Forward Plan
2012-2013

Providing Partnership Services in Bedfordshire,
Essex and Luton

SEPT

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

Name	Peter Wadum-Buhl
Job Title	Executive Director of Strategy and Business Development
e-mail address	Peter.wadum-buhl@sept.nhs.uk
Tel. no. for contact	**01268 407784**
Date	**31st May 2012**

In signing below, the Trust is confirming that:

- **The Forward Plan and appendices are an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the board of governors;**
- **The Forward Plan and appendices have 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 Forward Plan and appendices are consistent with the Trust's internal business plans;**
- **All plans discussed and any numbers quoted in the Forward Plan and appendices directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Lorraine Cabel
Signature	

Approved on behalf of the Board of Directors by:

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

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Ray Jennings
Signature	

Section 1: Forward Plan

A. The Trust's Vision

Our vision:

"Providing services that are in tune with you"

Our values:

People who use the service	VALUES	*Colleagues (including partners)*
In tune with me		***In tune with me***
We believe you can live a fulfilling life	**OPTIMISTIC**	Everything we do - every intervention - is focused on helping you feel better
We respect you as an individual, and expect you to respect us too	**RESPECTFUL**	We value each other's contributions
We listen to your point of view, and think about things in the context of your life	**EMPATHISING**	We consider each other's perspective
We will give you choices	**INVOLVING**	We work together as teams, within our organisation and with partners
We help you to take control of your life	**EMPOWERING**	We all have permission to innovate
We'll help you to play an active part too	**ACCOUNTABLE**	We want to be judged by our results

Our vision of "**providing services that are in tune with you**" and our organisational values were developed and designed to describe the Trust's intention of and commitment to responding to the strategic, as well as operational and day to day challenges that we face. Being **"in tune with**" patient expectation, national and local policy developments and requirements; the complex and competitive environment in which we operate and commissioning intentions, means that we will achieve our strategic and operational priorities.

The NHS and local government are facing the most radical structural changes and financial challenge in its history. Whilst SEPT is able to demonstrate a history of being able to respond to changes around us; the scale of the changes and challenge is such that we will need to use every ounce of our experience,

enthusiasm and commitment to high quality patient care to make sure that SEPT is in a good position to continue to provide the services that people we care for need, want and deserve.

The Board of Directors approved a strategic direction for the Trust in April 2011. This recognised the challenges faced and set out a high level strategy to respond appropriately. The Board of Directors, clinical leaders and senior management team confirmed a shared belief that SEPT should continue to be a provider of health and social care services in the future; “doing nothing” was not an option and therefore the overarching strategic priority is to be clinically and financially sustainable in the long term.

The Board of Directors originally identified that SEPT will need to take action in four specific areas of activity that were subsequently identified as our strategic priorities for 2011/12 and beyond. In November 2011 the Board of Directors reviewed the strategic priorities in light of the recent acquisitions of community health services in Bedfordshire, south east Essex and West Essex and the strategic context for the planning period and as a result identified an additional strategic priority relating to the Trust’s workforce and amended the focus of the other strategic priorities to reflect specific challenges. The 5 strategic priorities identified below provide a framework for action during 2012/13.

Strategic Priority 1

Delivering High Quality and Safe Services

Providing services that are “in tune with you”, requires a continued focus on day to day, local service delivery that has quality and patient safety as a priority, meets and where possible exceeds targets, standards and expectation, and delivers the best possible outcomes / encourages recovery, regardless of the challenging and ever changing environment in which the Trust operates.

The Trust will be required to take a range of actions in all areas of service delivery to ensure that patient experience is regularly and consistently monitored and levels of reported satisfaction improve; all services meet applicable national and local NHS and social care targets; issues of concern are addressed; and new stretching goals for quality improvement are achieved. The Board of Directors specifically identified that for 2012/13 and beyond there is a particular need for the Trust to clearly define quality and safety standards expected; put in place enhanced systems and processes to monitor those standards; escalate issues identified and have assurance that appropriate action is being taken.

Strategic Priority 2

Transforming Services

We will demonstrate that we can deliver complex change in an uncertain environment.

In the past we have focussed on transformation being estate related and service specific. Going forward we need to develop more innovative and visionary approaches to changing the way that

services are delivered across care pathways. Major challenge is best addressed via a small number of large changes, not a multitude of small ones and this has to happen across a whole health and social care economy. Quality failure, delay and waste frequently occur at hand off points between organisations. This will require identifying new ways of working; designing and implementing new care and treatment pathways; and ensuring that our focus is on easily accessible, fully integrated and multi-disciplinary pathways and services with health and social care partners.

Strategic Priority 3

Creating An Efficient and Effective Organisation

A range of activities will be required to ensure SEPT remains fit for purpose and financially viable. We have to have an efficient and effective infrastructure that is capable of supporting the delivery of high quality and safe local services in whatever future service configuration. The Board of Directors and senior clinical leaders will need to identify new ways of working that ensure a clear focus on strategy, without taking the "eye off the ball" when it comes to delivery of front line, operational local services. We want to create an organisation that is "healthy" (clinically and managerially), with great leadership, a positive culture and robust governance systems. New ways of working will also be required at all levels of the organisation. SEPT must continue to embrace new technology to reduce duplication and the administrative burdens associated with delivering healthcare; new technology must also be used to enhance clinical service delivery and deliver it in new and exciting ways.

Strategic Priority 4

Workforce Culture and Capacity

We need to develop an organisational culture that reflects the increasingly diverse nature of SEPT's service provision and the diverse communities which we serve and builds on the strong brand, ethos and values already in place. We will need to ensure that we have the right capacity at the right time; clear expectations and standards of performance expected of our staff and ensure that they have the right skills and support to deliver the Trust's objectives.

The key to achieving major service transformation is the engagement and incentivisation of frontline clinical leaders and teams who genuinely own change initiatives and ensure that improvement is sustainable and sustained. We will need to ensure that targeted investment in workforce development encourages greater local clinical leadership and prepares staff to respond to the challenges faced and that there is an on-going programme of engagement activities that ensure staff understand SEPTs vision and share responsibility for its delivery.

Strategic Priority 5

Clear Plans For A Sustainable Future

SEPT must have clear plans for tackling the scale, scope and speed of change required and the Board of Directors is prepared to make tough decisions about the Trust's priorities along the way. Our fifth priority confirms the SEPT Board of Directors' commitment to continuing to focus on the longer term plans for the organisation and making sure that patients and local communities benefit from the focus on the future, not just the here and now.

To be sustainable we will, in the short term, need to consolidate our position after a period of significant growth, in order to create a new baseline from which we can achieve our longer term ambitions.

National population increases predicted in the next 5 years, and continued restraint in public sector funding, will require radical service delivery solutions. Our vision is to be an integral part of efficient and effective, local, integrated care networks. We will therefore focus on developing service delivery models, strategic partnerships, infrastructure and operational management structures that support the delivery of care integrated around the individual at a local level which meet the aspirations of our partners, our own strategic direction and effectively supports the needs of our patients. We will prioritise the taking of proactive action to identify stakeholders who can bring added value and synergy to our integration agenda.

The Trust will need to increase income to remain sustainable. We will continue therefore to pursue carefully chosen partnership and commercial opportunities that contribute to the delivery of the integrated care vision and the Trust's financial stability.

Our 5 strategic priorities will be delivered through 19 Corporate Aims during 2012/13. The corporate aims were identified as a result of considering the local and national strategic context and feedback from staff, partners, patients, governors and members that we received as a result of hosting a number of engagement events between November 2011 and March 2012 involving approximately 1000 people. Each corporate aim is achieved as a result of identified and agreed business unit actions. Achievement of each key aim is monitored; measured by achievement of these specific actions and reported to the Board of Directors on a quarterly basis.

Our Corporate Aims for 2012/13 are:

Strategic Priority 1: Delivering high quality and safe services	
Ref.	**Key Aims**
1.1	Achievement of quality, regulatory and contractual requirements that ensure the Trust remains compliant and meets patient and commissioner expectation.
1.2	Implementation of consistent real-time Trust-wide systems for engaging with patients and staff.
1.3	Care pathways; protocols, outcome measures and minimum service standards developed in partnership with stakeholders.
1.4	Priority quality and safety improvement activities identified by partners, staff and patients implemented.
Strategic Priority 2: Transforming services	
Ref.	**Key Aims**
2.1	Year 3 milestones of Bedfordshire/ Luton Mental Health Transformation Programme delivered.
2.2	QIPP (Quality, Innovation, Productivity and Prevention) and other service developments agreed with commissioners delivered.
2.3	Social care developments set out in vision that develop the workforce, progress personalisation and enhance integration implemented.
2.4	Milestones agreed and delivered that facilitate partnerships with patients, volunteers and voluntary sector to deliver existing, alternative or complementary services.
Strategic Priority 3: Creating an efficient and effective organisation	
Ref.	**Key Aims**
3.1	Financial plan (including agreed Cost Improvement Programmes) delivered.
3.2	Continued development of internal and external organisational governance structures, systems and processes.
3.3	Short, medium and long term prioritised plan developed and 12/13 milestones achieved to utilise technology that enhances service quality and improves efficiency.
3.4	Action taken to reduce variation and increase standardisation (where appropriate) within clinical and support services.

Strategic Priority 4: Workforce culture and capacity	
Ref.	**Key Aims**
4.1	Clinical, organisational and board development and engagement activities undertaken that encourages shared vision, values and quality culture for enlarged organisation.
4.2	Workforce management and development initiatives undertaken that increase quality and productivity, achieve targets and ensure fitness to practice.
4.3	Action taken to further develop clinical leadership in all services and disciplines.
4.4	Customer service improvement activities undertaken in all services to improve patient experience and increase net recommender score compared to baseline.
Strategic Priority 5: Clear plans for a sustainable future	
Ref.	**Key Aims**
5.1	Initiatives that support integrated care vision, particularly those relating to improved care pathways, implemented.
5.2	Opportunities and ideas for further developing, retaining, expanding or contracting Trust services pursued.
5.3	Action taken to build new / enhance existing relationships and partnerships with LA/ PCT and CCG partners.

B The Trust's Strategic Position

SEPT delivers services in three separate health economies (Bedfordshire, Luton and south Essex), working with 3 local primary care trust clusters (NHS Bedfordshire and Luton; NHS South Essex and NHS West Essex), a regional specialist commissioning group (for the provision of specialist forensic mental health services and in-patient child and adolescent mental health services) and 6 local authorities (Bedford Borough Council, Essex County Council, Central Bedfordshire Council, Luton Borough Council, Southend Borough Council and Thurrock Borough Council). Whilst each local health economy has different challenges there are common themes and priorities; risks as well as opportunities; that the Trust will be required to respond to in its forward plan.

B 1 NHS landscape

- **Financial challenges**

  All local health economies are facing significant financial pressures over the three year planning period.

  In Bedfordshire and Luton the local strategic position was described in the (draft) Integrated Plan for 2012/2015 as "The Local challenge is formidable, but the underlying health of the system is good, with much recent progress made." In 2012/13 the system shortfall is approx £58 million.

  In south Essex, the (draft) Integrated Plan confirmed that the financial year of 2011/12 was challenging. "During 2011/2012 the South West Essex health system has continued to recover through the journey of Turnaround. By the year end it is anticipated that South West will achieve breakeven, with the possibility of a marginal surplus. In the South East Essex system, the relatively stable pattern of financial stability was shaken when significant pressures associated with Continuing Healthcare were identified as an unexpected financial pressure of c£5m as the demand and costs continued to rise. The implication of this had a knock on effect to the overall financial position. The effect of this pressure recurrently has left South East Essex with a larger financial gap to address in 2012/13. This has resulted in a total QIPP challenge for south Essex in the region of approximately £35 million in 12/13."

  The North Essex Cluster (which includes West Essex) has confirmed that the system challenge for 2012/13 is £101m which is an increase of £30m (43%) from that envisaged a year ago. Pressures during 2011/12 are part of the reason for this increase. This challenge remains a significant ask for the system and will require radical transformational changes in healthcare delivery over the coming years. Over the 3 year period 2012 to 2015 the challenge to the system is £225.6m based on current predictions.

  All contracts for services for 2012/13 have been agreed with our three commissioning clusters, which reflect SEPTs' contribution ("pass back" management savings as a result of acquiring contracts for community services in 2011) to the health system shortfalls as agreed. This is

reflected in the Trust's financial plan 2012- 2015, a summary of which is set out in section E and appendix 2.

- **Service Delivery priorities**

  All local health economies have confirmed that the focus of their service delivery plans going forward are consistent with the national priorities for health which are:

  - Preventing people from dying prematurely
  - Enhancing quality of life for people with long term conditions
  - Helping people to recover from episodes of ill health following injury
  - Ensuring people have a positive experience of care
  - Treating and caring for people in a safe environment and protecting them from avoidable harm.

  Transformation and integration are identified as the primary enabling strategies to deliver these priorities across all of the health and social care economies in which the Trust operates.

  The Trust is committed to supporting commissioners in achieving these priorities. Our strategic vision and operational clinical and quality development plans identify a number of initiatives that we will be taking forward that will contribute to local workstreams associated with delivery of the national priorities.

- **Local NHS provision**

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

  - Bedford Hospital has not yet achieved NHSFT status. It is estimated that the earliest it will be authorised is spring 2013. The organisation is currently reviewing its downside assumptions and is considering alternative routes to becoming a NHSFT (source Bedfordshire and Luton PCT draft Integrated Plan).
  - L&D is a NHSFT with a Monitor governance risk rating of amber-green and finance risk rating of 3.
  - Cambridge Community Services (provider of community health services in Luton) has not yet achieved NHSFT status. It is estimated that the earliest it will be authorised is summer 2013.

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

- SUFT is a NHSFT with a Monitor governance risk rating of red and finance risk rating of 3 (as at December 2011).
- BTUH is a NHSFT with a Monitor governance risk rating of red and finance risk rating of 4 (as at December 2011).
- NELFT is a NHSFT with a governance risk rating of green and a finance risk rating of 4. Its community health service provision in south west Essex is a "hosting" arrangement, with commissioner plans for market testing of services over the planning period.

