effective
2: Workforce Culture and Capacity
3: Transforming Care
4: Clear Plans for Sustainable Services and Resources Used to Deliver Them

The following sections provide a summary of the strategies that we will pursue within each of these priority areas.

2.2 Delivering Quality Services That Are Safe and Effective

Our priority is to ensure that we maintain quality consistently regardless of the external environment and the financial constraints that we are facing. The Board of Directors are clear that this is essential to achieving clinical sustainability which is the priority, but continued quality service provision is also essential to retaining contracts for services and therefore the financial sustainability of the Trust.

There are no existing quality concerns in respect of SEPT services raised by regulatory bodies or by our commissioners. During 12/13 the CQC published the findings of 6 reviews of Trust services. None of the reviews identified moderate or major concerns and no enforcement action was taken or is expected.

Key aims that contribute to delivering this priority:

1.1	Achievement of quality, regulatory and contractual standards that ensure the Trust remains compliant and meets patient expectation
1.2	Implementation of timely Trust-wide systems for listening and responding to staff, patients, carers and local communities
1.3	Development of outcome and efficacy measures and systems to evidence the impact of our services

2.2.1 Quality Strategy

Although we are not experiencing significant quality concerns, we are not complacent. Consistent with the approach set out in the Annual Plan 2012/15 and in our Quality Account 2012/13, SEPT's approach to clinical quality remains integral to and not separate from our overarching strategic vision and reflects the challenges set out in Section 2.0. Our clinical quality strategy is defined through all 12 of our corporate aims.

In developing the forward plan the Board of Directors was clear that the planning period is going to be challenging but this should not distract us from concentrating on the number one priority, which is to ensure that our patients receive safe and effective services and have a positive experience of care provided by us. Our focus therefore over the next three years will be consistent in relation to quality; ensuring we proactively respond to changes in quality expectation and regulation, develop better systems to learn and improve and take action to implement where necessary the recommendations from the Francis Inquiry.

2.2.2 Quality Priorities

All of our services will be taking forward quality improvement related actions that link to the12 corporate aims but the Board of Directors has specifically identified five Quality Priorities for 2013/14. We believe that these priorities will deliver the improvements most often identified by our stakeholders and will lead to improved health outcomes for our patients and service users:

Quality Priority 1: Physical Healthcare

Physical healthcare assessment is a vital part of the holistic assessment within elderly mental health inpatient wards where a majority of the patients have complex physical and mental health needs. Through recent audits, it has been identified that the competency of staff in undertaking physical health assessments is not standardised across the trust. By training staff and implementing competencies, there will be a standardised approach across the trust and will also facilitate earlier detection in the deteriorating patient.

Quality Priority 2: Pressure Ulcers

Avoidable pressure ulcers are seen as a key indicator of the quality of nursing care and preventing them happening will improve all care for vulnerable patients. During 2012/13 SEPT had a priority to reduce the number of category 3 and 4 avoidable pressure ulcers to zero (which was a target set nationally and by the East of England Strategic Health Authority). Although we did not achieve the zero target, we made significant progress in reducing the number of category 3 and 4 avoidable pressure ulcers, achieving 95% of our ambition which compares favourably with the anticipated benchmark achievement for the East of England. The work undertaken needs to be sustained to continue to strive towards this target and we also need to reduce the number of avoidable category 2 pressure ulcers.

Quality Priority 3: Falls

Falls prevention is a complex issue crossing the boundaries of healthcare, social care, public health and accident prevention. Falls prevention needs to consider the patient's individual needs and the different environmental factors

in different settings including home, care setting and hospitals. All of this needs to be reviewed, while balancing patient safety, independence and rehabilitation.

Quality Priority 4: Carers
Improving support provided to carers is a national priority, but overwhelmingly our local communities identified this as their priority during our planning process. We will take further action to ensure that all our staff are aware of their requirement to identify carers and sign post them to support services and for SEPT to continue to work collaboratively on carer support.

Quality Priority 5: Improved Patient Experience
There is a desire to increase the amount of feedback being received from patients to enable staff to be able to reflect on their practice based on direct feedback from patients in a way that the Francis Inquiry Report suggests is appropriate. Moreover, there is not currently a consistent approach to collecting patient feedback on services which brings difficulties in comparing like with like across the Trust. We will therefore rationalise the survey work that is currently being undertaken into a standardised approach across the Trust.

2.2.3 Stretching Goals for Quality Improvement

We will be taking forward 55 quality related projects during 2013/14 that deliver service improvement in the areas most important to our patients and commissioners. Examples include:

- Improving patient experience / patient rating of overall care measured by asking patients whether they would recommend SEPT services to their friends and family.
- Measuring staff rating of overall care by asking them (confidentially) whether they would recommend their service to their friends and family.
- Improving patient safety by continuing to reduce occurrence of pressure ulcers, falls, urinary tract infection in those with a catheter and VTE. We are also introducing measurement of and reduction to the prevalence of a further three categories of harm (Self harm, medication errors and violence and aggression) into mental health services
- Focusing on service improvements for patients and their carers either suffering from Dementia, or not yet diagnosed. These incorporate improved services for carers, new services to identify patients not yet diagnosed and initiatives to reduce waiting times and improve access.
- Focusing on new services/service enhancements where the outcome is reduced dependence upon A&E/ acute hospital services and care provided closer to home. Initiatives include working with service users in Essex identified as those that frequently attend A&E with a mental health need to identify support and treatment within the community. Also in South East Essex development of integrated services for children and young people to avoid hospital admissions. Within Bedfordshire, SEPT will work with at risk, high intensity users in their own homes to avoid potentially unnecessary admissions to hospital.

