North Essex Partnership
University NHS Foundation Trust

Operational Plan Document for 2014-16

North Essex Partnership University NHS Foundation Trust

Final Version for Submission
1st April 2014

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.
Annual plan review 2014/15 guidance is available here.
Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.
Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.
The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Operational Plan for y/e 31 March 2015 and 2016

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

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Date	**1st April 2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

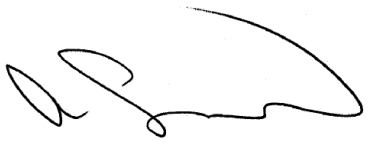
Name *(Chair)*	**Chris Paveley**

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Andrew Geldard**

Signature



Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Rick Tazzini**

Signature

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1. Executive summary

Introduction
North Essex Partnership University NHS Foundation Trust has entered this current period of financial stringency and organisational change with a full appreciation of the magnitude of the task ahead if it is to continue to thrive through 2014 – 16 and beyond, and meet the needs of its patients.

At the time of writing all contracts have been agreed with the exception of our main adult services contract. Monitor has been kept appraised of this situation as it has developed and we expect the adult contract to be agreed through mediation. The following plans and the financial submission are therefore based upon income, deflator and demographic uplift working assumptions which we believe to be a minimum outcome from negotiations.

Commissioning landscape
The 3 north Essex CCGs, our major commissioners which account for 70% of our income, share an overall philosophy of providing more care closer to patients' homes and as far as possible at primary care / community level through Stepped Care, which they have summed up in their joint Mental Health Strategy. All 3 have detailed plans that differ in emphasis and timing, and all 3 are working in the context of considerable financial challenges: the Mid-Essex LHE is in distress and will be the subject of a review initiated by Monitor, receiving expert help with strategic planning in order to secure sustainable quality services for their local patients. Both West and North-east Essex CCGs are responding to their financial situations (centred largely on their local acute activity) through programmes of community and mental health service redesign and reprovision. All 3 have committed themselves to maintaining sustainable mental health services and to prioritising the physical health of people with mental health needs.

While our major focus is the care of children, young people and adults with severe mental health and social care problems, we do not neglect the smaller patient groups we serve: adults with substance misuse problems, marginalised and vulnerable adults, and the patients of our 3 GP practices.

We will continue to embrace the overarching priority of the NHS to put quality (effectiveness, safety and experience) and innovation for our patients and their families at the heart of everything we do, whilst delivering improved productivity and value for money.

Internal planning process
We have a well-established planning cycle, involving and engaging the Executive Team (which has regular meetings devoted to strategy), Board Seminars and governor involvement. Area Directors develop their own Area Annual Plans which inform investment and CIP decision-making. We will continue with our unremitting focus on delivering to our local communities integrated, well co-ordinated and high-quality services, along with accessible information and support. Our geographical and specialist services directorates will continue to underpin the development of our Annual Plans with high levels of listening to and engagement with staff, governors, service users, families/carers, GPs and

local communities, but also with accountability to deliver against Trustwide priorities, standards, and measures. Our very active council of Governors continues to develop ways of improving engagement and dialogue with public and staff members, and it plays a full part in holding the Board of Directors to account and giving views on forward plans, including quality priorities, and on services. We have reviewed our Constitution and increased the proportion of staff Governors, and have clear development programmes for all our governors to ensure they are properly prepared for their increased responsibilities arising from the Health and Social Care Act 2012 and as recommended by the Francis Inquiry. We have always taken our public accountability very seriously and will continue to do so.

Involvement with commissioners' plans

The North Essex Mental Health Strategy is primary care-focussed but states a wish to retain sustainable mental health services within its vision for stepped care and a move toward integration of mental and physical healthcare. Engagement between the Trust and the CCGs has included presentation and discussion to the Board, to local Area clinical Boards and to our Governors. The Trust has formally responded to the CCGs, stressing the need to safeguard those with severe mental illness and multiple disadvantage within any redesigned community system, and we hope for a collaborative approach moving forward

This Annual Plan therefore draws on partners' Plans and on the emerging internal two year Plans which were being drafted during the drafting of this Plan.

Financial plans

The cumulative impact of 5 successive years of 4% CIP is major challenge. This is made all the more significant due to the unprecedented tariff deflator and the lack of previous service transformation investment monies to facilitate transformational change in mental health. As a result, the Trust has now reached a tipping point, with protracted and difficult 2014/15 main contract negotiations around the commissioners' desire to move the majority of the care of people assessed as falling into HoNOS care clusters 1 – 4 out of contract offering further uncertainty.

The Trust is planning for break-even revenue plan in contrast to previous years' plans for a surplus of £1.6m/pa (1.5%).

Our Financial Plan is summarised below

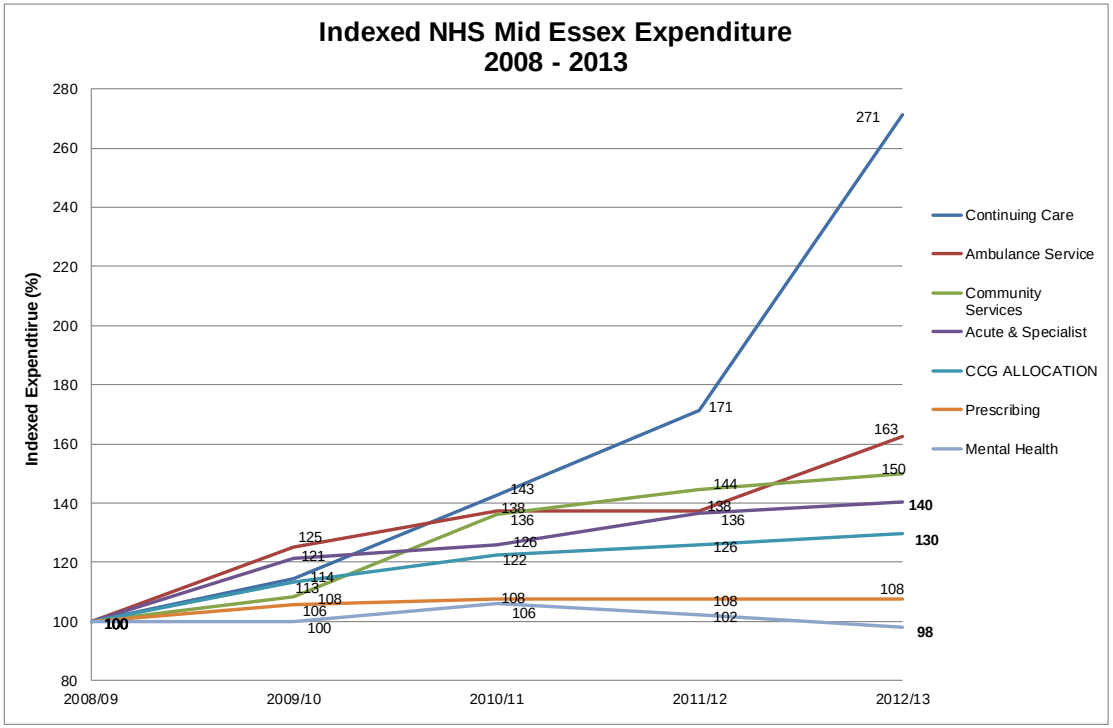
	2014/15	**2015/16**
Turnover	£108.3 million	£108.1 million
EBITDA	£5.5 million	£5.7 million
EBITDA margin	5.1%	5.3%
Revenue surplus	Zero	Zero

I&E Margin	Nil %	Nil%
Continuity of Service	3	3
CIP	£5 million	£5 million
CIPS – revenue cash	£2.5 million	£2.5 million

North Essex CCGs' commissioning intentions reflect the Mental Health Strategy: detailed discussion during contract negotiations has included a move to cost-&-volume for HoNOS care clusters 1 – 8, with an assumption that most patients in HoNOS clusters 1 - 4 will receive all their care through IAPT. This is in the context of a year-on-year reduction in investment in mental health services in real terms as against significant increases in overall CCG spend and in particular spend in acute hospital services. The following example is Mid-Essex CCG; the table shows change in spend per head of population between 2008 and 2013.

Expenditure per head of population	2008/09	2009/10	2010/11	2011/12	2012/13	Change 2008 - 2013
	£	£	£	£	£	
Mental health	82.91	82.41	87.33	83.54	79.61	**-4.0%**
Total acute hospital	403.23	483.52	502.97	540.48	552.92	**37.1%**
Community services (CECS/Provide)	93.91	100.95	95.55	100.88	100.35	**6.9%**
Ambulance	22.24	25.11	28.00	29.26	32.75	**47.3%**
Total CCG & commissioned healthcare	832.12	932.83	1012.13	1032.43	1055.60	**26.9%**

The graph below shows change in total spend for the same period:



Our financial modelling has included assumptions of no change in activity levels for HoNOS clusters 1 – 4 and an assumption that costs reduce as income reduces. It is possible, if HoNOS 1 – 4 activity does decrease, that HoNOS 5 – 8 activity will increase, offsetting cost reduction.

The current contract negotiation only covers 2014/15, with CCGs planning service redesigns for 2015/16, including in North-east Essex, where the Care Closer to Home programme includes the potential for re-procurement of some existing community services in the Colchester and Tendring areas. We continue to engage constructively and collaboratively with CCG colleagues, whilst trying to make sure that the benefits patients derive from the specialist expertise of our staff is not lost en route to a new, integrated provision.

CIPs

The current list of CIPs totals £5 million from the following sources;

Area	Value (£ million)
Cash reduction	2.5
Capital release	1.0
Cost pressures (absorbed)	1.5
Total	5.0

Our CIP proposals comprise £5 million (approximately 6% of our spend) of which £2.5 million is a cash reduction from expenditure budgets which is modelled in the financial plan. There is an additional £1million reduction in capital and £1.5 million of unfunded cost pressures which will need to be absorbed as an effective CIP.

Quality Strategy
We are overcoming some quality challenges uncovered by the new CQC inspection regime, with 3 CQC locations out of 15 receiving minor non-compliance and 1 location receiving minor and moderate non-compliance. As a result the Trust has submitted 4 comprehensive action plans to the CQC, all of which are well-advanced in implementation so that we are confident about our performance at the CQC's return visits.

In response to the Francis Report, we have completed our gap analysis and will be issuing our Board-approved action plan during April.