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

- Princess Alexandra Hospital has not achieved NHSFT status.
- NEPT is a NHSFT with a governance risk rating of green and finance risk rating of 4 (as at December 2011).

SEPT has demonstrated that it is able to respond to an ever changing environment and has a clear strategic vision for future service delivery that has resulted in acquisition of BLPT in 2010 and three community health service provider organisations in 2011. The Trust is a well established NHSFT; has achieved financial balance in successive years, has achieved all key targets in successive years and commissioners and regulators do not have any significant concerns about performance or quality of services provided.

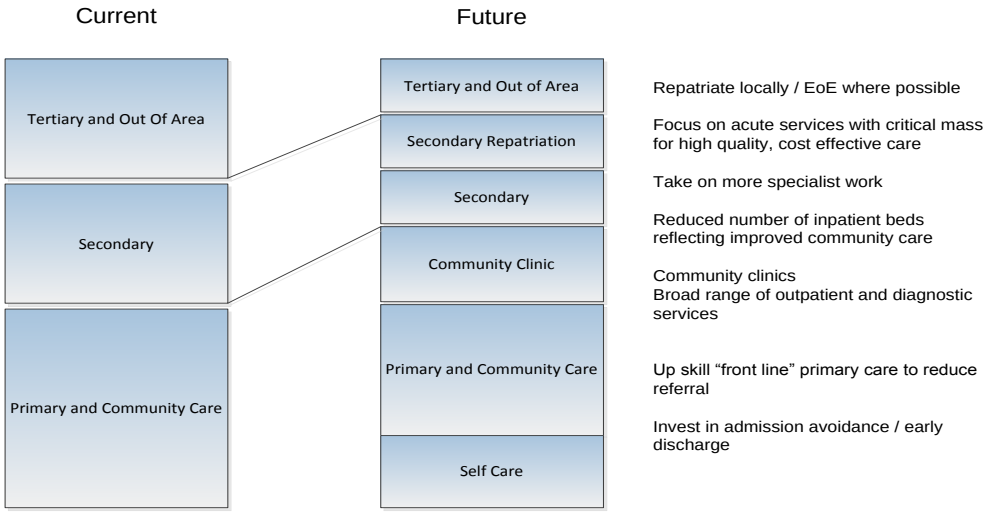
- **Productivity Priorities**

In order to respond to the significant financial challenges identified above, each local health system is required to develop and implement significant Quality, Innovation, Productivity and Prevention (QIPP) plans. There are common themes across all QIPP plans in respect of planned, unplanned care management and improved systems of care to manage patients with long term conditions and complex care conditions. SEPT will be developing and implementing new ways of working in community health services in line with these commissioning priorities, such as, integrated community service provision, single point of access/ referral and enhanced intermediate care services all of which are aimed at preventing hospital admission and facilitating early discharge from hospital. In mental health services we will (for example) be working with commissioners to increase support for patients with dementia and exploring alternatives to in-patient continuing care provision.

- **Commissioning Intentions**

Broadly the commissioning intentions of all of our health commissioners are focussed on increasing spend in community and primary care as more patient care is delivered outside the acute setting; whilst tertiary and out of area activity is repatriated to provide more services locally.

This is represented pictorially in the diagram contained in NHS Bedfordshire and Luton's Integrated Plan below. The principles are consistent with all published commissioning intentions.



Choice in mental service provision, development of the provider market through contestability and "Any Qualified Provider" (AQP) and extension of the tariff/ payments by results regime in contracting for mental health services and community health services are also common themes in published commissioning intentions. The Trust's assumptions regarding the impact of commissioning intentions are taken into account in our financial strategy (set out in section E) and considered in more detail below.

- **Possible risks associated with competition and commissioning intentions:**

The competition and commissioning landscape during the planning period is expected to remain complex and subject to constant change as the Health and Social Care Act comes into force. The Trust has assessed the overall risk associated with competition and commissioning intentions as low in the short term, but acknowledges that during the latter part of the planning period this could increase. Potential risk will be assessed on on going basis.

Risk associated with loss of existing contracts or competition for new contracts will potentially be experienced in specialist areas of service provision, where there is a strong local private sector presence, where pricing is extremely competitive, where there is a growing trend in third sector delivery and where synergies can be gained through a single provider of specific care pathways (for example drug and alcohol services). We anticipate that this will potentially impact on a small number of services without material impact on our financial plan.

Commissioners have confirmed that the services (few relevant to SEPT) that will be subject to the "Any Qualified Provider" regime are:

- Bedfordshire - podiatry, wheelchair, community diagnostics and audiology;
- South Essex - ultrasound and endoscopy
- North (West) Essex- MSK (in NEE), Glaucoma (in NEE), Children's Continuing Care (CCC) across the cluster

There will be a reduction in existing hospital bed commissioning during the planning period which will reflect the desire to shift care closer to home. The Trust expects this and assumptions regarding future bed based activity are incorporated into our efficiency plans.

Commissioners in south Essex have confirmed an intention to review the provision of community health services in south east and south west Essex. They plan to undertake a three stage review process during 2012 to confirm commissioning plans, service redesign plans and market testing plans for these services. The review process already appears to be behind schedule and therefore the risk associated with loss of income during the planning period as a result of market testing, alongside the Trust's commitment to transform local service provision in line with QIPP and local service delivery priorities is identified as low.

South Essex health and social care commissioners are finalising the development of a Joint Mental Health Strategy currently, the implementation of which will take place over the next three years. The risk associated with the strategy content cannot be assessed until it is finalised, but initial indications suggest that commissioners are considering separation of assessment and treatment service provision and this could lead to a small loss of activity and income associated with our community mental health service provision.

- **Opportunities**

Whilst there is a risk of loss of specialist contracts associated with competition and commissioning intentions, the Trust is confident that the opportunities available as a result of national and local policy implementation will be considerable. The Trust has established a "Strategic Think Tank" as an integral part of the governance structure, supported by external advisors as necessary, to assist the Board of Directors in considering potential growth opportunities which could contribute to the Trust's sustainability strategy.

Whilst there will be an expected reduction in existing hospital bed provision, the Trust is confident that there will be increasing demand for new community bed based services with a new focus on intermediate care, and rehabilitation. The Trust has the expertise and estate with which it can offer solutions to local health economy issues and as an example has recently opened a sub-acute unit in Houghton Regis to provide step up/ step down care to ease pressure on acute hospital beds in Bedfordshire.

The shift from acute hospital care to community based services will require the Trust to transform existing community health services to be more efficient and responsive, but will also offer potential to develop new and innovative service models and compete for more contracts for community based services going forward. Development of the Dementia Intensive Support Team in south west Essex and plans to extend this to south east Essex is an example of new service commissioning that has led to increased income.

Recent changes to the private patient regime for NHSFTs afford further opportunity for growth in future years. This is particularly relevant to SEPT, as we were unable to generate private patient income because the maximum value was set previously at the level being generated at the time of Authorisation which was £0. Proposals for generating private patient income are currently being developed through the Trust's Strategic Think Tank and not yet included in the financial forecasts.

(Note: section removed here as commercial in confidence and not for publication)

- **Health and Social Care Act 2012**

After much debate, the Act received Royal Assent in April 2012. It's implementation from June 2012 will have a number of implications for the Trust:

Many of the changes that the Act introduces have already begun to take place locally with the development of shadow Clinical Commissioning Groups (CCGs), which will replace Primary Care Trusts (PCTs) and Strategic Health Authorities as commissioners of local health services from April 2013. The challenge for the Trust and other providers of local health services is to ensure that new relationships are forged appropriately with the GPs who will be leading the CCGs and to ensure that during 2012/13, which is a year of transition, local health services continue regardless.

Our specialist secure mental health services will be commissioned by the NHS Commissioning Board going forward (replacing the Eastern Region Specialist Commissioning Group). Maintaining effective relationships with the commissioners of these services during transition will be critical.

Monitor's role as NHSFT regulator will be changing. It will in future be the economic regulator for all NHS funded services. All providers of NHS healthcare (unless exempted) will need to hold a licence with Monitor. The Trust expects that the obtaining of a licence will not pose any risks. It is likely that NHS healthcare providers will be required to pay a fee for the licence. This has been taken into account in our financial plan in assumptions regarding future local cost pressures.

NHSFTs are given greater scope to generate private patient income, although they will have to ensure that the majority of income is through NHS services. An increase in the proportion of private patient income of more than 5% would need majority approval by its governors and FTs will be required to document how non NHS income has benefitted NHS services in their annual reports. SEPT sees this as a potential opportunity to offset reductions in NHS income and is currently scoping this further.

The Act establishes a new patient and public involvement body, HealthWatch England which will support local HealthWatch bodies. Local HealthWatch will be commissioned by local authorities and held to account by Health Overview and Scrutiny Committees. The Trust is reviewing the structures in place to engage with local HealthWatch bodies when they are established.

The Board of Governors is required to be known as the Council of Governors going forward. The Act confirms the duties of the Council of Governors is to hold the Non Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of membership. With additional power, there is greater responsibility. The Trust will work with governors to ensure that they have the skills and knowledge that will be required to carry out duties effectively going forward.

The Board of Directors will be required to make provision for board meetings to be held in public. The Trust currently holds four meetings each year in public and this will be increasing during 2012.

B 2 Local Authority Landscape

The challenges facing the NHS also affect local government, which will see a reduction in funding of approximately 28% over the next four years as well as growing demand for social care services. All Local Authorities with which SEPT has section 75 Partnership Agreements are seeking efficiency savings which are reflected in our financial plan.

The Trust is committed to working with local authority partners to minimise the combined impact of NHS and social care reductions on all local people. Assisting local authority partners in achieving stretch targets for self directed care and delivering more integrated health and social care services is a shared priority of SEPT and our 6 local authority partners. Self directed care and integrated service provision has the potential to improve quality of service provision, reduce costs and increase the net promoter score for SEPT.

C. The Trust's Clinical and Quality Strategy Over The Next Three Years

SEPT's clinical and quality strategy is integral to and not separate from the overarching strategic vision set out in section A and reflects the challenges and opportunities set out in section B in respect of the strategic environment we operate. Clinical quality drives our vision to be sustainable in the longer term. Our clinical and quality strategy over the planning period is identified in 16 out of 19 corporate aims that contribute to the delivery of each of the Trust's strategic priorities. A wide range of activities will contribute to continued improvements in clinical quality and service delivery within each of these 16 priority areas for action and a range of enabling strategies (for example Estates, Workforce, IM&T, User Involvement) will support achievement.

Our clinical and quality strategy is summarised in the table below.

Strategic Priority	**Examples of key clinical and quality changes required**
Delivering high quality and safe services	Embedding harmonised quality and performance monitoring mechanisms across acquired community health services. Introducing harm free care monitoring in all appropriate services to reduce harm from pressure ulcers; Venous Thrombolysis Embolism (VTE), catheter acquired infection and falls. Introduction of systems Trustwide to collect and monitor net recommender score (friends and family test) on a monthly basis. Fully embedding recovery as the driving purpose of mental health care and treatment. Identification of outcome measures and mechanisms for monitoring in services where there are none. Defining minimum safe staffing levels in inpatient services and ensuring that these are consistently in place. Care pathway review and redesign in partnership with stakeholders to improve access, productivity, effectiveness and patient experience. A focus on the quality of care planning and increased emphasis on ensuring that care is personalised and that patients are actively involved in developing their care plans. Continued emphasis on safeguarding vulnerable adults and children. Ensuring that services are culturally sensitive and meet the increasingly diverse nature of local communities in which we provide services.
Strategic Priority	**Examples of key clinical and quality changes required**

Transforming services	Ensuring that year 3 plans for transformation of mental health services in Bedfordshire and Luton are delivered. This is the final year of the buildings based improvement plan and year 2 of the community service transformation process. Transformation of rehabilitation and continuing care mental health services in Essex. Radical redesign of community health services that are focussed on acute hospital admission avoidance and facilitating discharge from acute hospital care. Continued development of the social care workforce and delivery of social care vision. This will further encourage taking forward the personalisation agenda. Consideration of potential for parts of care pathways that could be delivered better in partnership with third sector.
Creating an efficient and effective organisation	Roll out of standardised, comprehensive, risk based clinical quality review process across Trust. Consolidation and embedding of governance systems, processes and structures and non-clinical support services following acquisition of community health services Implementation of electronic patient records within Trust services. Exploring potential for tele-health initiatives. Elimination of legacy IT systems; full use of CarePlus and Systmone and improved data quality used for decision making. Increased focus on benchmarking productivity and quality to reduce variation and increase standardisation within all services. Continued rationalisation of Trust estate.

Strategic Priority	Examples of key clinical and quality changes required
Workforce culture and capacity	Action taken to embed SEPTs quality culture, vision and values across the enlarged organisation. Continued modernisation of the workforce. Developing pathways that create capacity and free up advanced practitioners to focus on highest areas of clinical need and risk and making best use of non-medical prescribers. Increased links with shadow Local Education & Training Boards and higher education institutes to develop a more flexible workforce able to respond to current challenges. Further development of clinical leadership in all services and disciplines through targeted training and development and improved structures and support systems. Roll out of customer service improvement activities into community health services to improve patient experience. Target agreed for improvement in patient experience as a result of improved customer service compared to baseline.
Clear plans for a sustainable future	Development of integrated care teams and pathways for conditions, age groups and localities as appropriate to the needs of particular locality.

D. Clinical and Quality Priorities and Milestones Over The Next Three Years

In section C above, the Trust has identified a range of clinical and quality actions and changes that will be implemented over the planning period in order to achieve our strategic vision. Specific clinical and quality priorities that contribute to our strategic vision are determined each year in light of issues of potential concern or areas for improvement identified internally or by our stakeholders. During our 2012/13 planning process, we asked our staff, partners, service users and patients and members to identify the priorities for quality improvement for the coming year which the Trust has subsequently agreed as our top 5 quality improvement priorities in our Quality Account. The priorities identified are specific and measurable and progress with them will be monitored by the Board of Directors on a quarterly basis and reported in our Quality Account for 2012/13.

