

## **Strategic Plan for 2013-14**

**North Essex Partnership University NHS Foundation Trust**

**‘For Publication’**



Outstanding Care,  
Transforming Lives

# 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	22 May 2013

In signing below, the Trust confirms 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)	Chris Paveley
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Andrew Geldard
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Rick Tazzini
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Signature



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## Strategic Plan Review 2013-14

### Executive Summary

In 2011 we published our strategic direction: Delivering Outstanding Care, Transforming Lives – Our Strategy for 2011 - 2015. Since then much has continued to change in the environment around us. Our local population continues to grow significantly, with particular challenges to meet the needs of a much higher proportion of people over the age of 65 during the next decade. We have continued to develop new relationships with Clinical Commissioning Groups (CCGs), NHS England, and local authorities as the provisions of the Health and Social Care Act 2012 come into force.

We are all shocked by the findings of Robert Francis QC in the Public Inquiry into Mid Staffordshire NHS Foundation Trust. Whilst we do not recognise that picture in our organisation there is no room for complacency. Our Board has considered the findings and recommendations, hears the wider messages, and absolutely accepts its clear leadership responsibilities to ensure that we have an honest, open, patient-centred culture and strategy with effectively engaged clinical staff. This means that we will continually improve the opportunities to listen to and act upon patient, family and staff feedback, and that our systems for monitoring compliance with standards are open, transparent and robust. Our commitment is mirrored in NHS England's business plan and guidance *Putting Patients First 2013/14 – 2015/16*: placing transparency, and increasing patients' voice, at the centre of improving patient care. Our plans reflect the continuing cultural change necessary to ensure patients, their carers and families are at the centre of everything we do.

We will continue with our unremitting focus on delivering to our local communities integrated, well co-ordinated and high-quality services, along with accessible information and support. Our geographical and specialist services directorates will continue to underpin the development of our business plans with high levels of listening and engagement with staff, governors, service users, families/carers, GPs and local communities, but also with accountability to deliver against Trustwide priorities, standards, and measures. Our very active council of governors continues to develop ways of improving engagement and dialogue with public and staff members, and it plays a full part in holding the Board of directors to account and giving views on forward plans, including quality priorities, and on services. We have reviewed our Constitution, increased the proportion of staff governors, and have clear development programmes for all our governors to ensure they are properly prepared for their increased responsibilities arising from the Health and Social Care Act 2012 and as recommended by the Francis Inquiry. We have always taken our public accountability very seriously and will continue to do so.

We are a partnership by name and by nature and we recognise our responsibilities in the overall system of health and social care. We are committed to working with partners and in the wider community on system-wide integrated QIPP (Quality, Innovation, Productivity and Prevention) initiatives that improve patient and family journeys, outcomes and experience, and use available resources to best effect. In this regard we have played a full part with local commissioners in developing the North Essex System Integrated Plans 2013/14. We will also work with Essex County Council and other partners in taking forward the Whole Essex Community Budget pilot, one of four nationally. Responsive to local NHS commissioner need, and through our high levels of clinical engagement and innovation, we are pleased that our NHS commissioners have through our contract settlement acknowledged some of the demographic, acuity and capacity pressures in our services. We have agreed a small number of commissioner incentivised quality improvements through CQUIN (Commissioning for Quality and Innovation) which if successfully delivered will

secure 2.5% of contract value. We are working with local partners on integrated system wide initiatives, particularly around care pathways for frailty.

We will continue to embrace the overarching priority in the NHS to put quality (effectiveness, safety and experience) and innovation for our patients and their families at the heart of everything we do whilst delivering improved productivity and value for money. Our area Clinical Boards will continue to develop their role to empower health and social care professionals through improved clinician / practitioner engagement in the decision making of the Trust – meaning local management for local services, responding to local need.

We will continue to assertively compete to secure business opportunities in the following sectors, through a flexible and proactive approach in an environment which remains subject to rapid change.

- Developing in any health, or health-related social care, business in Essex or Suffolk
- Developing in mental health or community services markets on our other geographic borders
- Making the most of our expertise in specialist areas of service, delivering services outside local/ adjacent boundaries where considered appropriate

In doing so we will continue to develop and support our staff to meet the changing needs of services, ensuring we have an appropriately skilled, flexible and productive workforce, growing our future leaders and developing the necessary leadership skills. We will continue to promote a strong multi-professional ethos within a workforce that is adaptable to market demands.

We will maintain our strong financial and quality management and performance, maximise efficiency, productivity and effectiveness, and invest to ensure our estate is both fit for purpose and supports business development. This year we will open our new Low Secure Unit in Chelmsford and will progress the next major phase of development and refurbishment of our Derwent Centre in Harlow. This follows the opening of our new expanded Child & Adolescent Inpatient Centre in Colchester last year.

Our key financial planning data in 2013/14, with a planned FRR3, is:

Item	£m
Income	109.4
Cost Improvement Programmes	4.1
Loan repayments (principal)	2.2
Capital investment (excluding loan and planned PCT asset transfers)	10.3
Earnings before interest, tax, depreciation or amortisation (EBITDA)	7.1
Operating surplus	1.6

We recognise the importance of good information and are investing in and implementing our comprehensive clinical information and patient record system with its improved ease of use/accessibility for staff, including better use of mobile technology. As well as its importance in the delivery of effective treatment, care and support, good information and information management is essential for managing our performance well. This will also support the delivery of outcome based measurement and payment for activity (Payment by Results - PbR). The first release of our new system is to be implemented trust-wide by the end of Quarter 2 in 2013/14.

We continue to pursue with vigour our approach to service transformation, optimising care pathways and ensuring our patients, families and carers receive highly effective, evidence based services, measured against the outcomes people want to see achieved. Our involvement strategies will ensure high levels of participation of service users, carers and our members in the planning, monitoring and evaluation of our services. We will continuously improve patient and carer experience within our current service base. Our quality goals cover clinical outcomes, safety and patient experience and reflect local as well as national priorities, reflecting what is relevant to patients and staff. Our Board recognises its primary responsibility for maintaining and improving quality and, having assessed against Monitor's *Quality Governance Framework* we are satisfied that we have in place the structures and processes at and below Board level to lead on Trust-wide quality performance.

We are, and will continue to be, a strong, independent, flexible and well-respected organisation where people want to work and where ideas can thrive, flourish and stimulate innovation. We want to be the natural choice of provider as patient choice increases and the 'Any Qualified Provider' market develops. We hope that our rich experience of hosting Suffolk Community Healthcare services from 2011 – 2012 and new contracts for reablement, marginalised and vulnerable adults and PCT primary medical services will strengthen further innovation and partnerships in our existing services, and broader partnerships across the health and social care system for the benefit of patients and their families and carers. In preparation for greater competition and choice in service provision, we are already actively exploring appropriate opportunities that help us to maintain and improve quality and our financial stability.

We have our new Chairman in place from January 2013, and will on a phased basis, in line with the code of governance, progressively refresh the non-executive roles on the board as final terms of office expire over the next eighteen months for four of the five non-executive directors, all of whom, along with the previous Chairman, have made substantial contributions to the successes of the Trust to-date.

We are confident that we are prepared for the significant opportunities, risks and challenges ahead as we take forward our plans to implement our strategy '***outstanding care, transforming lives***'.

**Andrew Geldard,  
Chief Executive  
May 2013**

# 1.Strategic context and direction

## 1.1.Trust's strategic position within Local Health Economy (LHE):

### 1.1.1 Strengths and weaknesses in relative to key competitors

The Trust has undertaken an assessment of its key strengths and weaknesses against the range of NHS FTs around its borders along with known major competitors in the third and independent sectors. These have been taken into account when developing our forward plans. A brief summary is included for Monitor in confidential Appendix 5.

### 1.1.2 Forecast health, demographic and demand changes

Projected demographic change: the population of north Essex is projected to grow by 7.9% over the next 5 years to 2018 (ONS 2011-based subnational population projections). This will give an all-age population growth of nearly 77,600 people by 2018, with 50% of the growth in the 65 and over age range.

District	Population 2011	Projected population 2018	Growth (%)
Braintree	147,514	158,108	7.2
Chelmsford	168,491	176,672	4.9
Colchester	173,614	192,981	11.2
Epping Forest	124,880	134,591	7.8
Harlow	82,177	87,313	6.4
Maldon	61,720	65,313	5.8
Tendring	138,062	150,915	9.3
Uttlesford	80,032	88,012	10.0
North Essex total	978,501	1,056,069	7.9

With populations of people aged 65 and over projected to rise by up to 28.2% by 2018, there will have to be a change of health and social care focus locally, with the diseases and reduced independence of older people gaining more attention and investment. This will bring a focus on revised, integrated care pathways, a shift from acute to community provision, and changes to commissioning to make the situation manageable to GP commissioners. The future configuration of local acute hospital provision is likely to become increasingly uncertain.

### 1.1.3 Impact assessment of market share trends

The changing commissioner base, with 3 CCGs probably moving towards separate mental health contracting, brings both opportunities and threats. Section 1.2 gives more detail on this.

We have an aspiration to build on our success in achieving market share in other sectors, based on identifying solutions to achieve greater integration of services. This means evolving innovative ways of providing effective care, and identifying and implementing ways of improving collaboration and integration of care pathways for patients through community teams, ECC social services, and private care home provision. Recent successes include assuming responsibility for 3 primary care GP practices in Thurrock, South Essex, partnership with Essex Cares in a pan-Essex Reablement service and with Essex Probation

in a community-based offenders service,, as well as provision of services for marginalised and vulnerable adults, using a new, more inclusive service model, for the whole of Suffolk. Our new CAMHS adolescent intensive care unit in Colchester, the St. Aubyn Centre, complies with and exceeds NHS England's specialist service specifications as a high-quality, safe, therapeutic clinical environment and is of considerable importance to the Trust, both as a flagship facility embodying our philosophy of investing in the health and wellbeing of local people and for the robustness of our financial planning in the medium-term. It brings us into what is for us a new market, where demand comes from a wider local area via Specialist Commissioning.

Our new-build adult low-secure unit in Chelmsford, Edward House, similarly meets all new standards and secures our position in this market as well as providing a springboard for further specialist provision growing organically from our current areas of expertise in response to commissioner request.

Our recent experience of managing Suffolk community healthcare services places us in a good position to bid as local community services or aspects of them are retendered over the period of this plan or if current local providers fail. We have shown that we can produce credible, sustainable and performance improving plans in response to tenders whilst not jeopardising our financial stability.

Our partnership with Essex Cares in delivering the Essex-wide re-ablement contract, along with our Memorandum of Understanding with Anglian Community Enterprise (ACE), community healthcare services provider in NE Essex, enables us to work collaboratively together to achieve better patient care and experience through greater integration of care along care pathways.

## **1.2. Threats and opportunities from changes in local commissioning intentions**

### **1.2.1 Key changes to local commissioning strategy and intentions**

The commissioning intentions of the 3 north Essex CCGs (the Trust's local core commissioners) and of the specialist commissioning arm of NHS England can be summarised as:

#### Dementia / frail elderly

- Identify and provide earlier intervention and support to more people in the community so avoiding unnecessary admission to secondary care.
- Design and commission an integrated frail elderly service, including single point of referral, MDTs and community geriatricians
- Increased provision of memory assessment services
- Mental health liaison in acute hospitals.

#### Mental health

- Support for people with Long Term Conditions and Medically Unexplained Symptoms with depression that would benefit from services such as counselling and group based therapies
- Contribute to service re-design projects including those services aimed at supporting those patients with long-term physical health conditions
- Developing recovery-based services in specialist services
- Explore potentials for piloting of new services which potentially have QIPP benefits e.g. the Big White Wall, Medically Unexplained Symptoms and a service between primary and secondary care
- Review of people on HoNOS / PbR care clusters 1 – 3 and of data quality



- Continued development of care pathways with an emphasis on patients being on 'shared care' or transferred out of secondary care
- Support the development of services for veterans
- Review community mental health services re current efficiency, effectiveness and cost.
- Review all transition interfaces between CAMHS/Adult mental health and Adult/Older People's services.