Overall Strategy
We acknowledge that 4% efficiency saving year-on-year is not sustainable by the Trust in its current configuration and with its current portfolio of service provision, and therefore that radical transformation is needed. To achieve this in the short-term, our internal transformation programme, Journeys, has been underway over the past year with significant clinical involvement, offering a fundamental redesign of secondary mental health services around agreed, standardised care pathways. The intention is that Journeys will be able to release £1.8m of the required CIP savings over 2 years.

Our existing 5 year strategy comes to an end in March 2015, and during this year we will be refreshing that strategy. Our own planning cycle, and the requirements from this planning round therefore do not entirely match. However, within this context we are simultaneously working to maintain service and quality levels in the short-term and mapping and embedding a sustainable strategy for the next 5 years.

It is likely that our organisation and services will look very different in 2019 to how they look today. The focus in 2014 – 16 is on completion of contract negotiations, internal quality and clinical process transformation (through our Journeys programme) and opportunities for commercial growth.

However, we are also aware that ensuring sustainability for the 5-year strategic period and beyond will depend on grasping integration opportunities, business growth, continually improving quality and responsiveness, and investigating new potential corporate futures contingent upon the outcomes of both tenders of our existing business and opportunities for growth elsewhere.

2. Operational Plan

North Essex Partnership University NHS Foundation Trust has successfully reached the final year of a 5-year strategy that set the following strategic objectives and key priorities:

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

These strategic objectives and key priorities have been and remain the basis for the Trust's service development plans and the framework within which we are responding to the changing commissioning environment and the system financial imperatives. This Operational Plan for 2014 – 16 delineates how we plan to respond to this rapidly-changing environment so that we can continue to deliver high-quality health, wellbeing and social care across Essex and Suffolk to meet the evolving needs of our catchment populations.

2.1 Inputs to this Plan

2.1.1 Strategy development

During 2013/14, we have been working with staff, patients, governors and members to update our corporate values to reflect how we feel about ourselves and how we want to be seen. This project, called “Our NEP”, is refreshing our values, refreshing our objectives and re-presenting our voice.

Under the banner of “Our NEP” we have identified that

- Humanity
- Our Cause, Our Passion
- Strive For Excellence
- Commercial Head, Community Heart
- Creative Collaboration
- Keep It Simple

reflect truths about us, particularly the care and compassion we share with our patients combined with our desire to see of the business thrive and develop.

We are developing our 5-year strategy for 2014 – 2019 on the groundwork of these restated values, building on our existing strategic objectives and key priorities to ensure a sustainable direction.

Internal process

The Trust’s Board provides leadership on strategic direction, regularly reviewing the impact of the external environment, national policy direction and the intentions of local, specialist and other commissioners, the requirements of regulators, and how we can build on our strengths, address weaknesses, exploit opportunities and mitigate threats. The way in which it has regard to the views of governors is outlined in more detail below. The Board takes full account of feedback on patient experience and available benchmarking and external assurance.

In order properly to have regard to the views of the Council of Governors, we have an inclusive Annual Planning cycle and process agreed with Governors to ensure they are able to bring their views, and those of the membership they represent, to influence the forward planning of the Trust. Over the course of 2013/14 there have been 4 meetings of the Council of Governors in public, a separate Annual Public Meeting, and two joint meetings of the Board of Directors and Council of Governors, and a governor-led annual planning event where Governors present their constituency views on quality priorities and forward plans to their colleague Governors and Directors. Preceding this event, during the summer, constituency Governors have meetings with relevant Area Directors to discuss priorities for the local Area business plans which underpin the Trust Annual Plan, and as preparation for their annual plan event.

Our annual planning process continues to be underpinned by business planning in our Area Business Units, led by local Clinical Boards and informed by the views and priorities of local elected governors. In addition all corporate functions have produced their own business plans for 2014 /16. Our Lead Governor and a governor working group help develop the proposals for our annual quality account report.

2.1.2 Membership

Membership size and movement by constituency

The Trust has two main constituencies – public and staff, with no separate constituency for patients. We have 5,899 public members and 2,195 staff members, giving us a total membership of 8,094 as at 31 March 2014. The Council of Governors has established three workstreams: Membership and Public Engagement; Youth Matters; and Social Inclusion. The responsibility for membership lies with the Membership and Public Engagement workstream.

- **Public constituency**
  Membership has declined during the year with 155 recruits and 616 leavers. We are below where we had hoped to be by this time. The rate of recruitment has slowed in line with the Council of Governors' approach of trying to link recruitment to Governors' community activity. The recruitment has come from a broader range of activities rather than from any central recruitment drive.
- **Staff constituency**
  Membership has declined over the year, with additional membership of 165 but a loss of 416. This constituency is likely to be further affected by business changes during the year. The significant proportion of staff to public membership has been reflected constitutionally through an increase in the proportion of staff governors.

Commentary / analysis of public constituency

The Council of Governors approved a 3 year membership strategy in March 2011, which was subsequently approved by the Board. The emphasis was on quality of engagement and activity, with individual recruitment profiles for each Governor to achieve both numerical and representative membership improvements. The Council of Governors reviewed this further at their meeting on 13 March 2012, where it was agreed that the strategy be updated with the following estimates to be achieved over the next two years:

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

Representative diversity of the public membership continues to be a challenge. This was discussed at length in the report to Council in May 2012. Males of any age, young people of either gender, or those from social classes C2, D and E, are areas where improvements are particularly needed. This is an issue Governors need to address. Some people still seem to struggle with the idea of membership or do not always see the relevance of membership of the Trust to the local services with which they identify. Additional work on the Trust's digital and general social media presence will begin to address some of these issues.

There continues to be a considerable amount of public activity with members meetings (which include patient stories) and meetings with area service directors, schools engagement including a mental health drama competition, the introduction of a University Day, an anti-stigma conference, World Mental Health Day activity, Friends of…. groups and much more.

The membership strategy agreed in March 2011 is now at an end and we are working with the Membership and Public Engagement workstream to develop a new one. Techniques being considered include the greater use of social media, further work with schools and youth groups and the continuation of work by Governors in their constituencies.

Gender: Membership is broadly proportionate but males are under-represented, making up less than 45% of members, compared to 49% of the eligible population
Age The under 16 and the 17 to 21 categories continues to be under-represented with only 174 members in these age ranges. We have experienced some opposition from parents and schools in recruiting amongst this age group. This, of course, will lead to a consequential over-representation amongst the age groups 22+. However, this cannot be calculated as 1,326 members have not giving a date of birth.
Ethnicity Essex's ethnicity profile is 94% 'white' with other ethnic groups all less than 1% each of the population. While our membership shows 89% 'white' and others therefore, higher than the population (other ethnic groups 5%) the numbers are small and keep us within tolerance. The Trust recognises the need to maintain activity to engage effectively with minority groups in the population.
Socio-economic status This is the area needing the most attention. 72% of members come from ABC1 (a 17% over representation). C2s are 22% of the membership, over-represented by around 5%. Group D (semi -skilled workers) has remained at 0.7% and should be 15% and are, therefore the most under-represented group. Group E remained at a little over 5%. In line with the implementation of the Trust's Service User and Carer Involvement Strategy, service user/carer involvement will be offered to all members. We anticipate an increase in the number of patients and their families joining the membership of the Trust. Patients tend to be drawn disproportionately from the C2, D and E socio-economic categories.

Steps taken to achieve representative membership, and plans for the next 12 months
Every Governor is sent regular recruitment and representativeness report, with the objective of increasing recruitment, addressing areas of under-representation, and improving the quality of engagement. Central to this is to hold two Members Meetings in all 10 public constituencies this year. As we have also increased the number of staff Governors (from 5 to 9 and based on geographical units not professional groups) we anticipate more staff engagement (already high) from which staff Governors can draw.

Achievements in 2013/14 and our plans for 2014/15 include:

- Schools – we are now in contact with over 40 schools and colleges across Essex. Many of them participate in our drama competitions, and 4 performed at our Annual Public Meeting (APM) in September 2012 (which had over 300 people present). We are investigating changes to the youth structure that will address the deficit amongst young people, with the work around mindfulness and anti-stigma

being the launch area. We continue to work closely with Chelmsford College on health awareness and World Mental Health Day, which we plan to increase in both scale and the range of activities on the day.

- We held our first University Day to mark our becoming a University FT. The event in April, which was open to the public, was very successful and based around the theme “Madness and Lunacy to Psychiatric illness – a historical perspective on psychiatry and mental health”.
- We continued with the new style Member Meetings in Harlow, Colchester and Uttlesford, run by Governors, with public in attendance. Patient stories were included.
- Stakeholder groups – we have continued to work with large numbers of community organisations on mental health awareness.
- The Extra Mile for Mental Health (10 October 2013) was a big success with more than 200 participants. A larger event is planned for 2014 and we have campaigning groups of Governors, stakeholder organisations and patients/carers; the objective is to recruit more young people.
- Governors continue with local surgeries and engagement events to increase dialogue with constituency members and to aid further recruitment. Governors also use their individual existing community networks and connections to carry out recruitment activity.
- Governors appointed by partnership organisations to organise a recruitment event once a year
- As a major strand of addressing the issues around socio economic status we commenced a postal recruitment campaign that targets patients from particular areas.
- We will be exploring with Governors the use of social media and how they can support membership recruitment.

Elections during 2013/14

In the period January to March 2014 elections took place in accordance with the model rules in the following constituencies:

Constituency	Turnout (%)
Braintree	Uncontested (3 seats)
Colchester	Election in progress, (4 nominations for 2 seats)
Suffolk	Uncontested (2 seats)
Tendring	Uncontested (1 seat)

Governor Development

There has been a continuing programme of Governor development throughout 2013/14 with activity including:

- Locality-based induction for new Governors.
- ‘Buddying’ offered to new Governors.

- Participation in FT Network events including 'Govern well', the new National Training Programme.
- Joint meeting/s of the Board of Directors and the Council of Governors, a round table workshop, where topics have included Strategic Transactions, Non-Executive Director Accountability and Influencing Stakeholders.
- Continued participation in FTGA Networks.
- Use of Monitor's 'Your statutory duties: a reference guide for NHS foundation trust governors' (revised version) to be issued to Governors.
- Other training including Dementia Champion training, the Complaints Process, Safeguarding and the Serious Incidents Process.

