OPERATIONAL PLAN DOCUMENT FOR 2014-16

SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

FINAL
3 April 2014

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	**3 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.

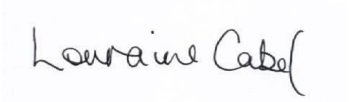
In signing below, the Trust is confirming that:

- **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)*	**Lorraine Cabel**

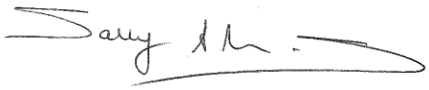
Signature



Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Sally Morris**

Signature



Approved on behalf of the Board of Directors by:

Name *(Acting Chief Finance Officer)*	**David Griffiths**

Signature

Executive Summary

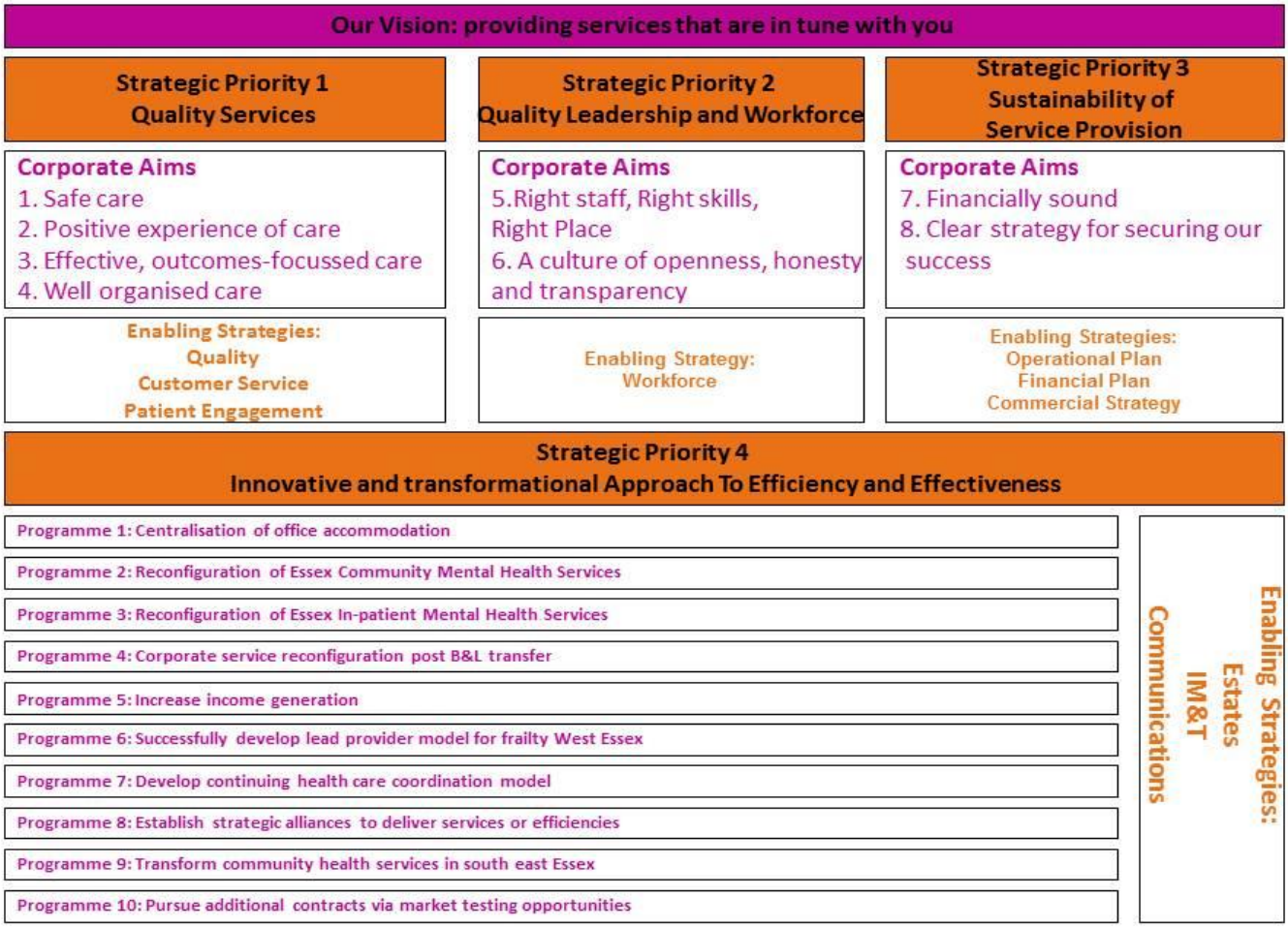
Our Operational Plan for 2014-2016 is consistent with the strategic outlook described in our Annual Plan 2013/14. Health and social care service provision continues to face significant challenges. At SEPT we have always responded to challenges and opportunities and ensured that our patients receive the best possible care and treatment. The Board of Directors has put considerable effort and energy into understanding the challenges faced; engaging with our staff, governors and local communities and having constructive dialogue with our commissioners to ensure our strategies are aligned, in order to set out our direction of travel for the future.

SEPT operates in a complex commissioning environment. We deliver a diverse range of services in five separate geographic areas, working with 7 local clinical commissioning groups (CCGs), NHS England, 6 local authorities and a private sector partner. Each of our commissioners has produced a local Operational Plan covering the same planning period. Their plans set out multiple priorities for service provision and ambitious aspirations for future health provision that will require radical service transformation across the health economy.

The risk identified in our last plan regarding the future of mental health contracts in Bedfordshire and Luton has crystallised as a result of procurement exercises carried out by the two CCGs. Our forward plan assumes that we will no longer be providing these services from 1 April 2015. However, we are delighted that following successful contract negotiations, all of our remaining contracts for mental health services in south Essex and community services in Bedfordshire, south east Essex and west Essex have been retained. Growth funding of £2.4million has been secured. The Trust has also been selected as the Lead Provider for an exciting integrated care project in west Essex which has also attracted additional new investment of £1.6million.

The local health economies in which SEPT operates are financially challenged. Our CCGs are planning to achieve either a breakeven position or a small (1%) surplus over the next five years. However, achievement of these plans will require local health economies to deliver significant QIPP (Quality, Innovation, Productivity and Prevention) programmes. In 2014/15 SEPT is required to contribute £2million to the QIPP programmes of south Essex CCGs. The majority of this contribution is to be delivered by secondary care mental health services.

Our strategy identifies four strategic priorities; delivered through eight corporate aims which are underpinned by 10 transformation programmes and a range of enabling strategies as follows:



We have modelled the impact associated with reduction in income from contracts by the end of 2015/16. Assuming that no other contract income is secured, SEPT is financially viable in the planning period as a smaller NHS Foundation Trust as long as it is able to deliver the year on year efficiency requirements.

In summary, our financial plan confirms that income will be £317.2m in 14/15 and this will reduce to £238.4m in 15/16. Expenditure is forecast as £333.7m in 14/15 and £248.0m in 15/16. This results in an efficiency requirement of £16.5m in 14/15 and £9.8m in 15/16.

In recognition of the significant pressures placed on both operational and support services to deliver cost reductions, the Board of Directors has agreed that the planned income and expenditure surplus for 2014/15 is reduced to £1.2 million from a previous plan of £3.3 million. Of the £2.1 million reduction, £1.5 million is being used to reduce the Cost Improvement Programme (CIP) requirements of Operational Divisions with the balance of £0.6 million being held as additional reserves for the expected costs of transition during 2014/15. In 2015/16 the planned surplus rises to £1.7 million. It is forecast that these levels of planned surplus are sufficient to maintain a Continuity of Service Risk Rating of 3 during the planning period.

We acknowledge that a strategy of contraction is not sustainable over the longer term. The Board of Directors is committed to a strategy that puts the safety and quality of services to patients first. We acknowledge that the Trust cannot stand still and doing nothing is not an option. We are now focussed on developing our longer term strategic plan covering the next five years and making a clear statement about SEPTs longer term sustainability.

1.0 Introduction

Consistent with the strategic outlook described in our Annual Plan 2013/14, health and social care service provision is facing significant challenges.

SEPT's success to date is built upon a significant investment in time and engagement in planning well for the future. Since 2006, when we became an NHS Foundation Trust, our focus has always been to develop and deliver transformative plans in partnership with local commissioners which bring clear and measurable benefits for our patients. Developing a response to the challenges faced started in July 2013.

In November 2013 the Board of Directors approved our new Strategic Direction which provides the framework for development of this Operational Plan for 2014-2016 and our Five Year Strategic Plan which will be developed in June 2014. The Board has held six Strategy Development sessions in addition to formal Board of Directors meeting discussions between July 2013 and March 2014 and two more are planned to finalise our five year plan. Five staff consultation events involving circa 300 staff took place in November and December 2013. In January 2014 we held two stakeholder engagement events and during January and February 2014, we asked our governors and members to help us identify our quality priorities for the coming year.

We have engaged regularly with our CCG partners to agree contracts and associated transformation plans. The (draft) commissioning operational plans of our major future commissioners have had a significant influence on our contract negotiations and on the development of our Operational Plan. We are confident therefore that our plans are aligned with those of our partners.

SEPT is a mature and successful organisation with a hard-earned reputation for working in partnership and delivering our promises. We are in a strong position now and our absolute commitment to learning from every experience means we are well placed to rise to the challenges and continue our unbroken run of success.

We understand that delivery of the safest and most effective services in an increasingly financially challenged environment requires transformational change. We are keen to seize the increased opportunity to be innovative and to be a collaborator in supporting system wide change which we believe will steer us successfully through the challenging times ahead.

2.0 OPERATING ENVIRONMENT

2.1 The National Context

The scale of the challenges facing the NHS is set out in many different publications and reports. The key question that needs to be answered is: ***how does the NHS continue to deliver a high quality service to all; that is free at the point of delivery; when more people are living longer, with more complex conditions; that is resulting in increased costs; whilst funding remains flat?***

The context to this fundamental question can be illustrated by the following facts regarding demand and demographics (*source: The NHS belongs to the people: a call to action; published by NHS England in July 2013*):

- the NHS treats around one million people every 36 hours;
- between 1990 and 2010, life expectancy in England increased by 4.2 years;
- the difference in life expectancy between the richest and poorest parts of the country is now 17 years;
- around 80 per cent of deaths from major diseases, such as cancer, are attributable to lifestyle risk factors such as smoking, excess alcohol and poor diet;
- one quarter of the population (just over 15 million people) has a long term condition such as diabetes, depression and high blood pressure, but they use a disproportionate amount of NHS resources, accounting for 50% of all GP appointments and 70 % of hospital bed days;
- hospital treatment for the over 75s has increased by 65% over the past decade and someone over 85 is now 25 times likely to spend a day in hospital compared to those under 65;
- the number of older people likely to require care is predicted to rise by over 60% by 2030;
- around 800,000 people are now living with dementia and this is expected to rise to 1 million by 2021;

- modelling shows that continuing with the current model of care will lead to a funding gap of around £30 billion between 2013/14 and 2020/21.

2.2 Short Term Challenges Facing The Local Health Economy

In developing our strategic vision and plans the Board has taken time to seriously consider and understand the environment and context that we are operating in order to determine the action that is required going forward. A summary of the operating environment was set out in our Strategic Direction published in November 2013 and a more detailed analysis will be provided in our Five Year Strategic Plan due to be finalised in June 2014. In this plan we have provided an overview of the challenges facing the local health economies in which we deliver services.