2.2.4 Quality Governance and Assurance

The governance arrangements of the Trust were subject to an independent review by KPMG in August 2012 which found that the arrangements were satisfactory and there were no significant gaps. We produce a comprehensive quality (including safety, experience and effectiveness) and performance dashboard on a monthly basis; we undertake internal compliance checks that mirror the CQC reviews; we have an active national and local clinical audit programme; we monitor patient experience, including complaints and incidents; we have an active risk management and escalation framework in place and regularly triangulate what is being reported with Board member service walkabouts. The quality governance system, actual quality performance and assurance on the arrangements in place are overseen by sub-committees of the Board (the Integrated Quality and Governance Steering Committee (IQGSC); the Performance and Finance Scrutiny Committee and the Audit Committee) which are all chaired by a Non-Executive Director and are required to provide assurance to the Board of Directors after each meeting.

Our adoption of and adherence to the quality governance framework principles is subject to regular self assessment (May 2011, June 2011, April 2012, September 2012, April 2013 (prior to publication of supplementary guidance)) and on-going action to continually enhance our governance systems is overseen by the IQGSC. Our priorities for the

planning period are set out below but the IQGSC will be reviewing these in June 2013 in light of the supplementary guidance published by Monitor 22 April 2013:

- In Section 3.4 we have set out the comprehensive process that the Board has put in place to assess the impact on quality of our cost improvement programme. The QIA process will be enhanced this year to include formal on-going assessment of any impact on quality as the CIP schemes are implemented.
- Our Board of Directors and Senior Leadership Team have and will continue to be subject to thorough review during 2013/14. The size of our leadership, including senior management structures will be reduced as our consolidation post acquisitions progresses and senior staff reach retirement age. The Board of Directors is adamant though, that any changes to the leadership structure must not compromise the Board's, nor the systems or processes below it, ability to deliver the quality agenda.
- We have good systems in place to collect, monitor and report quality information. We will be enhancing the availability of appropriate clinical quality performance information consistently at all levels of the organisation. The introduction of electronic real time clinical dashboards at individual, team and service level is a key part of our Mental Health IT strategy and we will be taking action to develop more efficient ways of producing and distributing existing quality and performance information, with drill down capability for all senior managers.
- We will be introducing a data quality assurance framework during 2013/14 which will over time develop into a comprehensive assurance picture for Board members. Our internal audit strategic plan covering the planning period has been adjusted to identify data quality testing as a priority to support the development of the assurance framework.

2.2.5 Quality Enabling Strategies

During 2013/14 we will develop and publish clear plans for customer service, patient and public engagement and Information Technology which we believe will "enable" the continued quality improvement priorities we have set out in our forward plan. We are at a critical point in developing the appropriate IT and information infrastructure for an organisation of our size and complexity. We have made significant investment and improvement in infrastructure, innovation and customer service but our staff want more; identifying this as their top priority for improving their experience at work. We have agreed plans to introduce an electronic patient record in mental health services; have significant development plans for SystmOne in community services; plans for improving ease of access where concerns have been raised (like for example use of a single sign-on for all systems instead of different ones for each application) and increasing use of much improved and secure mobile technologies for community based staff and with patients. In addition we will confirm the implementation of a number of efficiency related initiatives like E-Rostering, electronic signatures and full integration of the legacy networks resulting from the acquisitions. However, in parallel with these developments we have to change the current culture and reliance on "spoon feeding" information to managers and staff and disproportionate amount of time spent on validation processes, to a culture of self service and personal accountability for accuracy of data and information.

2.2.6 Potential Risks to Quality

The Quality Impact Assessment of the 2013/14 Cost Improvement Programme (details in Section 3.4) did not identify any significant impact on the safety of Trust services.

The Board of Directors considered the potential risks to delivering the corporate aims and by implication the risks to quality set out in this forward plan at a Development Session held in March 2013. The likelihood of the potential risk emerging and the impact of the potential risk were assessed and those that were considered to be "HIGH" form the basis of the initial Board Assurance Framework that was considered and approved at the Board of Directors meeting in April 2013. Potential risks relating to quality are identified below. All of the potential risks have adequate mitigation plans and the residual risk rating is "LOW".

Potential risks pre-mitigation are:

- If learning from incidents is not embedded quality and patient safety may not be maintained or improved. The Francis report has re-emphasised the risk to patient safety if learning from SI's are not implemented.
- If data quality is not robust this may impact on effective decision making, monitoring of targets and compliance with regulators
- If the Trust is unable to implement system for unified records or there is a delay in delivery this may impact on the availability of clinical information and compliance with regulatory bodies
- If the Trust does not meet the expectations of patients and commissioners this may potentially impact on the confidence of stakeholders in the Trust ability to deliver high quality and effective services
- If there is a significant lapse in staff attendance and achievement of mandatory training targets this will undermine the Trusts ability to provide services.
- If there is a significant lapse in staff attendance and achievement of core training targets this may lead to skills deficit and undermine the Trusts ability to provide safe quality services.
- If care is not personalised this may impact on the identification of individual clinical need and a high quality of outcome may not be achieved.
- CIP delivery impacts on quality (over and above that included in initial QIA process) or impacts on safety

2.2.7 Learning Lessons from The Francis Inquiry

The Trust has reflected on the recommendations from the Francis Inquiry in Board discussions and has carried out a thorough self assessment of the potential learning identified (which is relevant to SEPT as a provider of mental health and community health services and that which is within our gift). Four Executive Directors will lead four workstreams, aligned to the priorities set out in the initial Government response to the Inquiry, to take forward learning but the Board of Directors is keen that the Trust responds calmly; ensuring that learning is an integral part of existing strategies, not in addition to and making sure that we do not have a knee-jerk reaction to matters that will require a national or commissioning response.