Following a Governor self-evaluation, a new Governor training programme is currently under development for 2014/15.

2.1.3 Engagement with local health economy partners

There has been considerable ongoing positive engagement with all local external stakeholders including the 3 north Essex CCGs – our major commissioners – in the 2014 – 16 planning process. This has included regular director-level discussion around alignment of shared sector objectives.

All 3 CCGs have run a number of planning workshops at which our managerial and clinical staff have participated fully in helping to develop their operational plans and strategies. There is a shared vision of high quality, sustainable healthcare built around integrated services. This desire has helped bring both acute and community healthcare colleagues closer together with our shared plans better aligned to the needs of our local communities.

2.2 The short term challenge 2014 - 2016

2.2.1 Local health economy status

The following table shows the increasing allocations to CCGs 2014 -2016

CCG Allocations 2014/15 and 2015/16 - £000s

	2013/14	2014/15	Increase			2015/16	Increase		
					Distance From Target				Distance From Target
	£000s	£000s	£000s	%		£000s	£000s	%	
Mid Essex	379,825	391,149	**11,324**	*3.0%*	*-4.9%*	**399,951**	**8,802**	2.3%	*-4.7%*
North East Essex	399,103	407,644	**8,541**	*2.1%*	*4.0%*	**416,095**	**8,451**	2.1%	*3.5%*
West Essex	311,286	322,798	**11,512**	*3.7%*	*-4.9%*	**331,089**	**8,291**	2.6%	*-4.7%*
	1,090,214	1,121,591	**31,377**	*2.9%*		**1,147,135**	**25,544**	2.3%	
England	62,743,712	64,336,427	**1,592,715**	*2.5%*		64,336,427			

Source: NHS England Allocations 2014/15 & 2015/16

North East Essex CCG area considers itself to be in a financially challenged position; it hosts Colchester Hospital University NHS Foundation Trust, which was put into special measures in 2013 by Monitor to ensure all its patients receive good quality care. A formal investigation by Monitor found that the Trust had breached its licence to provide health services after the Care Quality Commission (CQC) found that cancer care at the Trust was inadequate. We are fully engaged in the development and procurement process for the CCG's Care Closer to Home community service redesign process. We see this as an opportunity, together with other community health and social care providers, to develop new service offerings to support the out-of-hospital agenda. The procurement is also, however, a potential threat in that some of the Trust's existing community mental health services, as yet undefined, will be included in the procurement. A new service model will be in place towards the end of the 2 year planning period.

Mid Essex CCG area is one of the 11 health economies in England that is “in distress” and is to receive expert help with strategic planning in order to secure sustainable quality services for local patients. The 11 areas have been chosen on the basis that they will most benefit from external support in the first few weeks of the new financial year, A programme of work lasting around 10 weeks across 4workstreams will be undertaken:

- a diagnosis of supply and demand;
- solutions development and options analysis,
- plan development
- implementation.

We will be playing our full part in co-operating with this important process. However, we are aware that existing independent reviews have showed significant rises in costs in acute and community services and significant underinvestment in mental health services.

West Essex CCG area also considers itself to have a considerable financial challenge; it has a savings plan for 2014/15 which includes reductions of activity, some from redirecting patients in HoNOS clusters 1 – 4 and also from their frailty programme, both of which could affect the Trust and in both of which workstreams we are working closely with the CCG. We expect any reduction in throughput of lower-acuity patients, and subsequent income reduction to be offset by cost reductions and/or increases in higher-acuity activity reflecting changing demographics and unmet need.

2.2.2 Local and national commissioning strategy and intentions

North Essex CCGs

The draft North Essex Mental Health Strategy envisages moving service provision for people with mental health problems towards primary care and integrating mental and physical health care more. We are in discussion with them seeking clarity about what the shift of resource to primary care means for secondary mental health funding and services for people with severe mental illness.

Each of the North Essex CCGs is looking to improve efficiencies and productivity whilst maintaining a high level of mental health service provision. Commissioners are seeking for 2014/15 to move to a cost-&-volume service for non-psychotic HoNOS clusters 1 to 8, retaining the block contract for activity for psychotic and organic disorders. They are also seeking a 2% activity ceiling for clusters 5 to 8.

The expectations of the CCGs are that people who are not psychotic and have mild to moderate problems (characterised by the CCG as the people who attract a HoNOS cluster score of 1 to 3) and those with severe to complex problems in HoNOS cluster 4 will receive a service from primary/community services including IAPT rather than from secondary services. This activity reduction, if it were to occur, would result in a reduction in funding for Trust services.

In North-east Essex, community care provision including community mental health will involve 3 new pathways:

1. Care closer to home: Community services for adults and older people which will include physical health, mental health and social care. This will also include some services currently provided in an acute general setting. This includes primary care mental health services for people with serious mental illness and Veterans.
2. Redesigned urgent care services, with a hub and spoke urgent care centre model.
3. End of life care which will support and enable patients' choices.

In Mid-Essex, an expanded IAPT service will incorporate serious mental illness. There will also be a focus on the Frailty Pathway, a transformational initiative to develop an integrated service across health and social care to provide differing levels of stabilising and pre-emptive management to those people who have become 'dependent', whether that is a physical, cognitive or social dependency.

In West Essex, work with both Princess Alexandra Hospital, NEP and the local IAPT provider with regard to the development of the redirection programme at the front door of A&E will ensure access to appropriate primary and secondary care mental health services, development and on-going delivery of the Frail Programme with particular development of services supporting patients with dementia and continuing to ensure patients are treated appropriately in a primary care setting

The CCGs will decide on whether to de-commission a psychiatric intensive care unit. The CCGs will work to re-provide a slow stream rehabilitation service for the current clients at Severalls House and at the right time for both parties withdraw monies from the block contract.

Although currently only relevant to Mid Essex CCG the results of the Recovery College pilot are awaited across all North Essex CCGs.

The CCGs will look to reduce the number of placements both in-county and out-of-area by a combination of working with providers to develop local service provision and transferring responsibility for defined categories of clients to the local NHS provider. (We are working with the CCG on a case-by-case basis).

The CCGs will wish to procure services on a revised personality disorder pathway, although work on this is in the early stages..

Suffolk commissioners

Ipswich and East Suffolk and West Suffolk CCGs will be undertaking the re-procurement in 2014/15 of community services. The likely tender start is October 2014 for a service implementation date of October 2015.

They will also work with partners to remodel learning disabilities services to deliver integrated pathways that promote progression and independence for people of all ages, delivering services closer to home removing barriers between services and providers.

Suffolk County Council will be re-procuring its county-wide substance misuse services during 2014 / 15.

NHS England
NHS England directly commissions 143 specialised services (3 from this Trust) and will be developing a commissioning framework for each service. At a clinical level, major changes in the scope of services directly commissioned by NHS England are not intended for 2014/15. Following the Child and Adolescent Mental Health Services Tier 4 review, it is expected that the recommendations to procure appropriate quality, access and capacity will be implemented.

Essex County Council
Supervision of last year's Section 75 staff transfer to Trust employment, and of the consequent deeper integration of health and social care for adults, is undertaken by a Partnership Board with members from the Trust and Essex County Council.

The Council will decide, based on stakeholder consultation and a soft market test via an RFI to potential suppliers, whether to procure integrated CAMHS Tiers 2 & 3 services, in collaboration with Southend and Thurrock Councils.

The ongoing intensive enablement service procurement will be completed. The Council will focus on reducing its residential care spend.

Essex Council County public health, now responsible for commissioning substance misuse in succession to the DAAT, has not made any changes to its commissioning plans for 2014/15 compared to 2013/14 in respect of our substance misuse community teams, but has notified us of its intentions to re-procure community specialist prescribing services with effect from April 2015.

2.2.3 Trust response to commissioning intentions
We are working constructively with the CCGs to discuss the sustainability of their solutions, ensuring that the needs of our patient cohort are protected in any subsequent redesign of services and that commissioners are convinced of the need to maintain safe workforce volumes and skill levels.

For example, we have challenged plans that imply that complex care of all people with severe and enduring mental illness can be carried out safely in primary care, for example that people assessed as falling into HoNOS cluster 4 have "moderate" problems. We are also challenging some of our commissioners' perceptions both that we are mainly a provider of inpatient care – most of our services are embedded in the communities they serve – and that our care is institution-based and inefficient – our benchmarked performance is excellent.

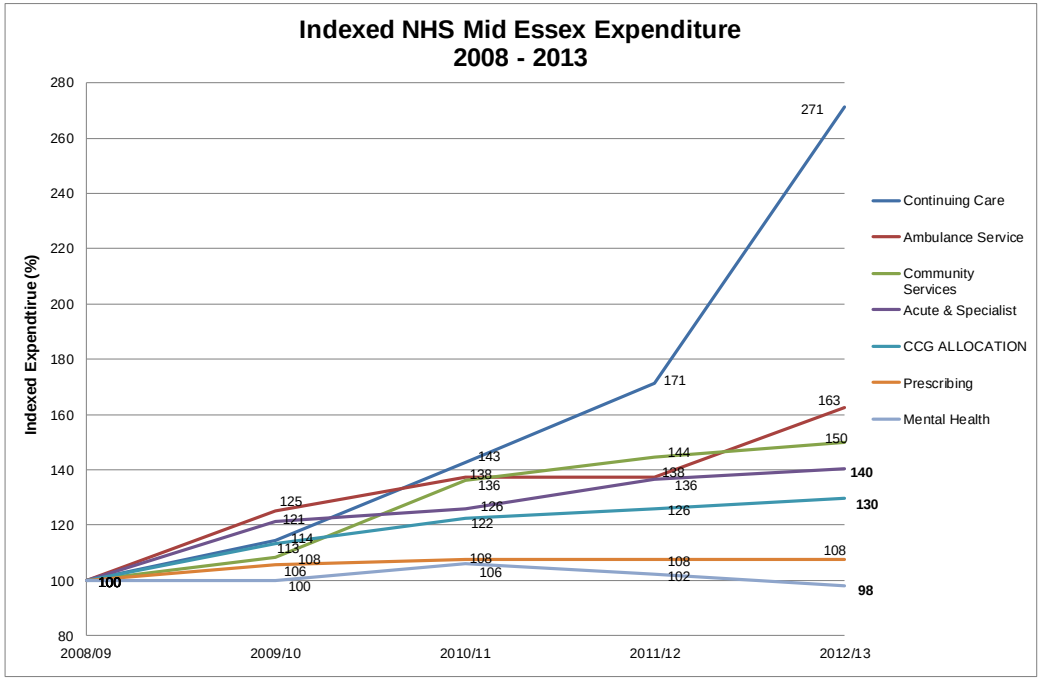
A key challenge is attracting widespread clinical interest from CCGs and avoiding simplistic managerial discussions about cost.