2.2.1 Local Public Health Context

Key Population Changes

The most recent population data are based on the 2011 census and are projected forward to estimate the change based on known trends in births, deaths and migration. These are used to estimate expected population change over the next two years but underlying trends may not be apparent in this limited time period.

Data show that all districts will experience a modest increase in total population size between 2014 and 2016; this increase ranges between 1.3 to 2.8 % in each district. This is an average increase of 2% in both Essex (including Unitary Authorities) and South Essex, and compares with an England average increase of 1.7%. This results in approximately 36,000 extra people in Essex, of which 14,000 are in South Essex.

The population structure in South Essex will also change, with a greater proportion of dependants. The under 18 population will increase by 2% and the 65 and over population will increase by 4%; adults of working age (18-64 years) will only increase by 1%. The pattern is slightly different in West Essex, where the proportionate increase is greater in children (3%) and less in older people (3%) despite a similar increase in overall population size.

The absolute increase in the number of working age adults in South Essex is similar to the increase in number of older people, due to their greater baseline number. However, this masks a longer term trend in Essex with the older population expected to grow by 28% and the working age group to decrease by 15% by 2033.

This information will inform our plans for the future. Changes in population structure will be used to inform geographical implementation of skill mix reviews and redesign of care pathways / development of integrated care models. Priority for testing new models of older people care should be in Thurrock, Castle Point, Southend, and Basildon. Priority for strategic review of youth related services and CAMHS is in Thurrock, West Essex and Brentwood. Over 40% of life time health expenditure occurs after the age of 65 years. However, the relationship between changes in demographic structure and health care expenditure is not simple. There is a small positive association between age and health care costs; these increase by 30% between the age of 65 and 85. However, there is a 10 fold increase in health care costs in the 5 years prior to death. So impact on expenditure must consider remaining life expectancy in populations.

Health Inequalities

Life expectancy is an important measure of overall life chances and can indicate where health is likely to be poor. It is influenced by economic and social determinants as well as access to health care. Life expectancy has been steadily improving but there can be marked differences between deprived geographical areas or in vulnerable populations.

Life expectancy for women in Southend, Thurrock and Luton is poorer than the England average. Male life expectancy in Luton is also poorer than the England average. Health inequalities between most and least deprived areas are noted in all areas. Between 60-70% of this life expectancy gap is due to coronary heart disease, stroke, cancer and respiratory illnesses. Research shows that even greater health inequalities exist between people with and without serious mental illness; this life expectancy gap is in the order of 20 years for men and 15 years for women. Research also suggests that health seeking behaviour is related to deprivation.

Thus, areas with poorer health and life expectancy would be expected to have higher rates of health risks such as smoking, poor diet and low exercise, and poorer access to and use of services, such as health screening and access to interventions.

Community health profiles map small area deprivation within each district. Access to services will be affected by deprivation, and this should influence our strategic development and any plans that are developed to change location of services or our estate. Our service developments must be meaningful to the local context.

Long Term Conditions
Like age, the impact of long term conditions (LTC) on future health service costs is more likely to be influenced by socioeconomic deprivation than demographic change. Certainly over the short term of this operational plan, there will be negligible impact on cost of LTC number. Although the prevalence of multi-morbidity increases with age, the absolute number is higher in people under 65. The key point seems to be that the onset of multi-morbidity starts 10-15 years earlier in more deprived areas than in least deprived areas. Also, MH problems are much more likely to be associated with multi-morbidity in more deprived areas, and with more morbidities. This argues for focusing services and considering access particularly in deprived areas rather than more in older person areas, although the nature of the services may be influenced by the distribution of the population in age terms.

2.2.2 Commissioning Complexity

The changes to NHS commissioning that were introduced in 2011 are beginning to settle down as the newly formed CCGs, NHS England and local authorities recover from the structural changes and take on their new responsibilities. However for providers of care services like SEPT, the complexity of the arrangements now in place means that there are multiple commissioners and multiple contracts for services. SEPT is currently commissioned to deliver a diverse range of services in five separate geographic areas, working with 7 local CCGs, NHS England, 6 local authorities and a private sector partner.

2.2.3 Commissioning Priorities

Alignment of our Operational Plan with those of our partners in the health and social care economies that we operate has had to be integral to the planning processes that have underpinned this plan. Contract negotiation meetings with our CCG colleagues and discussions at the various partnership and service delivery boards in which we participate has ensured that we understand specific local priorities and challenges and have wherever possible participated in identifying the most appropriate response.

In their (draft) Operational Plans, our CCGs have set out priorities that aim to:

- support delivery of the NHS Outcomes Framework;
- ensure that the NHS Constitution commitments are met;
- deliver greater efficiency;
- enhance delivery of better integrated care;
- develop stronger local commissioning.

The key challenges (relevant to services commissioned from SEPT) identified in (draft) CCG Operational Plans are:

Bedfordshire CCG
The CCG has set out a clear commitment to reshape the re-ablement and rehabilitation model for older people and has made it clear that it will use re-commissioning of existing community health services (currently provided by SEPT) to achieve this. The CCG has extended our existing contract for community health services for a further 3 years and we are committed to working with our CCG and local authority partners during the first two years of the contract to develop the model of service that responds to the identified challenges and position ourselves to be the provider of the new model in the longer term.

South Essex CCGs (Basildon and Brentwood; Castle Point and Rochford; Southend and Thurrock CCGs)
Mental Health Services

SEPT provides mental health services to all four CCGs in south Essex. Each CCG has developed an individual Operational Plan but the priorities are broadly consistent across the four plans. The CCGs have responded positively to the "parity of esteem" national priority and the priorities set out in "Closing The Gap" (25 priorities for mental health care best practice guidance published recently). Priorities identified in the CCG plans include:

- re-procurement of CAMH Tier 2 and 3 services;
- improving dementia diagnostic capabilities and diagnosis rates to 67%;
- increasing personalisation;
- increasing awareness and diagnostic training of mental health for primary and community services;
- implementing the use of Personal Health Budgets;
- increasing access to psychological therapies to achieve 15% target (for local population entering treatment);
- implementation of a recovery college model of service to promote greater independence;
- redesign of community mental health services and closer integration into primary care led multi-disciplinary teams;
- transfer of patients in diagnosis cluster 1-3 to primary care.

Two of our 10 Transformation programmes (set out in section 4.4.2) are focussed on radical redesign of current in-patient and community mental health service provision that will aim to respond to these priorities. SEPT is the current provider of Tier 2 and 3 CAMHs services and would want to retain this contract following the procurement exercise proposed. We are currently working with our commissioners to develop a new model of service that will form the basis of the re-commissioned service.

South Essex CCGs (Castle Point and Rochford and Southend CCGs)
Community Health Services

Providing more care closer to or at home; reducing admissions to hospitals and/ or reducing length of stay in hospital and diverting attendance at A&E units is a clear priority. Other common themes are:

- responding to the rising demand for dementia care;
- better management of patients with long term conditions;
- integrated service provision;
- prevention and early identification;
- more responsive crisis care;
- improved access to all services;
- improved satisfaction, listening and patient participation;
- utilising technology to enhance efficiency;
- improved productivity;
- higher standards, safer care.

Specific priorities that are relevant to our service provision include:

- establishment of integrated diabetes care as a single service across acute and community;
- an ambition to discharge 40% of patients from hospital through the Stroke Early Supported Discharge service (ESD);
- redesign of the respiratory (COPD) pathway;
- improvement to EOL pathways;
- our SPOR (Single Point of Referral) is integral to the CCGs 7 day service plans; with a pilot of 7 day working planned to commence from April 2014;
- enhanced integrated, primary care led multi-disciplinary teams in the community;
- development of a frailty pathway;
- review and redesign of the falls prevention services.

The Trust has reflected the need to radically transform community health services and potential of developing a CHC coordinating role as two of the 10 Transformation programmes that are integral to our strategy. Improved integrated care is dependent on better information sharing across provider services. The development of innovative systems to share information across health and social care providers is a key priority of our IM&T enabling strategy. We have been developing an Information Health Exchange portal that offers a unique way of accessing a patient/ user history across agencies.

2.2.4 Commissioning: Contracts For Services

In our strategic plan for 2013-2015 we identified a greater level of risk to our future contracts for services as a result of commissioning intentions.

The anticipated risk associated with our contract for mental health, learning disabilities and CAMH services in Bedfordshire and Luton has crystalised. Luton CCG's market testing of services is well underway as at the end of March 2014 and SEPT has not been shortlisted to participate in the second stage of the process.

Bedfordshire CCG commenced its separate procurement process in early March 2014. After detailed and careful consideration, the Board of Directors decided, regretfully, not to take part in the procurement process. The Board agreed that SEPT would be unable to provide a stand alone service for Bedfordshire to an appropriate standard within the funding available.

The Trust remains fully committed to our staff and services in Bedfordshire and Luton, and we have advised the CCGs that should their procurement processes not identify suitable new provider/s for the future, we would welcome further discussions on how we could continue to provide these local services.

Contracts with Bedfordshire and Luton CCGs for 14/15 were not finalised as at 21 March 2014. There are ongoing discussions with the CCGs regarding their individual contribution to the total contract value and the timing of their ongoing procurement. For the purposes of planning we have assumed a 12 month roll-over contract. To maintain the safety of services currently provided as an integrated service across Bedfordshire and Luton, we are urging the CCGs to harmonise their procurement timetables as we believe there is significant risk associated with transfer of the services to alternative providers at different times.

In Essex, CCGs have confirmed that Tier 2 and 3 CAMH services will be market tested during 2014/15. Commissioners are currently consulting on the proposed model of service and we are working closely with them on this. We anticipate that the formal procurement process will commence in late spring.

We are pleased to report positively on negotiations in respect of our other main contracts for services covering the planning period:

Bedfordshire CCG has confirmed an intention to extend our contract for community health services for 3 years. South east Essex CCGs have completed a contestability review and confirmed that they want SEPT to continue to provide community health services for a further 3 years; confident that the Trust is able to work with the CCGs to re-engineer services to meet commissioner aspirations. West Essex CCG has also confirmed an extension to our contract for community health services for a further 2 years and has appointed SEPT as the Lead Provider for the pilot phase of an exciting new integrated care project. This has the potential to radically reshape service provision for frail older people in that locality and if we can develop a successful service model during 2014/15, it could lead to additional income opportunities in west Essex and be a marketing opportunity in other areas.

South Essex CCGs have extended our contract for mental health and learning disabilities services for a further 3 years. There is significant challenge associated with meeting the CCGs service development, efficiency and QIPP priorities but we enjoy a good relationship with commissioners and are committed to delivering the transformation which will be required.

In addition to securing contract extensions, we have been able to secure total growth funding of £2.4million for south Essex mental health services, south east Essex community health services, west Essex community health services and Bedfordshire community health services

NHS England specialist commissioners have confirmed contracts for medium and low secure mental health service provision, in-patient CAMHs services, dentistry, criminal justice and health visiting services.

Our partnership/ contract with Serco for delivery of community health services in Suffolk ends in September 2015. SEPT delivers specialist children's services and podiatry services as part of Serco's contract for all community health services in Suffolk. Serco has experienced some difficulties in meeting its part of the contractual requirements but we are confident that the services we provide are being delivered in line with commissioners expectations. Suffolk CCG has confirmed that it will market test services in 2015. We will be considering our options for retaining this contract and potential for expansion over the next year.

The Trust holds individual agreements with Essex and Southend Drug and Alcohol Action Teams (DAATS) are currently being renegotiated for 1 April 2014 to run for a further one-year period. The Trust holds numerous other smaller contracts as Provider in the Essex, Luton and Bedfordshire area, all of which are currently being reviewed and will be amended where required in year.