2.3 Workforce Culture and Capacity

We need to continue to develop an organisational culture that reflects the increasingly diverse nature of SEPT's service provision and builds on the values already in place. Clinical leadership and personal accountability will be key to ensuring delivery of the Trust's objectives, as well as a commitment to ensure training and development is focussed on ensuring that our workforce has the skills, knowledge and expertise required to deliver the strategy.

Key aims that contribute to delivering this priority:

2.1	Alignment of workforce to principles and values contained in the NHS Constitution
2.2	Leadership and accountability structures and systems strengthened from the Board to service delivery
2.3	Action taken to ensure the "right staff, with the right skills are in the right place at the right time"

The Trust has achieved successive positive staff survey results despite the constant transition that our staff have been part of over the past three years. The 2012 survey confirmed high levels of engagement; motivation and job satisfaction and a high level of recommendation of the Trust as a place to work. Our sickness absence rate for 12/13 was 5.2% overall which is slightly above the national average rates for mental health and community services, but enhanced monitoring systems have been implemented to reduce this further. Turnover was 12.5% last year, mostly associated with the local transformation programmes and no significant difficulties are experienced in recruitment. Our medical training posts are all filled (the only Trust in the region) and the Trust is accredited by the Deanery with no conditions.

The Trust is currently undertaking a full refresh of its Workforce Strategy and Plan which will be complete in June 2013. The priorities and challenges associated with our strategy are:

2.3.1 Forecast Workforce Changes

As a result of the transformational efficiency programme that is required over the planning period (and excluding potential loss of contracts) the Trust is anticipating a reduction in wte as follows:

2013/14	2014/15	2015/16	Total
-153.97	-192.40	-130.50	-476.87

The Trust continues to maintain a suitable financial provision for managing transition and transformation.

We recognise that the changes to services, to ways of working, to funding arrangements and levels and to the structure of our organisation could have major implications on our staff. Our workforce remains our greatest asset and our programmes of organisational and personal development; workforce well-being and engagement will remain as a key priority.

2.3.2 Emerging Models of Service

Across both Mental Health and Community Health services there is a continued emphasis on providing greater care in the community, reducing reliance on inpatient services. In order to develop new models of service, consideration has had to be made to current workforce profile and skill set. A greater number of generic training programmes are being provided, as well as training on holistic assessments to skill our workforce to deliver services via new pathways and models. The development of new roles, such as generic workers, to support delivery of more integrated care, are being progressed, and training being offered to our workforce is focused on enabling staff to take a broader view of individual patient needs. This programme will continue over the planning period.

2.3.3 New Standards for Unqualified Staff

During 2013-14 we will be developing our strategy, based on the recently published Code of Practice, competency framework and minimum training standards, for our pre-professional workforce. The strategy will be implemented over the planning period and will focus on the development of consistent standards for our pre-professional workforce (Band 1 – 4), and will build upon the career pathway already in place with the Diploma qualifications at Levels 2 and 3 and the Foundation Degree for Associate Practitioners. The strategy will unify approaches across the Trust, especially across the mental health and community healthcare services.

2.3.4 Productivity

As we consider new models of care, we will also remain focused on improving workforce productivity, utilising technology to support us. Mobile working and electronic records are critical for productivity gains as well as quality improvement, and also links closely with the government's strategy to achieve paperless referrals in the NHS by March 2015. In addition, the Trust will be progressing Tele-Health initiatives for monitoring and management of patients with long term conditions, which again will support improved quality of care, whilst promoting self-management and enabling efficient use of resources.

2.3.5 Key Workforce Pressures

Profiling of our current staff demonstrates an ageing workforce, however the profile presented does not demonstrate any significant variation from that reported in previous years and would not be considered to present any new risks to the organisation. However, we are cognisant that the changes to the pension scheme could impact, whilst in the long term the trend is likely to see staff retiring later as the pension age is increased, there could be a short term risk associated with staff retiring earlier. In response to this risk, we are working with our local universities to ensure earlier advertising of roles and appointment of the latest graduates. Our current analysis does also not demonstrate any problems or pressures with the recruitment of other professional groups.

2.3.6 Leadership, Culture and Organisational Development

The challenges facing the Trust over the next five years require a culture of authentic and effective leadership at all levels of the organisation. Senior leaders in particular need to be confident and effective in strategic thinking and planning and have the ability to inspire and engage others internally and externally. The Trust's integrated Customer Service and Leadership Pathway, underpinned by clear values and standards has been developed to build and sustain a culture which facilitates the delivery of high quality, compassionate services within an open and honest culture. During 2013 the final stage of the pathway will be launched and a skills review undertaken to further support the Board Development Programme.

2.4 Transforming Care

We will demonstrate our ability to respond to the current and future environment by working collaboratively to transform delivery of care. Plans will need to be clear, explicit, communicated and "owned" by the clinical and support services to which they apply.

Key aims that contribute to delivering this priority:

3.1	Delivery of required changes and improvements agreed in QIPP plans, CQUIN schemes and CIPs in partnership with CCGs, Local Authorities , the NCB and other partners
3.2	Development of clear model and strategy to deliver integrated care provision
3.3	Increased application of technology to improve patient care and experience and clinical and support service delivery

2.4.1 Overview

Our transformation strategy over the planning period will be primarily delivered through the CQUIN, QIPP and efficiency programmes we have developed. In Section 1.0 the strategic landscape is set out in some detail. It is complex and challenging, but also offers opportunities for agile and responsive organisations like SEPT. Strategically we want to part of the solution for dealing with the health and social care economy financial and quality challenges; identifying opportunities and being responsible for implementing them with our partners; rather than being a target for additional efficiency savings when economies are unable to manage recurrent shortfalls in funding envisaged during the planning period.

2.4.2 Care Closer To Home

In Bedfordshire and Essex we have developed new sub-acute and community based services during 2012/13 that offer alternatives to hospital admission or reduce the length of stay in an acute hospital bed. We will look for opportunities to drive similar real efficiencies in the wider care system wherever possible rather than reduce the quantum of service.