We believe that the government's commitment to Parity of Esteem for mental health binds commissioners and ourselves together in a cycle of improvement. Unfortunately historic spend has shown a clear disinvestment in mental health which will need to be reversed.

We are concerned that continuing to reduce year-on-year spend on secondary mental health on the assumption that IAPT or an alternative to our own care co-ordination will meet patients' needs fully may disadvantage the least articulate, least insightful and most needy of our patients. We are, for example, concerned that commissioners wish the needs of Veterans to be met by IAPT, when our own clinicians' experience is that many Veterans have problems of such complexity that no high-volume, low-intensity service such as IAPT could meet them safely.

The following example is for Mid-Essex CCG; the table shows change in spend per head of population between 2008 and 2013. data:

Expenditure per head of population	2008/09	2009/10	2010/11	2011/12	2012/13	Change 2008 - 2013
	£	£	£	£	£	
Mental health	82.91	82.41	87.33	83.54	79.61	-4.0%
Total acute hospital	403.23	483.52	502.97	540.48	552.92	37.1%
Community services (CECS/Provide)	93.91	100.95	95.55	100.88	100.35	6.9%
Ambulance	22.24	25.11	28.00	29.26	32.75	47.3%
Total CCG & commissioned healthcare	832.12	932.83	1012.13	1032.43	1055.60	26.9%



The graph above shows change in total spend for the same period.

We note that Mid-Essex CCG has had a sustainability review by Capita which has suggested a correction of their year-on-year disinvestment in mental health through its commissioning process. We will co-operate fully with the review initiated by Monitor of the Mid-Essex LHE.

Where services that we currently provide are subject to tender, we will bid to continue to provide them in whatever redesigned form meets commissioner expectations, on the working assumption that we will be well-placed (and understood as well-placed) to provide continuity of care, ongoing innovation and excellent care. We intend to form new partnerships wherever possible to increase our chances of success in providing care and treatment in integrated pathway models.

2.2.4 Growth and development

Our Commercial and Service Development team continues actively to pursue opportunities, alone or in partnership with NHS, social care, community, commercial and voluntary organisations, appropriate to the Trust's Strategic Vision. Bids in response to formal procurements and business proposals in development for 2014 /15 are detailed at Appendix 4.

This portfolio offers opportunities for both consolidation of existing expert provision and diversification into new areas of activity and new (but adjacent) geographies. Each opportunity is considered on its own merits and we do not make any assumptions about any effect on income or financial planning.

2.2.5 Partnership and collaboration

We continue to work closely with health and social care provision partners across Essex in offering solutions to commissioners either in response to formal procurements or through business cases for service development. We see the future for the provision of many services as being through partnerships, including joint ventures, alliances commissioning and lead provider models.

We are currently engaged with the following organisations:

- Provide (community services)
- Interserve (facilities management)
- Essex Cares Limited (reablement)
- Anglia Community Enterprise (community services and frailty)
- Rethink Mental Health (IAPT)
- Samaritans (suicide prevention).

2.3 Quality plans

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

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

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

Our values underpin everything we do:

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

Our commitments:
To individuals and families:
- to work together, building on strengths, to improve mental health and wellbeing,

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

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

'**Outstanding care, transforming lives'**, enshrines the values of the NHS, and our statement of commitments looks both outwards to the people we treat and support, and inwards to our staff who can make our vision happen. Most people want services that provide expert

information and advice, treatment and support to assist recovery and promote independence, but importantly also want those services to place the quality of the relationship at the heart of what they do. That's what we aspire to do every day in all that we do.

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

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

2.3.2 National and local commissioning quality priorities

NHS England sets out a clear vision for quality improvement and clinical leadership including:

- Leadership alliance for the care of dying people – this is about phasing out the Liverpool Care Pathway (LCP) and moving towards a consistently-applied approach to caring for dying people across England, to ensure that everyone who is at the end of life, and their families, receive high quality care, tailored to their needs and wishes and delivered with compassion and competence.
    - We have always been committed to this kind of approach and have used the LCP appropriately to ensure people die in a peaceful and dignified manner. Changes have been made to our Palliative Care policy so it no longer refers to the LCP.
- Revalidation is the process by which the General Medical Council will confirm the continuation of a doctor's licence to practise in the UK. Its purpose is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practice.
    - We have implemented revalidation for its medical staff over the past year and will continue to do so in 2014/15.
- NHS England Call to Action – a request to patients, public, staff and partners to join a national conversation about the future demand on NHS services, the impact of changing health needs and how we will meet these challenges.

- Valuing mental health equally with physical health or “Parity of Esteem” – this is about having access to services which enable both mental and physical wellbeing and being able to use services which assess and treat mental health disorders or conditions on a par with physical health illnesses.
    - As a mental health provider, we have always been fully committed to this concept. We work hard to achieve parity through negotiation with local commissioners for appropriate and adequate funding to provide high quality mental health services as well as through our important public engagement work aimed at eliminating stigma.
- Clinical audit – the aim is to use clinical audit as a tool to find out if healthcare is being provided in line with standards. It also lets care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care through national and local clinical audits.
    - We are reviewing the way we conduct clinical audit in the Trust; there is an emphasis on using local audit groups to create ownership and accountability for local audit, whilst maintaining a trust wide focus with participation in national audits, audits as part of the CQUIN scheme and through local clinical commissioning groups.
- NHS Improving Quality – the driving force for improvement across the NHS in England, working to improve health outcomes for people by providing improvement and change expertise – NHS outcomes framework.
- NHS services, seven days a week (Keogh report).
- Winterbourne View Joint Improvement Programme – a programme of change to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them.
    - We are fully focussed on providing high quality compassionate care.
- Patient-led assessments of the care environment (PLACE), the new system for assessing the quality of the patient environment.
    - We have already successfully implemented PLACE.

2.3.3 Quality improvement: continuing clinical development (Trust innovation)

Strategic objectives	Key priorities	Development plans 2014 - 16
1. To provide high quality care that is effective, safe and as positive an experience as possible	1. Improving access to, and accessibility of, services	• As part of Journeys, develop locally-relevant single points of access / single points of referral for all Areas. • As part of Journeys, develop extended hours community services where appropriate. • Develop improved liaison services in acute hospitals, particularly in A&E / MAU / RAU departments. • As part of Journeys, implement new Area adult community service team and pathway configuration.

		• Continue to develop joint Frailty service offerings across north Essex with partner health and social care agencies. • Continue actively to advocate for enhanced services for Veterans. • Continue to seek to extend service provision for marginalised and vulnerable adults.
	2. Improving patient safety and general wellbeing, ensuring all care and other environments are appropriate, safe and therapeutic	• Complete local reconfigurations to provide more streamlined appropriate services, for example in Epping Forest. • Achieve accreditation status with the Forensic Quality Network for the low-secure unit (Edward House). • Seek Royal College of Psychiatrists accreditation for Edward House. • Continue to work with Cambridge University using their prospective Hazard Analysis method to understand and mitigate risk in designing new service delivery models and care pathways. • Continue to improve therapeutic engagement on inpatient units. • Continue programme of improvements at GP practices in Thurrock. • Comprehensively address and rectify CQC compliance deficits.
	3. Continuing to improve the experience of service users, families and carers, ensuring embedded systems for receiving and acting on feedback	• Develop Area-wide Practice Development Unit accreditation submissions for all our care pathways. • Continue to respond to priority action areas from Patient Survey. • Continue to upgrade and improve patient environment. • Consolidate enhanced services at HMP Chelmsford.
2. To be a model employer	4. Creating positive experiences for staff within an efficient and effective workforce	• Focus on areas in 2013 and 2014 Staff Survey where we can improve staff perceptions. • Continue to involve staff fully in consultations and service re-design projects. • Give all staff full information about changes to commissioned service provision as soon as the changes are firm. • Maintain exemplary staff support systems such as Respect and Dignity advisors, mediation service and Occupational Health and Wellbeing service. • Maintain effective existing communication channels for all staff through line managers and directly to senior staff.

3. To achieve good Governance, inclusive Involvement and excellent partnerships	5. Engaging widely with local communities and key stakeholders, developing productive partnerships with partner organisations and helping promote positive mental health	• Conclude negotiations with HMP Chelmsford to provide further services including medical and nursing input. • Further develop Health Outreach Suffolk, including an organisational review of service need and re-design. • Prepare for and contribute to a planned personality disorder pathway redesign.
4. To provide value for money (economy, efficiency, and effectiveness)	6. Ensuring an ongoing programme to ensure services are clinically and cost effective, use of estate is maximised and carbon footprint is reduced	• In tandem with Journeys, continue to investigate efficiencies in administration and cost-savings around support services. • Continue with the capital programme of disposal of surplus community premises consequent on rationalisation of estate use across the Trust. • Continue with Derwent Centre redevelopment, completing Phase 2-5 works and progressing subsequent phases, putting new care pathways in place. • Rationalise estate in Harlow to maximise use of the Derwent Centre footprint and reduce revenue costs. • Reprovide the community team base from Dunmow.
	7. Realising development of, and benefits from, the Trust's information systems	• Continue to refine the new Remedy system, embedding it in everyday clinical practice, so that its potential for development and its capabilities for mobile working, streamlined clinical practice and reduced administrative burden can be realised.
5. To expand the business	8. Exploiting opportunities for growth and broader business development	• See 2.2.3 above for Commercial & Service Development team workplan. • Develop new formal and informal partnerships with local and national health and social care providers to bid against tenders for integrated and other community services.

2.3.4 Workforce development

The Workforce Development team will continue its programme of work to prepare our staff for their developing roles. Priorities for 2014 – 16 include:

- implementing revised appraisal training for all managers.
- supporting work based on the talent mapping exercise, identifying and supporting senior clinical staff into band 7 management /leadership roles and developing a programme to support medical staff into leadership and management roles.