#### Improving Access to Psychological Therapies (IAPT)

Continue to develop IAPT service in line with national targets and the national aspiration to manage those with more severe mental health problems in primary care to include priority areas in LTC and vulnerable groups.

#### Single Point of Access (SPA)

To provide a simple alternative route for clinicians to access the community services available as an alternative to secondary care, which may include mental health, as well as learning from the secondary care SPA pilot in West Essex.

#### Any Qualified Provider

Where appropriate commission on this basis in line with the Contestability plans and National Guidance.

We have undertaken an analysis of the threats and opportunities inherent in the changing commissioning context and have taken these into account in developing our Annual Plan. A brief summary is included for Monitor in confidential Appendix 5.

### **1.2.2 QIPP & demand management**

The three CCGs have published integrated plans setting out local priorities and target QIPP savings for 2013/14. The plans set out a range of QIPP target savings for mental health, although these are often combined with learning disability services, so it is unclear how the proposals might impact the Trust's block contract. The main risk to the Trust arises from CCG general plans to transfer services from secondary to primary care for both physical and mental health services. The Trust can of course tender for work within primary care settings. The Trust is working with Commissioners and their agents, the NHS Essex Commissioning Support Unit (CSU), to continue to develop HoNOS care clusters and Payment by Results (PbR) within the parameters of the Department of Health's "Memorandum of Understanding" for PbR. The signed MoU ensures that neither party risks being destabilised by the introduction of PbR for mental health.

Previously we have supported the system delivery of our NHS commissioners' strategic aims through QIPP funded initiatives, achieving system priorities. The availability of CCG 2% non-recurrent funding seems severely restricted compared to 2011/12 and 2012/13.

The integrated plans do not set out in any detail how the CCGs plan to deal with increases in referral activity from an increasing and ageing population, or rising acuity. Nor are the plans sensitive to the current economic conditions and research that poor mental health correlates with economic cycles and the prevailing employment, welfare and family impacts that arise.

### **1.2.3 Decommissioning**

CCG commissioners in their early days are surveying the health provision landscape and setting out ambitions that inevitably centre on

- driving efficiencies out of secondary care

- “repatriating” care provision where appropriate to primary care particularly in relation to HoNOS / PbR care clusters 1 - 3
- dealing with perceived bottlenecks in the secondary care system.

It is not clear at this point which of the stated ambitions will result in systemic change. Decommissioning or competitive tendering of existing Trust services may become a reality when local CCGs make their CRS / non-CRS decisions.

#### **1.2.4 Potential “Any Qualified Provider” Tenders**

NHS Choice Guidance indicates that IAPT is a significant area where AQP may be applied in mental health. This presents potential opportunities for the Trust and its partners in Health in Mind to extend our effective and fully-compliant IAPT model. Moves to extend IAPT to people with severe common mental health problems will inevitably cross over current Trust community provision, but planning for this has already begun inside the Trust’s Psychological Therapies Directorate.

#### **1.2.5 Shifting care delivery outside of hospitals**

The Trust, as an established provider of community health and social care services, has worked with partners Essex Cares and Anglian Community Enterprise to offer enhanced joint services to North-East Essex CCG in the areas of frail elderly support, psychological support for people with Long Term Conditions and community inreach projects all explicitly aimed at reducing non-elective admissions and lengths of stay.

#### **1.2.6 Reconfiguration plans**

The Trust is not subject to externally-mediated health-economy scale reconfiguration plans at present, although it is reconfiguring its internal management structures to make it as responsive as possible to changing commissioner requirements and local demand patterns.

Internal reconfigurations include:

- Redesign of older adult services across North-East Essex, both in terms of an integrated frailty service and in specialisation of units in Colchester and Tendring into functional and organic hubs
- Development in West Essex of a Single Point of Access, changing the service’s ‘front door’
- The ‘Journeys’ Programme, being implemented during 2013/14, will result in a re-design of community and inpatient pathways across all care groups.

#### **1.2.7 An explanation of how the Trust has factored these considerations into its strategy**

We continuously consider our commercial position alongside our quality record. Dialogue with CCGs has started, and our strategy of diversifying into different markets as well as securing our core activity base is designed to give us security of income. Our Commercial & Service Development team is continuously working to expand our income base and searching for diversification opportunities.

### 1.2.8 Analysis of how the Trust's demand profile and activity mix has evolved over recent years and what changes are forecast

The following table shows the most significant aspects of the evolution of the Trust's current activity profile (2012/13) since 2010/11:

Activity type	Service change since 2010 / 11	Resultant activity change from 2010 / 11
<b>Adult services</b>		
Acute inpatient	Planned reduction in LOS to allow better access and quality; use of risk-share beds outside Trust to deal with rising demand	Overall occupancy of 88.5% without leave masks seasonal variation; admissions up 7.8% from 1391 to 1499. Higher acuity and occupancy peaks
TRUSTLINE	Pilot out-of-hours crisis triage telephone line through 3 <sup>rd</sup> sector partner	24,000 calls in 2012 / 13
Eating disorders	New intensive community service	Community contacts up by 191.4%
Rehabilitation / recovery	Reduction in bed complement with closure of Eaglehurst, improved community services and service redesign	Greater community service input
Low-secure	8 extra beds commissioned on block contract	18 to 20 beds occupied continuously
<b>Older adult services</b>		
Continuing care inpatient	Service redesign with reduction in number of functional beds and investment in ATRS home treatment service	New service model with decreased day care and more community service
<b>CAMHS</b>		
Community Tier 3	Success of CAMHS gateway, reducing inappropriate referrals	Referrals reduced by over 40% following gateway triage
Inpatient Tier 4	New unit opened during 2012 / 13, with 15 commissioned inpatient (Longview), and 10 regional ICU (Larkwood) beds offering a new service	Longview full, Larkwood at 60% - 70% occupancy (2 beds now on block contract)
<b>Caseload</b>		
No. on CPA	Demand and referral levels remain stable	Unchanged

We expect trends to continue in respect of

- focusing services away from hospital provision especially for older adults and adults needing rehabilitation and continuing care
- reducing outpatient follow-ups
- integration of some specialist services into mainstream provision.

However, it is also likely that activity in substance misuse services will increase in 2013/14 following increased commissioner funding for alcohol services; and the activity associated with other new services will start to show up in our comparative data.

### **1.2.9 Diversifying income streams**

We are aware of the need to diversify into, for us, non-traditional areas of health and social care both as part of the integration agenda better addressing physical and mental health and as a means of expanding our income base. So far, our record includes

- Successful partnership with Essex Probation developing psychological services for offenders with personality disorders
- Sustaining Enable East, our innovative consultancy and project-management business arm
- Health in Mind, the North-East Essex IAPT service delivered in partnership with Rethink and Mind
- Expansion of psychology training function around IAPT
- Managing Suffolk Health Outreach for marginalised and vulnerable adults
- Assuming management of three PCTMS GP practices in Thurrock, South Essex
- Partnership with Essex Cares in the Essex Reablement service, providing nursing expertise in the home care of people with Long Term Conditions
- Sustaining research such as the ThinkingFit project aimed at people with mild cognitive impairment
- Excellent experience of turnaround / support to community health care services in Suffolk
- Establishing a new intensive care adolescent inpatient unit, unique in the local NHS.

### **1.3. *Collaboration, Integration and Patient Choice***

#### **1.3.1 Integrate services to provide better care and/or increase efficiency**

Deliver 'Journeys' programme of clinical care pathway review and redesign over the three years of this plan. Improve patients' experience of local health services for adults and older adults and the safety of local services whilst achieving better value for money by redesigning the care pathways.

The 3 workstreams are:

- Piloting the single point of access to services in West Essex
- Older adult care redesign including specialist dementia service
- Review of CPA including reconfiguration of adult community teams.

Streamline access to services by developing a single point of access to all teams, release more clinical capacity to deliver frontline care and treatment, and explore the possibility of developing alternative, further evolved arrangements for adult community mental health services. Pursue inter alia: integration of mid-Essex community services; new ways of working in the Linden Centre; new models of care in north-east Essex; finalise single point of access for working-age adults to all care pathways in west Essex and design model for north-east Essex; develop new service-delivery models for older adult services in north-east Essex.

### **1.3.2 Development of partnerships and collaborations**

As detailed elsewhere in this Plan, we have active partnerships and collaborations in the following services:

- Frail elderly transformation bid: Essex Cares and Anglian Community Enterprise
- Reablement: with Essex Cares
- Health in Mind: with Rethink and Mind
- Community-based services for offenders with personality disorders: with Essex Probation
- Frail elderly integrated service development in West Essex with acute hospital and community healthcare services providers.
- Integrated adult mental health and social care provision (S.75 agreement with Essex County Council).

### **1.3.3 Impact of proposals**

The proposals in this Plan will have not consequences as far as the Choice and Competition Panel is concerned. They will however further the Trust's aim of giving service users greater choice of service delivery, increasing the options for community-based care closer to home.

## 2. Approach taken to quality

### 2.1 Outline of existing quality concerns

Three announced and unannounced CQC visits during 2012/13 have resulted in the following:

- One themed review at the Crystal Centre relating to dignity and nutrition was very positive and resulted in no recommendations nor actions required.
- A visit to our new St Aubyn Centre in January 2013 with a Mental Health Act Commissioner resulted in a very positive report.
- A responsive review at The Linden Centre on 1<sup>st</sup> May resulted in non-compliance on outcome 4, although the CQC judged that this had a minor impact on people using the service. A comprehensive action plan was produced and has been completed.

We have also received a number of separate Mental Health Act Commissioner visits.

### 2.2 Priorities for improvement

The Trust reviews its Quality Account annually and sets its own priorities for improvement., taking account of governors' views.

We continue to make substantial progress towards achieving our quality improvement targets:

Priority for improvement	Action	How we will measure
Social inclusion and recovery model	Continue to develop a framework of approaches, interventions and structured activities that are both socially inclusive and recovery-orientated for all acute in-patient wards.	<ol style="list-style-type: none"> <li>1. Produce and implement revised Linden Centre improvement plan aligned to the domains of the CQC Essential Standards of Quality and Safety.</li> <li>2. Develop recovery hub offering a range of services to patients and carers</li> <li>3. Develop recovery college offering study and training facilities providing courses &amp; resources for service users, carers and staff</li> <li>4. Embed and monitor the structured activity levels of 18 hours minimum per patient</li> </ol>
Mental health promotion	Community engagement	<ol style="list-style-type: none"> <li>1. Hold 20 members meetings across the new constituencies</li> <li>2. Develop staff representative meetings following elections for staff governors</li> <li>3. Develop the "Patient and Family Echo" with <i>clevertogether</i> to hear staff views and run five events in 2013/14</li> <li>4. Run drama competition with Essex schools</li> <li>5. Celebrate World Mental Health Day with activities aligned to older adult services</li> <li>6. Continue to implement the service user and carer involvement strategy</li> </ol>
	Physical healthcare	<ol style="list-style-type: none"> <li>1. Embed physical healthcare checks into the community (and outpatients) to ensure they are being offered to appropriate patients</li> <li>2. Monitor the recording of physical healthcare checks through the community quality barometer</li> </ol>