Our Quality Priorities are:

Quality Domain	Quality Priority	Target	Risks
Safety	Eliminating avoidable pressure ulcers that are acquired in our care	• Zero grade 3 or 4 avoidable pressure ulcers by December 2012 • Increased identification and reporting of all grade 2 pressure ulcers compared to 11/12.	Challenging target. Potential that quality of care provided by nursing homes and acute hospitals will impact on Trust ability to achieve.
Experience	Improving support provided to carers of patients and children in community health services	•Increase in number of carers assessments undertaken compared to baseline. •Development of community health service carers support systems and training programmes.	Capacity of CHS staff. Ability to secure funding.
	Improving patient experience	By March 2013, increase % of patients who would recommend SEPT service to friends and family compared to baseline	Complex system to introduce in diverse provision. Lack of benchmarks for comparison in mental health service provision. Drop in satisfaction compared

			to previous data collection methodology.
Effectiveness	Improving quality and personalisation of care plans	Development of critical information standards that evidence quality and personalised care planning. Baseline audit undertaken and % improvement by March 2013.	Challenging target. Practice does not improve quickly enough.
Effectiveness	Improving handover of care; transfer of patients in and between services and discharge of patients to primary care	Development of critical information standards and quality performance target expected for handover of care, transfer and discharge. Baseline audit undertaken and % improvement by March 2013. Improvement in performance and quality of providing discharge summaries to GP	Challenging target. Short timescale to improve practice.

For 2012/13 the Trust will be taking forward 43 stretching quality improvement projects as part of the Commissioning for Quality and Innovation (CQUIN) quality incentive scheme agreed with our commissioners. More detailed information about all of the projects is available on the Trust's website. Progress with implementing our CQUIN quality improvement projects against the milestones agreed with commissioners will be monitored by the Board of Directors on a monthly basis. Some examples of the quality improvement projects that we will be taking forward this year include:

Quality Domain	Quality Goal	Action and milestones	Risks
Safety	Improve awareness and signposting to relevant services for diagnosis and support of patients with dementia *Bedfordshire, West Essex*	Training package to be introduced and data collection processes developed for the referral and / or signposting of patients with suspected dementia. 85% of Clinical Staff within Adult Services to be trained by Q4 and establishment	Improved awareness and signposting impacts on capacity of specialist dementia

	and South east Essex Community Health Services	of baseline for improvement in 2013-14 in the referral and signposting of patients.	services
Safety	Measurement of harm free care and action to reduce harm as necessary *South Essex Mental Health Services*	Monthly monitoring of potential harm free care measures (VTE, catheter acquired infections, pressure ulcers and falls) in older peoples mental health services. Improvement in harm free care by end of year	None identified
Experience	Improved transition for young people with additional needs to adult services *Bedfordshire and Luton Mental Health and Bedfordshire Community Health Services*	Training and awareness raising in use of Multi Agency Assessment Tool. Data collection processes developed and implemented to evidence improvement Metrics to evidence improvement identified and trajectory agreed for improvement by year end.	None identified
	Improvements to the quality of community mental health service interventions with patients *Bedfordshire and Luton Mental Health Services*	Identify meaningful contact metrics with stakeholders. Develop audit tool and carry out baseline assessment Take action to improve on baseline and re-audit in Q4 to demonstrate improvement.	Ability to meet commissioner expectation in timescales identified.
	Implementing a single point of access to emotional wellbeing services to improve access to services. *Essex CAMH Services*	Implement single gateway pilot and carry out evaluation.	Failure of local authority to meet it's identified project obligations

Quality Domain	Quality Goal	Action and milestones	Risks
Effectiveness	Development and evaluation of enhanced out of hours and weekend support service for people with mental ill health *Bedfordshire and Luton Mental Health Services*	Identification of interventions to be provided, pilot areas and operational pathways to be included the pilot. Evaluate pilot and report to commissioners with recommendations for future service provision.	None identified
	Explore potential for caring for patients with mild to moderate mental health problems in alternative settings *South Essex Mental Health Services*	Carry out an audit of 30 service users and design and agree more effective pathways and support to enable GP's to manage the cohort more effectively in primary care. By end of year achieve a reduction in referral rates by GPs for service users with mild to moderate non psychotic disorders.	Increased demand on IAPT service. Ability to influence GP referral practice.
	Improve health of local population by using every contact to maintain or improve physical and mental health and wellbeing. *West Essex Community Health Services*	Development of strategy for health promotion and training of staff Demonstrate an increase of 30% on baseline data of people attending smoking cessation services 95% of identified staff participate in training and can demonstrate an improvement in healthy lifestyle knowledge and confidence	Part of target relies on behaviour of patients which cannot be totally influenced.
	Improvements to care pathways that lead to reduction in length of stay Forensic Mental Health Services.	Milestones developed and agreed for each part of the care pathway. Agreement of reduction target to average length of stay Action taken to achieve pathway milestones Agreed reduction in los achieved	Care pathway involves other partners where delays cannot be influenced by Trust.

Despite the challenges posed to the Trust during the planning period SEPT remains committed to continuing to develop local clinical services that respond to the needs of the diverse local communities in which we are delivering services; address issues raised by service users and patients and their representatives and deliver improvements in line with local and national policy developments. During the planning period, the Trust will be taking forward a range of service developments as a result of internal redesign or in partnership with health and social care commissioners. Examples include:

Quality Domain	Service	Development	Risks
Safety	Redesign model of inpatient service delivery. *South Essex Mental Health Services*	Implement a revised model of mental health inpatient service in south Essex, based on a functional model of service delivery not one based on the locality where the patient lives or their age. This means that each of our inpatient wards will care for patients with a specific diagnosis, enabling specialist medical opinion and nursing and therapy support targeted to meet the needs of particular patient groups.	Managing potential resistance to change. Minimising disruption to service users.
	Community Mental Health Service Transformation. *Bedfordshire and Luton Mental Health Services*	We plan to continue our redesign of community mental health services. We are specifically aiming to improve access to services as a result of improving the single point of referral / access service and extended weekend support services; strengthen links with GPs through better primary care liaison and support carers more effectively.	Managing expectation. Impact on staff morale as services are transformed.
Experience	Increase Improved Access to Psychological Therapies (IAPT) provision *South Essex Mental Health Services*	Additional funding has been received to respond to high demand for this effective service. The service is already confirmed as the best performing in the country with over 70% of referrals accepted for treatment, waiting times less than 28 days and over 60% recovery rates. In addition the service will participate in a national pilot for IAPT for people with long term conditions and unexplained medical symptoms.	Demand continues to increase.

Quality Domain	Service	Development	Risks
Experience	Continue to improve the physical healthcare environment. *Bedfordshire and Luton Mental Health Services*	Our plans will deliver completion of Limetree redevelopment at Luton & Dunstable Hospital and transfer assessment and treatment inpatient service from Oakley Court by July 2012. During the year we will also commence pre-construction activities and construction work to develop a new build facility at Bedford Health Village in readiness for the transfer of assessment and treatment inpatient services from Weller Wing by December 2013.	Ensuring that service users are actively engaged and support plans.
	Single Point Of Referral / Access *South east Essex and West Essex Community Health Services*	We will embed the establishment of services designed to ensure that the right person, from the community health service team, responds at the right time to referrals for support in the patient's home that prevents admission to or facilitates discharge from hospital.	None identified
Effectiveness	New Sub- acute Pathway *Bedfordshire Community Health Services*	This pathway has been designed to prevent unnecessary acute admissions, earlier discharges ensuring care closer to home provision and improved patient outcomes. This pathway includes a new sub-acute unit, single point of contact for referrals through the multi disciplinary team, integrated pathways between rehabilitation & enablement and Rapid Intervention Team and managing patients from care homes who have had frequent acute admissions.	None identified
	Early Supported Discharge Team (Stroke patients) *West Essex Community Health Services*	A new team will be established to support more patients in their own homes who have suffered a stroke. The team will aim to reduce lengthy hospital stays in hospital by providing intensive home support.	None identified

Quality Domain	Service	Development	Risks
Effectiveness	Intermediate care provision for people with dementia. *South Essex Mental Health services*	In 2012/13 we will create a step up/ step down in-patient facility through redesign of existing service provision that is aimed at preventing admission and facilitating discharge from acute hospital beds of people with dementia. Our new model of service will also provide patients with intensive rehabilitation to help people remain in their own homes for as long as possible instead of being admitted into long term care.	Support for changes to model of service from HOSCs and local communities.
	Integrated Care Teams *Bedfordshire, south east Essex and West Essex Community Health Services*	Implementation of SEPTs vision for future service delivery will see continued progress with establishing integrated adult care teams aligned to clinical commissioning groups and with social care provision. Our aim is to integrate children' and mental health services into our teams in the longer term and during this year we will take enabling actions to achieve seamless service provision tailored to meet the health and social care needs of specific local communities.	Minimising service disruption during transformation.

E. The Trust's financial strategy and goals over the next three years

Introduction and Background to SEPT's Financial Strategy

This section sets out SEPT's financial strategy for the period 2012-2015 which fits with and supports the strategic direction of the Trust. It has been developed alongside, and been significantly informed by, SEPT's Corporate and Operational Plans for the same period.

The strategy has been developed in challenging times for the UK economy, and the NHS in particular against a background of the need to demonstrate to all stakeholder groups that SEPT has clear and robust arrangements for financial planning and control and that these arrangements are embedded within the Trust's governance and management arrangements.

The financial strategy forms an integrated approach to the management of the Trust's finances and ensures business and financial issues are considered alongside clinical issues when significant changes are planned in activities. Financial viability and the long term sustainability are key to SEPT achieving its wider aims and objectives.

The strategy that is set out in this document is designed to address five key issues:

- The long-term viability of SEPT and matching resources with service requirements.
- Maintaining productive capacity to meet current and medium term service changes and developments.
- Financing development, innovation and transformation through efficient asset utilisation and investment.
- The evaluation of strategic alternatives and managing risks.
- Integrating financial and other corporate strategies.

At the same time the strategy needs to embrace a number of operational issues to ensure:

- Financial strategy is developed and integrated within SEPT's planning arrangements.
- The corporate plan is translated into an operating plan and annual budget.
- That SEPT's resources are managed, controlled and protected.
- Assets identified are safeguarded and fully utilised.
- That all liabilities are identified and managed.

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

- The requirement to generate an operating surplus each year (excluding asset sales) to maintain a Monitor Financial Risk Rating of 3 at the minimum. This will assist with ensuring the long-term future of the Trust and provide funds for future investment.
- Within the annual budget agreed by Board of Directors a centrally held and managed contingency is provided for. This contingency will provide a buffer against unexpected events and provide funds to support new initiatives.
- A clear scheme of delegation within the Trust so that responsibility for financial management and control is clear and unambiguous.
- Clear arrangements for the contribution from business continuity and sustainability activities and initiatives.
- Planned expenditure in the period 2012/15 on capital investments including maintenance, through a mixture of capital and revenue expenditure, to maintain its assets including buildings.
- the development of a clear pricing strategy for supporting the introduction of tariffs for MH services and the continued development of Service Line Costs for all services.
- No external borrowing is currently expected or required.

Capital Investment

As part of the Trust's operational planning process capital expenditure plans are developed annually and reviewed by the Board of Directors on the recommendations of the Trust's Executive Operational Committee. Potential new capital expenditure is evaluated against the Trust's business objectives and prioritised as necessary. Schemes will only proceed to formal approval if they:

- meet the Trust's objectives; and
- can be funded within the overall constraint of achieving the required annual surplus.

Managing Risk

As part of the Trust's internal control arrangements there is a comprehensive risk management programme in place which aims to manage and mitigate financial risks to the Trust. All risks are assessed for potential impact and likelihood of occurring and full mitigation plans are developed for all high or extreme rated risks. This plan ensures that such risks are closely monitored and are capable of financial management should the risk materialise in practice.

Financial Assumptions

To be able to produce a meaningful financial plan, a number of assumptions have to be made and regularly kept under review. Economic factors such as inflation and the NHS Operating Framework have a huge impact on the Trust's financial position. The main assumptions included within the finance strategy are as follows:

- The Operating Framework for 2012/13 sets out an underlying minimum efficiency requirement of 4%, including a real reduction in income ranging between 1.5% - 1.8%. The NHS is also required to internally address all inflationary pressures and other cost pressures, anticipated to be in the region of 2.5%.

- Inflation: The Government now measures inflation according to the Consumer Price Index (CPI), showing inflation above 5% (Oct/Nov '11) which has been modeled in to our financial plans.

- Pay Inflation: Although the 2-year pay freeze is in its 2nd year, those earning below £ 21,000 will receive a £250 increase from April 2012. There are also some minor changes to Employer National Insurance Contributions which net off in total. For years 2 and 3 of the plan, given the current state of the UK economy no further pay increases are modeled.

Other specific income, expenditure and capex assumptions are set out in the appendices.

Our Financial Plans

The closing position for 2011/12 provides the base position for the financial plan. A summary of forecast income by type for the 2012/13 financial year covering Essex Mental Health and Learning Disability Services, Bedfordshire and Luton Mental Health and Learning Disability services, Bedfordshire Community Health Services, south Essex Community Health Service and west Essex Community Health Services. Based on our assumptions the forecast 3-year income is shown in the table below:

TABLE 1: Contract Type	2012/13 £m	2013/14 £m	2014/15 £m
Mandatory Services			
Main Block Contracts	**263.0**	**252.0**	**248.0**
Other Block Contracts	**10.0**	**10.0**	**10**
Cost and Volume Contracts	**18.3**	**18.0**	**17.6**
Clinical Partnerships	**6.2**	**6.2**	**6.2**
Other	**8.7**	**8.7**	**8.4**
Total Income	**306.2**	**294.9**	**290.2**

Table 2 details the gross expenditure plan for the Trust. This forecast opening budget position for 2012/13 taken from the Trust's finance system at 11/12 year end and adjusted to reflect any developments / contract variations, together with the local and generic cost pressures as detailed in the Operating Framework. The Trust's budget setting process has identified a number of local cost pressures which are unable to be accommodated within existing resources which is included in the financial plan. Built-in to this schedule are prior year pressures and unachieved CIP's for all divisions.