- developing a programme that enhances the behaviours and attitudes our staff display to each other and clients , using our agreed values.
- ensuring our staff are consistently attending training and operating safe practices by monitoring and actively reporting on mandatory training uptake.
- developing skills in our staff which support the Journeys programme of major care pathway review and redesign, ensuring staff are well placed to deliver new skills.
- developing a programme with consultant psychiatrists to introduce junior doctors to effective communication behaviours.
- delivering new programme of 2 separate leadership programmes, the Emerging Leaders programme (band 3 - 6) and Leading for Excellence (bands 7 - 9).
- continuing to offer coaching to support the high performing staff and to develop staff into their roles.
- continuing to respond to Trustwide team development, including developing bespoke team days for staff and providing analysis and research projects related to exploring team dynamics.

2.3.5 Risks to quality and delivery

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

The key risks to quality and delivery, including quality governance, and planned mitigating actions are listed in detail in Appendix 1. Identified key organisational risks are listed in detail in Appendix 2.

We have performed well against relevant mandated healthcare targets and indicators in 2013 /14. However, the YTD performance in certain categories has been affected by the transition to Remedy, our new patient information system, with the inevitable temporary discontinuity of access, drop-off in staff IT skill-levels and consequently data entry:

These matters are on track for complete rectification by quarter 1 and will present no risk to overall corporate performance.

2.3.6 Board assurance of quality

The Trust is committed to providing a high quality service to people who use our services. We assess ourselves against Monitor's Quality Governance Framework on an annual basis and have used the Quality Governance guidance for Boards template to map our position as at January 2014.

Our RAG rating is assessed as green with a robust level of assurance and we comply with good practice and provide evidence against the 10 questions set by the Quality Governance Framework.

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

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

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

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

Our Quality, Risk and Patient Safety department proactively promotes safe and effective care, and monitors and reports on its delivery. It co-ordinates risk management, serious incident investigation and reporting, RIDDOR monitoring, clinical and corporate audit, quality reports and accounts, compliance and regulatory framework, patient satisfaction, claims and co-ordination of policy development.

We have a robust system of medical and nursing leadership providing medical and nursing advice and input to corporate and local management and governance decisions across its services. The Medical Director and Director of Nursing and Operations head the medical and nursing leadership structures and are directly accountable to the Chief Executive and the Board of Directors.

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

Trust-wide Clinical Boards oversee local practice and development, advising managers on professional and governance matters. The Boards proactively foster staff engagement, bringing clinicians' expertise to bear on whole-Trust governance in an integrative way; clinical staff's willingness to be involved and be influential in service transformation towards new ways of working, and by their contribution to Trust clinical

conferences, business planning and service initiatives is evidence of the effectiveness of this engagement. The Clinical Boards also oversee the development and agreement of local Cost Improvement Plans, the clinical quality and safety impacts of which are subsequently considered before Board approval by the Medical and Nursing Directors.

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

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

The Board action plan will include our formal response to the Francis Report building on actions already taken.

Self-assessment

1.1 Engagement on quality – QGF domains 1A; 2A; 2B; 3C

- The Board provides a clear steer on the strategic and operational quality outcomes it expects the organisation to achieve
- A quality culture exists across the different layers of clinical and non-clinical leadership
- The Board understands the effectiveness of the methods used by NEP for communicating to and involving staff, patients and stakeholders in the quality agenda

1.2 Gaining insight and foresight into quality – 4A; 4B; 4C

- The Board receives the right type and level of quality information
- We benchmark information against other Trusts of similar type and complexity
- The 'hard' facts and data are consistent with what we hear and observe around NEP
- We are assured that the data we use to inform decisions is robust and valid
- We can name the best and worst performing services from a quality perspective within NEP and how these services compare with other Trusts

1.3 Accountability for quality – 1B; 2A; 3A; 3B

- NEP has key sources of assurance upon which it relies
- We are able to distinguish between assurance and reassurance
- There is a clear trail of assurance underpinning the board statements and declarations

- We understand how quality governance assurance processes operate across our committee structure
- We understand the role of the audit functions in supporting Board assurance on quality governance

1.4 Managing risks to quality – 1B; 3B

- Our Board Assurance Framework and local risk registers are effective in capturing the risks to quality within NEP
- We are assured that patient safety incidents are reported and dealt with correctly and escalated to the Board appropriately
- We are assured that efficiency programmes are not adversely impacting on the quality of patient care

2.3.7 Existing concerns

The Trust has received planned CQC unannounced inspections in all of its in-patient areas during 2013/14. This has resulted in 3 CQC locations out of 15 receiving minor non-compliance and 1 location receiving minor and moderate non-compliance. As a result the Trust has submitted 4 comprehensive action plans to the CQC; these will be completed locally and monitored by Risk and Governance Executive. On completion these will be validated through local data quality audits, the action plan being sent to the CQC, triggering a return visit for external validation and lifting of non-compliance.

Common themes of non-compliance are around outcome 2 of the CQC Essential Standards of Quality and Safety, (consent to treatment) and around documentation and record-keeping. Actions in relation to rectification of these are included in our quality development goals.

We are engaged in developing and implementing action plans around these concerns, which will lead us to full compliance during quarter 1 of 2014/15 for all our facilities. Tabulated CQC compliance status as at March 2014 is detailed at Appendix 3.

2.3.8 Priorities for improvement outside CQC concerns

On an annual basis we meet with a small group of our Governors to discuss the outcome of planning events, progress against the 2013/14 priority improvements and suggestions for 2014/15 priority improvements. The table below outlines our 2014/15 priority improvements.

Priority for improvement	Action
1 Social inclusion and anti-stigma	1. Refresh the anti-stigma campaign 2. Target schools and employers to promote mental health and build on the work already done by the communications team 3. Improve engagement with local press in order to promote mental health and anti-stigma 4. Governors' social inclusion group (SIG) to set objectives for the year based on a list of targets discussed in January 2014
2 Improving medicines management	1. Review medicines security in relation to recent guidance from NHS Protect 2. Develop more meaningful reporting

	3. Focus on quality and benchmarking 4. Other actions to be agreed
3 Improving engagement and support of staff	1. Staff governors to form a conduit for feedback direct from grassroots through to the Council of Governors and the Executive Team 2. Take forward actions from the administration staff review 3. Other actions to be agreed e.g. staff family and friends test
4 Improving the patient and carer experience	1. Embed and monitor the structured activity levels of 18 hours minimum per patient 2. Implementation of service user and carer involvement strategy 3. Set up local involvement boards 4. Carers strategy implementation/action plan 5. Operational lead in each area 6. Develop formal feedback from public/governor events to the Trust complementing the verbatims from discharge questionnaires 7. Implementation of Journeys
5 Response to Francis Report	1. Implementation of actions identified by gap analysis 2. Actions from Chief Executive Board paper 3. Development of Duty of Candour 4. Staffing levels

2.3.9 Workforce implications

The Trust's key workforce priority over the period of the plan relates to a review and redesign of clinical pathways, with support to clinicians focused on maximising productivity. The Journeys Programme is designed to ensure that service users receive the most appropriate care for their condition following a process of comprehensive assessment. In terms of the workforce, new models of care, with care packages aligned to HoNOS clusters, will require a different approach to the way that teams are currently structured and skills deployed to deliver care. Clinical interventions have been initially assessed to determine the skills required to deliver care, and a skills audit is being undertaken. The skills audit currently nearing its conclusion is helping us identify the right professional at the right grade in the right place to deliver evidence-based and effective interventions. It is also assisting us in assessing learning and development needs to ensure our training and education plans are designed with the organisations objectives in mind. The skills audit in CMHS is completed and other services will complete early in the new financial year.

Our focus is on ensuring the best patient outcomes and experience and therefore any significant reductions in the clinical workforce will be avoided. New team structures, which have been designed and are in the process of agreement and implementation, are likely to result in an overall reduction in managerial and administrative support.

We have a record of low turnover of staff but this is anticipated to increase over the next few years with a number of staff either retiring this year or planning to retire in the near future. This is viewed as an opportunity and not a threat as it allows us the flexibility to review current structures and working arrangements and mitigates any need for compulsory redundancies.

Workforce Performance Indicators					
Indicator	**Threshold**	**March 2014**	**March 2015**	**March 2016**	**Commentary**
Sickness absence	4.5%	4.3%	Maintain performance against all current targets		2013/14 Achieved below threshold
Long-term sickness		1.4%			
Short-term sickness		2.9%			
Turnover	10%	8.3%			2013/14 Achieved below threshold

Any major change programme involving the workforce requires effective consultation and engagement. The Trust recognises that failure to achieve this could have a negative impact on morale and impede successful progress. It is for this reason that the Journeys programme from its inception has been clinically-designed and -driven. Engagement with trade union partners is also crucial and again helps to mitigate risk. The changes have been subject to a full, organisational wide consultation process.

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

2.3.10 Trust's response to the Francis, Berwick and Keogh Reports

Towards the end of 2013 the Department of Health published 'Hard Truths', a comprehensive report in two volumes which represents the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry, commonly known as the 'Francis Report'. The first of the two volumes focusses specifically on the key themes and looks at grouping the individual responses into a more coherent plan. The second of the two volumes deals individually with each of Robert Francis' recommendations detailing whether they are accepted by the Government (or not) and the specific actions to be put in place to address the issues.

The Trust's Board has a well-established working group to look at those implications from the Government's final response which particularly affect us. We have completed our gap analysis and will be issuing our Board-approved action plan during April.

2.3.11 Risks to delivery of key plans

Francis Report action plan

We set up a Hard Truths project team made up of a cross-section of key individuals to meet on a time-limited basis and undertake a gap analysis. The overall objective of the group was to identify the recommendations relevant to NEP and pull together an action plan that will then be implemented by key managers and staff within a limited timescale. Other key individuals have been involved in providing evidence and information in between meetings.

A group of stakeholders from the Council of Governors met in February to discuss Quality Account priority improvements for 2014/15 and it was recommended to and agreed by Risk and Governance Executive that one of these should be the implementation of our action plan in relation to the Francis Report. Risk and Governance has in turn made this recommendation to the Trust Board of Directors.

In addition the Chief Executive convened a sub-group of the Board of Directors and fed back to the Board meeting on 29th January 2014 with the early findings of this sub-group.

The key issues for us are:

- Culture and patient safety
- Openness and candour
- Listening to patients
- Safe staffing
- Detecting problems quickly
- Ensuring robust accountability
- Ensuring staff are trained and motivated.