Medicines management	Continue to implement the pharmacy 5-year business plan	<ol style="list-style-type: none"> <li>1. Develop the Quality Prescribing Group with a focus on NICE guidance and POMH UK audit results</li> <li>2. Achieve a more consistent pattern of pharmacy interventions across all Trust areas and use the information</li> <li>3. Roll out the MAPS system for all discharges</li> <li>4. Achieve access to System One and ensure phases 2 and 3 of the Remedy project enhance the medicines management template on the patient information system</li> </ol>
Customer and stakeholder relationships	Ensure the Trust is marketing itself in a positive manner and is in a position to bid/win new business	<ol style="list-style-type: none"> <li>1. Identify new key customers with influence and communicate with them</li> <li>2. Undertake a full customer analysis</li> <li>3. Manage intelligence and activity</li> <li>4. Refresh our branding and story/vision to be communicated to customers (encompassing Darzi's 3 definitions of quality)</li> <li>5. Communicate well internally</li> </ol>
Engagement and support of staff	Continue to meet CQC Essential Standards of Quality and Safety Outcomes 12, 13 and 14 all relating to staff.	<ol style="list-style-type: none"> <li>1. Roll out 'Strengthening resilience' programme</li> <li>2. Level 4 apprenticeships in business administration and HR management</li> <li>3. Administration conference 15<sup>th</sup> November 2013</li> <li>4. Local improvements around issues arising from the 2012 staff survey</li> </ol>
	Continue to act on staff survey results.	<ol style="list-style-type: none"> <li>5. Evidence of greater recognition by the Trust of the "little things that make a difference"</li> <li>6. Clinical Conferences in October 2013 and March 2014</li> </ol>
	Continue to engage with staff at all levels of the organisation	<ol style="list-style-type: none"> <li>7. Trust-wide discussion forums for ECC seconded staff</li> <li>8. Improvements in training management and mandatory training delivery and uptake through centralisation of administration and recording and progress against key action plan</li> </ol>
Patient experience	Continue to implement the service user and carer involvement strategy	<ol style="list-style-type: none"> <li>1. Establish how on-going central involvement co-ordination will take place for 2013/14</li> <li>2. Establish how the central database will be managed for 2013/14</li> <li>3. Reinforce key reporting mechanisms</li> <li>4. Ensure on-going communication with staff to embed the strategy into day-to-day working</li> <li>5. Achieve on-going printing and distribution of publicity and training</li> </ol>
	Improve service user survey results	<ol style="list-style-type: none"> <li>1. Improve service user experience, especially by focusing locally on the areas of day-to-day living highlighted in the patient survey, in particular support with accommodation and help with benefits</li> <li>2. Take account of weaker areas of the patient survey as part of the Journeys/Big Issues programme</li> </ol>

		3.Analyse and learn from the qualitative data gleaned from the local patient questionnaires 4.Embed the family and friends test in a reliable manner 5.Develop a business plan for the use of technology to achieve real-time patient feedback
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## 2.3 Key quality risks inherent in the plan and how these will be managed

The Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS. The Trust confirms that it is compliant with its licence, and has identified, assessed and mitigated material risks to ensure that it maintains compliance with the Conditions of its Licence going forward.

The table below sets out the key risks to governance, including quality governance, and planned mitigating actions.



Description of risk (including timing)	Potential impact	Mitigating actions / contingency plans in place	Residual concerns	How Trust Board will monitor residual concerns
<b>Corporate governance risk</b>  <b>The board intends to commission an internal review of governance processes and systems in 2013/14, taking into account Monitor guidance in its Risk Assessment Framework consultation document, and other relevant sources including guidance for boards on the Quality Governance Framework. This will assist the board in maintaining the quality of its performance.</b>				
<b>1 Board leadership</b>				
Failure to provide effective leadership through appropriate structures and committees	Breach of licence condition	<p>The Trust has been commended by the NHSLA on its Risk and Governance Executive (R&amp;GE) committee structure and processes. The Risk Register and Assurance Framework are regularly reviewed by R&amp;GE</p> <p>The Audit Committee: provides assurance to the Board that effective systems of integrated governance, risk management, and internal control across all activities (both clinical and non-clinical), supporting the Trust's objectives, are established and maintained; brings to the Executive's attention any concerns regarding these systems; ensures that an effective internal audit function is established by the executive, meeting the required Audit Standards; and oversees the work of the External Auditors, reviewing all its findings and the robustness and appropriateness of management responses.</p>		<p>The Risk and Governance Executive and the Audit Committee provide regular reports on their activity and key issues to the Board</p> <p>Periodic joint R&amp;GE and Audit Committee meetings to provide Board assurance Board assesses itself against the Quality Governance Framework –see 3 below.</p>
Failure to maintain Commissioner Requested Services (CRS)	Breach of licence condition Potential use of	New 2013/14 standard NHS contracts signed with local and specialist commissioners Negotiations in 2013/14 for new contract beyond		

<p>Failure to effectively assess the changing landscape, opportunity and challenge in NHS and social care commissioning and implications for QIPP in the whole system</p> <p>Failure to generate and monitor delivery of business plans and receive appropriate assurance on such plans and their delivery</p> <p>Failure to secure patient and public confidence, build effective relationships with local media, or promote the profile of the Trust and to retain positive reputation</p>	<p>enforcement powers</p> <p>Loss of business and income, destabilisation</p> <p>Breach of licence conditions</p> <p>Public disengagement, potential loss of income as personal budgets develop</p> <p>Reputation impact from negative stories, and loss of business opportunities</p>	<p>current 1 year contract.</p> <p>Effective stakeholder engagement / customer relationship-management plans in place and monitored by them. Regular Board review of business strategy.</p> <p>Area Directorate business planning processes embedded, informing development of Annual Plan which involves and takes into account the views of governors. Board approves and monitors annual plan including financial performance, Chief Executive establishes programme of internal audit and the Board receives assurance as outlined above.</p> <p>Public and member engagement campaigns</p> <p>Proactive use of the media High quality promotional and marketing materials.</p>	<p>Expertise and level of engagement of commissioning in transition</p>	
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## 2 Organisational Management and Oversight

Failure to ensure Trust remains legally constituted	Breach of compliance with licence Loss of competitive position / reputation	Regular review of constitution by Board and Council – latest update April 2013, further review process in 2013/14. All governor elections managed through Electoral Reform Services		
Failure to have regard to the NHS Constitution in provision of services	Breach of licence Legal challenge Reputational loss	Regular monitoring through R&GE		
Failure to ensure clear reporting lines and accountabilities throughout the organisation	Breach of licence Ineffective governance and increased risk	Area business directorates with clear structures, hierarchies and processes. Board approved Standing Financial Instructions, Standing Orders and Scheme of Delegation.		
Failure to address issues, concerns, and audit committee recommendations	Deterioration in governance standards	A robust process is in place to ensure timely follow-up of all audit committee recommendations. Audit Committee chair provides assurance to the Board		
Failure to achieve at minimum Level 2 IGSoC requirements	Poor information governance	Level 2 compliance maintained	Maintaining compliance as IGSoC requirements change	Year on year monitoring to address existing and new IGSoC requirements
Failure to ensure compliance with the Civil Contingencies Act 2004	Legal challenge	The Trust is compliant with the Act and has in place major incident, including business continuity, plans		
Failure to implement local risk assessments including health and safety risks, supported by a risk management training programme and risk management structure	Harm to patients	NHSLA Level 1 in place, reassessed in February 2013. Robust R&GE oversight of assurance framework and risk registers		Successful NHSLA level 2 assessment

Failure to redesign services and care pathways to maximise efficiency and effectiveness	Decrease in clinical quality and patient experience Capacity pressures	Major 'Journeys' care pathway review and redesign project with strong programme management, regular progress monitoring by the Executive Team and CEO Board reporting		
Failure to maintain the Trust as a going concern	Financial risk to future viability and potential Enforcement Actions	Robust Board leadership (see earlier) with rigorous monitoring, corrective action, and maintenance of planned continuity of services risk rating		
<b>3 Quality governance</b>				
Failure to maintain CQC registration	Inability to operate or conditions imposed, licence condition breached	Compliance assessments evidenced for each registered location, audited, and staff trained. Unconditional registration has been maintained.	Maintaining all standards in all locations	Monthly monitoring by Risk & Governance Executive (R&GE)
Failure to implement effective Quality Governance and assess against Monitor's Quality and Governance Framework and other information	Culture of quality not embedded and quality performance not appropriately managed	Regular Board overview of assurance framework and risk register. Monthly QRP exception reported with action plans to R&GE. Clear clinical quality priorities and goals and annual audit programme, including national clinical audit and accreditation schemes. Annual Board assessment against the Quality Governance Framework. Area, Trust and Board level monitoring and performance management of quality metrics	Ensuring robust processes sufficient to give assurance to Board and support corporate governance statement	The Board will continue to review performance management systems and reporting and ensure all new regulatory and key contractual performance measures are addressed.
Failure to ensure effective nursing and medical leadership	Safe, high clinical and professional standards compromised	Clear structures, roles, processes and policies Leadership development programmes along with coaching and mentoring.		
Failure to implement robust system for medical revalidation	Failure to ensure relevant processes and procedures in place	2012/13 System and processes established for implementation with Medical Director oversight. 2013/14 all medical staff appraised in new system		
Failure to ensure that the	Deterioration against	The Trust is satisfied that plans in place are		

Board receives accurate and timely performance information and forecasting, and that a robust internal performance management system is maintained.	performance standards	sufficient to ensure ongoing compliance with all existing metrics and with all known metrics going forward. Robust Area performance monitoring and improvement processes, and a regularly presented dashboard approach to Board monitoring.		
Failure to achieve meaningful clinical engagement in use of quality metrics	Quality improvements missed	Area Directorate performance managed through local Clinical Boards. Local metrics defined through Area Business Plans, developed through local clinical engagement		
Failure to ensure ongoing compliance with the Hygiene Code and to provide clean and infection free environment including appropriate decontamination	Increase in HCAs	An Executive body (the Risk and Governance Executive) oversees all of the risk and quality agenda on behalf of the Trust and provides assurance to the Board. HCAs included in patient safety dashboard overseen by R&GE. Infection control strategy and group in place.		
Failure to ensure clinician engagement and efficient implementation of new Clinical Information System	Poor compliance with health and social care records policy, increasing clinical risk, and clinical productivity gains not realised	Robust programme and project management with clinical involvement from the start in scoping and procurement phases. Clinical engagement and training embedded in project plans. CPA training and audit in place	Achievement of full productivity gains	Regular CEO report to Board on progress as a key business risk
Failure to maintain health & wellbeing of staff	Lost productivity improvement Risks to recruitment	Appointment of local health and wellbeing champions, focused campaigns		

#### 4 Capability

Failure to ensure appropriate Board development, roles and structures	Ineffective governance, increased risk and poor succession planning	New Chairman in place from January 2013, NED succession planning process in place with governors, and annual Board development programme continues. Existing board annual self-evaluation process to be reviewed in 2013/14 and future approach to evaluation determined		Regular monitoring of succession processes
Failure to have an effective relationship through which the CoG can hold the Board to account	Ineffective governance. Insufficient development of governors to take on future role	Joint meetings of CoG and Board, directors' attendance at CoG, and Board presentation of performance report quarterly to CoG. Monthly Chair/ Lead Governor/ CEO meeting, agreed governor development programme.		Performance report to Board and Council via Chief Executive
Failure to develop and maintain representative membership	Voice of minority groups insufficiently heard to ensure equitable access to services	Quarterly review at Council of Governors (CoG) Monthly membership reports to governors. Engagement and recruitment focused events	Recruitment unsuccessful and ineffective member engagement	
Failure to maintain a stable IT infrastructure, realise patient, carer, staff, governance and efficiency benefits of new Clinical Information System	Loss of patient data and consequent harm to patients  Productivity and experience gains not achieved	Full clinical engagement in REMEDY implementation programme from April 2013, effective communications strategy, programme review and evaluation. Monitoring and challenge through R&GE and Audit Committee		Regular CEO report to Board on progress as a key business risk
Lack of vision for new service models including international evidence	Loss of traction in terms of reputation, service improvement and new business	Maintain effective R&D and Commercial & Service Development functions within the Trust		

## 2.4 How our Board derives assurance on quality

The preceding analysis of key governance risks including quality demonstrates the Board's use of the Quality Governance Framework as a key part of its approach to assuring quality. The Board assesses itself regularly against the Framework, the last assessment being in March 2013, and identifies from the available evidence any areas on which it wishes to set improvement priorities for the following year.