Whilst we are pleased that we are able to confirm the extensions to contracts above, we are conscious that the CCGs that we work with do appear to prefer contestability as a means to deliver their priorities. This exposes SEPT to a greater degree of risk in 2015/16 and in the longer term than providers in some other economies. We are however confident that we can deliver the transformation required to retain contracts in the longer term.

2.2.5 LHE Financial Challenges

At the point this draft of our Operational Plan was finalised, local commissioners had not finalised their Operational Plans for 2014/15 and 2015/16. Nevertheless we are aware from working with them, and as set out in the (draft) CCG Operational Plans received, that they face significant financial challenges over the two year planning period.

The table below identifies the 2013/14 projected outturn for our local CCGs and variance from plan. All CCGs, bar one, are forecasting an adverse variance from plan, and significant under delivery of QIPP (Quality, Innovation, Productivity and Prevention) plans.

Table 1

CCG		Planned 2013/14 Surplus	Forecast Surplus/ (Deficit) as at M9	Variance from Plan	Forecast Surplus/ (Deficit) as % of Allocation		Forecast QIPP Delivery Variance
		£m	£m	£m	%		£m
Bedfordshire		4.9	3.7	-1.2	0.8		0.0
Luton		2.1	-7.3	-9.4	-3.3		-9.4
West Essex		1.6	0.0	-1.6	0.0		-5.2
Thurrock		1.8	1.8	0.0	0.9		-1.5
Basildon & Brentwood		0.3	0.2	-0.1	0.1		-2.4
Castle Point & Rochford		2.1	-1.9	-4.0	-1.0		-2.5
Southend		2.0	-1.5	-3.5	-0.7		-4.5
		14.8	-5.0	-19.8			-25.5

Notes

1. CCG 2013/14 Forecasts taken from M9 CCG Board Reports except Luton CCG (M6 figures - NHS England Q2 Performance Summary)
2. Forecast QIPP Delivery Variance taken from NHS England Q2 Performance Summary

In their forward plans, all of our local CCGs are forecasting breakeven or small surplus (1%) over the next five years. However, achievement of the forecast position will require delivery of significant QIPP targets. The majority of CCGs are looking to deliver the QIPP targets through reducing acute hospital services and shifting resources into community services which does provide the Trust with an opportunity to secure investment in new service models going forward like that which we have recently secured in West Essex. However, despite mental health and the parity of esteem agenda being identified as a priority in CCG Operational Plans, south Essex CCGs have identified a significant QIPP target for mental health services (see below).

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

Following contract negotiations, the Trust has agreed a number of schemes with commissioners in south Essex that recurrently reduces income by £1.5m in 2014/15, predominantly from mental health services. As a result we will be reviewing bed capacity in our in-patient specialist learning disability service; and passing on income generated from respite care in our specialist learning disability service, PICU and other out of area services. Our challenging behaviour dementia service will also be reviewed to deliver a further QIPP saving of £0.5m.

In addition, the Trust has agreed a further £0.5m non-recurrent reduction in 2014/15 (CQUIN reduction) and to work with South Essex CCGs to support them in delivering £0.6m of savings from their expenditure on Continuing Healthcare.

We are working closely with commissioners to identify health system wide initiatives that we can develop in collaboration with our acute and primary care partners. Based on previous experience, SEPT strongly believe we can be part of the solution, having identified initiatives in the past (e.g. Short Stay Medical Unit in Bedfordshire and Mountnessing Court in south Essex) to support local commissioners to deliver their ambitions and support the management pressures on other parts of the health and social care system.

2.2.7 Better Care Fund

The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. The BCF is a critical part of, and aligned to, the NHS 2 year operational plans and the 5 year strategic plans as well as local government planning. The fund does not in itself address the financial pressures faced by local authorities and CCGs; it brings together NHS and Local Government resources that are already committed to existing core activity. Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

We welcome the opportunity for delivering better integrated care. This approach does however introduce some risk in the longer term to the contracts for existing community service provision (mental and physical health) as CCGs and local authorities have identified funding for services currently within existing contracts for services that is to be included in the future pooled budget arrangements. The Trust's transformation programme for 2014- 2016 reflects the need for radical redesign of existing community health service provision in West Essex (frailty project), Bedfordshire and south east Essex and community mental health service provision in south Essex. The financial plan assumes that there is no material impact from the transfer of funding from CCGs to the Better Care Fund during this planning period and we are continuing to work with our partners to determine the longer term implications of this initiative.

2.2.8 Tariff/ Payment by Results

The introduction of a tariff or payment by results for mental health and community services is now less likely to occur in the planning period than has been reflected in previous plans, due to delays at a national level in determining the most appropriate mechanisms for introduction. All main contracts are on a "block" basis. Whilst this does offer a degree of certainty of income over the planning period there is some risk associated with increased demand without additional income and a vulnerability that block contracts historically are subject to greater efficiency and/ or QIPP targets as a result of over-activity in the acute sector where payment by results contracts are in place. We have put a great deal of effort into introducing service line costing and clustering arrangements as part of preparing for local tariff introduction which will continue. The learning from this action is vital for understanding productivity, efficiency and pathways as necessary to successfully deliver our planned transformation programmes.

3.0 OUR STRATEGIC RESPONSE

At SEPT we have always tried to be ahead of the curve, to have a plan to respond to challenges and opportunities and to ensure that our patients receive the best possible care and treatment. The Board of Directors has reflected on where we are now and the potential implications arising from the operating environment in order to set out our direction of travel for the future.

The challenges facing the whole health and social care delivery system are significant which make it impossible to determine the future with the same degree of certainty that may have been possible in the past but we are optimistic as uncertainty can also create opportunities. Our strategy has to align to the fluid nature of the operating environment and be flexible enough to change and adapt to outside conditions. A strategy for turbulent times is one that requires us to be "fleet of foot", making decisions based on the latest information available rather than developing a plan that is set in stone that we pursue regardless.

There is an absolute belief that SEPT; because it has great leadership, extremely hard working and dedicated staff and robust systems and processes that support care delivery; should be a provider of health and social care services going forward.

We recognise though that we operate in a competitive market and that commissioners will be developing different service models in order to respond to changing and increased demand for services. Competition is a key driver of quality and efficiency improvements and we have a great deal of experience of delivering both following acquisition of additional contracts. Going forward, we will assess new and revised contract specifications and work with our commissioners to ensure that the best care is commissioned and provided.

In a competitive market, organisations will win contracts and they may loose contracts. It is a natural cycle of business. We will make every effort to retain existing contracts for services by being responsive, creative and innovative; but operating in a market requires some difficult decisions to be made. We have to ensure that contracts delivered by SEPT meet commissioner and patient expectation and they can be delivered safely within the financial allocation offered by commissioners. The Trust will not enter into contracts where there is a risk that patient safety and/or service quality may be compromised.

We have modelled the impact associated with reduction in income from mental health, community services and public health contracts by the end of 2015/16. Assuming that no other contract income is secured, SEPT is financially viable in the planning period as a smaller NHSFT as long as it is able to deliver the required year on year efficiency requirements. We recognise that delivering the scale of efficiency requirements is no longer a case of "salami slicing" costs (incremental CIPs) out of each service and wholesale transformation is required. We have therefore identified 10 programmes of work that we believe will ensure the financial security of the trust and contribute to sustaining the local health economies that we operate in.

Whilst we are confident that a contraction strategy is possible, it will not be an easy strategy to deliver. Safe disaggregation and transition of services to new providers selected by commissioners will need to be implemented with as much care and attention as we took when the services were acquired to ensure minimal disruption to service provision. There will also be an increased efficiency requirement placed on remaining services to cover the additional overhead costs that will result from the loss of economies of scale.

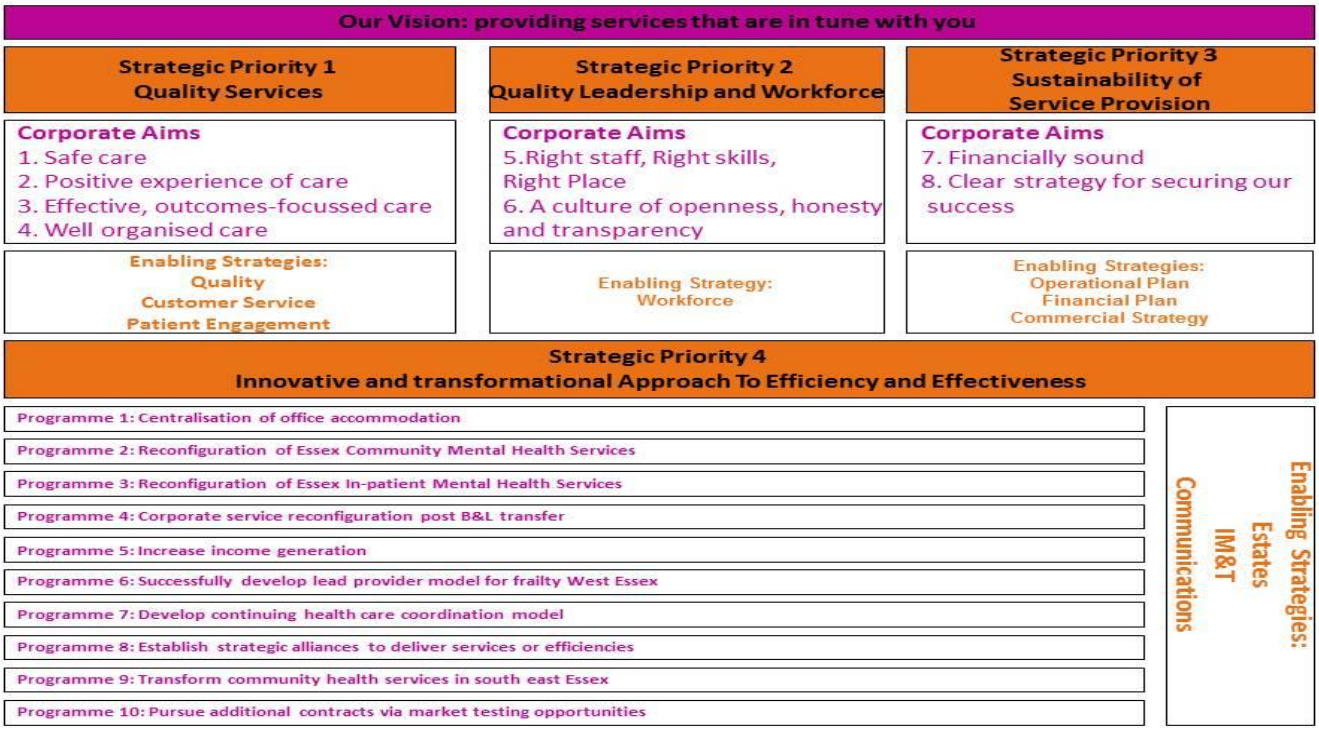
We acknowledge that a strategy of contraction is not sustainable over the longer term. Opportunities for growth (that contribute to overhead costs) will have to be pursued in order to minimise the longer term risk to sustainability.

The Board of Directors is committed to a strategy that puts the safety and quality of services to patients first. SEPT cannot stand still and it will evolve over the next few years as a result of the ever changing environment. The Board is committed to working with commissioners and other providers to deliver efficiencies and improved quality of care to our patients and in doing so become the provider of choice.