In overall terms therefore, **the Trust has a total gross initial expenditure plan for 2012/13 of £ 322.1 million.**

TABLE 2: Expenditure Type	2012/13 £m	2013/14 £m	2014/15 £m
Forecast Opening Budgets for 2012/13	306.8	296.2	290.9
CQUIN	6.7	-	-
National Cost Pressures (as per assumptions)	3.9	3.6	3.4
Local Cost Pressures	1.5	1.5	1.4
Unachieved 2011/12 CIPs (B/fwd)	3.2		
Unachieved 2012/13 CIPs (B/fwd)		0.0	
Unachieved 2014/15 CIPs (B/fwd)			0.0
Total Expenditure	**322.1**	**301.3**	**295.7**

The Trust's forecast expenditure of £322.1 million exceeds the forecast income of £306.2 million by £15.9 million.

TABLE 3 - Initial Shortfall	2012/13 £m	2013/14 £m	2014/15 £m
Total Income	306.2	294.9	290.2
Total Expenditure (Pre CIP)	322.1	301.3	295.7
Initial Shortfall	**(15.9)**	**(6.4)**	**(5.5)**

This increases to £ 19.1 million when the planned surplus of £ 3.3 million is included.

TABLE 4 - Financial Plan Shortfall	2012/13 £m	2013/14 £m	2014/15 £m
Total Income	306.2	294.9	290.2
Total Expenditure (Pre CIP)	322.1	301.3	295.7
Surplus Required	3.3	4.0	4.0
Financial Plan Shortfall	**(19.1)**	**(10.4)**	**(9.5)**

The table above demonstrates that from a combination of reduced funding together with other financial pressures results in a budget that is not sustainable. Therefore a range of efficiency measures have been considered to close the funding gap. The total planning shortfall facing the Trust in 2012/13 of £ 19.1 million represents 6% of the value of the Trust's total income. As in previous years, the preparation of the Trust's cost improvement and income generation plans follows a number of guiding principles which the Trust has adopted as part of the process of identifying and agreeing suitable cost improvement plans. These principles are as follows:

- Proposals should maintain existing service levels wherever possible.
- Proposals must be achievable and deliverable during 2012/13.
- Proposals should be sensitive to staff interests and minimise impact as far as practicable.
- Proposals should consider all management and administrative functions before impacting on clinical services while acknowledging that an acceptable level of management for the organisation must be maintained at all times.
- The Trust will not provide services that are deemed to be clinically unsafe.

A summary of the Trust's CIP plans by category of CIP is provided in table 5 below. Further detail is available in Appendix 2, where we have identified how the schemes were designed, subjected to a quality impact assessment and the financial risk associated with delivering them. The summary below identifies that around 54% of CIPs are planned to come from 'back-office' services, 29% from within Operational services and 17% from Service Transformation initiatives.

TABLE 5 - Planning Shortfall identified CIPs by division)	Essex MH £m	B & L MH £m	BCHS £m	SEE CHS £m	WECHS £m	Total £m
Financial Plan Shortfall	**(6.2)**	**(3.6)**	**(3.5)**	**(3.2)**	**(2.6)**	**(19.1)**
Estate Rationalisation	0.7	0.4	0.1	0	0.1	1.3
Service Transformation	0.1	0.1	0.8	0.8	0.2	2.0
Procurement and Non-Pay savings	0.1	0.1	0.2	0.2	0.1	0.7
Back Office and Management Savings	3.8	1.4	1.7	1.3	1.4	9.6
Operational Management and Skill Mix Reviews	1.5	1.6	0.7	0.9	0.8	5.5
TOTAL CIP SCHEMES	**6.2**	**3.6**	**3.5**	**3.2**	**2.6**	**19.1**

Key Actions Required to Support Delivery of the Financial Strategy

- The Trust has successfully used transformational change to drive major initiatives, efficiency savings and cultural change in a number of key service areas. We will continue to drive change throughout the Trust by supporting a future programme of transformation projects.
- The Trust is financing Project Support for the delivery of the major CIP programme and to deliver the agreed QIPP initiatives planned.
- The Trust will continuously keep under review and develop additional efficiency measures to meet the CIP requirements in future years.
- The Trust will also continue to review processes, including consideration for further outsourcing support services.
- Undertake due diligence on the transfer of potential Community Health Services assets to the Trust.
- The Trust will continue to develop the roll out of Service Line Costing for Community Health Services.
- With the imminent removal of the private patient cap the Trust will look to increase income from private patient activity for the direct benefit of local NHS services.

F. The Trust's approach to ensuring effective leadership and adequate management processes and structures over the next three years

SEPT has a tradition of leadership based on a strong ethos and values that encourage creativity and innovation. Our healthy, 'can-do' culture has been an important factor in our successes and our leadership and organisational strategy will ensure that these behaviours are embedded across the organisation. The scope of the challenges that we are facing will require us to further strengthen leadership, particularly clinical leadership, at all levels of the organisation. It is crucial to our ongoing success that all staff understands SEPT's vision and share responsibility for its delivery.

During 12/13, as the organisation consolidates its position post acquisition and growth, there is a particular need to reconsider the strategic leadership of the Trust. The composition of the Board of Directors was agreed as part of the acquisition strategies for community health services in 2010/11. Ensuring that the strategic leadership of the Trust remains fit for purpose as the organisation changes is a priority going forward. Recruitment to Non Executive Director vacancies has been unsuccessful and has been subject to ongoing review. As part of the review of composition we will reconsider the skills and competencies identified for potential Non Executive Directors to meet the needs of the organisation post acquisition. We will look to maximise the fallout from the structural changes in the health service to recruit Non Executive Directors at the earliest opportunity. The Trust has one Executive Director vacancy. The Executive Director of Clinical Governance & Quality role has been fulfilled by an Interim Executive Director for two years. This has enabled stable and consistent clinical quality leadership during a period of significant organisational change. As the organisation consolidates its position, this provides an opportunity to review job/ role design and to recruit a substantive postholder with the right skills and competencies for a very different organisation. Our Medical Director is planning to retire at the end of 12/13. During 11/12 she has implemented a robust Clinical Director structure and appointed high quality deputies as part of her previously agreed succession plan. The Trust will aim to recruit a replacement Medical Director by the end of the year.

Our leadership and organisational development strategy will ensure that frontline leaders and teams genuinely own change initiatives; and are equipped to implement them in a way that is sustainable and sustained. Our staff need to be clear about what is expected of them and the standards that they will need to achieve; and our leaders and managers will need to manage performance to these standards.

The Board of Directors remains committed to developing strategic partnerships that assist it in delivering the Trust's organisational and leadership strategy. The Leadership Development initiative with Yale University is on going and our partnership with local universities is driving up standards of capability, competence and leadership of our workforce.

Our leadership and organisational development strategy is summarised in the table below:

Link to Key Aim(s)	Key Risks (and gaps)	Actions to rectify / mitigate	Milestones
QIPP and other service developments agreed with commissioners delivered. **Financial plan (including agreed CIPs) delivered.**	Continued strengthening of the Board's financial and commercial skills; enhanced strategic planning; and risk management skills. Management structures will need to be revised in line with planned service delivery changes. Downside planning and mitigation will be required to be reviewed regularly and new and innovative solutions constantly identified.	Board annual self-evaluation completed. Board development programme reviewed in line with Trust's strategic priorities. Management structures revised in line with planned service delivery changes. Change management facilitation programmes continued as part of Workforce Strategy. Business Unit continues to support efficiency, productivity and sustainability programmes.	2012/13: Updated Board development programme in place; Year 2 integration and transformation plan milestones achieved; growth opportunities identified and pursued 2013/14: Year 3 integration and transformation plan milestones achieved; growth opportunities identified and pursued 2014/15: growth opportunities identified and pursued
Workforce management and development initiatives undertaken that increase quality and productivity, achieve targets and ensure fitness to practice.	Managers will need to manage individual and team performance to agreed organisational standards. Staff will need to be clear about the expectations and standards of performance expected of them, including the	Roll out of training for managers in place to support the management competency framework. Revised streamlined integrated supervision and appraisal processes implemented. Roll out of training to support the revised supervision and appraisal process is in place.	2012/13: Trust objectives achieved; management competency framework in place and roll out of training commenced 2013/14: Trust objectives achieved 2014/15: Trust objectives achieved

	achievement of quality and safety standard.		
Continued development of internal and external governance structures, systems and processes	Strategic leadership must be fit for purpose and appropriate for organisation as it consolidates position and prepares for further changes. Council of Governors may not have appropriate skills and competencies to take on responsibilities introduced as a result of Health and Social Care Act.	Review of Board of Director composition. Substantive appointment to all vacant posts NED and ED. Medical Director succession plan progressed Governor development programme reviewed and enhanced in response to identified developments.	2012/13: actions identified completed 2013/14: annual review completed and action agreed/ taken 2014/15: annual review completed and action taken/ agreed.
Action taken to further develop clinical leadership in all services and disciplines	Leaders will need to take ownership of change initiatives and implementation of sustainable and sustained improvements. Staff will need to understand leadership as a personal responsibility, not a job role.	Leadership development programme in place at all levels and in all services. Targets agreed with each Director for participation of frontline staff in leadership programmes. Performance monitoring in place in place.	2012/13: Trust objectives achieved 2013/14: Trust objectives achieved 2014/15: Trust objectives achieved

Clinical, organisational and board development and engagement activities undertaken that encourage shared vision, values and quality culture for enlarged organisation	Frontline leaders and teams will need to understand SEPT's vision and share responsibility for its delivery. Integration will require all leadership competencies and behaviours identified as key to SEPT's success at all levels of the organisation.	Trust Values and Service Standards are promoted and included in recruitment, induction, supervision and appraisal processes. Service Planning and Annual Planning events held. Organisational Development Programme at service /team level in place. Leadership programmes in place at all levels across the extended organisation.	2012/13: Trust objectives achieved 2013/14: Trust objectives achieved 2014/15: Trust objectives achieved
Customer service improvement activities undertaken in all services to improve patient experience and increase net recommender score.	Staff understanding of the need to deliver excellent customer service and increase net recommender score.	Customer service awareness training programme rolled out across community services. Patient experience is regularly and consistently monitored; new stretching goals for quality improvement are set. There is a programme of development sessions (team/service/locality) in place resulting in robust action plans, each of which is followed up by the relevant Director.	2012/13: Net recommender score increased 2013/14: Net recommender score increased 2014/15: Net recommender score increased

Initiatives that support integrated care vision, particularly those relating to improved care pathways, implemented.	Revised Board and Top Team management structure will be necessary to deliver an integrated care approach.	Staff and stakeholder engagement events held. Opportunities for integration or closer alignment of services and management structures identified and outline plan (road map) developed. Partnership and commercial opportunities identified and in place.	2012/13: Outline plan developed; implementation plan in progress 2013/14: Implementation plan in progress 2014/15: Implementation plan in progress

G. The Trust's other strategic and operational plans over the next three years

None identified for inclusion.

H. The Trust has had regard to the views of Trust Governors by:

The Trust actively engages with Governors throughout the year aiming to involve them in an on-going dialogue about the quality and level of service provision on a day to day basis as well as the forward plans of the organisation. However, Governors were specifically able to influence the forward plans as a result of:

October 11 – Strategic Direction Masterclass. Governors were provided with an opportunity to understand the context for service provision and the Trust's response to it.

December 11 –Annual Plan update to Board of Governors at formal meeting.

February 12 – Annual Plan update to Board of Governors at formal meeting

February 12- Governor participation in Stakeholder Planning Events (held in Bedfordshire and Essex)

January to March 12- Governors chaired member meetings in each constituency where the strategic context was discussed and local quality priorities were identified by members.

The draft forward plan was circulated to all governors on 25th April 2012 for comment and consultation meetings were held with governors on 1 and 3 May 2012 to discuss the content with and provide feedback to Trust officers prior to finalisation, approval by the Board of Directors and submission to Monitor.

Appendix 1: Key risks

1.1 Financial Risks

Category of Risk		Nature of Risk	Likely 5 Year Cash Impact (£000's)	Mitigating Actions/Contingency Plans in place	Residual Concerns	How Trust Board will Monitor Residual Concerns
REVENUE						
I5	Internal Risk – Non Recurrent	Agreed quality standards are not met in full and 20% of CQUIN funding is withheld	£1,250 – one year impact only	The Trust's financial plan requires 60% of CQUIN income to support time delays etc. in the delivery of the CIP scheme. Remainder of CQUIN income, dependent on receipt will be allocated to support future change management programmes.	None	
I7	Internal Risk	Possible loss of contribution of £300k per annum as a result of the impact from the loss of services currently provided by the Trust, being tendered by Commissioners.	£700k	Bring forward support services CIP schemes from 2013/14	None	
E1	Internal Risk	A further 0.5% of efficiencies required annually in addition to the efficiency of 4% in year's 2 and 3 of the financial plan	£3,000	The Trust's mitigation against the impact of this risk is as follows: a.Release cash from the capital programme to address cash shortfall on a non-recurrent basis. b.Implement the following schemes:	The longer term impact on the slippage on capital schemes requires assessment	

				£000's Director Downsizing 200 Senior Management Downsizing 300 Slipping Building Maintenance by 1-year 700 Release Transition Reserve 1,000 Vacancy Freeze 300 Further Back Office Savings 1,500		
E2	Internal Risk	20% slippage on delivered the CIP programme of identified schemes year on year	Excess of £ 6,500	The Trust's mitigation against the impact of this risk is as follows: a. Release cash from the capital programme to address cash shortfall on a non-recurrent basis. b. Implement the following schemes:	The longer term impact on the slippage on capital schemes requires assessment	

				£000's Director Downsizing 200 Senior Management Downsizing 300 Slipping Building Maintenance by 1-year 700 Release Transition Reserve 1,000 Vacancy Freeze 300 Further Back Office Savings 1,500		
CAPEX						
X2	Internal Risk	The Trust's capital plans assume that some of the Trust's non-protected assets are sold during the 5 year planning period. The risk of no sales going through of Non Protected Assets	£750	The capital programme as it stands currently has surplus cash available for investment; therefore there is no impact on cash.	None	
X4	Internal Risk	Capital Allocations for IT and Service Transformation schemes may require increased allocations over the planning period. Impact of a further 10% being required, for the enablement of scheme completion	£1,650	The capital programme as it stands currently has surplus cash available for investment; therefore there is no impact on cash.	None	

1.2 Non-Financial Risks (including quality)

Risks are assessed based on the I (impact) of potential risk and L (likelihood that it will materialise). The risk rating is calculated based on the 5 x 5 Australia/ New Zealand risk matrix set out in the Trust's Risk Management Framework, which is standard practice in most NHS organisations.