Our analysis of risk at a high level is consistent with the Trust's Risk Register and Assurance Framework which are regularly reviewed by the Trust's Risk and Governance Executive and monitored by the Board of Directors. The Trust has been commended by the NHSLA on its Risk and Governance Executive (R&GE) committee structure and processes. The Audit Committee, through its work, provides assurance to the Board that the Trust has established and maintains effective systems of integrated governance, risk management, and internal control across all the Trust's activities (both clinical and non-clinical) that support the Trust's objectives, and it brings to the attention of the executive any concerns regarding these systems. The Committee ensures that an effective internal audit function is established by the executive, meeting the requirements of the DH *Internal Audit Standards for the NHS*. The Committee also oversees the work of the External Auditors, reviewing all its findings and the robustness and appropriateness of management responses.

The Trust receives announced and unannounced inspections by the Care Quality Commission (CQC) to assess its continued compliance with the CQC Essential Standards of Quality and Safety, and unannounced inspections by inspectors in relation to the compliance with the statutory requirements of Mental Health legislation. The Trust also monitors monthly through its Risk and Governance Executive the CQC Quality and Risk Profile, taking actions where indicated to improve performance.

The quality directorate of the local cluster of clinical commissioning groups arranges a schedule of ward audits and the trust received very positive feedback from visits in 2012/13

As a NHS Foundation Trust, it is subject to the regulatory regime of its external regulator, Monitor, and it complies with the requirements of the Monitor Compliance Framework and it receives a governance and finance rating based on the Annual Plan Review and on a quarterly basis.

The Audit Committee ensures that the Executive has in place an effective internal corporate and clinical audit function meeting the requirements of the Public Sector Internal Audit Standards (PSIAS), which are based on the mandatory elements of the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF). The Board approves the Chief Executive's risk-based strategic audit plan, and the Chief Executive ensures it is completed by the Internal Auditor and the recommendations are implemented.

The Trust's internal auditors, Deloitte, are in their final year of contract, 2013/14. A procurement exercise using the East of England's Framework for internal audit and local counter fraud services (LCFS) is already underway to select a contractor for a 3 year contract (plus 1 year extension) starting on 1 April 2014. The work of the external auditors, Grant Thornton, is also overseen by the Audit Committee who review all its findings and the robustness and appropriateness of management responses.

The Trust commissions NHS Benchmarking (as part of its work with some 75% of mental health Trusts in England) to benchmark the Trust on a number of domains: for example the 2012/13 survey based on Quarter 2, shows that the Trust performs well on a range of productivity measures, with

- below-average acute adult admissions per 100,000 population

- below-average acute adult readmission rates
- below-average DNA rates.

The Trust is assessed by the NHS Litigation Authority and currently has recently retained its NHSLA Level 1 rating with an improved score.

The Trust actively engages with a number of external clinical accreditation schemes and quality improvement programmes. These include the Prescribing Observatory for Mental Health (POMH-UK), Royal College of Psychiatry Accreditation for Inpatient Mental Health Service (AIMS-PICU), Royal College of Psychiatry Quality Network for Inpatient CAMHs (QNIC), and Bournemouth University Practice Development Unit award (PDU). Uniquely the Trust is working with Bournemouth University to seek an accreditation process across the whole of its major Journeys service redesign programme.

The Trust also sought Investors in People (IiP) accreditation and achieved Bronze award in April 2011

#### **2.4.1 Clinical and corporate governance system**

The Risk and Governance Executive (R&GE) is the focus of the clinical governance system, providing detailed assurance to the Trust Board of Directors. It is chaired by a non-Executive Director and all Executive Directors attend. The Medical Director makes a quarterly formal report on behalf of the R&GE to the Board.

The key role of R&GE is to provide assurance to the Board on all risk, clinical governance, quality and audit matters. R&GE works in co-ordination with the Board of Directors' formal Audit Committee to assure the Board that the Trust has established and is maintaining effective systems of integrated governance, risk management and internal control across its non-clinical and clinical activities, in support of the Trust's objectives. It brings to the attention of the Board any concern regarding these systems.

#### **2.4.2 Clinical governance accountabilities within corporate governance**

The Trust has also developed a range of clinical quality KPIs including the relevant sections of Monitor's Compliance Framework and the CQC indicators and a number of Trust-instigated indicators. These are reviewed in detail by locality managers and Executive Team members at local performance meetings. The results feed into a monthly progress review meeting of Area Directors and Executive Directors (the Performance Executive Management Team). R&GE takes a more detailed qualitative approach, considering serious incidents, clinical policy and input from a range of Trust-wide groups,

The formal inputs to R&GE come from a Patient and Carer Experience Board, the Infection Control Group, Quality & Audit Group, and Medicines Management Group.

The Trust's Quality, Risk and Patient Safety department proactively promotes safe and effective care, and monitors and reports on its delivery. Through one multi-disciplinary team it co-ordinates risk management, serious incident investigation and reporting, RIDDOR monitoring, clinical and corporate audit, quality reports and accounts, compliance and regulatory framework, patient satisfaction, claims and co-ordination of policy development. The Trust follows and assesses itself against Monitor's Quality Governance Framework.

#### **2.4.3 Nursing and medical leadership**

North Essex Partnership has a robust system of medical and nursing leadership providing medical and nursing advice and input to corporate and local management and governance



decisions across its services. The Medical Director and Director of Nursing and Operations head the medical and nursing leadership structures and are directly accountable to the Chief Executive and the Board of Directors.

The Medical Director is a voting Executive Director sitting on the Board, R&GE and Executive Management Team. The Medical Director leads the risk, quality and safety function, manages the medical staff (supported by an Area Medical Director for each locality) and is the Trust's Caldicott Guardian. The Medical Director chairs a Patient and Carer Experience Programme Board which includes in its work monitoring national and local surveys and overseeing development and implementation of associated improvement plans, including from the continuous feedback mechanisms (e.g. survey follow-up of every discharged patient).

Trust-wide Clinical Boards oversee local practice and development, advising managers on professional and governance matters. The Boards proactively foster staff engagement, bringing clinicians' expertise to bear on whole-Trust governance in an integrative way; clinical staff's willingness to be involved and be influential in service transformation towards new ways of working, and by their contribution to Trust clinical conferences, business planning and service initiatives is evidence of the effectiveness of this engagement. The Clinical Boards also oversee the development and agreement of local Cost Improvement Plans, the clinical quality and safety impacts of which are subsequently considered before Board approval by the Medical and Nursing Directors.

The Director of Nursing and Operations leads the nursing structure, and is a voting Executive Director on the Board, R&GE and Executive Management Team. He provides integrated clinical and managerial leadership across all clinical services, supported by local Area Directors and a team of senior clinical staff. He leads and hosts the regional Nurse Leadership forum; the Trust devises, develops and runs the nurse leadership programmes across the Region.

This clinical governance structure provides capacity and expertise to co-ordinate performance management and reporting of quality parameters; it also supports operational staff in dispersed services. Operational managers ensure local compliance to clinical governance expectations through CQC evidence collection, clinical audit, supervision and appraisal.

#### **2.4.4 Metrics**

The metrics reported regularly to the Board provide evidence of performance across the quality domains of safety, effectiveness and experience. They have been chosen to reflect national requirements (e.g. Compliance Framework, CQC) and local priorities including the governor-identified indicator and measure for the Quality Report. The Board's initial priority, (now with measures that have been in place for three years) was on patient safety, recognising the imperative of people being and feeling safe but these have then been extended to ensure a rounded view of performance on quality with an increasing emphasis on patient experience. A patient safety dashboard focuses on nine clinically advised key safety metrics which are included in the Trust's Quality Report.

The Trust has developed a high-level 'Ward Quality Barometer' with a selected number of indicators with thresholds, against each of the three quality domains, that enable a monthly traffic light (red, amber, green) rating against each indicator but presented in a way that enables the rolling trend over the last 6 months to be seen in two ways. Firstly, for each indicator at individual ward level, and secondly, aggregated performance on each indicator Trustwide.

The table below demonstrates metrics reported regularly to the Board, including key HR metrics that impact on quality, followed by the outline of our Ward Quality Barometer. We are in the process of developing a similar 'Barometer' for our community based services. The Board also receives a quarterly report on complaints and serious incidents and a quarterly report from R&GE identifying any exceptional issues and actions on the much broader range of activities and metrics it monitors.

<b>Monitor Compliance Framework</b>				
<b>Indicator</b>	<b>Threshold</b>	<b>March 2013 performance</b>	<b>March 2012 position</b>	<b>Commentary</b>
Care Programme Approach (CPA) patients receiving follow-up contact within 7 days of discharge	95%	<b>98.8%</b>	99.2%	Continues to perform above target
Care Programme Approach patients having formal review within 12 months	95%	<b>96.5%</b>	96.7%	Q2 NHS national performance 79.8%
Minimising delayed transfers of care	<=7.5%	<b>2.4%</b>	0.8%	Maintaining acceptable limits with robust process in place
Admissions to inpatients services had access to Crisis Resolution/ Home Treatment teams	95%	<b>100%</b>	100%	Excellent performance
Meeting commitment to serve new psychosis cases by early intervention teams	95%	<b>106.8%</b>		Over achieved against target
Data completeness – identifiers (aggregate)	97%	<b>99.8%</b>	99.5%	Among the highest-performing mental health Trusts
Data completeness – outcomes (aggregate)	50%	<b>97.7%</b>	95.1%	Excellent performance
<b>Other Selected Performance Indicators</b>				
Maximum time of 18 weeks from point of referral to treatment – Consultant- led Services	100%	<b>96.8%</b>	95.1%	Consistent high performance
Maximum time of 18 weeks from point of referral to treatment – Non-consultant-led Services	95%	<b>99.7%</b>	99.9%	Consistent high performance
Carers' Assessments Completed	1332	<b>1612</b>	1389	Threshold exceeded
Assertive Outreach caseload	277	<b>294</b>	292	Threshold exceeded again
Readmissions	n/a	<b>2.4%</b>	10.7%	Improved performance

## Ward Quality Barometer

## Metrics relating to service users - blank template

[illegible]

Metrics with thresholds will receive a RAG ratings score for each inpatient unit:  
Green box = 1 Amber box = 2 Red box = 3

25 - 32 = Green 33 - 49 = Amber 50 - 72 = Red

## 3.Clinical Strategy

### 3.1. Trustwide and Area Business Strategy

#### 3.1.1 Our overall clinical strategy over the next three years:

Our Quality Strategy is reflected in our annual Quality Report (published separately and available from NHS Choices):

<http://www.nhs.uk/Services/UserControls/UploadHandlers/MediaServerHandler.ashx?id=633&t=634689782055459892>

We are very proud of the achievements of the Trust and our strategic ambitions going forward. We are reassured that there is a strong match between our strategic and governance objectives and many of the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry report. We see the Francis Report as, to a large extent, affirming our approach and our values, and can demonstrate a Board-to-ward focus on quality of care and standards of governance..

Our vision and values drive our approach to quality and quality improvement.

**Our vision** is to provide care that is outstanding in its quality, transforming the lives of individuals and families every day. Our communities will have total confidence in our services, our staff feel a strong sense of belonging and satisfaction, and our partners be proud to work purposefully with us.

**Our values** underpin everything we do:

- promoting dignity, respect and compassion
- demonstrating openness, honesty and integrity
- building on individual strengths
- tackling stigma, promoting inclusion and valuing diversity
- listening, learning and continuously improving to deliver quality and best value

#### **Our commitments:**

##### **To individuals and families:**

- to work together, building on strengths, to improve mental health and wellbeing,

##### **To our staff:**

- we will value everyone individually, promote wellbeing, support involvement and encourage personal development and leadership
- we will support teams in their delivery of best value, innovation and excellence

##### **To our commissioners and key partners:**

- we will listen, work with you, create ideas, demonstrate our effectiveness and flexibility and earn recognition as provider of choice.