4.0 OUR QUALITY AND SERVICE DELIVERY PLAN

There is not one course of action that will respond to the challenges faced. A strategy for turbulent times requires a range of initiatives that collectively contribute to the organisation's vision. The Board of Directors has identified four Strategic Priorities to provide the framework within which we will take action.

Three of our strategic priorities confirm our commitment to providing the best quality services; with the best possible leadership and workforce and sustaining SEPT and the health care delivery systems in which we operate. Eight corporate aims support delivery and achievement of these three strategic priorities. The fourth strategic priority sets out the Trust's radical transformation plan which we recognise is absolutely necessary to deliver the other three strategic priorities and the organisation's vision.



Our quality plan is set out in more detail in the following sections:

4.1 Strategic Priority 1: Quality Services

The NHS is the only healthcare system in the world with a definition of quality enshrined in legislation. An organisation delivering high quality care will be offering care that is clinically effective, safe and delivering as positive experience as possible for patients. We believe that SEPT is such an organisation; our main driver is to improve the health of the communities that we serve. We are realistic that less funding may mean that some of our high standards may have to be re-defined to be affordable but we are absolutely certain that we will not compromise safety as a result.

4.1.1 Current position

Our focus on the quality of service provision, regardless of the complexity of the external environment means that we, our commissioners and regulators do not have significant concerns about the quality of existing service provision nor our ability to continue to deliver quality services over the planning period.

Over the past two years the Care Quality Commission (CQC) has carried out 17 unannounced reviews of our services (six in 12/13 and 11 in 13/14). No significant concerns have been identified. As at the end of March 2014 we will be taking forward action to address just two moderate compliance actions that the CQC has identified as a result of its service reviews of the Weller Wing in Bedfordshire and the Hadleigh Unit in Basildon. We have been compliant with Monitor's quality targets consistently over the same period and are not forecasting any risk to continuing to achieve these targets over the planning period. We continue to enjoy positive staff survey results (in the national staff survey), despite the difficult context and whilst the national

patient survey results are average (these cover a small proportion of our services (community mental health services); our local FFT (Friends and Family Test) survey results indicate much higher levels of satisfaction.

4.1.2 Response to Francis, Berwick and Keogh

The Trust welcomed the findings of the Francis, Berwick and Keogh reports and the Government response published in November 2013, whose recommendations have been taken into account when determining our quality ambitions and CIP plans. We believe that the actions pledged and directed by Government will support organisations to further foster the desired culture of transparency, accountability and learning, making care safer for all. A task and finish group undertook gap analyses against all of the recommendations from these reports that are applicable to provider trusts and has considered them in the context of the wider findings. From this, the Trust identified a number of improvement actions to further strengthen existing Trust processes and contribute to an open culture, the majority of which are now completed.

Major workstreams commenced in response to the reports include:

- a refresh of our Customer Service Strategy, incorporating feedback from listening events held with patients and staff into which almost 1000 people input their views;
- a review of the Complaints Handling process, to ensure it is fully aligned with the incident investigation process and explicitly clarifies expectations in respect of honesty, transparency and learning from error;
- development of a training pathway for clinical staff, Bands 1-4, again reflecting the learning from the Inquiry report;
- a refresh of recruitment and induction materials and appraisal and supervision policies, with staff contracts revised to explicitly require compliance with the NHS Constitution;
- clinical handover improvements and introduction of Key Nurses on all wards/shifts;
- introduction of a new dissemination and monitoring system in respect of NICE guidance;
- revision of clinical risk assessment and management training;
- work to further enhance the role of Governors and non-Executive Directors in respect of holding the trust to account.

Harder to quantify but critical to our response is the work undertaken to foster and promote a culture of openness. We have introduced an "I am concerned about…." anonymous reporting facility on our intranet for staff to raise concerns that are investigated by the Chief Executive and then responded to for all staff to see. Our Board members and governors have implemented a new service review process that focuses less on compliance and more on behaviours and values; we have introduced a new public quality dashboard and we are in the process of agreeing an enhanced publication scheme.

4.1.3 Our quality strategy

Our Quality Strategy, that will support delivery of this strategic priority, describes our vision for quality to be:

"To promote a culture and approach where every member of staff has the passion, confidence and skills to champion and compassionately deliver safer, more reliable, care"

The Trust's Quality Strategy aims to deliver quality improvements in a transparent and measurable way covering four key domains (corporate aims):

- **Safe care**
- **Experience of care**
- **Effective, outcomes-focussed care**
- **Well organised care**

4.1.4 Safe care

Our priorities over the planning period are:

- early detection of the deteriorating patient;
- reduction in avoidable pressure ulcers;
- reduction in harm from falls;
- reduction in unexpected deaths;
- reduction in use of horizontal restraint;
- reduction in medication omissions.

Over the next two years we have committed to reducing the number of incidents in these priority areas. Our longer-term aspirational ambition is to have zero incidences of the use of horizontal restraint, avoidable pressure ulcers, avoidable falls and avoidable unexpected in-hospital deaths.

- Safe transfer of services to alternative providers

During 2014/15 our priority is to ensure that Bedfordshire and Luton mental health services are transferred safely to alternative providers selected by the respective CCGs as a result of their procurement exercises. We have acquired a great deal of experience of acquiring services and successfully integrating them without affecting frontline service provision in either existing services or those acquired. We will use this experience and effective project management arrangements to safely maintain frontline service provision during transition and disaggregate the support services that will transfer with them.

4.1.5 Experience of care

Our priorities are:

- receiving feedback from patients, relatives and carers;
- ensuring care is delivered with compassion, kindness and respect;
- increasing access to information allowing patients to make informed choices;
- improving end of life care.

We aim to provide our patients and their carers with the best possible experience whilst they are using our services. In support of this, we plan to increase the amount of feedback being received from patients to enable staff to be able to reflect on their practice and to encourage staff to view every received complaint or criticism as a learning opportunity. We will therefore further promote continuous reflection and improvement on practice through patient feedback mechanisms and we will strengthen the support offered to carers.

Specifically, we will:

- introduce a strengthened patient and carer feedback and reporting system across the organisation, including extended use of the NHS Friends and Family Test, to enable staff to receive regular commentary on their service from an end user perspective;
- ensure all community teams have staff trained in the "3 R's"(Recognise, Record and Refer carers to appropriate services);
- ensure that all patients have a personalised care plan;
- where appropriate to do so, and in keeping with patient expressed wishes in respect of information, ensure all patients receiving end of life care are offered the Preferred Priorities for Care document;
- introduce quarterly staff "friends and family test" surveys.

4.1.6 Effective and outcome- focussed care

Our priorities are:

- adoption of NICE and evidence based practice;
- use of clinical audit to improve care and not just for compliance;
- publication and benchmarking of clinical outcomes;
- learning from incidents, near misses and embedding change.

Providing effective, value for money service is always important and especially so within the current financial climate. We aim to secure best value for money within our available resources, with practice based on best evidence of outcome and value, information made widely available and assurance systems that support and drive good clinical outcomes.

Specifically we will:

- strengthen assurance systems to ensure that we are fully compliant with applicable NICE clinical guidelines wherever this is within the Trust's control and identify and escalate to Commissioners any non-compliance due solely to lack of funding;
- ensure that all audit activity has a clear patient benefit that justifies the resource used;
- maximise the use of electronically-available data to reduce duplication and unnecessary burden on staff;

- publicise a range of clinical outcomes;
- provide training sessions for senior staff on the implications of the Duty of Candour;
- encourage greater involvement of families and carers within root cause analyses of unexpected deaths from self-harm.

4.1.7 Well organised care (Quality Governance)

Our 4th quality priority is aimed at continuous strengthening of the arrangements in place that provide the Board of Directors with assurance on the quality of SEPT services and safeguard patient safety. We have used Monitor's Quality Governance Framework since 2011 to carry out regular self assessment of our systems in place (most recently in February 2014) that ensure our strategy for quality is appropriate; we have the right capabilities and culture to support quality; there are robust processes and structures for quality in place and effective systems to measure, monitor and report on the quality of our services.

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

In our Annual Plan 2013/14 we set out a commitment to reduce the size of our leadership structure without compromising the Board's ability to deliver the quality agenda. We have reduced the number of Executive Directors in post by three and have undertaken a review of portfolios and responsibilities as a result. A new post of Executive Director of Corporate Governance has been established to bring together a range of back office services that support the delivery of quality services; complementing the post of Executive Director of Clinical Governance & Quality in our new structure. A new leadership structure has enabled us to take a fresh look at our quality governance systems and as a result we have identified the following priorities for the planning period:

- take action to further strengthen our strategic planning arrangements;
- we will look to develop outcome measures across all of our services;
- our governance structure will be reviewed internally prior to the planned introduction of three yearly governance reviews required by Monitor to ensure that it remains fit for purpose;
- the development of electronic clinical quality and performance dashboards was started last year and will be carried forward as part of our governance improvement and efficiency programme;
- reviewing the proxy measures for quality used by the Board and developing improved early warning triggers have been identified as new priorities for 2014/15;
- we introduced an information assurance framework during 13/14. Over the planning period we will be increasing the amount of assurance on data quality available to the Board.

4.1.8 Potential Risks to quality

In developing this plan the Board has identified the following potential significant (pre-mitigation) risks to quality over the planning period:

- if support and monitoring is not undertaken consistently the Trust may not be able to achieve consistent compliance with all of the CQC fundamental standards in all of its services at all times;
- if staff are not supported appropriately through the transition of contracts from SEPT to alternative providers, uncertainty about their future may impact on the Trust's ability to retain them;
- if there is increased reliance on temporary staff during transition of services to alternative providers or during service transformation programmes there may be an impact on the quality of service provision;
- if appropriate governance and risk management arrangements are not in place to support the transfer of services to alternative providers, the safety of services may be compromised;
- if record keeping standards are not in line with Trust policy quality of care may be compromised;

- if the impact on quality of the agreed CIPs exceeds that identified in Quality Impact Assessments additional mitigation action will be required;
- if the scale, scope and speed associated with delivering the Trust's Transformation programme is not managed appropriately there may be an impact on the quality of existing service provision.

All potential risks have been assessed and are identified in the Board Assurance Framework (BAF) from April 2014 which is reviewed each month at the Board of Directors meeting. Mitigation plans are identified for each potential risk.

4.2 Strategic Priority 2: Quality Leadership and Workforce

We will only be able to achieve our strategic vision if we have the best staff and an organisational culture that supports staff in delivering the best quality services. Excellent leadership at all levels, clinically and managerially is key to delivering the other three strategic priorities. It's not just about the numbers of staff and the competencies they have; we want our staff to have shared values and belief systems that engenders trust from our patients and their carers.

The two corporate aims that support delivery of this strategic priority are 'right staff, right skills, right place' and a culture of transparency, honesty and openness. Our workforce plan underpins achievement of these aims and the strategic priority.

4.2.1 Right Staff, Right Skills, Right Place

There is clear evidence that healthcare organisations with the right workforce and leadership provide the most effective, high quality and compassionate care and improve patient and public satisfaction. In addition, there are established and evidenced links between appropriate staffing and patient outcomes. The Trust recognises that we must do all we can to support our staff in the provision of high quality, compassionate care.

There is no single ratio or formula that can be used to calculate appropriate staffing and skill mix. We recognise the importance of applying evidence based tools, professional judgement and a multi-professional approach at a local level to help us deliver appropriate care suited to our patient's needs. However, this cannot be done in isolation and we also recognise the need to review the skill mix of our nursing and healthcare staff to examine how skills and competencies are currently deployed, based on levels of care need and the levels of dependency and acuity of patients across all our service areas. This will inform a framework going forward, allowing for the appropriate utilisation of current skills and will inform decision-making in the future development of nursing and healthcare staff.