2.4.3 Integrated Care

A common theme across the commissioning bodies is the development of more integrated pathways of care, focusing on close joint working across professions and providers. Within West Essex, SEPT has been asked by the CCG to lead on the development of a Frail Elderly Care Pathway, bringing together health and social care professionals to provide a treatment pathway. A prime vendor model is being proposed, which will see one organisation responsible for the budget and the co-ordination of providers to deliver the pathway. SEPT believe the development of this type of model could offer benefits across the system and the development of the model in West Essex will offer an opportunity for learning which will be valuable in the establishing of further prime vendor models across different pathways and geographies. SEPT believe the development of these models / pathways will take time, and during 2013/14 we will undertake preparatory work to ensure we are clear where the opportunities for these models are and that we are equipped to support their implementation and delivery. Additionally, 2013/14 will be utilised to determine the role SEPT will take in these models, i.e. prime vendor or a provider within the pathway.

Our strategy for integrated service provision is now entering it's second full year of implementation. 2013-15 will see a gathering of momentum as we continue to integrate existing community health service provision that is within our gift. Our ability to successfully demonstrate service integration and it's positive impact will be essential to the Trust's reputation, retention of contracts and being considered as a potential provider for any further opportunities that arise. We will utilise 2013/14 to flesh out our plans for what integrated care provision looks like with our partners and the role SEPT is able to play in it.

2.4.4 Public Health and Children's Services

The transfer of responsibility for commissioning public health related community services to Local Authorities and NHS England increases the proportion of our income that will come from Local Authorities and specialist commissioners in future. This poses us with potential risks as well as opportunities. We will need to be proactive in our future service offering to the new commissioners. Joined up well being strategies and potential for radical

service transformation is possible as we are have well developed relationships with social care as a result of the 6 existing s75 partnership agreements in place for mental health social care service provision . During 13/14 we will work with our new commissioners to develop our strategic response.

2.4.5 Building Social Capital

When we became an NHSFT in 2006, the benefits of having a public membership that was interested in and supportive of local health care services was identified as a key benefit. We are very interested in the concept of building social capital as an extension of the original principles of involving local communities in local healthcare services. It offers the potential to mobilise local communities to support core service delivery, through third sector organisations and volunteering; particularly in areas of service provision that large, public sector organisations like ours may not be best at delivering.

2.5 Clear Plans for Sustainable Services and Resources Used to Deliver Them

In the Strategic Direction 2011-2015, the Trust set out its strategy to be clinically and financially sustainable. The acquisitions that we have pursued in the last three years have been in line with this strategy. Going forward, developing sustainable services that can continue to be delivered and meet the requirements of the population they are aimed at during continual change will be a key priority for SEPT. There is not one answer to achieving this, but carefully made decisions, pursued opportunities and partnerships will enable us to add value to quality of service provision, improve care pathways, be more innovative in our approach and contribute to financial stability.

Key aims that contribute to delivering this priority:

4.1	Development of clear service plans for clinical and support services that reflect local and national policy context
4.2	Continued action taken to maximise efficient clinical service delivery and support service infrastructure
4.3	Greater flexibility and responsiveness in our service offering pursued in all directorates

In the introduction to this section, we have been clear that the environment in which we are operating is increasingly complex and financially challenging. We have also identified potential risk associated with retaining existing contracts for services. Our focus in 13/14 is not to let the complexity of and changes to commissioning arrangements distract us from delivering quality services or force us into a knee jerk reaction. Good, strong providers are essential to bring about the required changes that address the commissioning challenges.

However, the Trust recognises that it is in a period of greater financial uncertainty in the light of recent commissioning changes, with providers having to deliver savings of around 14% over next three years on top of the 15% already delivered in previous periods. This challenge is made more difficult given the understandable position of commissioners not wishing to see any impact on front-line services. The financial plan for the Trust confirms that we have a credible plan to deliver the CIP in 13/14 and assumes that we will be able to deliver an ever more challenging accumulative efficiency programme over the planning period. The Board of Directors is aware of the potential risk associated with this challenge. Efficiency programmes, particularly in the latter part of the planning period, will need to be increasingly transformational in their nature and are potentially subject to more opposition from commissioners as the ability to derive efficiency from back office and infrastructure diminishes and the potential impact on front-line services increases. To maintain the continuity of services the Trust must also act quickly in 2013/14 to ensure that the full recurrent value of the planned 2013/14 CIP is delivered in order to avoid further increasing the challenge in the subsequent years.

The risk associated with the possible loss of contracts for services (as set out in section 1.0) is recognised. The Trust's base financial model assumes continuing delivery of Bedfordshire and Luton mental health services. However, we are developing plans for 14/15 and beyond to mitigate a scenario that assumes the loss of these current contracts; and that the Trust does not acquire Luton Community Health Services. This scenario will potentially result in contract income reduction of circa £100 million. This work has started and we have initially estimated that as a result of this loss of income there will be an additional efficiency saving required in 14/15 of potentially around £3million as a result of loss of contribution to overhead costs. Whilst this is significant, our initial modelling suggests the Trust

remains viable as a smaller organisation, as long as further efficiencies can be delivered from remaining operational services and the back-office/corporate infrastructure is not compromised to an extent that it is no longer capable of supporting service delivery. In effect, the Trust will return to a similar position it was in 4 years ago, having had the benefit of delaying the full impact of efficiency savings it would have had to deliver had it not been able to generate efficiencies from back office and management that accrued as a result of the growth in contract income.