The detail of our response to the Francis Report will appear in the 5-year Strategic Plan 2014 /19: the gap analysis is attached at Appendix 6.

Better Care Fund

CCGs and local authorities will have to agree how the money will be spent to achieve better outcomes for patients and to satisfy local needs and the national conditions attached to the grant. These include protecting social care services, ensuring seven-day working to support hospital discharge and relieving pressures on urgent and emergency care. It does not address the financial pressures faced by local authorities and CCGs which remain 'very challenging'. It is a joint fund of existing monies, not a transfer to social care.

£1bn of the £3.8bn fund will be linked to performance in 2015/16. None of the existing £900m transfer from the NHS for social care, nor the additional £200m for these purposes in 2014/15, is linked to performance.

All the funds included in the Better Care Fund in 2015/16 will be contingent on meeting the national conditions set out in the spending review settlement in July 2013:

1. A plan that is signed off by the Council, its Health and Well- being Board and the constituent Clinical Commissioning Groups with demonstrable engagement of providers;
2. Protection of social care services evidenced by sustaining eligibility;
3. Data sharing between health and social care using the NHS number as a unique identifier;
4. 7 day working in social care to enable hospital discharge and reablement ;
5. Joint assessment arrangements between health and social care to enable a single assessment and a single accountable professional;
6. A clear statement of the implications for hospital providers that are affected that is signed off by the health and well-being board; and
7. A risk assessment of the consequences of failing to achieve proposed changes in activity levels and a plan to mitigate these.

The Better Care Fund offers an opportunity better to align health and social care and is likely to strengthen the movement to integrated health and social care provision (integration of community care in north Essex is currently conceived of in health terms, and so a broader involvement of social care is welcome). As an established provider of integrated health and social care for people with severe mental illness, this might seem to favour our approach, but it is possible – in the absence of assurances to the contrary in CCG plans - that the combination of CCG and local authority priorities leaves services for already-underserved groups such as our major patient cohort further disadvantaged.

2.3.12 Contingencies

In the short-term, we are confident that we will remain viable as a provider of NHS health and social care should the most pessimistic commissioning scenarios materialise over the course of 2014/15. Our approach would be to:

- continue to grow and diversify our business
- continue with internal service reconfigurations
- accelerate our programme of internal economies
- run an in-year deficit while we restructured our staffing and finances
- support services using the major capital receipts, other asset sales and our reserves.

In the longer term, if we felt that the Trust was in danger of becoming unviable due to a loss of critical clinical mass and clinical quality assurance, we would at an early stage seek to work with regulators and commissioners and consult locally on the options. We are currently building stronger clinical links across the Essex health and social care system in more specialist services to create networks of service provision, which could even form the basis for development into a merger should the need arise.

2.4 Operational requirements and capacity

2.4.1 Demand 2014 - 2016

Demographic change – north Essex:

The population of north Essex is projected to grow by 3.4% between 2013 and 2016 (ONS 2011-based subnational population projections). This will give an all-age population growth of nearly 34,700 people by 2016, with 51% of the growth in the over-65 age range.

The change of health and social care focus locally, with the diseases and reduced independence of older people gaining more attention and investment, reflects the projected rise of 9.4% in the population of people aged over 65 by 2016. This focus on revised, integrated care pathways, a shift from acute to community provision and care closer to home, and changes to commissioning may make the situation more manageable for GP commissioners. The future configuration of local acute hospital provision is also likely to become increasingly uncertain, although locally in north Essex this seems to have a lower priority than the reconfiguration of community services.

The full population-change projections are:

	Population 2013	Projected population 2016	Change (%)	Population 2013	Projected population 2016	Change (%)	Population 2013	Projected population 2016	Change (%)
	Age 0 - 16			Age 17 - 65			Age 66 and over		
Braintree	31,459	32,585	3.6%	93,602	94,190	0.6%	25,330	28,231	11.4%
Chelmsford	34,002	35,129	3.3%	107,899	107,775	-0.1%	28,645	31,245	9.1%
Maldon	11,616	11,748	1.1%	38,187	38,025	-0.4%	12,894	14,490	12.4%
Mid-Essex	77,078	79,462	3.1%	239,687	239,991	0.1%	66,869	73,966	10.6%
Harlow	18,451	19,263	4.4%	53,107	54,069	1.8%	12,084	12,609	4.3%
Epping Forest	24,976	25,969	4.0%	79,682	81,460	2.2%	22,719	24,202	6.5%
Uttlesford	17,922	19,062	6.4%	50,342	51,168	1.6%	13,935	15,450	10.9%
West Essex	61,348	64,294	4.8%	183,131	186,697	1.9%	48,738	52,261	7.2%
Colchester	34,812	36,559	5.0%	116,674	120,092	2.9%	28,032	31,169	11.2%
Tendring	24,544	25,361	3.3%	79,004	80,476	1.9%	38,050	41,304	8.6%
North-East Essex	59,356	61,921	4.3%	195,678	200,568	2.5%	66,083	72,473	9.7%
North Essex Total	197,782	205,676	4.0%	618,496	627,256	1.4%	181,689	198,699	9.4%

Ethnic minorities
It was estimated in 2011 that just over 10% of Essex residents are from mixed, Black or Minority Ethnic (BME) groups, while across England this figure is over 16%. Whilst this is an increase from 2001, it is still lower than averages across England, the East of England and the South East in 2001. At this time Essex also had a lower proportion of its population identifying with white minority ethnic groups than elsewhere (3.5% compared with an English average of nearly 4.6%).

As Essex continues to grow it is becoming more diverse. The county's BME population is growing. Those in Essex belonging to Mixed, Black, Asian or Chinese ethnic groups in fact more than doubled between 2001 and 2007, when it reached nearly 90,000 people. Recent immigration from Eastern Europe has increased the proportion of people from "Other white backgrounds" , although there is no particular focus of Eastern European population to compare to that of Ipswich in north Essex.

Travellers have a small presence in north Essex compared to the high-profile presence they have in south Essex.

A 2013 caseload snapshot showed the following ethnic mix of patients:

Ethnicity	Proportion of caseload
White British	94.50%
White Irish	0.73%
Other white	1.97%
Mixed	0.92%
Asian or Asian British	0.92%
Black or black British	0.56%
Chinese and other	0.41%

Incidence of mental illness
A projected increase of 4.5% the number of adults in north Essex expected to have a mental health disorder compares to a 3.7% projected increase in overall population for the same age group. The 3 Essex JSNAs show:

North-east Essex: "The prevalence of metal health problems in NE Essex (0.8%) is similar to the national average (0.8%), although there is a lower prevalence of depression in the local population. The mental health spend in NE Essex (£17.2m/100,000 population) is only marginally lower than our ONS group of PCTs (17.7m/100,000 population) but much lower than the national average (20.4m/100,000 population)."

Mid-Essex: “The total CCG-level expenditure for Mental Health Disorders in 2011-12 was £15.89m per 100,000, which was one of the lowest in the country. Some of the QOF indicators are well below the national average, especially around the lifestyle risk factors. Based on national evidence, it is likely that the GP recorded number of patients with a mental health conditions is underestimating the local prevalence.”

West Essex: “The prevalence of metal health problems in West Essex (0.6%) is significantly lower than the national average (0.8%), although there is a higher prevalence of depression in the local population with 11.7%.” The JSNA does not contain accurate data on mental health spending.

Deprivation

Although Greater Essex is a prosperous part of southern England (within the 20% least deprived), it has some pockets of deprivation. Most severe of these is Jaywick, on the Tendring coast, which is the 3rd most deprived neighbourhood in England. Suffolk has a higher level. Thurrock suffers from a higher level of deprivation than the counties.

Tendring and Harlow districts are classed as within the 38% most deprived districts nationally. However, deprivation occurs not at a district level, but in small neighbourhoods. North Essex contains 18 neighbourhoods that are calculated to fall within the 20% most seriously deprived areas nationally. These areas fall within Chelmsford (1), Colchester (3), Epping Forest (1), Tendring (12) and Harlow (1).

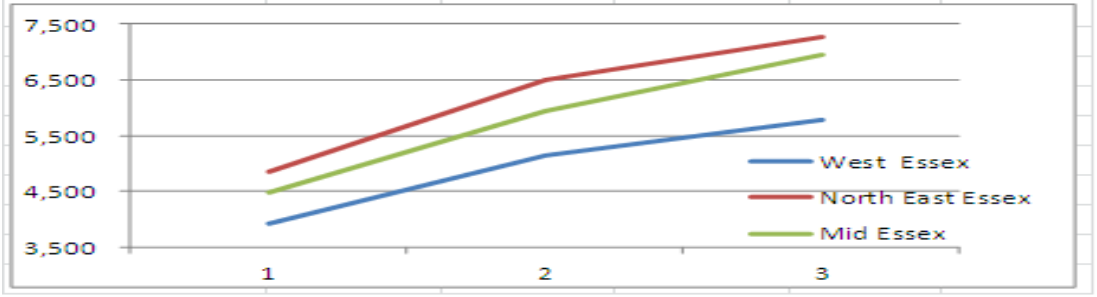
Approximately 17% of children in Greater Essex live in families that are income deprived (i.e., in receipt of Income Support, Income based Jobseeker's Allowance, Working Families' Tax Credit or Disabled Person's Tax Credit below a given threshold). This is lower than the national figure of 21.0%. However, as with the wider deprivation measure, it is how this manifests itself at the local level that is critical. In north Essex, Harlow and Tendring have the highest child poverty scores, while Uttlesford has the lowest.

Historical demand trends

Demand for mental health services in north Essex continues to rise, with GPs continuing to refer more patients than the service can treat.

Number of People Referred To The Trust Each Financial Year by Registered GP Surger

PCT/CCG	GP Referrals			Change	%
	2010-11	2011-12	2012-13		
West Essex	3,918	5,137	5,784	1,866	*48%*
North East Essex	4,856	6,487	7,259	2,403	*49%*
Mid Essex	4,481	5,952	6,941	2,460	*55%*
North Essex	**13,308**	**17,630**	**20,038**	**6,730**	*51%*



2.4.2 Activity

Service models have been re-designed, particularly in the areas of psychiatric consultation, day services, dementia care, continuing care and rehabilitation and recovery, leading to planned decreases in outpatient and day care attendances and rehabilitation and continuing care inpatient stays.