Category of Risk	Nature of Risk	Likely 5 Year Cash Impact (£000's)	Mitigating Actions/Contingency Plans in place	Residual Concerns	How Trust Board will Monitor Residual Concerns
Patient Safety Compliance Financial Reputation	If the Trust is unable to demonstrate robust governance and assurance systems to address any areas requiring improvement there is a potential that quality is undermined and risk of regulatory intervention Risk Assessment I4 x L3 = 12 high	None	Robust action plans have been developed to address areas identified for improvement by the CQC. CQC action plans implemented Trust wide. The CQC have now revisited the Weller Wing and Heath Close and identified no concerns. Unannounced spot checks undertaken against CQC criteria on a regular basis by Compliance Team, Exec Directors, Directors, Non Execs, Governors and Links. Further guidance being developed for staff at all levels. Review of the SEPT CQC audit tool. Outcomes of audits being shared between Bedfordshire and Essex CHS	Post mitigation risk assessment I4 x L1 = Medium	Consideration of Monthly quality and performance report; CQC review outcomes/ and progress with action plans. Internal and external assurance reports. Assurance from Integrated Quality and Governance Board Sub-Committee Consideration of Board Assurance Framework (BAF) on monthly basis
Patient Safety Reputation	If learning from incidents is not embedded quality and patient safety may not be maintained or improved. Risk Assessment I4 x L4 = 16 high	None	Internal investigations undertaken. Action plans developed and implemented. Evidence portfolios in place. Process in place to communicate learning to staff including team brief, Trust today and system for team and individual learning. Wider training in human factors and Root Cause Analysis (RCA) rolling programme in place. Learning summaries and learning from experience Only 1 historic external SI	Post mitigation risk assessment I4 x L1 = Medium	Progress and action plans reported to the Executive Operational Committee and IGC. Random audits undertaken of action plans. Consideration of BAF on monthly basis

			report remains in B&L mental health services Historic SI cases remain in other parts of the Trust. Further work to investigate processes and clinical pathways		
Patient Safety Compliance	If the Trust is unable to implement system for unified records or there is a delay in delivery this may impact on the availability of clinical information and compliance with regulatory bodies Risk Assessment I4 x L4 = 16 high	None	Summary record developed and implemented across Trust. Record tracing system in place. Trust systems to collect all records on admission in place. Electronic record roll out programme – Phase 1 release (read-only) of system now in place. Staff on pilot wards in Essex (Cedar) and Beds & Luton (Calnwood Court) are now being trained and first patient records have been scanned onto system. All inpatients in these wards will be progressively added to the system, starting with new admissions. Community teams being engaged to maintain electronic record on discharge. Evaluation of project under way. Roll out plan across the Trust to be developed April.	Post mitigation risk assessment I4 x L1 = Medium	Plan monitored by project Board and reported to EOC Board sub-committee. Pilot areas to be reviewed in 3 months to assess fit for purpose. Consideration of BAF on monthly basis
Patient Safety Compliance	If there is a significant lapse in staff attendance and achievement of mandatory training targets this will undermine the Trusts ability to provide services. If there is a significant lapse in staff attendance and achievement of core training targets this may lead to skills deficit and undermine the Trusts ability to provide safe quality services.	None	Mandatory training review being carried out and nearly complete, actions identified. Follow up of non-attendance and compliance by managers and directors. Policy and procedures harmonised. New reporting systems being developed by IMT	Post mitigation risk assessment I4 x L1 = Medium	Performance monitored by EOC Board sub-committee and Board of Directors via the monthly quality and performance report. Consideration of BAF on monthly basis

	Risk Assessment I4 x L3 = 12 high				
Patient Safety Reputational	Acquired services may impact on the organisation ability to maintain and improve results in national patient survey Risk Assessment I4 x L3 = 12 high	None	Action plan have been developed to address areas identified for improvement relating to both the community and inpatient survey. Programme of audit to be undertaken commencing in November. Audit tool and programme reviewed. Training session for staff groups delivered by care and service user commenced in Jan 12. Outcomes to be reported to the Patient Survey Group. Community patient survey commenced for 2012. Outcomes to be analysed. Mystery shopper conference organised for 23/3/12	Post mitigation risk assessment I4 x L1 = Medium	Reporting to patient survey group and ET. Spot checks against progress to be undertaken against plan by Head of PPI and Head of Assurance in conjunction with Impact (Beds and Luton). Consideration of BAF on monthly basis
Patient safety Reputation	If transition plans are not implemented in a timely and effective manner this may impact on the provision of high quality services Risk Assessment I4 x L3 = 12 high	None	Engagement with staff in community services. Expertise and consultants to be sourced if required. Identifying of appropriate community staff to assist with capacity issues. Regular staff meetings. Transition plan in place. Restructure consultation completed and being recruited too and capacity gaps being identified.	Post mitigation risk assessment I4 x L1 = Medium	Reports provided to Transformation and CIP Board sub-committee. Consideration of BAF on monthly basis
Reputational	If engagement is not effective with CCGs and Health and Well Being Boards then the organisation may not be able to respond to local commissioning requirements Risk Assessment I5 x L2 = 10 high	None	Programme of engagement underway to engage with emerging consortia. Working with partners in sub-economy. Long term plan to have GP representation by locality. Emerging leadership for Clinical Commissioning Groups being supported. All directors encouraged to build relationships. Awareness also being raised with senior managers	Post mitigation risk assessment I5 x L1 = Medium	Consideration of BAF on monthly basis

1.3 Risks to Quality

The Trust has documented processes for escalating risks relating to service quality to the Board set out in the Risk Management Framework. The governance structure in place has escalation processes implicitly documented in the terms of reference for each Board sub-committee in the form of reporting arrangements to the Board of Directors and explicitly in the requirement for each sub-committee to identify any risks or issues requiring escalation as a standing agenda item and for the Chair of each sub-committee to produce an assurance report after each meeting advising the Board of any risks or issues.

At the start of each year, each director is required to identify all potential risks to achieving the corporate or directorate objectives. Risks to achieving corporate objectives, many of which relate to the quality of Trust services are identified either on the Board Assurance Framework (BAF) or corporate risk register as a result of impact assessing the risk of not achieving each objective. Risks to achieving directorate objectives are recorded on directorate level risk registers. On a monthly basis the risks to achieving high impact corporate objectives (those on the BAF) are considered by the Executive Operational Committee (EOC) (sub-committee of the Board) and the Board of Directors. The EOC will consider the existing risks and make recommendations to the Board of Directors regarding the risk scoring and status that will result in the risk remaining on the BAF or being de-escalated to the corporate or directorate risk registers.

The Trust has established a number of sub-committees of the Board of Directors with responsibility for overseeing the quality of service delivery. Non Executive Directors (NEDs) are actively involved in these committees, providing scrutiny and challenge that assists with mitigating potential risk. The Integrated Quality and Governance Steering Committee oversees and coordinates all aspects of clinical governance, patient safety and risk management. The Audit Committee has an active role in ensuring the systems and processes for delivering quality care are robust. The Mental Health Act Managers group ensures that the rights, care and treatment of detained patients are maintained to the highest standard and in line with legislation and CQC requirements. The Transformation and Finance Group oversees all major service transformation programmes (currently focussing on the improvement to estate and service quality in Bedfordshire and Luton and CHS integration as a result of acquisitions) and delivery of service divestment and CIP programme.

Whilst NEDs are not members of the Executive Operational Committee, the CEO chair of this committee provides an assurance report to the Board of Directors each month that identifies significant issues and potential risks. Minutes of the meetings that have taken place in the previous month accompany this report to provide NEDs with the opportunity to scrutinise operational, organisational and quality issues discussed, request further information as necessary and challenge Executive Directors as appropriate.

The Board considers a number of quality related issues and activities at each meeting and therefore has an impact on reinforcing and improving quality performance on an on-going basis.

The formal process of monitoring quality and performance of Trust services against national and local targets, contractual requirements, benchmarks or previous years outturn/ baseline has been developed over a 10 year period and is entirely embedded in the governance arrangements. A detailed quality and performance report (content agreed by the Board each year) is prepared for the Executive Operational Committee by the third week of each month; having been considered in its constituent parts by the appropriate (operational) service management boards first. This provides operational directors with an opportunity to consider adverse quality or performance issues, investigate them and develop recovery plans as appropriate. Adverse issues are defined as any variation from agreed targets set by Monitor or CQC, or as identified by the Board as necessary or appropriate or more than 10% from agreed target, requirement, and benchmark or baseline position. Adverse issues are highlighted as "hotspots" to the Executive Operational Committee in the summary report that accompanies the detailed quality and performance dashboards and reports. The Executive Operational Committee consider the quality and performance report hotspots, dashboards and detailed quality and performance reports and agree escalation of "hotspots" to the Board of Directors in the fourth week of the month. Since April 2011, the Executive Operational Committee has also begun to identify "emerging risks" for the Board's attention to provide an early warning of potential risks to service quality or performance.

The Chair and Chief Executive meet regularly. They will agree issues that should be escalated to the Board as necessary.

There are various examples of processes in place to learn from quality performance issues:

- All Serious Incidents that occur are managed in line with documented procedures set out in the Trust's Adverse Incident policy and procedure. This ensures that SI's are investigated appropriately; that high quality reports with recommendations are agreed; that implementation of recommendations is monitored and that learning is shared. The Executive Operational Committee and Integrated Quality and Governance Steering Committee ensure that SI processes are followed appropriately and that learning is identified and shared. SI investigation reports are shared with ward, team and senior managers in the same way as "Safety Alert Bulletins"; with an expectation that each manager formally acknowledges receipt and confirms that action as appropriate has been taken.

- Any learning or improvement identified as a result of a complaint is recorded and implementation monitored. All reports on complaints identify learning.

- Clinical audit is used as a mechanism to provide assurance of clinical quality and identify issues for improvement. Audit results are presented at various forums to share learning. POMH UK national audits (prescribing audits) are also presented to the Executive Operational Committee. The Quality Account contains case studies of learning from clinical audits.

- There is a Clinical Effectiveness Group that receives presentations on completed clinical audits and SI learning. The Trust magazine includes a "clinical effectiveness" section in each edition through which audit results and SI learning is shared.

The internal audit plan for 12/13 explicitly includes reviews of systems and processes linked to service quality and the quality governance framework. The internal audit programme has in previous years included reviews of planning processes, CIP programmes, risk management systems, integrated governance arrangements, CQC compliance systems, data quality etc. all of which are component parts of the quality governance arrangements in place in the Trust.

Individual performance management issues are dealt with through regular clinical and/ or managerial supervision; annual appraisal and taking action as necessary under the Trust's policy on Managing Conduct and Capability.

1.4 Use of external assurance (including internal audit)

The Trust has a rigorous programme of Internal Audit which is monitored via the Audit Committee, which provides assurance to the Board of Directors. The programme is based on a 3-year strategic risk assessment that takes into consideration the Trust Board Assurance Framework and Corporate Risk Registers. The programme also takes account of operational risks identified by the Directors of the Trust.

In addition to the core programme in 11/12 which included Finance, Procurement, IT, HR and Data Quality/Performance Reporting related audits; the Trust's Internal Audit Programme reviewed the following key material assurance projects:

- Delivery of the Cost Improvement Programme
- Board Assurance Framework
- Safeguarding
- Compliance with Policies and Procedures
- Quality Governance Framework
- Self-Certification Assurance

There are no issues outstanding, or requiring attention, that have been highlighted in these material assurance audits.

The Head of Internal Audit Opinion for 2011/12 confirms that "**Significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently".

Appendix 2 - Cost Improvement Plans (CIPs) in the Forward Plan period

2.1 CIP Design

Opportunities were provided in February, March and April of 2012 for the Board of Directors to review, shape and approve the emerging CIP programmes. This included consideration of the impact of CIPs on service quality and further details on the improved quality impact assessment processes followed by the Trust in developing the CIP programme are set out in subsequent Sections of this document.

During the development of the CIP programmes opportunities to utilise benchmarking were taken. A comparison of the relative costs of the three Community Services acquired by the Trust was undertaken, which highlighted a number of areas for further review (including the average cost per wte in district nursing establishments and variation in the ratio of qualified and unqualified staff in some children's services), although the nationally recognised issues with data quality in respect of community services limited the extent to which detailed CIP schemes could be identified specifically from this data. In respect of Mental Health services additional benchmark data around the relatively long lengths of stay for Essex adult and older people's inpatient services supported the inclusion of two service transformations aimed at improving lengths' of stay through reconfiguring services.