2013/14 is therefore identified as a consolidation and decision making year. We will bed down community health services; focus on creating a strong and efficient leadership and corporate infrastructure to support service delivery in light of a planned review and reduction of the senior management structure and build the capacity and capability required to move forward. We will also put energy and effort into thoroughly understanding the future viability of each contract (or service line where block contract arrangements not in place) and making decisions based on the outcome. We shall also consider whether there are other mitigating options (such as further mergers acquisitions, or integration of services) to the potential risks associated with a loss of contracts for services.

We will reflect on the risks and opportunities posed internally and externally and develop a clear future strategic direction for 2014-2017. We have already considered with our stakeholders the potential for strategic change and we will be further considering scenarios for contraction, growth or merger in year 3 of this planning period in light of the developments that take place during 2013/14.

3.0 Productivity and Efficiency

The total planning shortfall facing the Trust in 2013/14 of £18.4 million represents 5.9% of the value of the Trust's total income. Although the Trust has an excellent track record of delivering CIPs, the level of efficiencies now required to be recurrently delivered year on year is significant and will inevitably impact on front line services.

Opportunities were provided on 14th November, 20th March and 27th March 2013 for the Board of Directors to review, shape and approve the emerging CIP programmes. This included consideration of the impact of CIPs on service quality and further details on the improved quality impact assessment processes followed by the Trust in developing the CIP programme are set out below.

3.1 Historic CIP Delivery

The Trust has a good track record of dealing with CIP programmes in recent years, achieving around 90% of planned CIPs over the last three years and 86% recurrently.

Table 1 Historic CIP Achievement	2010/11 £m/%	2011/12 £m/%	2012/13 £m/%	Total £m/%
CIP Plan	10.3	20.3	19.4	50.0
CIP Achieved	9.4	19.7	16.0	45.1
% CIP Achieved	92%	97%	84%	90%
CIP Achieved Recurrently	10.0	17.3	15.5	42.8
% CIP Achieved Recurrently	98%	84%	80%	86%

During 2012/13 both in-year and recurrent achievement rates fell compared to previous years. However, the in-year shortfall was covered by underspends elsewhere in the organisation and did not impact on our overall financial performance. The fall in implementation rates arose as a consequence of delays in implementing a small number of larger, more complex, schemes which had been included in the original CIP programme.

In 2012/13 the Board of Directors reviewed and strengthened its arrangements for overseeing the implementation and performance management of CIPs going forward by:

- Introducing a monthly CIP Project Monitoring Group to review performance year to date and forecasts, and with the powers to call in Executive Directors where concerns are identified. This Project Group reports to the Executive Operational Committee, chaired by the Chief Executive;
- Establishing a CIP Performance Management Office with additional project managers in place from April 2012. This strengthened project governance arrangements for CIPs assessed as high risk or material in size;
- Appointing, from October 2012, a full-time CIP Programme Director to strengthen the process for assessing the quality impacts of CIPs and ensuring strong clinical engagement.

Existing accountability arrangements remain in place with Executive Directors accountable to the Chief Executive for the implementation of CIPs within their division. The Executive Chief Finance Officer is also accountable for ensuring effective arrangements are in place to provide assurance to the Board of Directors around the implementation of CIPs and the effect on the Trust's financial position.

The Board receives a summary position on CIPs each month within the overall Financial Performance Report. In addition, the CIP Project Monitoring Group and Finance and Performance Scrutiny Sub-Committee receive detailed reports on the progress of CIP schemes. This allows key risks to be highlighted to the Board on a timely basis and remedial action taken as necessary. Risks associated with the implementation of CIPs are also included in the Trust's BAF and were subject to a review by Internal Audit during 2012/13 (with Adequate Assurance) and is included in each of the three years of the Internal Audit Strategy for 2013/14 to 2015/16.

3.2 CIP profile

The process of identifying cost reduction schemes started in October 2012. As in previous years, the Trust's cost improvement and income generation plans follow the latest DH guidance. Provider organisations now need to undertake a Quality Impact Assessment (QIA) for every CIP proposal. The QIA needs to consider a range of potential impacts on services including access to services, patient safety and patient experience. The Trust has also added compliance and training impacts to our own QIA processes to ensure there are no additional risks to the compliance regime or the training requirements for operational staff as a result of implementing CIPs.

Monitor guidance actively encourages clinical and commissioner involvement in this assessment process and this approach has been adopted in the development of CIPs for 2013/14 with a series of meetings taking place during February.

SEPT has also retained a number of guiding principles for identifying and agreeing suitable cost improvement plans from previous years. These principles are:

- the Trust will not provide services that are deemed to be clinically unsafe;
- proposals will consider all management (including director positions) and administrative functions before impacting on clinical services, while acknowledging that an acceptable level of management for the organisation must be maintained at all times;
- All proposals must have an approved QIA. Each QIA must be developed and reviewed by the Senior Management Teams (SMTs), with clinical input and involvement from CCGs and be subject to a peer review by Executive Directors prior to an independent assessment and sign off by the Medical Director and Executive Director of Clinical Governance and Quality;
- proposals should maintain existing service levels wherever possible;
- proposals must be achievable and deliverable during 2013/14
- Proposals should be sensitive to staff interests and minimise impact as far as practicable.

A summary of the Trust's cost reduction target to be delivered in 2013/14 is provided in table 2 below. This identifies that recurrently around 50% of CIPs are planned to come from 'back-office' services and other non-pay savings and 50% from within Operational Services.