**‘Outstanding care, transforming lives’**, enshrines the values of the NHS, and our statement of commitments looks both outwards to the people we treat and support, and inwards to our staff who can make our vision happen. Most people want services that provide expert information and advice, treatment and support to assist recovery and promote independence, but importantly also want those services to place the quality of the relationship at the heart of what they do. That’s what we aspire to do every day in all that we do.

We have clear strategic objectives with eight associated key priorities as below:

Strategic objectives	Key priorities
1. To provide high quality care that is effective, safe and as positive an experience as possible	<b>Effective</b>
	1. Improving access to, and accessibility of, services
	<b>Safe</b>
	2. Improving patient safety and general wellbeing, ensuring all care and other environments are appropriate, safe and therapeutic
	<b>Positive Experience</b>
	3. Continuing to improve the experience of service users, families and carers, ensuring embedded systems for receiving and acting on feedback
2. To be a model employer	4. Creating positive experiences for staff within an efficient and effective workforce
3. To achieve good Governance, inclusive Involvement and excellent partnerships	5. Engaging widely with local communities and key stakeholders, developing productive partnerships with partner organisations and helping promote positive mental health
4. To provide value for money (economy, efficiency, and effectiveness)	6. Ensuring an ongoing programme to ensure services are clinically and cost effective, use of estate is maximised and carbon footprint is reduced
	7. Realising development of, and benefits from, the Trust's information systems
5. To expand the business	8. Exploiting opportunities for growth and broader business development

We do not underestimate the importance of the need for people to feel safe with us, our treatments and care working effectively for people in receipt of our services, and how people feel about their treatment and care. Our Patient and Carer Experience Board, chaired by the Medical Director, oversees our local patient and carer survey and other feedback processes to ensure we continue to listen to what people say and take action where necessary to continuously improve our services. Our Quality, Risk and Patient Safety Department works proactively with operational services both on responsiveness to patient and carer feedback and to ensure serious incidents are not repeated and that we learn from our mistakes. We help staff to recognise early warning signs of things going wrong so these can be rectified and ultimately avoid serious incidents and complaints. Our Risk and Governance Executive (R&GE), chaired by a non-executive Director, provides assurance to the Trust Board on risk quality and clinical governance. While applying the Friends and Family Test is not a requirement for mental health providers, we are nevertheless implementing it as part of our programme of using patient feedback at discharge from inpatient care to improve service delivery standards.

Our annual planning process continues to be underpinned by business planning in our Area Business Units, led by local Clinical Boards and informed by the views and priorities of local elected governors. In addition all corporate functions are producing their own business plans as we go forward into 2013/14. A number of our priority improvements for 2013/14 and

beyond address governor views and priorities. Our Lead Governor and a governor working group help develop the proposals for our annual quality account report.

Our Cost Improvement Programme (CIP) is developed by directorates and local Clinical Boards from the bottom up, through a continuous service-line process linked to the Trust's area business planning process. Proposals are presented in draft form in December/ January to the Executive Management Team and discussed in detail by the Board, and with the council of governors, before being formalised with Board approval of the revenue and capital budgets in March. Both the Medical Director and the Director of Operations & Nursing are required to consider the clinical quality and safety impacts of proposals as part of this process.

We have negotiated five adult/ CAMHS CQUIN (Performance Incentive Schemes) for 2013/14 with CCG commissioners, and six new schemes with Specialist Commissioners to meet national, and local requirements. Overall these secure 2.5% of contract income for specific quality improvements.

<b>Scheme</b>	<b>Description</b>	<b>Value</b>
<b><i>With North Essex CCGs</i></b>		
Compassionate care	Response to the Francis Report - Compassion	£1,744,588
Dementia	Timely diagnosis in Dementia Services	
NHS Safety Thermometer	Monthly reporting of pressure ulcers and falls. Develop thermometer to cover violence, drug errors and self-harm.	
Lithium monitoring	Monitoring of Lithium Results and improvements in the communication of path lab results	
CAMHS gateway	Provide information to support commissioner's understanding of numbers involved in Care Pathways	£ 174,624
	To continue to provide the existing monthly CAMHS Gateway Activity Summary for North Essex CCGs	
Total value		<b>£1,919,212</b>
<b><i>With Specialist Commissioners: 6 schemes affecting low secure and specialist services</i></b>		
Total value		<b>£ 166,084</b>
<b>TOTAL</b>		<b>£2,085,296</b>

We are continuing with a major transformation programme in the way we deliver our services, known as our 'Journeys' (care pathways and processes review programme), with the first pieces of major service redesign scheduled for 2013/14. This huge transformation project has been designed to align the provision of a high quality, safe, innovative and efficient service delivery model with the requirements of the HoNOS / PbR care clusters. We are in the process of populating these clusters with best practice evidence to ensure that our service users receive the highest quality care and treatment we can provide appropriate to their particular presentations and holistic needs. We are currently working through the demographic data of our service user population to ensure that our staff resources and skills are best used to meet the demands of the presenting service user need.

Our mantra is that form must follow function. We will design the service delivery model to meet the needs of our presenting service user population's clinical and social care needs, rather than create structures and squeeze our service users into it. We are working with

Bournemouth University to accredit our organisation as a Practice Development Trust. This project will be the first of its kind in the country to have all its pathways accredited against their stringent quality standards. We are also working with Professor John Clarkson from Cambridge University (EoE Patient Safety Consultant) to assess the safety of our pathways and service delivery models.

Alongside the 'Journeys' programme we will also be implementing (from quarter 2) the first stage of our new electronic patient record system, which offers future benefits of more mobile working, following the project plan for full roll-out of the new Remedy clinical information system and finalising plans for enhanced mobile working, interoperability and paperless working. 'Go Live' of the new Remedy clinical information system is in Quarter 2, including the implementation of new mobile devices to access the 'right' information, at the 'right' time, in the 'right' place. Implementation and ongoing use of the new Business Infrastructure Service Management process will allow us to map business and system change. There will be partial integration with 'Journeys' Programme outcomes. There will be further roll out of the Electronic Data Records Management (EDRM) project linking to Remedy and reduction of Medical Records Storage

We publish a three year clinical audit plan updated annually, and national and local clinical audits are reviewed through our Quality and Audit Group (QAAG) which reports to our Risk and Governance Executive. Each audit report has an action plan and implementation is monitored by the audit group and/or the most appropriate group working to R&GE. The Board will in 2013/14 also receive a separate annual report on clinical audit and the Audit Committee has agreed with R&GE that a more rules based approach to assurance be developed with a very clear focus on graded priorities and organisational learning.

Progress has been made on one of the strategic goals for R&D, to increase the diversity and range of studies open at the Trust and give service users increased opportunities to take part in research relevant to them. Trust-based researchers are leading on a number of national studies of neurodegenerative diseases, and are involved in research into psychosis, child and adolescent mental health and older adult mental health. We have been recognised as the highest recruiting Trust in the UK for the bipolar arm of the DNA Polymorphisms in Mental Illness (DPIM) study, a study aiming to increase understanding of genetic factors in mental illness.

Relationships continue with research partners in developing an portfolio of mental health and learning disability research in the region, including with the Essex and Hertfordshire Comprehensive Local Research Network (CLRN), the North London and East Anglia Mental Health Research Networks (MHRN), the North London Dementias and Neurodegenerative Diseases Network (DeNDRoN), Universities and other local Mental Health Trusts. A Trust R&D lead is an executive team member on the Essex and Hertfordshire CLRN Board, and a consultant clinical psychologist in CAMHS is Chair of the Children's Health Local Speciality Group (LSG) for Essex and Hertfordshire. In summary, the Trust remains a key player in the local R&D economy with a number of prominent researchers conducting and publishing regionally and nationally significant research.

Our Data Quality Policy provides the framework for managing the quality of data within the quality / safety arena. Data quality is performance monitored on key indicators through the Executive Management Team with Area Business Directors in attendance, and this is supported at a local level by regular and more intensive drill-down into team level data. On information governance, the Trust Board establishes a year on year plan to address not only Level 2 compliance but also year on year improvement and meeting any new Information Governance Statement of Compliance (IGSoC) requirements.

In line with all the above we have established a suite of national and local performance indicators and robust performance monitoring processes to ensure we provide outstanding care, and to provide some external assurance we participate in Audit Commission benchmarking.

#### Data Validity

In July 2012, the Trust received notification of its “Data Validity” performance from the NHS Information Centre. The Trust exceeded the MH average in 9 out of the 10 “identifier completeness” datasets and also in 6 out of the 9 “other attributes” including ICD10 and HoNOS. This is a positive indication of the completeness of the information supplied to the Board and clinicians to manage patient care.

### 3.1.2 Our service line strategy over the next three years

#### 3.1.2.1 Trust-wide service development priorities:

##### Deliver the contract for 3 Primary Care Trust Medical Services (PCTMS) GP practices in Thurrock

Transfer management of 3 PCTMS GP practices in Thurrock to the Trust, TUPE transferring all staff as of 01.03.2013, including completing contract negotiations with commissioners including Business Transfer Agreement, establishing working relationship with local GP partners, re-assessing practice premises, policies and procedures and appointing appropriate staff.

##### Deliver improved Marginalised and Vulnerable Adults (MVA) services across Suffolk.

Build the MVA service “Health Outreach Suffolk” for whole of Suffolk, along the lines of the Care Programme Approach, to ensure effective case management and safeguarding of client group, including evaluating current service delivery, locations and staffing, and implementing new model.

##### Complete development and implementation of Edward House, adult low secure services in new facilities in Chelmsford

New-build development providing 20 adult Low Secure beds meeting the ‘National Minimum Standards for General Adult Services In Psychiatric Intensive Care and Low Secure Environments’, ensuring a modern, safe and therapeutic environment. This will replace the services currently provided in Colchester. The unit will be operational in July 2013. The existing unit in Colchester will be mothballed in case it is needed within the next 3 years to meet future commissioner needs.

##### Continue development of new adult services integrated provider agreement with Essex County Council

- a) Following agreed extension of existing S75 arrangements until October 2013, conclude negotiations on a new adult services Section 75 3 to 5 year agreement following ECC re-commitment to integrated health and social care system delivered through partnership.
  - b) Negotiate on the basis of a joint commitment to include older adult services in S.75 in the future if possible.
  - c) Scope options for taking responsibility for ECC adult care commissioning budget
- Continue and conclude negotiations with ECC on the basis of a clear understanding of the complexities of older adult social care and of delegation of ECC adult care commissioning budget to Trust. Continue implementation of agreed service developments and cost-savings.

##### Implement with Essex Probation a community-based service for offenders with a personality disorder

Implement psychologist-led consultation Essex-wide service to Essex Probation for offenders with a personality disorder, establish the service with Essex Probation.



Develop the Trust's specialist nursing input to the Essex Reablement service

With Essex Cares Ltd., optimise the role of the 5 Band 6 nurse advisors in the Reablement Service across Essex and explore opportunities for expansion, including gathering information about need and potential high-impact interventions as service becomes established.

Extend existing police custody pilot Trust-wide from 01.04.2013

Following the pilot in 2012/13 in Clacton and Colchester, provide expert on-demand assessment advice and where appropriate diversion for people with mental health problems from police custody, as well as joint risk assessment with police to promote safer custody arrangements and information-sharing between agencies.

Provide one mental health worker in the main custody suites in Harlow, Chelmsford & Colchester on weekdays from 8 a.m. to 4 p.m., with out of hours provision at peak times (9 p.m.to 7 a.m. Thursday to Sunday) and a learning disabilities specialist nurse on weekdays from 8 a.m.to 4 p.m.

Continue redevelopment of the Derwent Centre to support better care models

Follow the agreed redevelopment schedule to create an environment for care that meets modern standards and provides therapeutic and fit-for-purpose surroundings. Reprovide Stort and Chelmer wards on the ground floor as single-sex wards with a shared daytime and eating area. Finalise redesign of rehabilitation services from Cam ward. Reform staff groups on common shift rota, with agreed rotation between acute wards.