Specifically, we will:

- implement strengthened systems and processes to ensure that there is sufficient staffing capacity and capability to provide high quality care to patients across all service areas (the "safer staffing initiative");
- publish staffing and skill mix data in line with national requirements;
- increase staff attendance at Level 2 of the leadership pathway by 10%.

4.2.2 Culture of transparency and openness

One of the recommendations within the Francis Inquiry report was for a common culture to be shared throughout the system, requiring:

- openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

In line with the recommendations of the Francis Inquiry and other reports, the Trust has committed to further strengthening of existing systems. Specifically, we will:

- increase our no harm/low harm/near misses incident reporting level to reflect a strong reporting culture;
- encourage the involvement of family and carers within investigations;
- comply with emerging national guidance in respect of the implementation of a culture of care barometer;
- invest in supporting creation of a culture of innovation and supporting change programmes.

4.2.3 Workforce Plan

The detailed Workforce Plan that will support delivery of our operational plan 2014-2016 has been produced through collaboration with service directors and operational leads. The Trust operates a comprehensive workforce planning process; the process is iterative and updates are gathered throughout the year to reflect the on-going nature of service planning. Service leads are asked to create their training plans at the same time as they review their workforce plans to ensure that service, workforce and training plans are interlinked.

Key priorities set out in our strategy:

Workforce Strategy for Clinical Bands 1-4

The Cavendish Report published in 2013 made a number of recommendations on how the training and support of both healthcare assistants and social care support workers can be improved to ensure they provide care to the highest standards. The review proposes that all healthcare assistants and social care support workers should undergo the same basic training, based on the best practice that already exists in the system, and must get a standard 'certificate of fundamental care' before they can care for people unsupervised.

In response to this, the Trust is developing a strategy for the pre-professional workforce. The proposals include standard job descriptions and competency frameworks that contain generic skills and values that we would expect all staff at a given grade to be able to demonstrate. The proposals would introduce new assessments on literacy and numeracy at pre-interview stage and a preceptorship period for all new staff during which they would be assessed against the competencies appropriate to their role.

Skill- Mix Reviews

Further work will be undertaken to ensure that skill-mixes within teams are reviewed and adjusted to meet service delivery plans. The focus is on appropriate use of staff so that skills are deployed effectively and costs are kept within budget. Skill-mix reviews will focus on ensuring that there is clear leadership within teams supported by appropriate and safe staffing levels. The report from the National Quality Board 'How to ensure the right people are in the right place at the right time' follows on from the Berwick review on patient safety and the Cavendish review of support worker roles. It recognises that there is no such thing as an 'optimum' skill-mix but there should be periodic reviews and monitoring for the impact on patient care. This is the approach adopted by SEPT.

The focus on clear leadership and appropriate staff mix will lead to a number of changes, examples of which are:

- management restructure to improve leadership levels within mental health in-patient areas in Essex;
- increasing use of non-medical prescribers and nurses competent with assessment and diagnostic skills, in mental health and adult community services;
- increase use of generic workers within integrated teams to improve flexible working potential;
- community dentistry will work to extend the scope of practice of therapists and dental nurses to achieve increased service capacity;
- increasing use of Band 4 roles within community children's services to increase capacity in response to increasing workload and number of continuing care packages;
- community occupational therapy will have increased use of technician and Associate Practitioner staff; this will require up-skilling of current Band 3 / 4 staff to undertake a wider range of duties.;
- community nursing in Bedfordshire is reviewing skill-mix; there will be a move from the current 80:20 qualified: un-qualified staffing ratio to a 60:40 mix.

The examples show that the guiding principles are to provide cost-effective and safe care whilst maximising staff potential and under-pinning this with appropriate development and training.

Grade Standardisation

Work on generic job descriptions to provide improved grade standardisation will continue. The work is led by Human Resources but is progressing through full consultation with service directors. The aim is to achieve generic job descriptions and person specifications that can be used by managers. Managers would add specific

tasks and competencies that would be required for specialist roles, if necessary, but the generic job descriptions would ensure core competencies and role expectations are in place.

Clinical Leadership and Workforce Modernisation
Workforce modernisation is an integral part of the work on productivity. The introduction of extended and enhanced roles is part of this work. Previous work has looked at modernising working practices in psychiatry, psychology and nursing. The Trust has not developed Advanced Practitioner roles to date but there is a commitment to revisit this in line with the work on service re-design and skill-mix reviews.

There is increased investment in leadership programmes and recent commissions have included bespoke programmes designed to support and develop leadership within the newly evolving integrated teams. A strategic leadership programme, co-produced by health and social care providers in the local economy, was launched in March 2014; it has been designed to promote the development of leadership from middle-grade staff by giving the opportunity to undertake work placements within SEPT and within partner organisations.

Estate Management and Technology
The Trust has reduced its Estates portfolio over the past few years and by extending mobile working, and integrated teams this reduction will be taken further to cut running costs and maintenance. This will mean that staff will work with touchdown facilities at central bases. Mobile working will eventually be introduced for all community staff so additional resources will be put into ensuring that all grades have the appropriate IT skills to enable this. There will be increased use of technology to enable telephone follow-ups and increased use of tele-health monitoring equipment. Community staff will need to undertake triage and recognise signs of deterioration using remote technology as these become embedded in everyday practice.

4.3 Strategic Priority 3: Sustainability of Service Provision

We want SEPT to be a provider of health and social care services going forward and therefore ensuring that we remain viable is a key priority. However, we recognise that sustainability of strong health and social care economies is as important and therefore our strategy will be developed and delivered in partnership with our CCG and local authority colleagues and will prioritise the benefits to patients, not organisations.

Two corporate aims are identified to deliver this strategic priority: being financially sound and focusing on the strategic position of the Trust in the longer term. This strategic priority and the aims that support it reflect the stark reality that the organisation is facing. A joint letter from the Local Government Association, Trust Development Authority, Monitor and NHS England which was sent to all health and social care leaders in November 2013 makes it clear that to respond to the significant challenges being faced, the NHS has to change. All parties must develop and implement bold and transformative long term strategies and plans for their services, otherwise many will become financially unsustainable and the safety and quality of patient care will decline.

4.3.1 Financially Sound

The key proxy measures for being financially sound are achieving a Monitor Continuity of Services risk rating of at least 3 and delivering a sufficient small surplus over the planning period that will enable us to reinvest in maintaining the highest possible quality of service. Our financial plan to achieve this was approved by the Board of Directors in March 2014 and a summary is provided in Section 5.0 below.

Achieving financial sustainability will require the delivery of total efficiency savings of £16.5m in 2014/15 and £9.8m in 2015/16. We have provided details of our efficiency programme in Section 5.3.3.

4.3.2 Clear Strategy For Securing Our Success

We recognise the complexity and scale of the issues that are faced by the Trust makes it difficult to plan with any degree of certainty but we also acknowledge that longer term sustainability will require us to identify and articulate a clear strategic position beyond the two years covered by this plan. Year on year efficiency targets at the current level are not possible to sustain in the longer term.

Delivery of the transformation programmes agreed during 2014-2016 will be key to our strategic positioning. Each programme is entirely aligned with commissioning priorities but is also aimed at securing the organisation's longer term success. The service re-configurations planned that deliver the financial efficiencies required by commissioners and the better integrated care ambitions will demonstrate to our partners that SEPT can be trusted and relied on to identify and lead system wide solutions to the challenges faced. If we can successfully develop a new model of service provision based on the integrated care (frailty) pilot project in west Essex we may be able to use our experience to secure additional contracts. Using our reputation in secure service provision to generate additional income; developing new services that repatriate tertiary provision to local commissioners and developing services for private patients could create new income streams that contribute to longer term sustainability.

Our five year strategy is currently being developed and our Board of Directors will make a clear statement in it about the Trust's sustainability. We have acquired a range of skills and experience through recent acquisitions to position ourselves for sustainability. We are up for the challenge and positive about our future viability.

In the meantime we will also be taking action to strengthen our strategic planning processes. Our existing systems have served the Trust well and enabled us to be successful so far; but the scale of the challenges faced require our processes to be "moved up a gear". The Board has undertaken a self assessment of our strategic planning arrangements against best practice guidance issued by Monitor. We will be increasing the frequency of strategic discussion and review; creating a new strategy focussed board sub-committee and enhancing resources to support strategic, commercial and transformative development.

4.4 Strategic Priority 4: Innovative and Transformational Approach to Efficiency and Effectiveness

We want to add value, make a difference and be a key partner in identifying and implementing the solutions to the system wide transformation of health and social care that is required.

4.4.1 Cost Improvement Programme (CIP)

The total planning shortfalls facing the Trust in 2014/15 and 2015/16 are £16.5m, 5.2% of forecast income and £9.8m 4.1% of forecast income respectively. Although the Trust has an excellent track record of delivering CIPs, over the past two years it has been increasing difficult to deliver planned efficiencies as the 'low hanging fruit' schemes have been identified and delivered. This also has the impact of requiring 'transformational' schemes to deliver an increasing proportion of our CIP programme, and this is particularly the case for our 2015/16 plans.

Opportunities were provided in November 2013 and March 2014 for the Board of Directors to review, shape and approve the emerging CIP programmes. This included consideration of the impact of CIPs on service quality and further details on the improved quality impact assessment processes followed by the Trust in developing the CIP programme are set out below.

Historic CIP Delivery

The Trust has a good track record of dealing with CIP programmes in recent years, achieving around 92% of planned CIPs over the last three years and 80% recurrently.

Table 2 Historic CIP Achievement	2011/12	2012/13	2013/14	Total
	£m/%	£m/%	£m/%	£m/%
CIP Plan	20.3	19.4	18.4	58.1
CIP Achieved	19.7	16.0	17.6	53.3
% CIP Achieved	97%	84%	96%	92%
CIP Achieved Recurrently	17.3	15.5	13.8	46.6
% CIP Achieved Recurrently	84%	80%	75%	80%

During 2013/14 in-year achievement rates improved back to historic levels, although recurrent achievement rates fell compared to 2012/13. The in-year shortfall was covered by underspends elsewhere in the organisation and did not impact on our overall financial performance. The continued fall in recurrent implementation rates arose as a consequence of difficulties in implementing a small number of larger, more

complex schemes which had been included in the original CIP programme and which had been assessed as high risk at the beginning of the financial year.

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

The Board receives an assurance report on CIPs each month within the overall performance report. The Performance and Finance Scrutiny Sub-Committee of the Board receives detailed reports on the progress of CIP schemes. This allows key risks to be highlighted to the Board on a timely basis and remedial action taken as necessary. Risks associated with the implementation of CIPs are also included in the Trust's Board Assurance Framework (BAF) and were again subject to a review by Internal Audit during 2013/14. Following the embedding of improvements introduced in late 2012/13 a "Full Assurance" report over the Trust's procedures for implementing and monitoring the Trust's overall CIP programme was received from Internal Audit. Additional Internal Audit work planned for 2014/15 and 2015/16 is therefore likely to focus on the project management arrangements in place for Transformational schemes.