2013/14 CIP Programme

Table 2 Planning Shortfall	2013/14 Actual £m	2013/14 Recurrent £m
Essex MH Bed Review	**0.0**	**0.5**
Suffolk Integrated Paediatrics Service	**0.6**	**0.7**
Back Office Pay Savings	**1.0**	**1.8**
Maintenance & IT Expenditure	**4.1**	**4.1**
Procurement and Non Pay Savings	**3.5**	**3.5**
Service Transformation	**0.0**	**1.8**
Other Effective Operational Management	**4.2**	**6.0**
Non-recurrent savings	**5.1**	
TOTAL RECURRENT CIP SCHEMES	**18.4**	**18.4**

In planning for 2013/14 the Trust has recognised that some of the more complex schemes will require consultation and/or an implementation phase. This will lead to approximately £5.1m of the £18.4m being delivered by non-recurrent measures (primarily use of anticipated CQUIN income and tighter controls over non-clinically essential vacancies) in 2013/14.

For 2013/14, the Trust is proposing a number of transformational schemes, one of which (Essex Bed Based Review) is separately identified in the table above. A summary of the key schemes is detailed below:

Slow Stream Rehabilitation Services – Bedfordshire & Luton (BMH02): This scheme aims to change existing arrangements for slow stream rehabilitation services for people with mental health problems in Bedfordshire and Luton. By redesigning the service to provide additional activities and an events co-ordinator the Trust anticipates greater patient satisfaction, earlier discharge and more interactive support than previously provided by the service.

Essex Bed Based Review (EMH06): This bed based review aims to reduce the number of inpatient mental health beds in south Essex. This will be achieved by focusing on a range of community based interventions and support including:

- a reduction in the length of stay by six days for both adults and older people wards;
- the prevention of admission through an effective A&E diversion programme;
- early work with patients upon admission to ensure timely and effective discharge;
- the development of 'moving on teams'; and
- The implementation of a Maintaining Adherence Programme to prevent relapse.

Day hospital Review (EMH03): This CIP scheme aims to change the provision of day hospital services for people with mental health problems and provide a range of alternatives in community settings.

Review Clinical management (WEC 01 & 06): These schemes involves significant service redesign, a move towards mobile working through the use of new technology, shifting towards greater partnership working with the voluntary sector and changes to existing practices.

The 2013/14 planning process also identified a number of potential schemes that form the basis of years 2 and 3 of the CIP programme. A summary of the 2014/15 and 2015/16 draft CIP programmes is show in table 3 below.

CIP Programme

Table 3 Planning Shortfall	2014/15 £m	2015/16 £m	Total £m
Carry Forward	**5.1**		**5.1**
Back Office / Corporate Savings (5%)	**1.0**	**1.0**	**2.0**
Procurement and Non-Pay savings	**1.5**	**1.5**	**3.0**

Service Transformation:	**6.6**	**5.0**	**11.6**
Other Effective Operational Management:	**2.9**	**2.6**	**5.5**
TOTAL RECURRENT CIP SCHEMES	**17.1**	**10.1**	**27.2**

Overall, the balance of schemes in year one continues to reflect more traditional CIP areas with a limited amount of transformational change. However, the Trust recognises that the environment within which it now operates makes it harder to sustain delivery of significant levels of CIPs from traditional areas, and the plan is therefore significantly more reliant on transformation change in years 2 and 3 where around 50% of the planned CIPs fall into this category.

Given the importance of the overall CIP programme it was formally Risk Assessed as part of the development of Trust's Financial Plan. The risk was rated as 'Extreme' and thus subject to further sensitivity testing within the Financial Plan. This sensitivity test modelled the impact of only 80% of the CIP programme being delivered. The Trust's mitigation against the impact of this risk was to:

- Release cash from the capital programme to address cash shortfall on a non-recurrent basis.
- Implement additional CIPs focused on further downsizing of the Director and Senior Management teams; deferring non-essential discretionary spend on buildings; and making further reductions in back-office pay and non-pay costs.

These actions, when modelled through, were sufficient to maintain a FRR of 3 over the planning period.

3.3 CIP enablers

Each CIP scheme has an approved QIA which details the dates of each assessment/approval. The QIA also details the clinical lead responsible for delivering the project. As each CIP project has a Project Initiation Document (PID) the details of the clinicians involved in delivery of the project are also identified. A number of schemes identify in the QIA the need for additional resources. This information is also clarified in the PID for each scheme. The investment relates to infrastructure changes including the requirement for 'tough books' for community services and a move to home working, additional investment to facilitate a reduction in premises and specific external support to deliver more complex clinical transformations.

3.4 Quality Impact of CIPs

This section sets out the core principles followed by the Trust in developing the Cost Improvement Plan for 2013/14. The Trust has reflected the latest DH guidance and incorporated a QIA assessment within each CIP proposal. This combined process ensures that clinicians and CCGs have been involved in developing and reviewing each scheme. A number of independent assessments have also been introduced including financial, quality and compliance checks. These were undertaken separately by the appropriate lead departments within SEPT. Each SMT has also met and discussed each clinical CIP/QIA with commissioners. In view of the overall size of the CIP requirement facing the Trust, the final review of QIAs by Executive Directors was retained to provide assurance to the Board that a range of appropriate assessments on the potential impact of the CIPs on service quality and safety had been undertaken. This arrangement also enables the Medical Director and Executive Director of Clinical Governance and Quality to gain further insight into the detail of each QIA and the to observe discussion between Executive Directors prior to completing their independent review.

The impact of each CIP will also be monitored during the year by the appropriate quality groups reporting to each locality SMT. The table below identifies the QIA criteria and the range of risks assessed as part of the QIA process. In addition, the Executive Team has added Compliance and Training categories to ensure there is no adverse impact on the Trust's compliance with external compliance requirements (e.g. CQC or Monitor) or on the Training requirements for clinical staff.