Continue joint review with commissioners of recovery and reablement services, piloting new approaches in Mid and North-East Essex

Complete joint review with commissioning partners of service delivery model, accommodation, approach and funding, including the use of a Care Farm in north-east Essex and a staff, service user and carer Recovery College and community recovery hub in mid-Essex.

Apply for, and if successful implement, a Big Lottery Funded regional wellbeing programme "Building Resilience in the East".

Our Enable East consultancy and project management business arm has applied for £2.7m grant funding over 2 years to deliver a portfolio of health promotion activities and wellbeing outcomes to further beneficiaries, consolidating the wellbeing work they delivered between 2007 and 2011 as part of a £3.9 million programme called "Wellbeing in the East". The proposed programme will focus on building resilience in armed forces families and communities (working with armed forces families in East of England and also the Midlands and NE England), and supporting looked-after children and users of food banks to access activities evidenced to improve family or individual wellbeing. An announcement on outcome of the application is imminent.

### **3.1.2.2 Clinical Area service development priorities:**

In addition to the above Trust priorities, the Area Directorates have the following local priorities;

North-East Essex

- Consolidating and evaluating a new model of care for adults, with dedicated specialist psychiatric/medical input separately to inpatient care and to community teams in Colchester & Halstead, with a view to extending to Tendring
- Piloting an electronic GP 'advice line' in Colchester giving quick access to consultant psychiatrist advice

- Working with health partners to improve the overall care pathway and patient experience for frail older people
- Developing accredited 'centre of excellence' specialist service hubs for dementia care in Colchester and functional disorders in Tendring, with improved and extended community services including home treatment and support.
- Continuing a review of adult rehabilitation and recovery services to improve service effectiveness and patient journey through services, including the development of an age-inclusive north-east recovery services team
- Develop an age-inclusive North East Essex Recovery Services team
- Review crisis resolution and home treatment services taking account of in-year commissioner decisions on future funding of the successful TRUSTLINE phone crisis triage pilot, delivered in partnership with Mid Essex MIND
- Leading on a review and further development of veterans' mental health services with key partners
- Working with local commissioners to take forward trust proposals in relation to psychological interventions for people with long term conditions, services for marginalised adults, veterans services, and dementia prevention/early intervention and exercise programmes
- Developing an electronic GP 'advice line' in Colchester giving quick access to consultant psychiatrist advice.
- Undertaking a thorough review of all the accommodation / estate.

#### Mid-Essex

- Completing our modernisation programme at the Linden Centre, Chelmsford, focusing on patient and carer experience, the patient and staff environment, improving pathways with community teams including home treatment, improving outcomes, reducing bed occupancy and improving staff recruitment and retention
- Following review of community-based services, optimising use of our estate to ensure that services are easily accessible, fit for purpose and deliver improved patient outcomes: this includes integrating adult community services into two teams in Maldon and Braintree/Witham, and co-locating all the older adult community teams in Witham
- Working with local health partners to streamline the point of referral to access services, improve liaison within A&E, and improving coordination of care pathways for frail older people
- Review crisis resolution and home treatment services taking account of in-year commissioner decisions on future funding of the successful TRUSTLINE phone crisis triage pilot, delivered in partnership with Mid Essex MIND
- Review the functioning of Amethyst day hospital
- Developing adult recovery and reablement provision as part of a local pilot scheme, including a local Recovery College.

#### West Essex

- Reviewing community team pathways and implementing the most effective model of service delivery, taking account of an outpatient services review
- Piloting a Single Point of Access for referral and assessment to streamline communication, avoid duplication and support effective co-ordination with other health and social care services

- Working with local health delivery partners across community and general hospital services to improve the effectiveness of care pathways for frail older people
- Developing nurse-led clinics for dementia care and treatment, and for treatment resistant psychosis (Clozaril clinic)
- Developing therapeutic and productive activities in inpatient settings and access to a gym
- Consolidating the west-wide recovery-focused model of day service delivery, improving equity of access, and delivering more intensive short term recovery support to people in their own home
- Review crisis resolution and home treatment services taking account of in-year commissioner decisions on future funding of the successful TRUSTLINE phone crisis triage pilot, delivered in partnership with Mid Essex MIND

### Children & Young People

- Building on the success of the new St Aubyn Centre child & adolescent mental health unit, evaluating its innovative and effective model of treatment, and seeking QNIC (quality) accreditation
- Redesigning the specialist care pathway for children and adolescents (Tier 3) as part of the Journeys programme and establishing a single entry gate
- Developing the children's learning disability care model, with therapeutic space in Trust accommodation
- Redesigning and co-locating Mid Essex child and adolescent mental health (CAMHS) community team services centrally at the C&E Centre, Chelmsford, improving equity of access and offering more flexibility in time and locations of delivery
- Completing an accommodation review in West Essex, co-locating the community CAMHS Tier 3 team and the EIP (early intervention in psychosis) team
- Integrating the management of children's and adult community eating disorder services to provide an age inclusive care pathway
- Learning from new service user feedback processes including from the under-11s whilst continuing to develop the role of 'young consultants' to inform quality and service improvements
- Continuing to develop proposals to expand our business in related areas of work.

### Applied Psychology & Psychotherapy

- Reviewing the development of Trustwide acute, specialist services and recovery functions as part of the Journeys care pathway redesign
- Ensuring expertise in relevant NICE-recommended psychological treatments is located in all major centres of service delivery
- Exploring the feasibility of a specialist psychological treatment unit for service users with high levels of self-harm
- Explore the feasibility of establishing specialist inpatient services for adults with eating disorders.
- Improving the psychological mindedness of the Trust through piloting new service models and supervision, consultation, training and support of other professional staff groups. This includes personality disorder awareness and junior doctor training
- Developing new business, particularly in the areas of IAPT (Improving Access to Psychological Therapies), Stroke and long-term conditions, personality disorder, Asperger's/ autistic spectrum assessment and diagnosis, and medically unexplained symptoms

## Substance Misuse

- Developing blood-borne virus services in Mid and West Essex further and extending the post Trust-wide after our successful securing funding for a BBV specialist nurse on a full-time basis to develop the services.
- Embedding the work of the alcohol liaison nurse specialists after a successful pilot that resulted in the funding for these posts being secured Trust-wide.
- Following recognition from our commissioners that our services provide particular specialist expertise, last year's 10% cut in budget has been reinstated allowing us to respond to GPs' requests to access our clinical expertise
- Restructuring Trust-wide substance misuse services, to offer cost improvement savings..

## Pharmacy

- A pilot of pharmacy service access to Summary Care Records where possible initially for inpatient admissions, ensuring wards have electronic access to an updated medication profile
- Outpatient dispensing for the Chelmsford & Essex Centre, where outpatient adult consultant clinics will all be based.

### **3.1.3 Inputs to this Strategy**

**3.1.3.1.** The board provides leadership on strategic direction, regularly reviewing the impact of the external environment, national policy direction and the intentions of local, specialist and other commissioners, the requirements of regulators, and how the trust can build on its strengths, address weaknesses, exploit opportunities and mitigate threats. The way in which it has regard to the views of governors is outlined in more detail below. The board takes full account of feedback on patient experience and available benchmarking and external assurance. Section 2.4 gives an example of this in the Trust's commissioning of NHS benchmarking.



**3.1.3.2** In order to properly have regard to the views of the Council of Governors we have an inclusive Annual Planning cycle and process agreed with governors to ensure they are able to bring their views, and those of the membership they represent, to influence the forward planning of the Trust. Over the course of 2012/13 there have been 4 meetings of the Council of Governors in public, a separate Annual Public Meeting, and two joint meetings of the Board of directors and council of governors (focusing on the Health and Social Care Act

2012, the new NHS architecture, future governance arrangements, and governors' code of conduct), and a governor-led annual planning event where governors present to their colleague governors, and directors, their constituency views on quality priorities and forward plans. Preceding this event, during the summer, constituency governors have meetings with relevant Area Directors to discuss priorities for local Area business plans, which underpin the Trust Annual Plan, and as preparation for their annual plan event.

The Council of Governors has recently reviewed its workstreams that have been in place for a number of years and proposes a direction of travel for three workstreams as follows:

- *Membership, Marketing and PR (MMPR)* – to focus primarily on community engagement, giving added attention to Braintree constituency where attraction of governor candidates has been difficult, and pushing on recruitment of a representative local membership,
- *Youth Matters* – to continue its focus on effective engagement of young people, including exploration of establishing a youth council,
- *Social Inclusion* – to refocus its attention towards service user experience

At its annual plan event governors identified key quality priorities which included:

- Continuing investment in improving the fabric and quality of the built environment
- Responding to feedback, improving access to advice and support on benefits, accommodation, medication side-effects, and personal budgets
- Renewing attention to physical health care, and protecting and extending, as resources allow, alcohol liaison nursing and blood borne virus services trust-wide
- Continuing to improve dementia advice, training, treatment and support services along an age inclusive care pathway
- Improving equity of access to psychological therapies, crisis support and develop, as resources allow, community personality disorder services
- Ensuring effective discharge arrangements through early planning, skill mix, and access to supportive community interventions and services

At its meeting held on 12 March 2013 the Council of Governors unanimously resolved that it was satisfied that the Trust's proposed activities in 2013/4 re Non NHS income will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose of the provision of goods and services for the purposes of the health service in England or the performance of its other functions.

## **3.2 Clinical workforce strategy and sustainability**

### **3.2.1 Clinical workforce strategy**

#### 1 TUPE transfer of ECC social care staff

Subject to successful negotiation of new S75 Agreement transfer seconded social care staff from Essex County Council to Trust direct employment in support of the provision of social care services, following employment legislation and appropriate ECC & Trust procedures.

#### 2 Realise recruitment/ retention benefits of the campus of Mid Essex inpatient units "Broomfield campus"

Develop a programme of staff rotation between our adjacent mental health units on the Broomfield campus to increase experience and make hard-to-fill posts more attractive.

#### 3 Support service changes

Support modernisation programmes that assist in the delivery of the 'Journeys' programme, support local Area service redesign, and secure contracts for expansion of new services.

#### 4 Use of resources

- a) Improve staff sickness performance against Trust threshold of 4.5%.
- b) Control spend on bank, agency and locum staff, through i) completing introduction of e-rostering on an agreed basis across Trust services, and ii) effective recruitment to medical staffing establishment to reduce agency / locum spend.
- c) Refine establishment control and ensure accurate vacancy reporting

#### 5 Staff development

- a) Improve uptake of statutory and mandatory training.
- b) Implement Talent Management Strategy, including career coaching, creation of a Talent Bank, secondments and shadowing.
- c) Improve succession planning arrangements

#### 6 Retention of staff

- a) Continue implementing Health & Wellbeing strategy 2011 – 2014, including local health champions, Resilience training, zero tolerance of bullying and harassment and "Staying Safe at Work" staff awareness campaign.
- b) Implement learning from 2012 staff survey, building on our good performance (in the top 20% nationally for staff recommending the Trust to patients), focusing on
  - strengthening the Respect agenda, extending it to staff's expectations of patients and carers
  - reducing harassment and bullying
  - building resilience amongst staff to reduce workplace stress
  - proactive promotion of staff health and wellbeing.

### **3.2.2 The impact of the Workforce Strategy on costs (short-term and long-term)**

The Trust is currently undertaking a full review of its clinical pathways in the Journeys programme to ensure that service users receive the most appropriate care for their condition following a process of comprehensive assessment. This new model of care will require a different approach to the way that teams are structured and care is delivered.

Whilst the model is yet to be agreed, it is clear that the skills of our clinical staff will need to be deployed differently. Our focus will be on maximising clinical capacity in the right place and minimising and reducing managerial input where appropriate. As a consequence there will also be a need to review the way in which administrative support is provided both in

terms of structure and role content. Again where possible administrative capacity will be reduced. Alongside the review of clinical pathways and models of care, the Trust will also review management structures to ensure maximum efficiency and to address the need for clear succession planning.