CIP Requirement

The final estimated level of CIP programme required is calculated to be £19.1. This represents just under 7% of total Trust income. The breakdown of this, by Division, is analysed as follows:

2012/13 CIP requirement	Essex MH £m	B & L MH £m	BCHS £m	SEE CHS £m	WECHS £m	Total £m
Income						
1.5 % – 1.8% income reduction	(2.1)	(1.0)	(0.6)	(0.7)	(0.7)	(5.1)
Reduction in Income for Management Savings Pass-back to Commissioners			(0.5)	(0.6)		(1.1)
Expenditure						
National Cost Pressures	(2.2)	(1.5)	(0.8)	(0.6)	(0.8)	(6.0)
Local Cost Pressures	(0.5)	(0.3)	(0.2)	(0.5)	(0.0)	(1.5)
B/Fwd CIPs from 2011/12	(0.1)	(0.3)	(1.0)	(0.5)	(1.3)	(3.2)
Other						
2011/12 net reduction from contribution from Income Generation Target	(0.7)					(0.7)
Net loss of contribution from income from West Essex PCT	(0.1)					(0.1)
Net loss of contribution from Market Testing of Drugs and Alcohol Services in		(0.3)				(0.3)

Bedfordshire						
FYE Surplus requirement	(0.5)	(0.2)	(0.2)	(0.1)	(0.1)	(1.1)
CIP Requirement	**(6.2)**	**(3.6)**	**(3.4)**	**(3.0)**	**(2.9)**	**(19.1)**
CIP requirement as % turnover	6.8%	4.9%	7.8%	8.8%	7.2%	6.8%

The Trust's CIP Programme contains five key themes that are aligned to the Trust's Strategic Priorities as follows:

CIP Programme Themes	**Trust Strategic Priority**
Estates and facilities rationalisation	These three themes all reflect the Trust's Strategic Priority of being an "*Efficient and Effective Organisation".* A significant element in 2012/13 (£2.2m) represents the planned efficiency savings resulting from the acquisition and integration of the three community services acquired during 2011/12.
Corporate and other overhead services	
Non-pay and procurement efficiencies	
Service Transformation	This theme reflects the Trust's Strategic Priority of "*Transforming Services – delivering complex change in an uncertain environment*"
Effective Operational Management	This theme reflects the Trust's Strategic Priority of "*Delivering High Quality and Safe services*"

A summary of the Trust's CIP programme by category of CIP and Division for 2012/13 is provided in the table below. This identifies that around 54% of CIPs are planned to come from 'back-office' services, 29% from within Operational services and 17% from Service Transformation initiatives.

2012/13 CIP Programme	Essex MH £m	B & L MH £m	BCHS £m	SEE CHS £m	WECHS £m	Total £m
Financial Plan Shortfall	**(6.2)**	**(3.6)**	**(3.5)**	**(3.2)**	**(2.6)**	**(19.1)**
Estate and Facilities Rationalisation	0.7	0.4	0.1	0	0.1	1.3
Non-pay and Procurement savings	0.1	0.1	0.2	0.2	0.1	0.7
Corporate and other overheads services	3.8	1.4	1.7	1.3	1.4	9.6
Service Transformation	0.1	0.1	0.8	0.8	0.2	2.0
Effective Operational Management	1.5	1.6	0.7	0.9	0.8	5.5
TOTAL CIP SCHEMES	**6.2**	**3.6**	**3.5**	**3.2**	**2.6**	**19.1**

A similar spread of CIP initiatives by theme is apparent over the three-year planning period:

Table 3 - 2012/13 – 2014/15 CIP Programme	2012/13 £m	2013/14 £m	2014/15 £m	Total £m
Estate and Facilities Rationalisation	1.3	0.9	0.1	2.3
Non-pay and Procurement savings	0.7	0.2	0.2	1.1
Corporate and other overheads services	9.6	1.5	2.2	13.3
Service Transformation	2.0	3.5	2.1	7.6
Effective Operational Management	5.5	4.3	4.9	14.7
TOTAL CIP SCHEMES	**19.1**	**10.4**	**9.5**	**39.0**

2.2 CIP Focus - Top 5 CIP Schemes

Ref	Scheme	Scheme description including how Forward Plan will reduce costs	Under-pinning IT / information or management systems	Total savings £m	Phasing over three year period (%)			WTE Reduction	Has the Forward Plan been subject to a quality impact assessment (Y/N)	Who is responsible for signing off on the quality impact assessment	Key measure of quality for plan	Scheme Lead
					Yr. 1	Yr. 2	Yr. 3					
1	Backlog maintenance reductions	Implementation of Trust's Estates Strategy has resulted in significant improvement to the quality of MH facilities in South Essex in recent years, and a number of large capital schemes are underway in Beds and Luton. The Trust is therefore planning to reduce expenditure on backlog maintenance in the coming year.	Estates Strategy	£2.0m [£1.25m Essex, £0.75m B&L]	100%			None	Y	Board of Directors on advice from Medical Director and Executive Nurse (Operational)		Executive Chief Finance Officer
2	Community Services Integration	Restructuring of senior management and support services associated with three acquired community services		£2m [£0.7m WE; £0.6m SEE; £0.9m Beds]	100%			50-60 wte posts	Y	Board of Directors on advice from Medical Director and Executive Nurse (Operational)		Executive Director Integrated Service Essex
3	Service Transformation (Beds CHS)	This workstream is focusing on the review of the inpatient facilities at Biggleswade Hospital and Archer Unit and the development of a community based Rehabilitation Service for		£1.2m	50%	50%		25-35 wte Final number dependant on numbers redeployed in alternative service and existing	Y	Board of Directors on advice from Medical Director and Executive Nurse		Executive Director Integrated Service Bedfordshire and Luton

		the Elderly. The aim is to modernise the delivery of rehabilitation services and to deliver efficiency savings through service transformation						vacancies in service.		(Operational)		
4	Reconfiguration Adult Inpatient services	Reviewing LOS (length of stay) and functionality of adult wards with aim to reduce the LOS and therefore the bed numbers. This will link in with developments in the community such as MAP (Munich Adherence Project) which should reduce reliance on inpatient beds		£0.9	10%	90%		Estimate 19 WTE	Y	Board of Directors on advice from Medical Director and Executive Nurse (Operational)		Executive Director Integrated Service Essex
5	Reconfiguration Older People Inpatient MH services	Reviewing the Continuing Care function of Clifton Lodge and reassigning some of these beds to OP assessment beds. The reduced number of assessment beds will be possible due to the impact of the community rehab team and improving early liaison with the acute trust to avoid admissions.		£0.8	25%	75%		Estimate 15 WTE	Y	Board of Directors on advice from Medical Director and Executive Nurse (Operational)		Executive Director Integrated Service Essex

2.3 CIP Process

2.3.1 Involvement of clinicians

Our CIP development process started in December 2011. Seven staff planning events took place involving approx. 530 clinical frontline staff and senior clinical leaders. These events provided an opportunity for staff to understand the strategic context and financial challenges facing the Trust and for a dialogue to take place with them and in groups, in respect of the changes that were required and possible. The outputs from the planning events and additional ideas for efficiency were refined during Senior Management Team meetings (which are attended by senior clinical leaders and directors), through extra-ordinary meetings of the Transformation and CIP board sub-committee and through contract negotiation meetings which were attended by the Medical Director and/ or Clinical Directors during January to March 2012. Our CIP schemes were shared and discussed with local Clinical Commissioning Groups, particularly identified GP leads for mental health and community health services, to ensure that the schemes are supported through to implementation.

2.3.2 Quality Impact Assessment

The Board of Directors is required to self certify as part of Monitor's annual planning and compliance regime that: "The Board is satisfied that, having used its own processes and having assessed against Monitor's Quality Governance Framework (supported by relevant information from the trust and third parties such as the Care Quality Commission), it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients."

The Board of Directors completed an assessment of SEPTs systems and processes for monitoring and improving quality against Monitor's Quality Governance Framework as part of the acquisition of community health services in May 2011. The assessment identified the need to enhance the formal systems in place in the Trust to assess the impact of the annual cost improvement plan (CIP) on the quality of service provision.

The Board of Directors therefore considered and agreed an approach to facilitate the assessment of the impact on quality of the 12/13 CIPs and accountability arrangements associated with it.

2.3.3 Process for Quality Impact Assessment of 12/13 CIPs

A structured quality impact assessment process was undertaken as part of finalising the Annual Plan 12/13. Priority was given to impact assessing the schemes which were likely to have a direct impact on clinical services. It was agreed that the corporate CIP was unlikely to impact in the same way; but these schemes will be monitored during implementation to identify indirect impact.

The starting assumption for assessing the impact of the CIP on quality for 12/13 was that the Trust has to deliver efficiencies and the programme put forward reflects the least worst options. It was acknowledged that the programme had already been subject to extensive consultation, engagement and negotiation with clinical leaders and commissioners, and schemes with an unacceptable impact on quality had already

been ruled out, but this may not have occurred in a structured way and this stage of the process had not been recorded. Going forward, the process agreed will be required to be implemented in a structured way at the start of the CIP development process.

The impact on quality of each proposed CIP scheme was assessed across 5 domains by multi-disciplinary teams: compliance, access, experience, effectiveness and safety. A score out of 5 was allocated as a result of the impact assessment of each scheme in each of the 5 quality domains (negligible impact = 1; significant impact = 5). The Executive Directors of Operations (Mental Health), Community Health Services (Bedfordshire and Essex) and Partnerships undertook the impact assessments of schemes relevant to their divisions in conjunction with their senior leadership teams and senior clinicians/ practitioners to provide multi-disciplinary input into the process. The Executive Director of Strategy and Business Development observed the majority of the quality impact assessment processes undertaken by the various senior leadership teams to ensure consistency of approach.

The overall impact on quality of each scheme was determined by deriving an overall score across the 5 domains of quality (maximum score of 25). The safety domain was weighted more heavily (x 6) than the other four domains (each being weighted by 0.5); reflecting the Board's commitment to maintain safe service delivery. Overall quality impact ratings were based on scores identified as follows:

1-10 LOW

11- 15 MEDIUM

16- 19 HIGH

>20 SIGNIFICANT

If an individual scheme resulted in a quality impact score of 16-20, the relevant Executive Director and MDT was required to confirm the mitigation strategy required to minimise the impact and carry out a residual impact assessment post implementation of the mitigation strategy.

If an individual scheme resulted in a quality impact score of >20, the relevant Executive Director and MDT was required to take the same action as above, but also consider whether an alternative scheme should/ could be identified which offered the opportunity of less impact on quality.

The results of the quality impact assessment, mitigation strategies and / or alternative schemes were presented to the Medical Director and Director of Executive Nurse (Operational) who undertook an independent scrutiny exercise; seeking additional information and assurance as necessary from Executive Directors, in order to be assured that the quality impact assessments had been carried out appropriately.

- No significant (>20) or high (>16) quality impact scores were identified for any scheme.
- Forensic mental health services: all schemes were assessed as having a low (<10) quality impact score

- Essex mental health services: 4 schemes were assessed as having a medium (11-15) quality impact score:
  - –Heath Close to Hadleigh transfer (14) 120k
  - –Implementation of functional IP model/ ward closure (13) 87k (fye in 13/14)
  - –Therapy Review (12) 500k
  - –Review of organic assessment beds (11.5) 822k

- Bedfordshire & Luton mental health services: 2 schemes were assessed as having a medium (11-15) quality impact score:
  - –CMHT skill mix review (11.5) 268k
  - –Staff savings Townsend to RP2 savings realisation (12) 101k

- Child and Adolescent Mental Health Services: 1 scheme was assessed as having a medium (11-15) quality impact score:
  - –Skill mix review B&L teams (11.5) 150k

- Bedfordshire Community Health Services: 3 schemes assessed as having medium (11-15) quality impact score:
  - –Vacancy removal (15) 690k
  - –Integrated teams restructure savings (11) 400k
  - –Management savings (13.5) 876k

Essex Community Services schemes were subject to protracted negotiation with the PCTs and CCGs and completion of the scrutiny process was further delayed by sickness absence of Medical Director. Initial scrutiny has now taken place and no significant issues were identified. However further clarification of some impact scores and additional scheme detail was requested by the Medical Director and Executive Nurse (Operational) before full sign off can be given.

The scrutiny process undertaken to date by the Medical Director and Executive Nurse (Operational) resulted in one scheme being referred back to the Executive Director of Operations for further assessment of impact (Heath Close relocation). As a result the Clinical Director and Operational Managers have agreed an alternative scheme.

The Medical Director and Executive Nurse (Operational) confirmed to the Board of Directors that the quality impact assessment process had been extremely valuable and worthwhile and the Board of Directors were assured that it had provided a robust assessment of potential impact on the quality of services going forward. Risks identified have been included in the Board Assurance Framework 12/13 and will be monitored on a monthly basis by the Board of Directors.

2.4 CIP Management

2.4.1 Historic CIP Delivery

The Trust has a good track record of dealing with CIP programmes in recent years, achieving around 96% of planned CIPs over the last three years and 89% recurrently, as set out below. This is particularly strong performance given the significant acquisitions that the Trust has made over this period.

Table 4 - Historic CIP Achievement

	2009/10 £m/%	2010/11 £m/%	2011/12 £m/%	Total £m/%
CIP Plan	5.1	10.3	20.3	35.7
CIP Achieved	5.1	9.4	19.7	34.2
% CIP Achieved	100%	92%	97%	96%
CIP Achieved Recurrently	4.8	10.0	17.3	32.1
% CIP Achieved Recurrently	94%	98%	84%	90%

The drop in recurrent achievement rates in 2011/12 was primarily focused within the three community services and reflected a number of reasons:

- the Trust did not take operational ownership of the Community Services until August/ September 2012 which was later than originally planned;
- Some CIPs included in the inherited position on acquisition were found to be of a non-recurrent nature;
- Changes in PCT commissioner requirements during 2011/12 meant that some CIPs originally planned for delivery were unachievable and have needed to be replaced by alternatives on a recurrent basis.

The recurrent CIP gap not achieved in 2011/12 (£3m) has been included within the 2012/13 CIP programme.

2.4.2 Accountability for CIP Delivery in 2012/13

Given the scale of the CIP challenge in 2012/13 (at just under 7%), and with large estimated requirements in the two subsequent years, the Board of Directors has reviewed its arrangements for overseeing the implementation and performance management of CIPs going forward.

These have now been strengthened with:

- A monthly CIP and Transformation Project Board that reviews performance year to date and forecast, and with the powers to call in Executive Directors where concerns are identified. This Project Board reports to the Board of Director's Finance and Transformation Sub-Committee, and is chaired by the Executive Chief Finance Officer.

- Establishment of the equivalent to a Performance Management Office with three additional project managers in place from April 2012, and a refocusing of the Service Improvement and Delivery team onto CIP projects. This has strengthened project governance arrangements for CIPs assessed as high risk or material in size.