CIP Profile

The process of identifying cost reduction schemes started in October 2013 and was discussed at the Trust's planning events with staff and stakeholders. As in previous years, the Trust's cost improvement and income generation plans follow the latest DH guidance. Provider organisations undertake a Quality Impact Assessment (QIA) for every CIP proposal. The QIAs consider a range of potential impacts on services including access to services, patient safety and patient experience. The Trust has also added compliance and training impacts to our own QIA processes to ensure there are no additional risks to the compliance regime or the training requirements for operational staff as a result of implementing CIPs. The QIAs are validated internally against compliance with the Trust licence and other guidance and are assessed by the quality team within the Trust. The Executive Directors also undertake a 'peer review' before independent assessment by the Medical Director and Executive Nurse is undertaken

Monitor guidance actively encourages clinical and commissioner involvement in this assessment process and this approach has been adopted in the development of CIPs for 2014/15 and 2015/16 via contract discussions and the QIAs have been shared with commissioners during March 2014. Completed CIPs are also monitored against KPIs to ensure no unexpected quality issues arise following implementation.

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

- the Trust will not provide services that are deemed to be clinically unsafe;
- proposals will consider all management (including director positions) and administrative functions before impacting on clinical services, while acknowledging that an acceptable level of management for the organisation must be maintained at all times;
- all proposals must have an approved QIA. Each QIA must be developed and reviewed by the Senior Management Teams (SMTs), with clinical input and involvement from CCGs and be subject to a peer review by Executive Directors prior to an independent assessment and sign off by the Medical Director and Executive Director of Clinical Governance and Quality;
- proposals should maintain existing service levels wherever possible;
- proposals must be achievable and deliverable during 2014/15 and 2015/16 as required;
- proposals should be sensitive to staff interests and minimise impact as far as practicable.

A summary of the Trust's cost reduction target to be delivered in 2014/15 and 2015/16 is provided in table 3 below. The CIP programme has been classified in line with Monitor's guidance to distinguish between schemes that are transformational in nature, those that reflect more traditional efficiency measures and income generation.

2014/15 &2015/16 CIP Programme

Table 3 Planning Shortfall	2014/15	2015/16
	£m	£m
Incremental CIP - Corporate	1.5	-
Incremental CIP – MH & Specialist Services	5.6	2.3
Incremental CIP – Community Services	3.0	3.6
Transformational – Corporate	-	1.0
Transformational – MH & Specialist Services	1.4	2.7
Transformational – Community Services	0.3	2.6
Revenue Generation – Specialist Services		0.7
Revenue Generation – MH Services	0.7	0.7
Revenue Generation – Community Services	0.1	0.1
Non-recurrent savings	3.9	-
TOTAL RECURRENT CIP SCHEMES	**16.5**	**13.7**

In planning for 2014/15 and 2015/16 the Trust has recognised that some of the more complex schemes will require consultation and/or an implementation phase. This will lead to approximately £3.9m of the 2014/15 requirement of £16.5m being delivered by non-recurrent measures (primarily use of anticipated CQUIN income and tighter controls over non-clinically essential vacancies) in 2014/15.

The total CIP programme of £13.7m in 2015/16 consists of **£9.8m** of new savings required to address the 2015/16 planning shortfall plus the full-year effect of those 2014/15 schemes which are being covered non-recurrently in 2014/15 **(£3.9m**).

4.4.2 Transformational CIPs

As recognised in previous plans the proportion of savings now planned to be delivered from transformational schemes will rise in both years. There is also a greater emphasis on income generation than in previous plans. We have identified 10 transformation programmes that we will pursue as enablers of our strategic priorities of quality services, quality leadership and workforce and sustainability of service provision. The programmes that we will undertake are aligned with the CCGs Operational Plans and opportunities that Monitor has identified ("Closing The NHS Funding Gap" October 2013) as those that offer the best opportunities for better value healthcare for patients and contribute to the response to the financial challenges faced.

Programme 1: Centralise office accommodation

The Trust has made significant progress in reducing the cost of its overhead associated with its estate. Changes to service models and developments in technology and ways of working can deliver further efficiencies. The Trust is actively examining options for centralising all corporate and administrative functions into a single facility or as few facilities as is possible. This programme is also being discussed with other statutory sector organisations to maximise savings across the local economy.

Programme 2: Reconfiguration of Essex Community Mental Health Services

In their Operational Plans, Essex CCGs have set out ambitious plans for community mental health services in line with the "parity of esteem" (physical and mental health being given equal priority) agenda. Creating better integrated primary care led teams involving physical and mental health, social care and primary care staff; transfer of responsibility for patients with cluster 1-3 diagnosis to primary care; redesign of care pathways for specialist community healthcare; improving dementia diagnosis rates and extending access to psychological therapies (age range and coverage) alongside delivery of challenging efficiency targets will require a complete redesign of current service provision across adult, older people and learning disability community services.

Programme 3: Reconfiguration of Essex In-patient Mental Health Services

Changes that we have already introduced to strengthen crisis and community support services and reduce length of stay in hospital have reduced the number of in-patient beds in previous years and further reductions are planned in the next two years. As a result the Trust is examining whether a reduction in the number of inpatient sites is now feasible to reduce estate overhead costs.

Programme 4: Corporate service reconfiguration post Bedfordshire and Luton contract transfer
Major corporate reconfiguration (including a senior management restructure) will be required when contracts for mental health services in Bedfordshire and Luton transfer to alternative providers. Integration of our corporate infrastructure as a result of the acquisitions of contracts over the past 5 years has created economy of scale efficiencies. Our challenge is to dis-aggregate support services and significantly reduce overhead costs associated with those remaining services. Investment in new technology that drives efficiency, reduces paperwork and eliminates duplication of processes; moving to more self-service based support and if necessary making difficult decisions about what the "back office" can continue to provide are priorities in this transformation programme. The Trust will also seek to utilise and build upon synergies that exist between support functions as part of this reconfiguration process.

Programme 5: Increase income generation
This transformation programme includes a small number of income generation projects that the Trust has scoped and aims to market in 2014/15 and deliver in 2015/16. These schemes may also influence the strategic positioning of the Trust in the future.

Programme 6: Successfully develop lead provider model for frailty West Essex
The Trust has been selected as the lead provider to co-ordinate this project in the pilot phase. This is an extremely exciting opportunity to radically redesign service provision for frail older people in partnership with West Essex CCG, Princess Alexander Hospital, North Essex Partnership Trust and Essex Cares with the aim of delivering much improved outcomes for patients through better integrated and coordinated care and delivering efficiency savings for the health economy through reducing admissions to hospital and reducing length of stay in hospital. The Trust has secured £1.6m in additional investment from the CCG for the project and has agreed a risk/benefit share arrangement with the CCG to encourage success. If we can successfully develop and deliver this model, ahead of competitors, it will provide us with a unique selling point and competitive edge in securing additional similar contracts. Integrated care is a critical priority in health and social care quality and efficiency policies.

Programme 7: Develop continuing health care coordination model
The Trusts strategic planning has identified a market opportunity to undertake a coordinating role in continuing health care provision which, using our experience of supporting people in the community, could realise savings in continuing health care spend for CCGs. This is an area that CCGs are experiencing significant difficulties in controlling spend and a partnership with them on activities like this which are not part of our core contract demonstrates our commitment to being part of economy wide solutions focussed on benefitting patients not just our organisation.

Programme 8: Establish strategic alliances to deliver services or efficiencies
This programme is aimed at exploring potential joint working arrangements with other organisations with a view to partnering in service delivery and sharing specific support functions. This is seen by the Trust as a faster, more efficient and less distracting option to pursue in the short term, rather than considering a full merger as a sustainability option. Given the uncertain nature and timing of these opportunities no specific monetary contribution has been assumed within our 2014/15 and 2015/16 plans.

Programme 9: Transform community health services
The CCG Operational Plans have a clear focus on developing better integrated community health services; designing pathways of care aimed at preventing admission to hospital and reducing length of stay in hospital and shifting care from hospital to community settings where possible.

In Bedfordshire, health and social care commissioners have identified that in the next two years community health services will need to be radically redesigned to focus on reablement and rehabilitation. In the third year of our contract (16/17), community health services will be re-commissioned based on new service models that we have hopefully jointly developed and successfully delivered. If we cannot re-engineer our services and deliver improved productivity we will not retain the contract.

In south east Essex we will need to redesign our model of service to meet 7 day service aspirations, new pathways for EOL and COPD, enhanced single point of referral requirements and targets such as 40% of patients who have had a stroke and are admitted to the local acute trust are supported by our early supported discharge team. We will need to undertake a complete review of the current model of service and undertake a thorough skill mix review to achieve the efficiency and service delivery ambitions of our commissioners. The CCG has extended our current contract following a contestability exercise. They have confidence in what we have delivered so far and in our ability to do more.

Programme 10: Pursue additional contracts via market testing opportunities
The Trust will continue to seek opportunities for growth through competitive tendering. We will only pursue these if they make a contribution to overhead costs and where they build on our strengths or add value/ have synergy with existing service provision. Given the uncertain nature and timing of these opportunities no specific monetary contribution has been assumed within our 2014/15 and 2015/16 plans.

Table 4 below sets out how each of these transformation programmes will recurrently contribute towards the identified savings requirement over the next two years.

Table 4: Transformational Programmes		**2014/15 £m's**	**2015/16 £m's**	**Total £m's**
Programme 1	Centralise Office Accommodation	-	1.0	1.0
Programme 2	Reconfiguration Essex Community MH Services	0.5	-	0.5
Programme 3	Reconfiguration Essex Inpatient MH Services	2.4	0.5	2.9
Programme 4	Corporate Service reconfiguration post B&L	-	1.0	1.0
Programme 5	Increase Income Generation	1.3	1.0	2.3
Programme 6	West Essex Frailty - lead provider model	-	0.6	0.6
Programme 7	Continuing Healthcare Co-ordination model	-	0.3	0.3
Programme 8	Strategic Alliances	No savings yet assumed		
Programme 9	Transform community services	0.5	1.1	1.6
Programme 10	Additional contracts via Market-Testing	No savings yet assumed		
Total Transformational CIPs		**4.7**	**5.4**	**10.1**
Total CIP Programme (Incremental + Transformational)		**16.5**	**9.8**	**26.3**

Given the importance of the overall CIP programme to our sustainability assessment, it was formally Risk Assessed as part of the development of Trust's Financial Plan. The risk was rated as 'Extreme' and thus subject to further sensitivity testing within the Financial Plan. This sensitivity test modelled the impact of only 70% of the CIP programme being delivered.

The Trust's mitigation against the impact of this risk was non-recurrently to release centrally held contingencies and slow-down non-essential backlog maintenance and IM&T replacement whilst identifying additional CIPs that could be implemented from Year 2 onwards to replace those schemes that had not been delivered.

These actions, when modelled through, were sufficient to maintain a Continuity of Service Risk Rating of 3 over the first two years of the planning period.

5.0 SUPPORTING FINANCIAL INFORMATION

5.1 Current financial position

The Trust's operational financial plan for 2014/15 – 2015/16, is set against a background of continuing financial constraint within the public sector including the NHS. Services are facing a fourth year of significant efficiency measures and an expectation that this will continue over the planning period. In addition the Trust is now beginning to experience further change as the new commissioners introduced from April 2013

complete their commissioning reviews of services and implement changes, including an increasing emphasis on the competitive tendering of services.

The Trust is forecasting ending 2013/14 with an underlying surplus (excluding technical adjustments such as impairments and revaluation gains) of £1.0 million, giving a Monitor Continuity of Service Risk Rating of at least 3. The Trust also continues to have good underlying liquidity in terms of working capital. Whilst the forecast surplus is less than originally planned this reflects the decision of the Board to invest additional funding in IM&T infrastructure and support the South Essex health system. However, as in 2012/13 the Trust was unable to implement recurrently a significant proportion of its CIP plan (£4.6 million) which has increased the scale of change required in 2014/15.