### **3.2.3 Findings of benchmarking or other assessment**

Over the course of 2012/13 the Trust's workforce indicators remained strong. The sickness absence target of 4.5% was not exceeded and fell well below the national average for mental health Trusts at 5.3%. There are no plans to reduce the target but we will continue to focus on reducing absence particularly through a programme of concentrated health promotion, ensuring we remain proactive and not reactive to handling ill-health issues.

Whilst our turnover has remained low, we expect a number of retirements over the course of the coming year. The Trust does not view this as a threat but rather an opportunity to restructure services as outlined in section 3.2.2.

<b>Workforce Performance Indicators 2012 / 13</b>				
<b>Indicator</b>	<b>Threshold</b>	<b>March 2013</b>	<b>Rolling 12 months year-end outturn March 2013</b>	<b>Commentary</b>
Sickness absence	4.5%	4.5%	4.4%	Achieved below threshold
Long-term sickness		0.9%	0.9%	
Turnover	10%	0.7%	7.7%	Achieved below threshold
Turnover excluding retirements		0.5%	6.2%	
Leavers		13.9 wte	193.9 wte	
Leavers excluding retirements		10.5 wte	161.7 wte	

### **3.2.4 Clinical sustainability**

Our approach to succession planning, leadership development and career development for individuals at first-line and middle manager level gives the Board assurance that we will be able to recruit to key roles in clinical and other services. A relatively large cohort of experienced and influential middle managers is approaching retirement age, but a mix of astute recruitment, internal secondments and promotion and structural changes has so far ensured that Trust services remain well-managed and adequately staffed.

In addition, our establishment some years ago of agreed skill-blends for inpatient units protects them from staffing-based CIPs and consequent degradation of staff cover.

### **3.2.5 Identification of which of the Trust's services could potentially lack critical mass (defined by Royal Colleges etc.)**

None of the Trust's services could potentially lack critical mass as they are currently configured.

### **3.2.6 Identification of which services have consultant cover below those recommended by Royal Colleges etc. (link to financial template)**

None of the Trust's services has consultant cover at a level below that recommended by the relevant Royal College.

### **3.2.7 Innovations in care delivery developed at the Trust or in conjunction with partner organisations.**

Sections 1.3 and 3.1 above give details of the joint and individual innovations and developments in care delivery that we are proposing for the next period.

## **4. The Trust's other strategic and operational plans over the next three years, including our membership plan**

### **4.1 Other operational and strategic plans:**

**4.1.1 Enable East** – The Trust hosts a business unit 'Enable East', an innovative, independent NHS team that assists health and social care organisations in the public, independent and third sectors to deliver effective projects and measurable improvements. Providing a common sense alternative to commercial management consultants, it offers a safe pair of hands and a fresh pair of eyes at competitive NHS rates. The Trust board approves its business plan annually and appropriate governance arrangements are in place. Application has been made for a £2.7m Big Lottery Fund grant over 2013 – 2015 for a regional wellbeing programme "Building Resilience in the East" (see 3.1.2.1)

**4.1.2 Eastern Academic Health Sciences network (EAHSN)** – The Trust will be participating in the 'Colchester Node' of EAHSN which is bringing together universities, hospitals, mental health services, primary care, clinical commissioning groups, public health, social care, the voluntary sector and industry, translating world-class research into improved patient care, thus driving economic growth. EAHSN will work across four large established biomedical and clinical communities, with a clear commitment to drive sustainable improvements, through partners with a track record of excellence in research, teaching and education, health services and industry. Working with our local partners, Colchester Hospitals, Anglia Community Enterprises and The University of Essex, EAHSN will innovate and evaluate new ways of healthcare delivery.

### **4.2 Our membership report, commentary and plan:**

#### **4.2.1 Membership size and movement by constituency**

The Trust has two constituencies – public and staff, with no separate patient constituency. We have 6360 public members and 2,336 staff members, giving us a total membership of 8,696 at 31 March 2013. Service user and carer involvement became a membership issue so we did recruit more patients through this activity, though still modest; the Council of Governors will also set up a Patient Experience workstream that will feed into this. The responsibility for membership lies with the Membership, Marketing and Public Relations (MMPR) Governors' workstream. This workstream is also being rethought and is likely to become a Membership and Engagement workstream.

**Public constituency** Membership is up 165 this year with 246 recruits and 81 leavers. We are 85 below where we had hoped to be by this time. The rate of recruitment has slowed in line with the Council of Governors' approach of trying to link recruitment to Governors' Community activity. The recruitment has come from a broader range of activities rather than from any central recruitment drive. The leaver rate has slowed. We must expect some turnover – possibly around 69 this year though we will lose the small numbers from East Hertfordshire which is no longer a public constituency for the Trust – so will set a recruitment trajectory of about 281 new members to reach our 3% membership growth.

**Staff constituency** Membership has grown to 2,336. This reflects additional membership of 366 with loss of 220, in-year. This constituency will be affected by business developments during the year. The significant proportion of staff to public membership has been reflected constitutionally through an increase in the proportion of staff governors.

#### **4.2.2. Commentary / analysis of public constituency**

The Council of Governors approved a new three year membership strategy in March 2011 (subsequently approved by the Board). The emphasis was on quality of engagement and



activity, with individual recruitment profiles for each Governor to achieve both numerical and representative membership improvements. The Council of Governors reviewed this further at their meeting on 13 March 2012, where it was agreed that the strategy be updated with the following estimates to be achieved over the next two years:

- A net increase of the greater of 250 members or 4% (on 31 March 2012) by 31 March 2013
- 3% net increase in membership (on 31 March 2013) by 31 March 2014

Representative diversity of the public membership continues to be an issue. This was discussed at length in the report to Council in May 2012. Males of any age, young people of either gender, and anyone from an ethnic minority or social classes C2, D and E, are required to improve representativeness.

The Trust held a workshop to consider Monitor's *Current practice in NHS Foundation Trust Member Recruitment and Engagement* (July 2011). Governors found this a very useful publication and generated many ideas out of it – including suggesting levels of membership (bronze, silver and gold). As yet, however, there is no evidence this has made any difference to recruitment.

There has been a considerable amount of public activity – members meetings, schools engagement, Alzheimer's campaign, schizophrenia campaign, mental health drama, two conferences, world mental health day, *Friends of...* groups and much more. Few people have joined the Trust from this activity and it is something to be addressed. Some people still struggle with the idea of membership or don't always see the relevance of the Trust to the local services which the public identify as the face of those services. We have been speaking to the workforce at Tendring Council and we have recruited 35 from this activity. We think this is a model so we recruit from every meeting we (Governors and staff) address.

**Gender** Membership is broadly proportionate but males are under-represented by about 264 or around 9% more. Recruits were 2:1 female to male in the last year but both groups have increased. A greater number of this year's leavers appear to be males.

**Age** The under 16 category is under-represented (eligible membership is only 14-15 year olds in this category but we do not know the proportion of the 0 – 16 age band that is aged 14-15). However, we would expect the current membership to be higher than it is, around 100, instead of the 11 reported. We have experienced some opposition from parents and schools about recruiting amongst this age group when we have visited schools. The age range 17-21 is at 4.5% of membership (which is lower than the 6.6% of eligible members in this age range) and this will be addressed through the recruitment strategy. This is also reflected by the concomitant over-representation amongst the age groups 22+, at 95% rather than the 89% of the population. There is also a statistical anomaly here with 1448 members not giving a date of birth and this appears to be the area we have most difficulty overcoming.

**Ethnicity** Essex's ethnicity profile is 97% 'white' with other ethnic groups less than 1% each of the population. Our membership is representative for all groups (95% 'white') except 'mixed' (at 0.7% rather than 1%). The numbers are small and keep us within tolerance. The Trust recognises the need to maintain activity to engage effectively with minority groups in the population.

**Socio-economic status** This is the area needing the most attention. 72% of members come from ABC1 (and is a 19% over representation). C2s are 22% of the membership, over-represented by around 6%. Group D (semi -skilled workers) has remained at 0.7% and should be 15% and this appears to be the most under-represented group. Group E remained at a little over 5%. In line with the implementation of the Trust's Service User and Carer Involvement Strategy, service user/carers involvement will be offered to all members. We

anticipate an increase in the number of patients and their families joining the membership of the Trust. Patients tend to be drawn disproportionately from the C2, D and E socio-economic categories.

#### **4.2.3. Steps taken to achieve representative membership, and plans for the next 12 months**

Every Governor is sent a monthly recruitment and representativeness report. Our overall objective is to increase recruitment, address areas of under representation in the course of it, and to improve the quality of engagement. Central to this is to hold two members meetings in all 10 public constituencies this year. As we have also increased the number of staff Governors (from 5 to 9 and based on geographical units not professional groups) we anticipate more staff engagement (already high) from which staff Governors can draw.

Achievements in 2012/13 and our plans for 2013/14 include:

- Schools – we are now in contact with over 40 schools and colleges, many of whom participate in our drama competitions, four of which performed at our Annual Public Meeting (APM) in September 2012 (which had over 300 people present). We are proposing to work on a new youth structure that will address the deficit amongst young people with the work around mindfulness and stigma being its focus. A Youth Conference held with schools in December 2012 will be repeated. Gathering views is as valuable for the Governors as recruiting as it influences the Governors' views. Recruitment remains a challenge for the younger age groups.
- We continue to work closely with Chelmsford College on health awareness and world mental health day.
- We have inaugurated a University Day to mark our becoming a University FT. This will include a public lecture on the latest thinking around mental health and illness, aimed at students and schools, as well as key stakeholders like commissioners.
- We held a new style member meeting in Harlow, Colchester and Uttlesford, run by governors, with around 70 people in attendance. Governors reported on a topic (what is a FT, Trust services, and patient survey) and we also had an awareness session and a patient story. The governors found this approach productive.
- Stakeholder groups – we have conducted, and continue to do so, mental health awareness work with large numbers of community organisations like HomeStart, LINks, Age UK, Headway, and the Red Cross, Victim Support, Citizens Advice Bureaus (CABs) and community associations. A new feature has been work places like Tendring District and Suffolk Coastal Councils. This will continue to build reputation and opportunities to recruit.
- The Extra Mile for Mental Health (10 October 2012) was a big success with over 200 participants. A similar event is planned for 2013 and we have campaigning groups of Governors, stakeholder organisations and patients/carers; the objective is to recruit more young people, especially men.
- A dementia campaign with schools, community and service-level activities.
- Governors continue with local surgeries and engagement events to increase dialogue with constituency members and to aid further recruitment. Governors also use their individual existing community networks and connections to carry out recruitment activity.
- Governors appointed by partnership organisations to organise a recruitment event once a year
- As a major strand of addressing the issues around socio economic status we commenced a postal recruitment campaign that targets patients from particular areas but as yet this has not brought many members.

#### **4.2.4. Elections during 2012/13**

In the period January to March 2013 elections took place in accordance with the model rules in the following constituencies:

<b>Constituency</b>	<b>Turnout (%)</b>	<b>No. elected</b>
Braintree	Uncontested	1
Chelmsford	13.4	4
Colchester	11.4	1
Epping Forest	23.4	2
Harlow	22.3	2
Maldon	20.8	2
South Essex	Uncontested	2
Suffolk	Uncontested	2
Tendring	13.6	3
Uttlesford	Uncontested	1
Staff Mid Essex	22.8	3
Staff North East Essex	19.2	3
Staff West Essex	Uncontested	3

#### **4.2.5 Governor Development**

There has been a continuing programme of governor development throughout 2012/13 and there will be an increased emphasis on this in 2013/14 in the context of the implementation of the remaining parts of the Health and Social Care Act, and elections in the majority of our public and all staff constituencies (see above).