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

In addition to regular detailed reporting of the CIP implementation position to the CIP and Transformation Project Board, and Finance and Transformation Sub-Committee the Board also receives a summary position each month within the overall Financial Performance Report. This allows key risks to be highlighted to the Board on a timely basis and remedial action taken as necessary.

Risks associated with the implementation of CIPs are also included in the Trust's BAF and was subject to a review by Internal Audit during 2011/12 (with Substantial Assurance) and is included in the 2012/13 planned programme.

2.4.3 Risk Assessment

The Trust's CIP programme has been subject to a risk assessment process in respect of phasing and deliverability. The phasing of the CIP programme has been modelled and appropriate actions taken to identify non-recurrent funding that can be used to mitigate the fact that some schemes will not be implementable fully from 1 April.

Given the significant scale of the Trust's CIP plan for 2012/13 further analysis of the risk to deliverability has been undertaken, particularly focusing on those areas where there are significant factors outside the Trust's control (i.e. those initiatives that require public consultation to be undertaken by commissioners). Table 5 below assesses, by Division, these risks between Red (significant factors outside of the Trust's control); Amber (high level of risk, majority within Trust's control); and Green (implemented or low risk).

Risk assessment of CIP delivery	Essex MH £m	B & L MH £m	BCHS £m	SEE CHS £m	WECHS £m	Total £m
Red	1.1	0.3	-	0.8	0.4	2.6
Amber	1.0	1.5	2.4	1.0	1.0	6.9
Green	4.1	1.8	1.0	1.2	1.5	9.6
CIP SCHEMES	**6.2**	**3.6**	**3.4**	**3.0**	**2.9**	**19.1**

For those schemes classified as Red an assessment of the impact of slippage in the deliverability of the schemes was undertaken. Table 6 below shows the cumulative savings assumed in the phased CIP plan for all schemes assessed as Red for deliverability. Allowing for a 4-6 month period for consultation and implementation the analysis indicated that urgent action in the first quarter will be required to ensure that these schemes are progressed in sufficient time to allow delivery in Quarters 3 and 4. These projects are therefore those that are being prioritised by the newly appointed CIP project managers.

Table 6 - Red Risk Projects – phasing risk assessment	Qtr 1 £m	Qtr2 £m	Qtr 3 £m	Qtr4 £m	FYE £m
Reconfiguration Organic Assessment services (Essex MH)	-	-	-	0.2	**0.8**
Reconfiguration Adult Inpatient services (Essex MH) plus £0.8m further impact in 2013/14 CIP plan	-	-	-	-	**0.1**
Reconfiguration Essex Learning Disability inpatient services	-	-	-	-	**0.1**
Reconfiguration Older People inpatient services (B&L MH)	-	-	0.1	0.2	**0.4**
Urgent Care Centre (WE CHS)	-	-	0.1	0.1	**0.3**
District Nursing Evening and Night Services (SEE CHS)	-	-	0.1	0.2	**0.3**
Integrate Jigsaw service with Health Visiting (SEE CHS)	-	-	0	0	**0.1**
Schemes below £100k (Essex MH/SEE CHS)	0	0.1	0.2	0.3	**0.5**
TOTAL	**0.0**	**0.1**	**0.5**	**1.0**	**2.6**

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

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

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

Appendix 3a: Financial Commentary - Income

In line with the overall economic climate the Trust is anticipating that there will be a net reduction of its total income over the coming three years. All major income contracts have been agreed and signed.

The Trust also has a range of commercial opportunities that it continues to explore. These are **NOT** included within the financial plan and are based on establishing new markets and supporting core services. Plans also include alignment of partnership models and real opportunities to co-produce through sub-contracting.

A number of assumptions have to be made to produce a meaningful income forecast and projection. The main assumptions included within the forecast are as follows:

- Income reductions are those set out in the Operating Framework
- There will be on-going support from south Essex Commissioners relating to the transformation of continuing care facilities in south Essex
- No adverse impact from the current QIPP programmes
- 2.5% of CQUIN (Commissioning for Quality and Innovation) funding will be received in full in relation to all main NHS contracts
- No material impact from changes in contract payment mechanisms including any move to a local or national tariff, or, increase/decrease in cost and volume contracts
- Levels of other income remain constant over the planning period
- No financial impact from Choice and the move to Clinical Commissioning Groups over the planning period

The closing income position for 2011/12 provides the base position for income. A summary of forecast income by type for the 2012/13 financial year is shown below:

TABLE 1: Contract Type (Appendix (i) for details)	**Total £m**
Mandatory Services	
Main Block Contracts	263.0
Other Block Contracts	10.0
Cost and Volume Contracts	18.3
Clinical Partnerships	6.2*
Other	8.7
Total Income	**306.2***

** Budgeted Clinical Partnership income is £7.2 M; £ 6.2 for MH services and £ 1.0 M for Community Services. However, the Monitor Financial Model does not have a category for Clinical Partnerships in Community and therefore has been incorporated in Block Contracts – Other.*

*** Included in this figure is the income from service developments.*

There are no planned CIP schemes financed through Income Generation Activity for 2012/13 – 2014/15.

The combined Trust will continue to receive the majority of its income in the form of block payment contracts. This income accounts for around 91% of the combined Trust's total income base in respect of **protected / mandatory clinical income.** The Trust's block income is primarily related to capacity levels in terms of beds and community contacts, and is not affected by changes in patient activity or demand. The income is subject to legally binding contracts, and is therefore largely fixed, guaranteed and stable.

The Trust's **clinical partnership** income predominantly relates to mental health services with Bedfordshire, Central Bedfordshire and Luton Borough Councils. These contracts are negotiated separately and are not subject to the inflation assumptions detailed in the Operating Framework.

The **other income** in part relates to a number of minor income streams for mental health services which are covered under invoicing arrangements. In addition, South East Essex community services holds a number of contracts predominantly for scheduled adult and children's services and Bedford receives income from the Local Authorities. This also includes income streams for medical education and training, salary replacement costs and the provision of non-clinical services to other NHS organisations. Although not protected, this income is also technically secure so long as the Trust continues to provide the existing range of services at current levels. In the event that income is withdrawn, the Trust's expenditure plans would correspondingly reduce.

Appendix 3b: Financial Commentary – Service Developments (excluding transactions)

Service development priorities	Financial Impact	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress 2011/12 2012/13 2013/14
Organic / innovation:					
Reconfiguration of Dementia Services in south Essex	£ 1.6 M	This transforms an existing in-patient facility for older people in to a rehabilitation facility which will reduce the impact on acute inpatient services.	Actions identified in and agreed via Contracting Process.	Revenue funding: Allocation in plan to support efficiency and transformation programmes. Workforce: Strategy identifies range of actions required to support change management programme	Transformation and Finance Committee (Sub-committee of the Board of Directors), chaired by Trust Chair will monitor delivery of agreed plans.
Transferring Out/Discontinuing an activity: NONE					

Appendix 3c – Financial Commentary: Transactions and PFI / Significant Investments

Note: Section removed here. Commercial in confidence. Not for publication.

The Trust has 2 PFI schemes – two homes for Older People with mental ill health and the Secure Services unit; approvals for both schemes predate FT status. The Trust's capital plan continues to allocate funds to future capital repayments to the Trust's two PFI funded schemes. The revenue income is underwritten by the respective PCTs.

The Trust's plans do not include any new PFI schemes or Material or other significant investments during this planning period.

Appendix 3d: Financial commentary: Activity

The Trust's plan assumes that the majority of contracts will remain on a block basis and is therefore not sensitive to activity reductions.

Appendix 3e: Financial commentary: Workforce

The Trust has compiled clear service plans that give details on service changes for 2012/13. Following acquisition of community services, Trust priorities remain focussed on some of the service redesign areas in outpatient and integrated community care. Other changes that were under consultation last year are now being finalised and will be implemented over the course of 2012/13. At each stage of any proposed change the Trust has a clear aim of delivering high quality and safe services. To this end changes are impact assessed and involve all key stakeholders, this would include local care partners, Acute Sector Partners, Local Authorities, and other interested parties.

The key risks to implementation

There are risks associated with any change implemented; these range in complexity and depth. There are also associated risks that arise from not implementing changes, which in turn could lead to loss of contracts that would have a knock on effect of having services decommissioned. Financial risks would include any reductions in overheads being greater than the value in reduction in service to ensure that there is still a contribution to surplus. In mitigating against these risks the Trust has incorporated a pathway that will see it win additional contracts that will enable it to maximise service synergies. It is recognised that in delivering new models of Clinical services there is an emphasis on providers to work together to provide skills and capabilities. The Trust has identified the challenges that it faces and has developed plans that will ensure that it meets the demands of the workforce. The Education and Training Strategy includes plans for raising development needs with our providers and working collaboratively to ensure that education is provided in a timely manner and will deliver the competencies required.

The resourcing requirements (financial, staff and site)

Each year within the Trusts workforce plan there is a detailed analysis and understanding of the demography of the workforce and the potential from within the workforce and from the labour market. This is a conjoined piece of work that involves all of the Service Managers and highlights the work that is both going on currently and potentially any service changes. A prime example of this is the work currently being undertaken in looking at the role of the Associate Practitioner and gaining a greater understanding of how this role can be developed to bring new ways of working within the Trust. Additionally there are several estates projects under way that will improve both the service users experience when attending appointments as well as improving the working environment of the workforce.

The measures by which delivery of the planned changes in workforce size, mix or configuration will be tracked

Progress will be tracked through the Trust reporting structure and the Executive Operational Committee will have delegated authority from the trust Board to monitor progress at key stages. This will be a transparent process that will consider all staff and trade union concerns. Any comments will be logged and responded following the final deliberations. A summary of responses to the consultation and the consequent proposed management response will be provided to the EOC before they are ratified and shared with staff and their representatives. Any proposed changes in skill mix will be mapped against the new structure, along with the drafting of KPI's and SLAs that will closely monitor the changes post implementation.

How the Trust Board is assured that workforce changes will not impact quality

We will continue to support our staff, and service users through change. We recognise that the changes to services, to ways of working, to funding arrangements and levels and to the structure of our organisation will have major implications on our staff and our service users. Our workforce remains our greatest asset and our programmes of organisational and personal development; workforce well-being and engagement will remain as a key priority. Staff satisfaction and morale, measured by the annual national staff survey is one way that we measure this. Along with external audits such as CQC. We are also committed to continuing to undertake the engagement activities in place with our service users and local communities that ensure we listen to our stakeholders through our Board of Governors, our FT member meetings, planning events, focus groups and individual consultation opportunities.

Where proposed workforce changes may risk impacting service provision or clinical quality, this should be recognised explicitly in the Forward Plan together with the specific actions proposed to mitigate it.

The key to achieving major service transformation is the engagement and incentivisation of frontline leaders and teams who genuinely own change initiatives and ensure that improvement is stainable and sustained. We will need to ensure that targeted investment in workforce development encourages greater clinical leadership and prepares staff to respond to the challenges faced and that there is an on-going programme of engagement activities that ensure staff understand SEPTs vision and share responsibility for its delivery. (SEPT Strategy)

Workforce priorities should be consistent with activity assumptions and CIPs.

Over the course of the new financial year the Trust has planned for changes in headcount within its workforce. The changes to numbers are planned and are in line with service changes. This is documented within the workforce triangulation tool that was submitted to the SHA in Jan 2012. Within the plans are the ways in which any shortfall in workforce is met and this includes use of flexible means i.e. Bank.

Key recruitment, training, retention and development initiatives

The Trust Education and Training strategy reflects the skill development that will be required. This data is gathered within both the workforce plan and the workforce development & training strategy. The Trust undertakes a whole workforce training needs analysis each year and this information is collated together with outputs from the workforce, service and financial planning exercises, to inform the Education and Training Strategy. The data is also discussed at service planning days; these days are attended by a wide range of stakeholders, including service users, to ensure that the forward plans are informed by the needs and experiences of our patients. The Workforce Plan and Education and Training Strategy outline the steps that the trust is taking in identifying and addressing workforce issues.

Redundancy and natural wastage programmes

In terms of mitigating the impact of any such structural changes the trust will follow a detailed set of actions as set out in its organisational change policy. These actions, which reflect ACAS good practice guidance, will include use of natural wastage/ non-filling or temporary filling of vacancies and the use of voluntary redundancies. The trust has in recent consultations made very clear statements that voluntary redundancy will be considered as a means of avoiding compulsory ones so long as this is contained in the overall financial envelope available for compensation payments as outlined in the Organisational Development policy from 2011.

Pay, rewards and other key remuneration initiatives or work streams

There are national negotiations taking place that could impact on pay and rewards, it is recognised that pay bands are an emotive subject that can have a wide impact on workforce. The Trust has endeavoured to address any issues that arise through its policies and welcomes open communication on the subject.

Other workforce issues which may impact the Forward Plan

New legislation relating to health will come into effect over the next year and the impact of this is difficult to predict. The proposals outlined in Liberating the NHS: Developing the Healthcare Workforce will also be implemented over the next year as Local Education and Training Boards start up in shadow form. These have the potential to impact on the education and training environment and to deliver greater ability for providers to shape education provision to meet the needs of the workforce.