Balancing this, major unplanned increases in crucial areas of acute activity (within the block contract) have occurred across the Trust in acute inpatients (including psychiatric intensive care), CMHTs and psychological therapies (including the community eating disorders service). Expressed per 100,000 population these increases have been:

NORTH ESSEX				
ACTIVITY PER 10,000 POPULATION: CHANGE 2010/11 - 2013/14				
ADULT		**Activity 2010/11**	**Activity 2013/14**	**Change 2010/11 - 2013/14**
Acute inpatient	OBDs	44,812	46,437	3%
CMHT	Contacts	70,858	75,538	6%
Psychological therapies	Contacts	18,019	19,347	6%
OLDER ADULT				
CMHT	Contacts	22,762	26,448	4%
2013/14 activity is projected out-turn from 7 months' data				

Current mental health activity profile

We have been working hard to clarify and rationalise the use of HoNOS care clusters to help understand demand and workload and to form a firm basis for the development of inclusive and effective care pathways under Journeys. This work has informed and encouraged commissioners to define their commissioning intentions in terms of HoNOS care clusters.

While the timing of the "go-live" for Remedy, the new patient information IT system, has meant a break in the continuity of reporting around HoNOS, we are confident that our current adult mental health caseload is appropriate for a secondary, community-based service and that our practitioners are offering appropriate care and treatment to people with complex health and social care needs.

The value of services covered by Care Cluster in the indicative 2014/15 activity plan, before the Commissioners' planned reduction in Clusters 1-4' is set out in the table below:

Super MH Care Cluster	Care Clusters	Value Incl £m
A. Non-psychotic – mild, mod & severe	**1-4**	**11**
- very severe & complex	**5 – 8**	**16**
B. Psychosis	10 – 17	20
C. Organic (Dementia)	18 – 21	17
Assessments		3
Total		**67**

This new risk, currently under negotiation with Commissioners is the move from a "block" to a cost-&-volume contract for non-admitted care in the non-psychotic care clusters (1 - 8). The approximate value for this cohort of activity is £20 million. This will be a considerable change in the Trust's exposure to financial risk. The breakdown of the care cluster income based upon 2013/14 activity (cluster days) is shown below;

- Cluster 1-4 Mild, moderate and severe £8.9 million
- Cluster 5-8 Very severe and complex £10.8 million

Negotiations have centred on the release of income (in the event of activity reductions) to commissioners at 65% of full-price, but on a stepped basis at 20% threshold intervals. This is to assist the safe reduction in staff resources that in a way that does not destabilise the Trust's provision of Commissioner Requested Services (CRS). Equally, any increase in activity would mirror a change in income in a similar stepped and marginal rate fashion.

Commissioners believe that, as a result of (a) their investment in IAPT, (b) a new clinical protocol and (c) a new clinical referral service, that the Trust's activity in the clusters 1 - 4 will fall by 85% in 2014/15. The Trust's exposure in a full year if the CCGs' planning assumption is borne out would be a reduction in Trust income of £5.6 million in a full year. The Trust would need to reduce costs to avoid financial destabilisation of its services.

The Trust has risk-assessed the activity and financial model. The table below details the 2014/15 activity plan, the CCGs' assessment of the reduction and the Trust's own assessment of the likelihood that the CCGs' plans will materialise.

Care Cluster	*Description*	*Non-admitted care £000*	*CCG planned reduction*	*Trust Assessed Likelihood*
	Mild, moderate & severe			
1	Common mental health problems (low severity)	268	-100%	H
2	Common mental health problems	413	-100%	H
3	Non-psychotic (moderate severity)	1,143	-90%	M
4	Non-psychotic (severe)	7,065	-80%	L
	Sub total	**8,890**		
	Very severe and complex			
5	Non-psychotic (very severe)	1,485		
6	Non-psychotic disorders of overvalued Ideas	606		
7	Enduring non-psychotic disorders (high disability)	6,706		
8	Non-psychotic chaotic and challenging disorders	2,048		
	Sub total	**10,844**		
	TOTAL – Non-Psychotic Disorders	**19,735**		

The Trust's own assessment of the impact of the commissioner changes is nowhere near as large as that of the commissioners. But any move to a formal cost-&- volume arrangement will be contractually applied. The Trust is believed to be the first in England to move such a considerable volume of activity onto a cost-&-volume contract. No commissioner elsewhere has such an appetite to increase their own financial risk.

Capacity in workforce and beds

The Trust's innovative Journey's programme, a bottom-up service redesign based on true staff engagement, will lead to modernised service delivery through re-engineering the existing the workforce. The efficiencies are ensured through freeing up clinical staff from administrative duties to increase patient facing time whilst up skilling non clinical staff to embrace wider roles. The Trust is supported in this service re-configuration though its award winning consultancy, EnableEast, as well as expert HR advice and leadership.

The Trust is in the midst of a transformation project designed to modernise care pathways and service delivery models. The workforce plan has been developed to reflect the changes in the way that care will be delivered. It is evident from the plan that the Trust will invest in the unregistered workforce with a view to ensuring that qualified clinical time is maximised where it is needed the most (numbers contained in the plan are estimated given we have not agreed the final service delivery model).

The Trust is currently able to recruit to all vacant posts but experience some difficulty recruiting middle grade doctors. We are also acutely aware of our ageing workforce profile and a key focus for this year is succession planning arrangements.

Establishment FTE		Projected		% Change in Establishment	
	Mar-14	Mar-15	Mar-16	2014/15	2015/16
Medical & Dental	125.4	122.5	120.5	- 2.4%	- 1.6%
All registered nursing, midwifery & health visiting staff	1068.2	1056.5	1048.4	- 1.1%	- 0.8%
All Scientific, Therapeutic and Technical Staff	228.7	223.7	218.7	- 2.2%	- 2.2%
Healthcare assistants	75.6	75.6	80.6	0%	0.7%
Social care staff	91.5	90.8	90.1	- 0.8%	- 0.8%
Qualified ambulance service staff	0	0	0	0%	0%
Non-clinical staff	497.6	477.6	457.6	- 4.0%	- 4.4%
All Staff in Post excluding Bank staff, Locums and Agency staff (FTE)	**2086.9**	**2046.7**	**2015.9**	**- 1.9%**	**- 1.5%**

Impact of the CCGs' commissioning intentions on demand and service provision

North Essex commissioners' intentions for 2014 -16 have the potential to impact the Trust's operations, particularly from October 2014 around the care and treatment of patients falling in HoNOS clusters 1 – 4. It is unclear at this stage precisely what impact this will have, as the complexity of the situation and the multi-factorial nature of many patients' difficulties are such that we consider that a simple transfer of these patients from secondary services to IAPT is both unlikely and, for many of the patients concerned, undesirable. In 2015, the probable procurement of an integrated community service for north-east Essex presents both a challenge and an opportunity to the Trust; the impact may be small – if we succeed in continuing to provide the service, or if the eventual procurement is limited in scope – or significant – if we are unsuccessful and the scope is wide.

Similarly commissioners' nascent plans to re-procure Tier 2 and 3 CAMHS services offer a challenge and an opportunity; we believe that integrated provision of Tier 2 and 3 services is clearly the best way forward, and would favour further and wider integration with community

children's services such as community paediatrics, therapies and school nursing. However, failure to win all or any of the locality-based services would present the CAMHS service with a serious challenge.

2.4.3 Capital development

We have a full programme of disposals and capital developments during the Operational Plan period, aligned to service and quality development plans. These are laid out in detail at Appendix 5.

2.4.4 Risks to activity

Risk	Likelihood	Trust mitigation activity	Implications
GPs cease to refer patients in HoNOS clusters 1 to 4 to the Trust.	Likely if IAPT services very effective.	Trust seeks to maintain service levels to patients whatever their HoNOS cluster and to persuade the commissioners of the benefits of AQP.	Potential loss of income from cost-&-volume contract albeit at marginal rate.
GPs refer patients in HoNOS clusters 1 to 4 to the Trust subsequent to IAPT treatment.	Possible if IAPT services less effective.	Trust seeks to maintain service levels to patients whatever their HoNOS cluster.	Potential formal contractual activity review as 2% ceiling breached, depending on baseline.
GPs refer more patients in HoNOS clusters 5 – 8 to the Trust and waiting-times increase.	Possible as the evidence suggests unmet need.	Negotiate with commissioners over waiting-times, resources and increased demand.	Potential formal contractual activity review as 2% ceiling breached.
Integrated community service provision contracts are awarded to new providers instead of the Trust.	Possible.	Submit convincing and competitive bids in partnership with other providers with excellent records. If necessary, TUPE transfer staff and reduce fixed costs proportionately.	Potential sustainability problems. Dislocation of care pathways and support systems for patients.
CAMHS Tier 3 service provision contracts are awarded to new providers instead of the Trust.	Possible if service is tendered.	Submit convincing and competitive bids in partnership with other providers with excellent records. If necessary, TUPE transfer staff and reduce fixed costs proportionately.	Dislocation of care pathways and support systems for patients.

One of more north Essex CCGs becomes unsustainable financially during this Operating Plan period.	Possible given financial challenges of local CCGs.	Maintain our own excellent governance and quality standards. Collaborate with regulatory turnaround regimes as needed.	We recognise that we are embedded in our local LHEs and would make every effort to maintain their sustainability.
Impact on LHE of management review at CHUFT.	Low.	Seek to ensure Parity of Esteem.	Contractual discussions on price.
Impact on LHE of acute Trusts' financial positions.	Medium.	Seek to ensure Parity of Esteem.	Contractual discussions on price.
The Better Care Fund impinges on funding of Trust services in 2015/16.	Unlikely – BCF guidance states: Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.	Work with local commissioners and providers.	Contractual discussions on price.
High level of retirements of senior clinical and managerial staff over Operating Plan period.	Probable given age profile of workforce.	Continue with succession planning (such as the aspiring leaders' course) and seek to promote talented individuals from inside and outside the organisation.	Some loss of organisational memory is inevitable.

2.5 Productivity, efficiency and CIPs

2.5.1 Current performance

The 2013 Mental Health Benchmarking exercise showed the Trust to be delivering clinical services at a high level of efficiency in most areas, with, in general, lower-quartile or below-average admissions, readmissions, lengths of stay and community waiting-times.