The Planning Guidance for 2014/15 and 2015/16 sets out an underlying minimum efficiency requirement for providers of 4%, comprising a reduction in income of 1.8% and provider inflation of 2.2% in 2014/15 and 4.5% in in 2015/16. In addition to these national requirements, other local cost pressures including the impact of demographic growth mean that the Trust is anticipating an actual efficiency requirement of around 5.2% in 2014/15 and 4.1% in 2015/16.

The Trust's two year financial strategy that underpins this Operational Plan makes a number of key assumptions around future income levels in the light of the changes in the commissioning environment. As a general principle it assumes that, for contracts where commissioners have formally provided notice that a competitive process will be undertaken to select a new provider, SEPT will not retain the contract. This affects the following contracts:

- Luton and Bedfordshire CCG Mental Health Services (and S75 agreements with local authorities). It is assumed that the services will not be provided post April 2015;
- Suffolk Community Services. It is assumed that the service will not be provided post October 2015.
- South Essex CAMHS Tier 2/3. It is assumed that the service will not be provided post April 2015.

For all other contracts it is assumed that these will continue to be provided over the planning period, although we are aware of a number of other potential services that may be subject to change (for example community services for children) and the impact of these will be monitored and the Financial Strategy refreshed as appropriate.

Given the planned changes in Luton and Bedfordshire and the system-wide challenges facing the South Essex health system the Trust has agreed with all CCGs that contracting for Mental Health services will remain on a block basis for 2014/15 and any move to PbR will not be undertaken until post implementation of any service redesign.

In respect of the transition away from Luton and Bedfordshire the Trust's operational financial plan assumes that direct and indirect costs of service provision will reduce on a £ for £ basis as income reduces and that all affected staff will TUPE to new provider(s). In respect of corporate and overhead costs it is assumed that back-office functions will be separated as far as possible, with again staff transferring to the new provider(s). It is assumed that the majority of redundancy and other transitional costs will therefore be met by the new provider following transfer to new service provider. However, if this proves not to be possible then the costs will be covered by working capital without impacting on the Trust' risk rating.

In line with the Trust's new Strategic Direction, the financial priorities for 2014/15 are therefore to:

- manage the transition of MH services in Luton and Bedfordshire, redesigning corporate and support functions accordingly;
- support the delivery of an increasing number of transformational CIPs that are now required to maintain the Trust's medium to longer term stability;
- support the development of plans for generating additional income, either through responding to opportunities as they arise or more speculatively through development of new services.

In recognition of the significant pressures placed on both operational and support services to deliver cost reductions, the Board of Directors have agreed that the planned income and expenditure surplus for 2014/15

is reduced to £1.2 million from a previous plan of £3.3 million. Of the £2.1 million reduction, £1.5 million is being used to reduce the CIP requirements of Operational Divisions with the balance of £0.6 million being held as additional reserves for the expected costs of transition during 2014/15. In 2015/16 the planned surplus rises to £1.7 million. It is forecast that these levels of planned surplus are sufficient to maintain a Continuity of Service Risk Rating of 3.

5.2 Key financial priorities and investments

The key elements of the financial strategy are summarised as follows:

- taking all necessary action to ensure that the Trust's income and expenditure remains in recurrent balance through implementation of recurrent efficiency savings;
- non recurrent income is used to manage in-year financial pressures, including any arising from delays in the implementation of efficiency savings;
- the requirement to generate an operating surplus each year to maintain a Monitor Continuity of Service Risk Rating of 3 at the minimum. This will assist with ensuring the long-term future of the Trust and provide funds for future investment;
- within the annual budget agreed by Board of Directors a centrally held and managed contingency is provided for. This contingency will provide a buffer against unexpected events and provide funds to support new initiatives;
- maintaining a clear scheme of delegation within the Trust so that responsibility for financial management and control is clear and unambiguous;
- external borrowing is not currently factored in our two or five-year plans. However, external borrowing will be permitted for activities with an associated revenue stream or where there is a clear infrastructural or strategic benefit to SEPT. External borrowing will be contained to the levels authorised by Monitor, our Regulator;
- development of a clear pricing strategy for supporting any future introduction of tariffs for MH services and the continued development of Service Line Costs for all services;
- increasing our income from non-NHS sources. Any such increase is unlikely to exceed the 5% limit above which formal approval from the Council of Governors is required;
- invest in pump-priming service transformation including additional project management capacity and the setting-aside of capital funding for estates redevelopment.

5.3 Income and Expenditure Plans

5.3.1 Income

In line with the overall economic climate the Trust is anticipating that there will be a net reduction of its total income over the coming two years. All major income contracts with Essex CCG commissioners and NHS England Specialist Commissioning Team have been agreed and signed. The Trust's income assumptions for these contracts are therefore in line with commissioners' assumptions. The Trust is in the process of agreeing roll-over contracts with Bedfordshire and Luton CCGs for mental health, learning disabilities and CAMHS services with final confirmation still required from each CCG as to their respective share of the total contract value. The Trust's contract with Bedfordshire CCG for Community Services expires at the end of August 2014, and an updated finance schedule for 2014/15 has been agreed.

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

- no further income reductions are levied other than the national tariff deflators;
- income will continue at the current levels unless Commissioners have given a clear indication that services will be subject to procurement processes;
- no financial impact from the transfer of Bedford and Luton MH and LD services, Luton Community Health services, South Essex Tier 2 CAMHS services and Suffolk services;
- no adverse impact from the 2014/15 QIPP programmes of individual health systems;
- CQUIN (Commissioning for Quality and Innovation) income reflected in plan will be received in full and will be used to fund the cost of CQUIN projects and provide non recurrent support to the Trust's CIP plans;
- income generation is achieved in full for both existing and planned schemes;
- PbR for MH services is not being implemented in 2014/15 and will be implemented following the remodelling of MH services;
- no financial impact from rebasing of income across Essex Commissioners until the remodelling of services is complete Increasing our income from non-NHS sources;
- baseline adjustments made to CCG's in respect of the Better Care Fund has no financial impact for the Trust.

A summary of forecast contractual income for the 2014/15 and 2015/16 financial years are detailed in tables 5 and 6 below.

Table 5

Division	Closing Income 31 Mar	Income Deflation	Growth	Invest-ments Recurrent and Non-Recurrent	CQUIN	QIPP Reduc-tions	Opening Income 1 April
	£m	£m	£m	£m	£m	£m	£m
Essex Mental Health and LD Specialist Services	84.7	(1.5)	0.8	2.9	1.6	(1.5)	87.1
(Essex, Bedfordshire and Luton) Bedfordshire and Luton	26.5	(0.5)	0.0	0.2	0.6	0.0	26.9
(MH, LD and CAMHS)	64.3	(0.2)	0.0	1.2	0.4	0.0	65.7
Bedfordshire Community	38.1	(0.7)	0.6	1.0	1.0	0.0	40.0
South Essex Community	33.0	(0.6)	0.2	0.2	0.6	(0.1)	33.4
West Essex Community	36.5	(0.6)	0.7	0.6	0.8	0.0	38.0
Suffolk Community Services	11.2	0.3	0.0	0.1	0.0	0.0	11.6
Non-Contract Income	13.8	0.0	0.0	0.0	0.0	0.0	13.9
TOTAL	**308.1**	**(3.7)**	**2.4**	**6.2**	**5.1**	**(1.6)**	**316.5**

As set out in our assumptions, the contracts from Bedfordshire and Luton CCGs for the provision of mental health, CAMHs Tier 2/3 services and learning disability services are not factored in our modelling assumptions. Also the contract for Suffolk services is assumed to cease in as at the end of September 2015. In overall terms therefore, the Trust has a total initial income for 2015/16 of £229.7 million.

Table 6

Division	Closing Income 31 Mar	Contract Cessation	CQUIN Reversal	Income Deflation	Opening Income 1 April
	£m	£m	£m	£m	£m
Essex Mental Health and LD Specialist Services	87.1		(1.6)	(1.6)	83.9
(Essex, Bedfordshire and Luton) Bedfordshire and Luton	26.9	(3.8)	(0.6)	(0.5)	22.0
(MH, LD and CAMHS)	65.7	(65.3)	(0.4)		0.0
Bedfordshire Community	40.0	(4.1)	(1.0)	(0.7)	34.2
South Essex Community	33.4		(0.6)	(0.6)	32.2
West Essex Community	38.0		(0.8)	(0.7)	36.5
Suffolk Community Services	11.6	(5.8)		0.1	5.9
Non-Contract Income	13.9			1.2	15.1
TOTAL	**316.5**	**(79.0)**	**(5.1)**	**(2.7)**	**229.7**

There are a number of planned CIP schemes that reflect Income Generation in 2014/15, with a further increase in 2015/16, reflecting two of the Trust's 10 transformational priorities being focused on potential market opportunities in respect of Acquired Brain Injury and other income generation activities. It is assumed that these two priorities will contribute £2.3m by 2015/16 to the Trust's CIP requirements.

5.3.2 Expenditure

The main cost assumptions are set out below:

- a minimum increase of 2.2% increase on expenditure in each year of the planning period is assumed. This reflects a blended average of expected cost pressures in the main expenditure categories such as pay, utilities, clinical supplies etc;
- the Trust CIP programme of identified schemes is delivered in full across the planning period and the year-on-year financial plan is to breakeven, maintaining a minimum Continuity of Service Risk Rating of 3;

- all expenditure associated with transfer of service to new providers can be accommodated within the Trust;
- no additional financial impact from workforce strategy / recruitment and retention issues or difficulties;
- the Trust's supporting plans including the non-recurrent expenditure programme will be delivered on target, and, central and delegated budgets are adequate;
- all redundancies arising from the savings initiatives will be accommodated within the Trust's available reserve;
- combination of CQUIN and contingencies are sufficient to cover the non-recurrent shortfall in the short-term financial plan;
- no quantifiable financial impact from population/demand changes;
- any impact from reductions in S75 income are cost neutral;
- no significant impairment of assets over the two year planning period is assumed, although this assumption will need to be reviewed in the light of the final treatment of SEPT property associated with providing mental health services in Bedfordshire and Luton.

Modelling for the expenditure plan for the Trust starts with the forecast year end budget position for 2013/14 taken from the Trust's finance system at December 2013, by division. In addition to the 2.2% (£6.3m) of national cost pressures, the Trust's budget setting process has identified a number of local cost pressures which are unable to be accommodated within existing resources. These total £2.3 million and predominantly relate to the Bedfordshire and Luton mental health, CAMHs and learning disability contract. No local cost pressures are modelled for 2015/16. Finally, built-in to this 2-year financial plan are unachieved CIP's of £4.6 million for all divisions for 2014/15 and no unachieved CIPs in 2015/16.

Tables 7 and 8 detail the resulting gross expenditure plan for the Trust, by division for each of the next two years.