Activity during 2012/13 has included:

- Trust Governor Development Sessions (01/03/12, 04/09/12); topics included Non-Executive Recruitment, Financial Performance, Capital Programme, Presentation by CQC on Working with Governors, CAMHS Care Pathway)
- Locality-based induction sessions for new governors
- Joint meetings with the Board of Directors (27/06/12, 30/01/13) with a key focus on the Health & Social Care Act
- FTN Development Sessions (14/03/12, 20/07/12)
- East Midlands Leadership Academy (18/01/12): 'Invest to Govern'
- FGTA Experienced Governors' Network (13/02/13)
- Governors accessing HFMA on-line development resources re Healthcare Finance (Nov-Dec 2012)
- Monitor document 'Your statutory duties: a draft reference guide for NHS foundation trust governors' issued to governors (30/01/13)

Activity Planned for 2013/14 includes:

- Participation in FTN events including the new 'National Training Programme':
  - Pre-induction material
  - Induction on-line toolkit
  - Core module
  - Six Specialist modules
- Trust Development Sessions (commencing Mar/Apr 2013) continuing the focus on the implications of the Health and Social Care Act in practice for Councils of Governors; potential for joint delivery of some aspects are being explored with another FT
- Joint meeting/s of the Board of Directors and the Council of Governors
- Locality-based induction for new governors
- 'Buddying' offered to new governors
- Continued participation in FGTA Networks
- Promotion of FGTA on-line resources
- Monitor document 'Your statutory duties: a reference guide for NHS foundation trust governors' (revised version) to be issued to governors.

## 5. Productivity and Efficiency

### 5.1 Overview

The delivery of the annual 4% efficiency requirement has been genuine challenge for the Trust, and in the main this has been achieved without significant service reductions.

The Trust starts from a historic “value for money” base of a reference cost index (RCI) of 93, but nonetheless seeks to drive efficiencies where they can be safely delivered.

According to recent NHS benchmarking data, based upon Q2 2012/13, the Trust performs well on a range of productivity measures, with

- below-average available acute adult beds per 100,000 population
- close to the median admissions for acute adult patients per 100,000 population
- below-average acute adult readmission rates
- above the upper quartile occupancy rates
- mean average length of stay
- below-average DNA rates.

The Trust has, for the past 2-3 years, recorded relatively high in-patient occupancy rates in particular on adult acute wards and older adult functional wards, which at times can exceed 100%, when the use of home leave is included within the calculation. Lower occupancy rates for continuing care, rehabilitation, older acute organic wards is usually as a result of service redesign, with services provided in the home or other settings, e.g. recovery colleges.

The comparative spending on mental health by three former local PCTs is nationally in the lowest two quintiles (source DH programme budgeting).

As part of the 2013/14 contract, the Trust has agreed to a 2% uplift in the indicative activity plan for community and outpatient services. The value of the non-cashable efficiency is c £0.8m/pa.

As a result of the negative tariff, cost pressures and investment, the CIP requirement total for 2013/14 is approximately £4.1m. However a significant value of cost pressures including increments will be absorbed. As a consequence, the actual cash releasing CIP target is £2.6m (2012/13 - £3.3m). This is a very significant challenge, not least with the potential for future QIPP demands from Commissioners.

Some of the CIP can be achieved from new margin and spot income contributing to the overall CIP target. The balance of cash released savings has been identified from reductions in expenditure budgets. The Trust plans to deliver real budget reductions without reducing service quality, capacity, activity and frontline staff numbers.

### 5.2 CIP Governance

The Trust has a solid track record of CIP delivery. Since 2009/10 the Trust has delivered c. £15million of recurrent CIPs, averaging 4%pa. The Trust has always delivered CIPs in a timely fashion, achieving or exceeding financial plan targets/FRR.

Each month the Trust establishes performance against in-year CIPs targets, plus the balance of reserves, forecasts on contingencies and an assessment of in-year budget performance risks, such as locums, agency and drugs pressures.

The Trust has adopted a two-pronged approach to CIPs:

- Local schemes- CIP schemes are developed by Directorates and Clinical Boards from the bottom up, through a continuous service-line process linked to the Trust's Area business planning process. Proposals are presented in draft form in December/January to the Executive Management Team and these are shared in detail with the Board of Directors in January. Both the Medical Director and Director of Operations and Nursing are required to provide their opinion on the clinical quality and safety impacts of proposals.
- Corporate schemes - Corporate CIPs are developed from themed areas and projects such as Clinical Care Pathways, REMEDY ICT, Estates, Pharmacy, Procurement and Service level agreements.

CIPs go through a two stage process for quality/safety. Schemes that are deemed to impact front line services through redesign or staffing mix changes require a formal template. Straightforward income or non-pay schemes are listed and ratified.

To date, the CIP has been developed from a mixture of the budget holder's incremental efficiency savings, opportunistic schemes and developed themes. The broad CIP headings embrace the following strategic priorities: Clinical Services, Recovery/Rehab, Care Pathway redesign, Estates and Facilities, Workforce & reward, Repatriation, Procurement, Overheads and Support Services.

The CIP programme has always and will continue to be supplemented from elements (both recurrent and non-recurrent) not recognised as "CIP" in the Monitor returns. This will include elements of negotiated divestment/reductions in activity, repatriation, risk/reward schemes, margin on new business, capital charges including depreciation and marginal profit from NCA activity increases. The Trust can evidence significant genuine contributions from these measures over the past three-years to the financial plan. Often many of these schemes are developed and delivered from the local Area business plans. This approach serves to protect clinical areas from further capacity reductions in order to meet CIP targets.

Past performance and delivery of CIPs has been solid, often with schemes fully delivered by September/October. The schemes also offer linkages into the local System QIPP plan.

### **CIP Process**

CIP schemes have been developed by Directorates and Clinical Boards from the bottom up, through a continuous service-line process, linked to Area business planning. Each team will involve clinicians, finance, workforce and quality audit colleagues in the formulation and selection of approved schemes for submission to the Executive. The team is multi-disciplinary and will normally include nurses, medical staff, social workers, psychologist and therapists.

Each submission is risk-assessed for impact on patient/service quality, safety and contractual activity. Where staff resources are reduced, an assessment of historic vacancies, workload and impact on colleagues is undertaken as part of the assessment. Proposals were presented in draft form in December/January to the Executive Management Team and these were shared in detail with the Board of Directors in January. Both the Medical Director and Director of Operations and Nursing are required to provide their opinion on the clinical quality and safety impacts of proposals.

CIP schemes are RAG rated. Greens are taken forward in full. Reds are not progressed. Amber schemes will be assessed in terms of probability and timing of delivery, so that

generally the in-year saving is estimated at between 40% and 60% of the CIP scheme. This provides a margin for achievement in year. Close monitoring ensures that where one scheme fails to meet its target, other schemes can be accelerated or new schemes identified. The full list of CIPs reported to the Board are shared with local Commissioner quality leads and chief financial officers during the contract round and before the start of the financial year.

### 5.3 CIP Profile

Appendix 2 (confidential): Cost Improvement Plans – details the Top 5 CIP Schemes  
A number of the 2013/14 CIP schemes involve service redesign, albeit on a relatively modest scale. These are:

- North East Essex older Adult – reconfiguration/ redesign of older adult services £233k
- North East Essex rehab and age inclusive services £199k
- West Essex rehab/recovery £150k.

### 5.4 CIP Enablers

CIP delivery is embedded in local financial and operational accountability. The Board's comprehensive monthly finance report includes a detailed account of CIP delivery and risks by service line.

### 5.5 Quality impact of CIPs

The Board has established a rigorous risk-based approach, given the introduction and scale of larger themed projects into the CIP strategy. The Board assess the quality/safety aspects of CIP schemes with the completion and review of the assurance of the template below.

Cost Improvement Programme Project Implementation Plan				
Scheme Title				
Scheme Reference No.				
Planned saving		Recurrent R or Non Recurrent N		Saving Realisation Date
Responsibility and Accountability	Name	Title	Signature	
Accountable Director				
Project Lead				
Action details and proposed outcomes				
Non financial benefits				
Current performance				
Project timescale				
Key assumptions	1) _____ 2) _____ 3) _____ 4) _____			
Interdependencies with other services				
Confidence in delivery of financial saving (RAG)	RAG	Commentary on RAG status		
Key Tasks, Milestones and Deadlines	Tasks & Milestone		Deadline	
	1.			
	2.			
	3.			
	4.			
	5.			
	6.			
	7.			
	8.			
	9.			
	10.			
Risk	Likelihood of adverse risk 1 –rare, 2-unlikely 3-possible 4-likely 5 –almost certain	Severity of adverse consequences 1-insignificant 2-minor 3-moderate 4-major 5-significant	Risk score 1-3 Very low 4-6 Low 8-12 medium 15-25 High	Mitigating actions planned
Clinical Effectiveness				
Patient Safety				
Patient Experience				
Other Risks:				
1.				
2.				

The Board and its sub-committee the Risk & Governance Executive continually monitor the full range of finance reports, compliance, productivity and safety KPIs, Sis and complaints by service areas. These are an essential indicator for service standards.

## 6. Financial and Investment Strategy

### Assessment of current financial position

The Trust continues to retain its strong financial position, building upon its successful track record of delivering year on year its planned surplus and FRR4. The 2013/14 plan provides for a strong FRR3 (weighted 3.45) and sufficient surplus to fund the capital programme. The Trust has sufficient liquidity, balance sheet strength, affordable debt to balance the capital programme; building upon the ambition of the Board to maximise the financial flexibilities that FT status affords the organisation to strategically invest in technology, information systems and the built environment to improve safety, quality and experience for patients and staff. The plan provides for Continuity of Service risk rating 3, criteria as follows:

- Liquidity - 3
- Debt service cover - 2

Headline figures for 2013/14 include:

- EBITDA of £7.1m 6.5% margin
- Revenue surplus of £1.6million 1.7% margin  
(£1.54m after technical adjustments for impairments and profit & loss on disposals)
- Turnover of £109.4 million
- Financial Risk Rating 3 (weighted 3.3)
- Continuity of Service Risk Rating 3 (weighted 2.5)
- Cost Improvement Programme £ 4.1million (£2.6million cash releasing);
- Liquidity 28 days
- Forecast Cash holding 31.3.14 £ 8.0m
- Outstanding loans 31.3.14 £11.7m

Block contracts including CQUINs comprise 95% of all planned income.

### Key financial priorities

The key financial priorities include;

- Delivery of the Journey's programme pathway and service redesign to deliver medium term CIP / QIPP savings;
- Continuing to reduce overhead costs;
- Continuing to secure new business from existing customers and business from new customers, for the pursuit of margin and cost efficiency, not just income growth;
- Maintaining EBITDA and I&E Surplus at or above the median for the FT sector;
- Making use of FT flexibilities to secure finance at appropriate rates to drive the business forward;
- Investing surpluses to deliver safer, high quality and efficient services;
- Managing cash and liquidity including debtors;
- Rationalisation of the estate and increased mobile working;
- The disposal of the Severalls hospital site.

Previous borrowing within PBL tier 2 has enabled the Trust to invest in new systems and building infrastructure to secure new business and retain existing, rationalise estate.

### Key risks to achieving the financial strategy and mitigations

The key risks to the successful achievement of the plan include:

- delivery and timing of CIP plans;
- managing the cost of enhanced observations on inpatient wards;
- meeting CQUIN targets to secure reward monies;
- achieving target occupancy for cost per case "spot" beds and accurate billing.

The Trust's mitigation includes;

- Monitoring and management of CIP plans and budgets by way of scheduled monthly meetings by Director of Resources and Director of Operations & Nursing with Area Directors and their Finance Manager;
- An increase in observation budgets - monitoring the use of shift rotas including 1:1 observations and a centrally held contingency reserve;
- Robust co-ordination, monitoring and management of CQUIN schemes
- Active marketing and effective case management of spot beds together with timely and accurate invoicing and debt recovery.

The Trust has successfully negotiated for 2013/14 a reduction in its maximum exposure on the risk share for adult acute inpatient activity. The Trust's maximum exposure has been reduced from £100,000 to £75,000/pa. This builds further upon the renegotiation in 2011, where the Trust liability was uncapped after £200,000 of 50/50 risk-shared spending.