Benchmarked position in relation to other mental health Trusts:

Patient group	Category	Parameter (populations of appropriate age where specified)	Performance
Adult	Acute inpatient	Bed numbers per 100,000	Lower quartile border
		Patients admitted per 100,000	Below average
		Admissions under MHA per 100,000	Lower quartile
		Emergency readmissions within 30 days per 100,000	5th lowest Trust in sample
		Occupied bed days excluding leave per 100,000	Below average
		Mean length of stay excluding leave	Lower quartile
		Mean length of stay when admitted under MHA	Lower quartile
	CMHT	Wait for urgent appointment	Lower quartile
Older adult	Inpatient	Bed numbers per 100,000	Average
		Patients admitted per 100,000	Below average
		Emergency readmissions within 30 days per 100,000	Lower quartile
		Occupied bed days excluding leave per 100,000	Above average
		Mean length of stay excluding leave	Lower quartile
		Mean length of stay when admitted under MHA	Lower quartile
	CMHT	Wait for urgent appointment	Lower quartile

Source: Mental Health Benchmarking 2013

2.5.2 Service transformation

Our service transformation efforts are focussed across mental health services on our Journeys programme of care pathway-based remodelling and reconfiguration facilitated by our new, flexible and responsive patient information system, Remedy.

Journeys

Local community service configuration solutions are being developed across north Essex, taking the relevant commissioners' plans into account and seeking to meet the Trust's core aims of:

- providing the best quality services
- making the best use of resources by releasing more clinical time
- providing services that users' and commissioners' needs.

This is Journeys – a 2-year programme of radical change in the way services are provided underpinned by the principles of:

Responsiveness - a responsive, expert access and assessment service ('Right Place, First Time') through a single point of access, effective planning and delivery of specialist, evidence-based treatment and support for those requiring secondary mental health care.
Effectiveness and safety - planning and delivery of treatment and care underpinned by agreed evidence-based holistic care packages that offer a choice of interventions to service users and their families. Clinical practice that ensures a focused, mindful approach to every action and intervention undertaken in the delivery of assessment, treatment and care.
Person-centred care - care and treatment based upon the identified needs of the individual. Services delivered in the setting and by the professionals most appropriate to the needs of the individual. Flexibility in the use of CPA with the option to use either a CPA or non-CPA based approach as appropriate.
Streamlined services – clearly described care pathways that inform the work of all professionals. Bottlenecks, duplication, waste and delays avoided. The benefits of new technology introduced through Remedy fully realised enabling clinical staff to work flexibly and responsively, prioritising their time around the needs of service users and their families. Accurate information recorded that informs the measurement of outcomes and transparent capacity and demand management.
High quality - organisational policies and procedures which drive an organisational culture of compassion, clinical excellence and a genuine sense of service.

Condition-specific care pathways have been developed by Trust practitioners and form the foundation for local multi-disciplinary age-inclusive services, for psychotic clusters, non-psychotic clusters and organic illness (dementias), augmented by a Tier 3 C&YP pathway, a home treatment team and a single point of referral / access and assessment service. The solution offers multi-disciplinary clinics, extended hours opening and mobile working, plus access to recovery services and easy routes into and out of inpatient and specialist services.

Our **West Essex area** has started a phased pilot of a new model of delivering services with a new Mental Health Access and Assessment Service (MHAAS). The MHAAS is the front door to services for people of adult working age (with the aim to be age-inclusive in time) and has a multi-disciplinary team including a consultant psychiatrist, a psychologist, community psychiatric nurses, social workers and administrative staff and occupational therapists.

The team is responsible for carrying out the screening of referrals, comprehensive clinical assessments and brief interventions where necessary. After a robust clinical assessment, the patient is placed into the appropriate care cluster and could be either signposted back into primary care or to the most appropriate partner agency for care, receive brief interventions from the MHAAS team or handed onto the Locality Treatment Teams for longer-term care and support.

Our **Mid-Essex area** implementation model consists of a 24-hour-a-day age-inclusive single point of access triaging to home treatment or psychosis or non-psychotic pathways, working alongside a memory assessment and organic illness service and a children and young people's service.

In **north-east Essex**, a single point of referral provides a gateway to all services, screening and triaging into 4 needs-led multi-disciplinary teams caring for children and young people, and adults with functional illness, those with organic illness and a home treatment service.

All 3 areas will have detailed plans in place during quarter 1 of 2014/15, with delivery dates for the new, streamlined and responsive service during quarter 2. Consequent savings plans will be implemented during quarter 3.

Remedy
The ageing CareBase patient information system has been the mainstay of the Trust's clinical information and performance-management strategy since its formation. A new system, Remedy, based on a proprietary platform, has been introduced to offer increased functionality, versatility, safety, reliability and ease of use. Configured and specified in conjunction with Trust staff, Remedy offers:

- All related information available from one screen
- Clear indicators on all screens if alerts are present for a service user
- Clear information on all referrals
- Diagrams that can be annotated
- Comprehensive appointment booking and staff diary functionality
- Risk assessment tailored to the Trust's requirements
- Support for attachments in any file format – including genograms
- Comprehensive reporting facilities
- Management information and performance statistics.

2.5.2 Cost Improvement programmes
We have a solid track record of CIP delivery. Since 2009/10 the Trust has delivered circa £15 million of recurrent CIPs, averaging 4% p.a. The Trust has always delivered CIPs in a timely fashion, achieving or exceeding financial plan targets.

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

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

- Local schemes - CIP schemes are developed by Directorates and Clinical Boards from the bottom up, through a continuous service-line process linked to our Area business planning process. Proposals are presented in draft form in December/January to the Executive Management Team and these are shared in detail with the Board of Directors in January. Both the Medical Director and Director of Operations and Nursing are required to provide their opinion on the clinical quality and safety impacts of proposals.

- Corporate schemes - Corporate CIPs are developed from themed areas and projects such as Journeys, Remedy, estates, pharmacy, procurement and service level agreements.

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

To date, the CIP has been developed from a mixture of the budget holder's incremental efficiency savings, opportunistic schemes and developed themes.

The CIP programme has always and will continue to be supplemented from elements (both recurrent and non-recurrent) not recognised as "CIP" in the Monitor returns. This will include elements of negotiated divestment and reductions in activity, repatriation, risk/reward schemes, margin on new business, capital charges including depreciation and marginal profit from NCA activity increases. The Trust can evidence significant genuine contributions from these measures over the past 3 years to the financial plan. Often many of these schemes are developed and delivered from the local Area business plans. This approach serves to protect clinical areas from further capacity reductions in order to meet CIP targets.

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

Approximately 40% of our contract value provides comprehensive inpatient services to less than 9% of all our patients. Over 90% of patients are treated at home or in outpatient settings.

The Trust's costs are 80% pay-based, with the relatively fixed overhead of 19 contracted inpatient wards across five geographic sites (Epping, Harlow, Chelmsford, Colchester and Clacton). The cumulative impact of 5 successive years of 4% CIP is major challenge. This is made all the more significant due to the lack of service transformation investment monies to facilitate transformational change in mental health. As a result, the Trust has now reached a tipping point.

The Trust's current 2014/15 Financial Plan is summarised below

Plan	**2014/15**	**2013/14**
	£000's	**£000's**
Income	108,356	110,154
Costs	102,878	103,133
Planned EBITDA	5,478	7,021
Loss/Profit on Disposal	11,175	-8,424
Fixed Asset impairment		-2,095
Less Depreciation	-3,270	-2,681
Less Dividends	-1,735	-2,187
Less Unwinding discount provisions	-100	-100
Less Net Interest (Receivable)/Payable	-373	-453
Planned Surplus	**11,875**	**-8,919**
Surplus after technical adjs	**0**	**1,600**

The current list of cash releasing CIPs totals £2.5million

The approximate headcount reduction net of skill-mix changes is around 40 WTE posts, from clinical and corporate areas.

The CIP proposals will be assessed by the Director of Nursing & Operations and the Medical Director in terms of quality and safety, for Trust Board and commissioner sign-off. We are confident that these CIP schemes will meet the necessary thresholds.

There are no CIP proposals from inpatient services, as it is not possible to deliver any further financial saving from the current level of commissioned beds, without significant redesign and new investment in community-based mental health services.

2.6 Financial plan

Assessment of current financial position
The delivery of the annual 4% efficiency requirement is a very significant challenge for the Trust, and in the past this has been achieved without service reductions. Successful bids for new business have historically generated additional margin to support the CIP, i.e. retained I&E margin did not increase. Such opportunities for margin from growth are rare as commissioners almost exclusively now procure on price.

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

According to recent NHS benchmarking data, the Trust performs well on a range of productivity measures (see 2.5.1)

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

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

The Trust will experience a significant reduction in its margins. The plan provides for Continuity of Services of 3 with risk rating criteria as follows:

- Liquidity - 4
- Capital Servicing Capacity - 1

Headline figures for 2014/15 include**:**

Revenue I&E	Break even
Turnover	£108 million
EBITDA	£5.5 million
EBITDA margin	5.1%

Continuity of Service Risk Rating	3
Cost Improvement Programme	£5 million (£3.5 million cash releasing);
Capital Investment 2014/15	£6 million
Property Disposals – excluding Severalls	£3.4 million
Debt repayments Net debt 01.04.14 to 31.03.16	£2.2 million /p.a. £13.9 million down to £9.5 million

Key risks to achieving the financial strategy and mitigations
The key risks to the successful achievement of the plan include the 8 Cs of financial risk:

- Cost and volume risks in non-admitted, non-psychotic care clusters (new risk)
- Cost control (in particular bank and agency spend)
- CIP delivery
- CQUIN income
- Cost per Case inpatient income
- Capital spend including disposals
- Cash and liquidity balances
- Contractual performance

The Trust's mitigation includes;

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

2.7 Conclusion

North Essex Partnership University NHS Foundation Trust is determined to meet the needs of its patients through 2014 – 16 and beyond. We believe that we are the right organisation, with the right philosophy, the right governance standards, the right infrastructure and the right management skills, to do this best for the people we serve. In short, we need to remain a thriving and flourishing Foundation Trust to be able to deploy the vast reservoir of skills and expertise amongst our multi-disciplinary staff with increasing efficiency and innovation. Our care pathway redesign, our new patient information system and our benchmarked clinical performance give us confidence that we can achieve this.