QIA Criteria used to measure the Quality Impact of CIP delivery

Compliance	Access	Experience	Effectiveness	Safety	Training

Potential impact on ability to meet Monitor compliance requirements, contractual requirements or CQC registration standards	*Potential impact on patient access to appropriate care / treatment; waiting times; on travelling times for patients.*	*Potential impact on level of patient satisfaction; number of justified complaints.*	*Potential impact on patient outcomes; modernisation plans; NICE compliance; other policy or best practice requirements; staff capability, effectiveness and productivity of the service*	*Potential impact on health or safety of patients number of serious incidents; number of incidents and severity of incidents*	*Potential impact on training for junior Doctor training or training requirements for clinical and nursing staff.*

The QIA risk scores and the associated risk mitigation actions developed by SMTs, were formally presented to, and reviewed by, the Executive Team prior to a final assessment and approval by the Medical Director and Executive Director of Clinical Governance and Quality. The Medical Director and Executive Director of Clinical Governance and Quality presented the results of their independent review to the Board in March 2013 and gave assurances on the QIA process for schemes to proceed to the implementation phase.

Prior to the Executive Team review and the independent review by the Medical Director and Executive Director of Clinical Governance on quality impacts, all financial information was removed from the QIA forms. This enabled the discussion to focus on quality criteria only without the added pressure of knowing the level of savings generated by each scheme. Table 4 below summarises the schemes approved, rejected or deferred at each stage in the QIA process

Table 4 CIP/QIA Process	**Medial Director/Exec Nurse Review**
Outcome of the QIA process	
Number of CIP/QIA approved	67
Number of CIP/QIA partly approved (to review service)	11
Number of CIP/QIAs rejected/withdrawn	4
Number of QIAs deferred (further information requested /reviews to be completed)	10
TOTAL	**91**

The Trust has an established performance reporting structures. As part of the QIA process service leads have identified the key performance indicators (KPIs) and tolerances levels that would indicate if the implementation of the CIP is causing operational or quality impacts (e.g. waiting times, complaints, contracted activity levels, readmissions etc.). The Trust's routine monitoring arrangements will highlight those existing KPIs that are linked to CIP monitoring. Routine monitoring reports are reviewed monthly at departmental, SMT, committee and Board level within the organisation and are prepared independently by the performance team. An exception performance report will also be made available for members of the CIP Monitoring Group, which includes the Medical Director and Executive Director of Clinical Governance and Quality.

4.0 Financial & Investment Strategy

4.1 An assessment of the Trust's current financial position.

The Trust's financial plan for 2013/14 – 2017/18, is set against a background of continuing financial constraint within the public sector including the NHS. Services are facing a third year of significant efficiency measures and an expectation that this will continue over the planning period. There is also significant change to the Commissioning landscape with the demise of Primary Care Trusts and the introduction of the National Commissioning Board, Local Authorities and local Clinical Commissioning Groups.

The Trust ended 2012/13 with a surplus of £4.3 million, giving a Monitor Financial Risk Rating of 3. The Trust also continues to have good underlying liquidity in terms of working capital. But the continuing impact of delivery of high levels of efficiency savings is now impacting on the Trust's recurrent position. 2013/14 is therefore proving more difficult financially than envisaged last year.

The Planning Guidance for 2013/14 sets out an underlying minimum efficiency requirement for providers of 4%, comprising a reduction in income of 1.3% and provider inflation of 2.7%. In addition to these national requirements, other local cost pressures including the impact of demographic growth mean that the Trust is anticipating an actual efficiency requirement of around 6% in 2013/14.

The Trust's plan for 2013/14 to 2017/18 continues to be based on current block income arrangements and does not assume any loss of the Trust's main contracts. However, we recognise that the emergence of new CCG commissioners has led to a number of greater risks, including:

- our experience from 2012/13 suggests there is reluctance amongst some CCG commissioners to recognise that an increasing proportion of CIPs need to be based around transformational service changes;
- some CCG's, particularly in Essex, are financially changed and consequently there is a risk of growing pressures on the Trust to accept additional QIPPs, which can only be delivered through transformational changes;
- Increased potential for contracts to be subject to market-engagement exercises and potentially a subsequent competitive process. As outlined earlier in this plan this is already underway by Luton and Bedfordshire CCGs in respect of mental health and Luton CCG in respect of community health services.

There is also the added complication for 2013/14 that commissioner responsibilities for some services are changing. Public Health commissioning which includes for example drug and alcohol services and school nursing, is transferring to local authorities. There are also changes to specialist commissioning arrangements; specialist services' commissioning is transferring to the local area teams of the National Commissioning Boards. These changes will inevitably lead to a period of greater uncertainty and it is likely that these services will be further market-tested over the three year planning period.

In common with the Trust's overall strategy, the Financial Strategy for 2013/14 is primarily therefore a year of consolidation, with a focus on ensuring delivery of the recurrent CIP programme for 2013/14; renewing the Financial Strategy in the light of the new Strategic Direction for the Trust that will be developed over the year and developing risk mitigation strategies in the light of the potential loss of income from existing contracts should they be retendered and lost. This will include exploring the scope for further increases in non-NHS income.

In recognition of the significant pressures placed on both operational and support services to deliver cost reductions, the Board of Directors have agreed that the planned income and expenditure surplus for 2013/14 is reduced from the current £3.8 million to £3.3 million. The reduced surplus is the very minimum required to achieve a Monitor risk rating of 3. We have also taken into consideration Monitor's current consultation on a new Continuity of Service risk rating framework for Foundation Trusts. Assessing our financial plan against the draft Continuity of Service indicates a Monitor risk rating of 3 or 4.

Therefore the current financial plan is based on an annual surplus achieved through service efficiencies and income generation, of around £3.3 million in each of the next three years. However, in light of the uncertainties created by the financial challenges facing the public sector, the structural changes to commissioner organisations, the need for collaboration across organisational boundaries and the potential market testing of individual services, the Trust's Plan also recognises that fundamental revisions are likely to be required throughout the planning period.