Appendix 3f – Financial Commentary: Capital Expenditure

Key capital expenditure priorities	Amounts and timing	Contribution to the strategy (incl. service delivery)	Key actions and delivery risk (inc. finance risks)
Existing Developments:			
Purchase of additional land at Runwell Hospital (Essex)	2012/13: £ 80k	The land and refurbishment costs are required to enable increase in capacity at the Trust's current Head Office, required as a result of centralisation (and associated recurrent efficiency savings) of corporate services in acquisitions. This contributes to Strategic Priority 3: Creating an efficient and effective organisation.	Key actions: Negotiations re. purchase of land are ongoing with landowner. Head office works will require a Project Manager to be appointed. Specification developed. Works tendered. Project management of works until completed.
PFI charges and lifecycle expenditure for EMI homes and forensic unit (Essex)	2012/13: £821k + £29k 2013/14: £696k + £175k 2014/15: £852k + £66k	Investment in the quality of patient environments is integral to the Trust's Strategic Priority 1: Delivering high quality and safe services.	No significant risks identified to programmes or funding.
Transformation Plan (Bedfordshire and Luton)	2012/13: £5,930k 2013/14: £6,672k 2014/15: £141K	The transformation plan is designed to improve quality of patient care and to realise significant cost improvement initiatives on a recurrent basis. Capital investment is required to achieve this. Over the first two years of the planning period, approx £7.5 million has been assigned to this plan which was agreed with commissioners as part of SEPTs acquisition strategy for the former BLPT. The plan includes major works to	Key actions: There is a detailed transformation plan with agreed milestones for completion in 2011/12 and 2012/13. There is a potential risk of delay to the new build programme associated with obtaining full planning permission. This is identified on the BAF and will be

		Luton and Dunstable Hospital and a new build development on the Bedford Health Village site to replace existing facilities. The transformation of services in Bedfordshire and Luton is integral to delivery of Strategic Priority 2: Transformation of services.	monitored by Board of Directors monthly. There is a potential risk associated with funding as some elements are dependant on sale proceeds
Equipment Replacement and Maintenance:			
IT replacement	2012/13: £900k 2013/14: £900k 2014/15: £900k	The Trust has invested significantly in IT and will continue to do so going forward to improve clinical care, patient experience, productivity and efficiency associated with electronic health care records, activity collection and back office support systems. This is integral to delivery of all of the organisations strategic priorities.	Key actions: identified in IM&T strategy and integration plan. No significant risks identified to programmes or funding.
Medical and Other Equipment	2012/13: £390k 2013/14: £390k 2014/15: £390k	Ensuring that medical and other equipment is purchased and replaced is integral to the delivery of Strategic Priority 1: Delivering High Quality and safe services.	Key actions: Priority purchases will be identified as a result of risk assessments, environmental audits and replacement programmes.
Carbon Reduction Schemes	2012/13: £878k 2013/14: £700k 2014/15: £700k	The Trust is committed to an agreed carbon management and sustainable health strategy that will also deliver recurrent revenue savings. This investment contributes to delivery of Strategic Priorities 3 and 4: Creating an efficient and effective organisation and	Key actions: identified in carbon management and sustainable health strategy.

		clear plans for the future.	
Other capital expenditure:			
Miscellaneous Allocations **Thurrock Switch Room** **Staff Comms Software** **IT Warrior House** **5 Heath Close Generator** **Estates Help Desk Pride House**	2012/13: £196k 2012/13: £20K 2012/13: £170k 2012/13: £55K 2012/13: £80K		
Other estates strategy			
Strategic Allocation/ Contingency	2012/13: £**1,700k** 2013/14: £**3,200k** 2014/15: £**4,200k**	The capital plan includes funding that is provisionally allocated to specific schemes.	There is a potential risk associated with confirming additional capital resources as this may be dependant on sale proceeds and slippage on CIPs.

Appendix 3f – Financial Commentary: Costs (Entire section is confidential and not suitable for disclosure as it contains sensitive information)

Membership Report

1. Membership Commentary

The Trust has two categories of membership:

- **Public Members**

  Membership is available to anyone aged 12 years and over and living in Bedfordshire, Essex and Luton.

  Public membership is divided into eight geographical areas using electoral boundaries:

  1.Bedford

  2.Central Bedfordshire

  3.Luton

  4.Rest of Essex (electoral area covered by Essex County Council excluding the following four areas)

  5.South Essex (Basildon, Brentwood, Castle Point and Rochford)

  6.Southend

  7.Thurrock

  8.West Essex (Epping Forrest, Harlow and Uttlesford).

We actively encourage our service users, carers and families, as well as the broader communities we cover to join as members, ensuring that membership reflects the ages and diversity of our local population.

- **Staff Members**

All staff on permanent or fixed term contracts that run for 12 months or longer automatically become members (unless they opt out). Staff who are seconded from our partnership organisations and working in our Trust on permanent or fixed term contracts that run for 12 months or longer are also automatically eligible to become members.

Staff membership is currently divided into five groups:

1.Medical

2.Nursing

3.Other Clinical Specialities

4.Social Workers

5.Non-Clinical Support Staff.

In September 2012, on the expiry of the transitional arrangements following the acquisition of community health services, the total number of groups will be six: the Nursing group will be split into two to represent nurses working in mental health services and nurses/registered midwives working in community health services.

The total membership target for 2013 is 23,000 members made up of 17,250 public members and 6,000 staff members. This increase reflects the additional constituencies following the acquisition of community health services in Bedfordshire, South East Essex and West Essex but also takes account of the changes in the staff category following implementation of efficiency savings activity. The estimated figure for public members leaving in 2012/13 has been calculated using the same ratio for 2011/12, i.e. 4% of total public membership.

2. Membership Analysis

The following is an analysis of current membership; the public constituency includes comparison with eligible membership by age, gender, ethnicity and socio-economic groupings.

Membership size and movements		
Public constituency	**2011/12**	**2012/13 (estimated)**
At year start (April 1)	13,300	14,603
New members	1,875	3,025
Members leaving	572	628
At year end (March 31)	14,603	17,000
Staff constituency	**2011/12**	**2012/13 (estimated)**
At year start (April 1)	3,068	5,986
New members	2,923	14
Members leaving	5	0
At year end (March 31)	5,986	6,000
Patient constituency	**2011/12**	**2012/13 (estimated)**
At year start (April 1)	n/a	n/a
New members	n/a	n/a
Members leaving	n/a	n/a
At year end (March 31)	n/a	n/a
Analysis of current membership		

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	138	486,677
17-21	1,465	142,536
22+	10,294	1,743,825
Ethnicity:		
White	11,164	2,051,382
Mixed	271	23,758
Asian or Asian British	943	65,822
Black or Black British	618	25,567
Other	104	13,191
Socio-economic groupings*		
ABC1	7,595	902,952
C2	2,811	321,021
D	3,185	208,792
E	1,001	62,826
Gender analysis		
Male	5,687	1,169,683
Female	8,844	1,203,351
Patient constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	n/a	n/a
17-21	n/a	n/a
22+	n/a	n/a

Notes:

The analysis section of the above report excludes:

(a)2,706 public members with no dates of birth

(b)1,503 members with no stated ethnicity

(c) 72 members with no gender.

General exclusions:

(a)Suspended members

(b)Inactive members

* Socio-economic data should be completed using profiling techniques (e.g. post codes) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make a direct approach to members to collect this information.

3. Elections

Elections to the Board of Governors

Members of the Trust elect Governors from the public and staff constituencies. These elections are conducted under the auspices of the Electoral Reform Services and conform to the election rules as set out in the Trust's Constitution. An analysis of the elections turnout for 2011/2012 is detailed below:

Analysis of election turnout

Date of election	Constituencies involved	Election turnout %
September 2011	Public -South Essex	9.4%
September 2011	Public - Southend	11.9%
September 2011	Public - Thurrock	10%
September 2011	Staff - Nursing	11%
September 2011	Staff - Support Staff	22.2%
September 2011	Staff - Medical	uncontested
November 2011	Public - West Essex	13.2%
November 2011	Staff - Community Health Services Beds	uncontested
November 2011	Staff - Community Health Services West Essex	32.5%

4. Membership Plan

4.1 Membership during 2011/2012

4.1.1Overview

The Trust is keen to ensure a there is a representative and engaged membership. It is also keen to ensure that the membership grows and areas of under-representation are addressed with targeted campaigns.

The Trust is pleased to report overall that our membership is well represented in the majority of socio-economic categories, although is under-represented in the Wealthy Achievers category. Both Females and 22+ categories are also very well represented but there is under-representation in the Males, White British and 12-16 Age groups.

The Trust believes the latter is most likely due to young people under the age of 16 require parental consent before they can sign up to be a member. The Trust is continuing to work within schools to raise understanding of mental health issues. We tailor the talks to the requirements of the particular class and have delivered sessions on mental health awareness, self-harming, eating disorders, keeping mentally healthy, etc. Our talks also now cover the community services we provide as well as learning disabilities issues.

In view of acquisition of the community health services in Bedfordshire, South East Essex and West Essex during 2011/2012 membership recruitment has focused particularly on these areas to ensure that we are representative of the local population.

During 2011/2012 there were 4,798 new members of which 1,875 were recruited from the pubic constituencies and 2,923 were new staff members bringing the total membership for the Trust at 31 March 2012 to 20,589.

4.1.2Membership recruitment activities

Over the past 12 months we have undertaken the following membership recruitment activities, particularly focusing on areas of under-representation and new areas:

- Governors and members continued to recruit on behalf of the Trust with a particular focus on the areas of under-representation
- Continued to recruit members across all localities but also particularly focusing on the two newest areas of Central Bedfordshire and West Essex where membership now stands at 1,666 and 1,249 (approx 0.5% of geographical population)
- Hosted stalls at various community bases including shopping centres, community centres, leisure centres, markets, supermarkets, etc. Although the numbers of new members recruited varied from 10 to 100, the events also provided the opportunity to raise the Trust's profile

- Hosted a stall at The Mall Shopping Centre in Luton one day during Men's Health Week with 100 new members recruited
- Successful event at the Harlow College Open day with over 100 new members recruited
- Attended various community, health and wellbeing events including the Bedford Kite Festival weekend with 150 new members recruited
- Staff recruitment drive in Central Bedfordshire and West Essex, encouraging staff to talk to their clients, friends and family about membership. Three members of staff alone recruited over 200 new members
- Attended community services and clinics to raise awareness of the Trust following the acquisition and to encourage membership, with over 30 new members recruited at Epping Forrest Unit and three individuals interested in standing as a governor
- Worked with existing forums and with service users, carers, partner organisations, community, voluntary sector, staff networks
- Marketing and communications campaign promoted membership through various activities including the production of postcards which advertised membership which were displayed in GP surgeries, posters were displayed in public areas, membership literature were issued to wards, community bases and other premises.

4.1.3Membership engagement

During the last 12 months we organised various activities to encourage involvement from members and the local community providing the opportunity to contribute to the development of the services provided by the Trust and the well-being of the community served by the Trust.

There are now seven Governor/Director Constituency Groups which have been set up to ensure there are regular links between the Governors and the Directors, the local community and our members. These groups meet regularly to discuss the options for ensuring the membership is representative and that the local constituency public and members meetings focus on relevant mental and community health and learning disabilities issues for the locality. Feedback from these meetings is taken to the Membership Development Strategy Groups (MDSGs).

In addition to the membership recruitment activities, various steps were taken during the last 12 months to engage with members and the wider population:

- 15 constituency public and members meetings held to address issues relevant to the locality. Presentation topics included the Stepping Stones Gardening Project in Grays; how service users and carers have been involved in developing the Trust's dementia strategy; direct payments. Attendees at the cluster of meetings held in the spring were also given the opportunity to contribute to the development of the Trust's annual plan for 2012/2013

- Produced three issues of the members' magazine which includes regular articles on governor and membership activity and details of the elections. Governors were actively involved in the production and members were also encouraged to write articles. There was also a service user/carer representative on the editorial board

- Raised awareness of Trust events through regular communications with members and key local community stakeholders

- Inclusion of details of membership activity and elections in staff weekly enewsletters

- Successful comprehensive governor election publicity campaign which included workshops for potential governors

- Continued to develop links with CVSs, local employers and schools

- Attended various community events and forums to promote the work of the Trust, membership and constituency meetings

- Involved in the national 'Time to Change' campaign

- Invited members to the Trust's annual general meeting with approx 100 members attending.

4.1.4Review and monitoring

All membership activities and representativeness are monitored and reviewed by the MDSGs which is a committee of the Board of Governors. There are two groups, one in Essex and one in Bedfordshire and Luton. The Groups meet approximately four times a year and are active in reviewing the membership demographics, identifying plans to ensure a represented membership and promoting engagement from members and the wider community. The MDSGs produce a report for the quarterly Board of Governor meetings. The Board of Directors also receive regular updates on membership activities and representation.

The Trust's Membership Strategy and Action Plan has recently been updated and will be reviewed regularly by the Board of Governors to ensure that all objectives are being met and that it remains meaningful and relevant.

4.2Membership plan for 2012/2013

The total membership target for 2012/2013 is 23,000 members. Our strategy is to build a broad representative membership that is evenly spread geographically across the local area served by the Trust and reflects the ages and diversity of our local population.

The Trust recognises that it needs to encourage people in local communities to want to become a member of our Trust. We are keen to use the opportunity of having greater community involvement in our activities to promote good health, improve the understanding of mental illness and learning disabilities to help overcome barriers like stigma and greater social inclusion.

The Trust is also keen to improve the election turnout and will take steps to ensure that candidates and members actively participate in the election of public and staff governors.

Plans for the next 12 months include:

- Holding constituency group meetings which involve governors and directors. This will ensure under-representation is discussed and appropriate events are planned to address gaps
- Continuing to organise the two clusters of constituency public and members meetings in all localities
- Working with the Trust's Patient Experience team to ensure all opportunities of promoting membership recruitment and engagement are optimised
- Developing appropriate literature to support governors with recruitment and engagement activities
- Working with existing forums and links with the community, services users, carers, partner organisations, voluntary sector and staff networks, in attracting and building a membership representing the people of Bedfordshire, Essex and Luton
- Working with minority groups and those experiencing social inclusion
- Working with local religious and faith groups within the local communities
- Continuing to include governors, members, the public and key stakeholders in the annual planning for the Trust
- Encouraging staff, as champions of community and mental health and learning disability services to promote Trust membership with service users, friends and family
- Building on the work with young people in schools and colleges to promote mental health and well-being, encouraging membership and increasing representation from this group
- Developing partnerships with likeminded organisations and key stakeholders in the community and pursuing co-operative projects which resolve important local issues

- Engaging with local organisations to enable the Trust to communicate with hard-to-reach groups
- Publicising the governor election process in advance to members and arranging workshops for potential governors
- Ongoing communications and PR activities including production of the members' magazine, building on the members' area of the Trust's website, sending appropriate mailshots.
- Reviewing, identifying and developing opportunities for public and staff governors to extend their reach with the particular groups they represent, recognising that they are tailored to meet different needs of their membership constituency.

END