Table 7

Division	Closing Expend-iture	Generic and Local Cost Pressures	CIPs Brought Forward from 13/14	Growth	Invest-ments Recurrent and Non-Recurrent	CQUIN	Surplus	Opening Expend-iture before CIP
	£m	£m	£m	£m	£m	£m	£m	£m
Essex Mental Health and LD	(84.0)	(2.8)	(0.7)	(0.8)	(2.9)	(1.6)	(0.1)	(93.0)
Specialist Services (Essex, Bedfordshire and Luton)	(26.2)	(0.8)	(0.3)	(0.0)	(0.2)	(0.6)	(0.4)	(28.5)
Bedfordshire and Luton (MH, LD and CAMHS)	(63.6)	(2.8)	(1.4)	0.0	(1.2)	(0.4)	0.0	(69.4)
Bedfordshire Community	(37.7)	(0.7)	(1.1)	(0.6)	(1.0)	(1.0)	(0.1)	(42.2)
South Essex Community	(32.7)	(0.6)	(0.6)	(0.2)	(0.2)	(0.6)	(0.1)	(35.1)
West Essex Community	(36.1)	(0.7)	(0.5)	(0.7)	(0.6)	(0.8)	(0.1)	(39.6)
Suffolk Community Services	(10.7)	(0.2)	0.0	0.0	(0.1)	0.0	(0.5)	(11.4)
Non-Contract expenditure	(13.8)	0.0	0.0	0.0	(0.0)	0.0	0.0	(13.9)
TOTAL	**(304.9)**	**(8.6)**	**(4.6)**	**(2.4)**	**(6.2)**	**(5.1)**	**(1.2)**	**(333.0)**

Table 8

Division	Closing Expenditure	Contract Cessation	Generic Cost pressures	CQUIN Reversal	Opening Expenditure before CIP
	£m	£m	£m	£m	£m
Essex Mental Health and LD	(87.1)	-	(2.4)	1.6	(87.8)
Specialist Services (Essex, Bedfordshire and Luton)	(26.9)	3.8	(0.7)	0.6	(23.2)
Bedfordshire and Luton (MH, LD and CAMHS)	(65.7)	65.3	0.0	0.4	0.0
Bedfordshire Community	(40.0)	4.1	(1.0)	1.0	(35.9)
South Essex Community	(33.4)	-	(0.9)	0.6	(33.7)
West Essex Community	(38.0)	-	(1.0)	0.8	(38.2)
Suffolk Community Services	(11.6)	5.8	(0.1)		(5.9)
Non-Contract expenditure	(13.9)	-	(1.2)		(15.1)
TOTAL	**(316.5)**	**79.1**	**(7.3)**	**5.1**	**(239.5)**

5.3.3 Efficiency Requirement

Combining the forecast Income and Expenditure positions and the reduced level of Planned Surplus that the Trust Board has set for 2014/15 and 2015/16, produces the Trust's forecast Cost Improvement Plan or efficiency requirements in both years. These are set out in Tables 9 and 10 below. In 2014/15 the CIP requirement equates to approximately 5.2% and 4.1% of income respectively.

Table 9

Division	Opening Income 1 April	Opening Expenditure (inc Surplus) before CIP	Efficiency Requirement by Contract	Closing Expenditure (inc Surplus)
	£m	£m	£m	£m
Essex Mental Health and LD	87.1	(93.0)	(5.9)	(87.1)
Specialist Services (Essex, Bedfordshire and Luton)	26.9	(28.5)	(1.6)	(26.9)
Bedfordshire and Luton (MH, LD and CAMHS)	65.7	(69.4)	(3.7)	(65.7)
Bedfordshire Community	40.0	(42.2)	(2.2)	(40.0)
South Essex Community	33.4	(35.1)	(1.6)	(33.4)
West Essex Community	38.0	(39.6)	(1.6)	(38.0)
Suffolk Community Services	11.6	(11.4)	0.1	(11.6)
Non-Contract expenditure	13.9	(13.9)	-	(13.9)
TOTAL	**316.5**	**(333.0)**	**(16.5)**	**(316.5)**

Table 10

Division	Opening Income 1 April	Opening Expenditure (inc Surplus) before CIP	Efficiency Requirement by Contract	Closing Expenditure (including Surplus)
	£m	£m	£m	£m
Essex Mental Health and LD	85.5	(89.2)	(3.7)	(85.5)
Specialist Services (Essex, Bedfordshire and Luton)	27.1	(28.3)	(1.2)	(27.1)
Bedfordshire Community	35.9	(37.5)	(1.6)	(35.9)
South Essex Community	32.8	(34.2)	(1.5)	(32.7)
West Essex Community	37.3	(38.9)	(1.6)	(37.3)
Suffolk Community Services	5.9	(5.9)	(0.0)	(5.9)
Non-Contract expenditure	15.1	(15.1)	-	(15.1)
TOTAL	**(229.7)**	**(239.5)**	**(9.8)**	**(229.7)**

5.3.4 Capital Plans

The Trust's capital plan has also been reviewed, and incorporates a number of enabling schemes which allow CIP's to be achieved. The only sale proceeds which have been factored into the plan is the sale of properties previously deemed surplus to requirements which slipped from the 2013/14 Capital Plan. The capital plan includes allocations for carbon reduction, IT and other equipment. The Trust does not plan to make use of external finance for any of the planned capital expenditure, using internally generated cash or asset disposals. A summary of the Trust's Capital Plan for the next two years is given in Table 11.

Table 11: Capital Plans

	Year 1 2014/15 £ M's	Year 2 2015/16 £M's
Capital Cash Carried Forward	23.3	28.0
Cash from Depreciation	5.4	3.7
Property Disposals	4.1	
Planned I & E Surplus	1.2	1.8
Total Capital Resources	**34.0**	**33.5**
PFI Charges	0.9	0.8
ICT	0.9	0.7
Carbon Reduction	0.6	0.5
MEMS & Other Equipment	0.3	0.2
Backlog Maintenance	1.0	1.0
Income Generation / CIP's	1.0	
Remodelling / Replacement of Inpatient Facilities	1.0	5.0
Other	0.3	
Total Allocations	**6.0**	**8.2**
Capital Cash Carried Forward	**28.0**	**25.3**

5.3.5 Cash Planning

The Trust's cashflow forecasts have been updated in the light of the revised Income and Expenditure and Capital plans and a summary of the projected position is shown in Table 12 below. Over the two year planning period the Trust's cash position remains strong.

Table 12: Cash Plans 2014/15-2015/16

Cash Plan	2014/15 £m	2015/16 £m
Cash Balance B/Fwd 1 Apr	37.0	40.7
Total Receipts	325.3	234.8
Total Payments	(321.6)	(236.2)
Cash Inflow/(Outflow)	3.7	(1.4)
Cash Balance C/Fwd	**40.7**	**39.3**

5.3.6 Key risks to achieving the financial strategy and mitigations

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

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

	NATURE OF RISK	CATEGORY
1	30% slippage on a £14.9 million CIP programme anticipated	Extreme £ 8.9 m
2	The Trusts ability to reduce its corporate back office by £11.0 million as a result of the decision to withdraw from the provision of mental health and learning disability services in Bedfordshire & Luton	High £1.5 m
3	Differential dates of transfer of services to a new provider by Bedfordshire and Luton Commissioners with loss of income for integrated services provided across Bedfordshire & Luton, and, contribution to Back Office	High £1.5 m
4	All other risks associated with the transfer of services in Bedfordshire and Luton, for example redundancy costs, pension liabilities.	High £3.05

These risks were then assessed to determine the potential impact on the Trust's Continuity of Service Risk Rating if they all occurred and no mitigating actions were undertaken. In 2014/15 this analysis identified that Trust's cash balances would reduce by £9.05m and a deficit of £7.85m would be incurred. In 2015/16 the Trust's cash balances would reduce by £7.2m and a deficit of £5.5m. However, whilst this a worst case scenario as it assumes that all risks will materialise and no action is undertaken, in both Years the Trust would retain a Continuity of Service Rating of 3, reflecting the strong cash position of the Trust.

A number of mitigating actions were also considered and modelled against these scenarios. In Year 1 the Trust's central contingency (£5m) could be released, non-essential backlog maintenance and IT replacement expenditure deferred (£1.25m) and non-essential vacancies could be held (£0.5m). With these mitigating actions it is forecast that the Trust's potential deficit would be £1.1m and with a Continuity of Service Risk Rating of 3.

In Year 2 mitigating actions would include the release of some central contingencies (£2m) and the implementation of alternative CIP schemes (£4.5m). With these actions the Trust's financial position would improve to a surplus of £1.0m, again with a Continuity of Service Risk Rating of 3.

The Trust's Financial Plan includes provision for the following contingencies which, if required, would mitigate £6.2m of risk (approximately 2% of turnover) in a single financial year:

- reserves provisionally allocated for maintenance and IT (£1.2m) which will only be released if the Trust's financial circumstances permit; and
- reserves held for restructuring costs - £5.0m.

In addition, the Trust has only planned on achieving 70% of CQUIN income. Any income received above this level would also be used as contingency. At a 90% level of achievement this would equate to a further £0.5m.

6.0 OPERATIONAL REQUIREMENTS AND CAPACITY

As stated previously, all of our main contracts are agreed on a "block contract" basis. Whilst this does carry some risk associated with increased demand we are able to confirm mitigation strategies are in place to minimise financial risk to the trust. All contracts have agreed indicative activity levels contained within them, expressed as numbers of beds (in-patient services) or contacts (community services) expected by service line; as well as key quality and performance targets.

If there is demand for beds over and above that which is available at any given time, patients will be placed in alternative provision and the cost is borne by the relevant commissioner. However, based on current demand, the need to place patients in alternative provision has been rare, which would indicate that the level of commissioned beds is equal to demand.

Fluctuation in demand for community services, over and above indicative activity levels are and will continue to be managed through flexing of existing capacity. Regular monitoring of quality (targets and performance) and activity takes place with commissioners and we have been able and will continue to agree mitigation plans with them, to secure additional investment and / or changes to service specifications/ models.

During 2014/15 our activity plan is based on 2013/14 contracted outturn less minor (immaterial) adjustments made to reflect changes to agreed contracts. The 2015/16 activity plan reflects the assumptions set out previously, that from April 2015 the Trust will not be delivering mental health services in Bedfordshire and Luton and CAMHs Tier 2 and 3 services in Essex. The plan therefore identifies a significant reduction in numbers of beds, OBDs, wards, and community teams associated with delivery of these services. There are potential further reductions as a result of CIPS/ QIPP in Essex but these are not material and are subject to completion of service reviews and consultation.

During 2014/15, our workforce plan assumes that the majority of the CIP is being delivered from non pay transformation/ initiatives. Therefore the minor (immaterial) impact of CIPs plus additional investment results in a broadly static plan. The 2015/16 plan identifies significant reduction as a result of the assumptions identified above. It is anticipated that staff will transfer to alternative providers under TUPE/ cabinet office guidelines as agreed with commissioners.

7.0 KEY POTENTIAL RISKS TO DELIVERY OF THE PLAN

In Section 4.1.8 the potential risks to quality and in section 5.3.6 the potential financial risks have been identified. There are 11 quality and financial risks that have been assessed (pre-mitigation) as high or extreme.

In concluding the development of this plan, the Board has reflected on the risks already identified and considered the risks to delivery of the overall plan. It is clear that the challenges facing the Trust are significant both financial and operationally. The assumption is that the Trust will be able to deliver the plan as set out. However, the Board has acknowledged that there is an accumulative potential risk associated with the Trust's existing management capacity to respond to the scale, scope and speed of action required to ensure delivery of the plan. This has therefore been identified as a high potential risk on the Board Assurance Framework from April 2014. Mitigation plans have been developed. The Board has approved additional resources to support the Transformation Programme; has established a Project Management Office led by a director and has enhanced the monitoring and governance arrangements for managing transformation and dis-aggregation through establishment of separate Project Boards that report into Board sub-committees. In addition the CEO and CFO have been invited to attend Luton CCG's transition project board.