4.2 Key financial priorities and investments and how these link to the Trust's overall strategy.

The key elements of the financial strategy may be summarised as follows:

- Taking all necessary action to ensure that the Trust's income and expenditure remains in recurrent balance through implementation of recurrent efficiency savings.

- Non recurrent income is used to manage in-year financial pressures, including any arising from delays in the implementation of efficiency savings.
- The requirement to generate an operating surplus each year to maintain a Monitor Financial Risk Rating of 3 at the minimum. This will assist with ensuring the long-term future of the Trust and provide funds for future investment.
- Within the annual budget agreed by Board of Directors a centrally held and managed contingency is provided for. This contingency will provide a buffer against unexpected events and provide funds to support new initiatives.
- Maintaining a clear scheme of delegation within the Trust so that responsibility for financial management and control is clear and unambiguous.
- Clear arrangements for the contribution from business continuity and sustainability activities and initiatives.
- External borrowing is not currently factored in our three-year plan. However, external borrowing will be permitted for activities with an associated revenue stream or where there is a clear infrastructural or strategic benefit to SEPT. External borrowing will be contained to the levels authorised by Monitor, our Regulator.
- the development of a clear pricing strategy for supporting the imminent introduction of tariffs for MH services and the continued development of Service Line Costs for all services.
- Exploring the scope to increase our income from non-NHS sources. Any such increase will not exceed the 5% limit above which formal approval from the Council of Governors is required.

Key financial investments in 2013/16 include:

- Continued investment to IT assets and infrastructure to facilitate mobile working and other technological enhancements. This will be through a mixture of capital and revenue expenditure
- Continued investment in the Trust's estate to improve the patient environment and maximise the usage of the estates. This will be through a mixture of capital and revenue expenditure.

4.3 Key risks to achieving the financial strategy and mitigations.

As part of the Trust's internal control arrangements there is a comprehensive risk management programme in place which aims to manage and mitigate financial risks to the Trust. The medium term approach enables the Trust to take a pro-active stance to changing circumstances. The risk assessment process should highlight all potential factors that might impact on its aims and objectives and allow preparatory measures to be effected early, managing the risk and either minimising any detrimental outcome or maximising the benefit that can be gained.

In reviewing the Trust's financial plan a number of key assumptions regarding revenue, expenditure, capital and cash have been made. Consideration has also been given to the potential impact of the continuing current economic downturn is likely to have on NHS finances. Inevitably, there will be some variability around these assumptions which could pose the Trust with a degree of financial risk over the coming years. Each risk has therefore been assessed in accordance with impact and likelihood of crystallisation and is expressed in terms of a risk rating. The extreme and high risk, together the proposed mitigating actions should the risk materialise are shown in the table below:

	NATURE OF RISK	LIKELY CASH IMPACT (£000'S)	MITIGATION	RESIDUALS CONCERNS
1	Agreed quality standards not met in full and CQUIN funding unavailable to support cost reduction schemes non-recurrently.	£3,000 – one year impact only	The Trust's mitigation against the impact of this risk is to negotiate with CCG Commissioners to ensure the Trust has achievable CQUIN targets. If shortfall in target the following action to be taken a. Release cash from the capital programme to address cash shortfall on a non-recurrent basis b. Implement further non-pay and back-office	None

			savings.	
2	25% slippage on the Trust cost reduction programme of identified schemes is delivered in full across the planning period.	Excess of £6,500	The Trust's mitigation against the impact of this risk is to undertake close monitoring of all CIP initiatives. This will inform a quarterly review of the Trusts Annual Financial Plan. If the CIPs do not deliver savings then the following to be actioned as follows: a. Release cash from the capital programme to address cash shortfall on a non-recurrent basis. b. Implement a number of other saving schemes including finding further savings from Operational Divisions, Director and Senior Manager downsizing, further back-office savings and further reductions in IM&T and non-essential backlog maintenance programmes.	The longer term impact on the slippage on capital schemes requires assessment
3	Financial impact of transferring Public Health commissioning to the Local Authorities manifesting in 3-high rated risks: - Cost of services commissioned is not supported by the income transfer or vice versa; - No legally binding mechanism to rebase income to match expenditure; - Local Authorities imposing a 10% efficiency reduction from 2014/15	£2,000	The Trust's mitigation against the impact of this risk is to work closely with LA partners and CCG Commissioners to ensure funding withdrawn from Trust by CCG reflects the cost of services provided and contracts in place are based on the actual costs. If however a residual loss materialises the following action to be taken; a. Release cash from the capital programme to address cash shortfall on a non-recurrent basis. b. Implement a number of other saving schemes including finding further operational savings from Community Health Services, Director and Senior Manager downsizing and further reductions in IM&T and non-essential backlog maintenance programmes. n.b. Services transferring to Local Authorities are predominantly related to Community Health Services and therefore savings have to be delivered from these divisions.	None
4	A contract reduction of £1.5 million will be levied by Basildon and Brentwood CCG	Excess of £6,500	The Trust's mitigation against the impact of this risk is to negotiate with commissioners to ensure robust QIPP savings in place to release current savings on a recurrent basis. If QIPP savings not made then the following to be actioned: a. Release cash from the capital programme to address cash shortfall on a non-recurrent basis. b. Implement further non-pay and back-office	The longer term impact on the slippage on capital schemes requires assessment

		savings, Director and Senior Manager downsizing and further reductions in IM&T and non-essential backlog maintenance programmes.	
5 Community and Mental Health Services in Luton and Bedfordshire may be subject to re-tendering from April 2014	£3,000 from 2014/15	The Trust's mitigation against the impact of this risk is to undertake the following action: a. Release cash from the capital programme to address cash shortfall on a non-recurrent basis. b. Implement further non-pay and back-office savings, Director and Senior Manager downsizing and further reductions in IM&T and non-essential backlog maintenance programmes.	