Surrey and Borders Partnership NHS
NHS Foundation Trust

Strategic Plan Document for 2014-19

Surrey and Borders Partnership NHS Foundation Trust

Executive Summary – For Publication

Our Strategic Plan – 2014/15 – 2018/19

Executive Summary

1.0 The Context We Work In

1.1 Healthcare needs assessment, based on demographic and healthcare trends

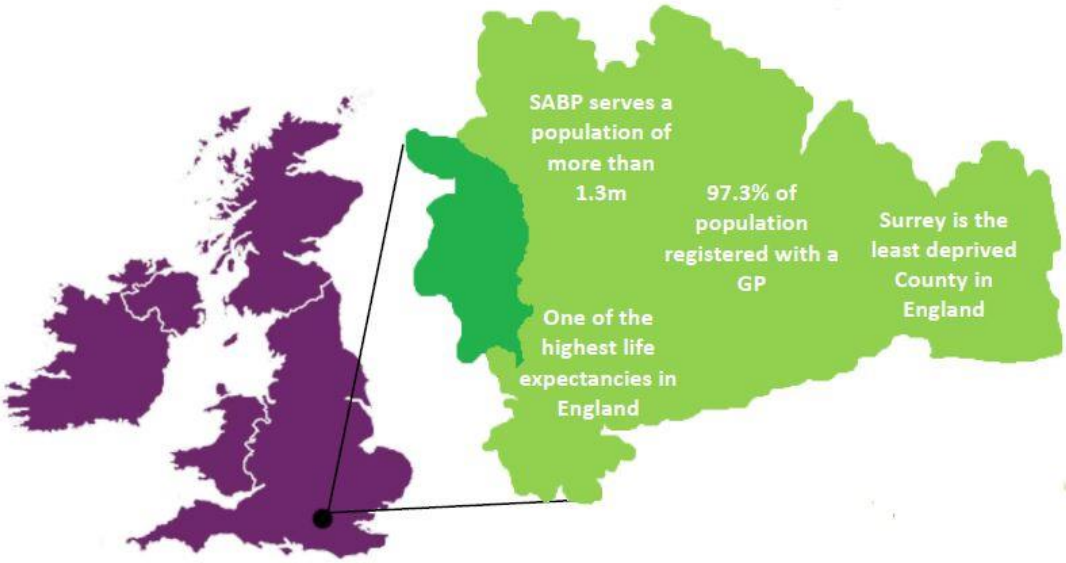
Surrey and Borders has traditionally had a very clearly defined customer group along with a suite of services that have been based primarily on geography and history. However for any future strategy globalisation and democratisation of services will be a greater driver of provision.

To this end we consider our market in three distinct ways:

- Local – the traditional geographic boundary of Surrey and Borders Partnership
- National – the UK as a whole and how our services are benchmark, best practices that are best shared over a wider geography
- International – where we a leaders in service provision we should look to alternative geographies to broaden our marketability and experience

1.1.1 Local Health Needs Assessment

We are currently the major provider of secondary mental health, drug and alcohol and learning disabilities services to the 1.3m population of Surrey and North East Hampshire. We also provide some services to the surrounding counties and London Boroughs on our borders, and in-reach and liaison services into local prisons and acute hospitals.



The demographics our local area can be defined by the following distinctive features:

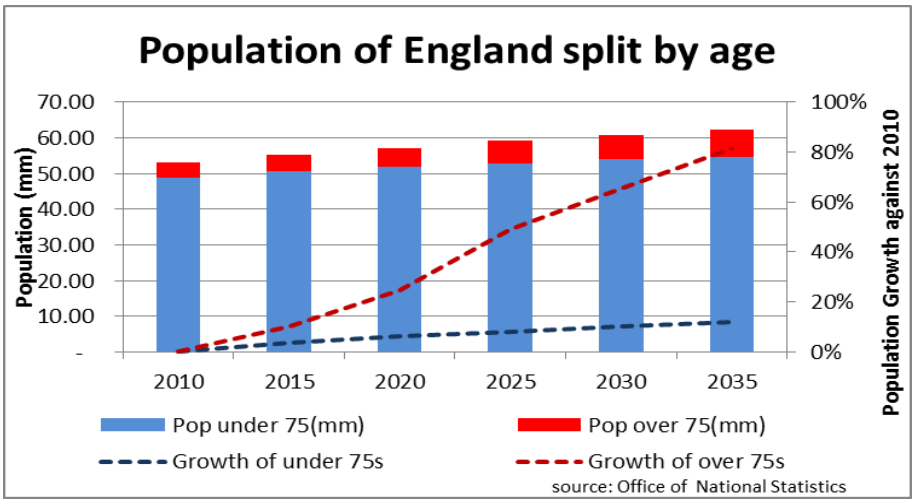
- One of the healthiest and wealthiest parts of the country
- Pockets of deprivation and significant need
- Health, generally, and mental health specifically on the whole better than the English average with the most significant exception being the number of adults with dementia
- Increasing population of over 65+yrs
- High life expectancy
- Increasing population of children with neurodevelopmental and complex needs – already evident within primary education
- Increase in suicides nationally reflected in Surrey population (not in those known to services but in wider population)
- Relatively large population of people with learning disabilities due to historic institutions
- High than average number of GPs to population – relatively high quality of primary care
- A relatively low proportion of its population from minority ethnic groups –5% against an average for England and Wales of 8.7% with concentrations of some well-established Black and Minority ethnic communities in certain localities e.g. Nepalese community in North East Hampshire, Asian community in Woking, Gypsies and Travellers (4th largest in country).

The identified priority health needs for our local area are summarised as

- Older people and Living longer – particularly dementia
- Alcohol
- People with learning disabilities
- Children with complex needs
- Military families
- Prison population
- People with mental ill-health – i.e. with a higher than might be expected level of depression

1.1.2 National Health Needs Assessment

We know the national population is expected to grow by 17% over the next 25 years. England has a current population of 53mm people. This figure is set to grow by 17% over the next 25 years:



In the same period there is set to be a growth in the population over the age of 75 of nearly 85%. As our population grows and ages its needs will evolve and change.

The identified priority health needs for the national population reflect local priorities, notably for our portfolio

- Almost half of all ill health among people under 65 is attributed to mental illness.
- Only a quarter of people with mental illness are in treatment
- A minimum of £1 in every £8 spent on long-term conditions is linked to poor mental health and wellbeing
- Evidence suggests a need for drug treatment services specifically targeting the younger population
- Over 70% of the prison population has two or more mental health disorders
- FASD is the leading known preventable disability with 1 in 500 children are born with FASD and 1 in 100 children are born with alcohol-related disorders from the spectrum
- Around 40% of hospitals have no access to liaison psychiatry services.

1.1.3 International National Market Assessment

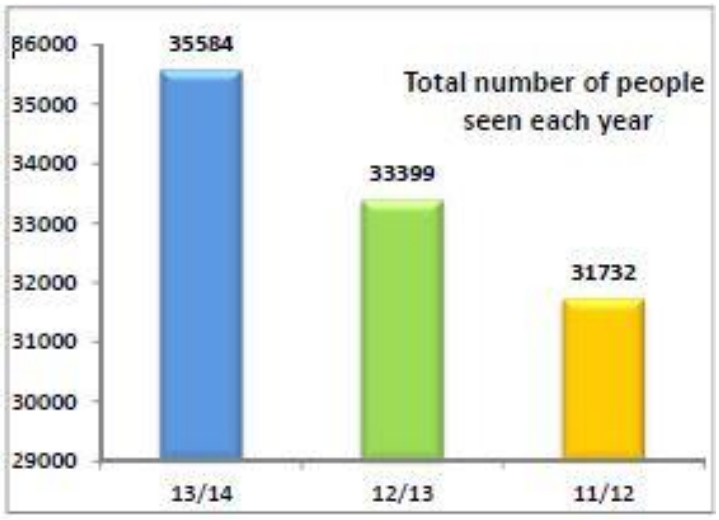
Globally there are many trends in healthcare of interest. Some are reflective of the movement towards globalisation caused by the interconnectivity bought about by social media and online technologies, others created by the rapid development of countries such as the BRIC block or the decline of established western countries and even the current economic situation that impact on every country.

Internationally it is important to note

- The global population is increasing at a rapid rate
- Mental health and neurological disorders are responsible for 13% of the global burden of disease

1.2 Our capacity analysis

The number of people we see has been increasing over recent years.



We are ambitious to reach as many people as we can with the resources we have available to us. In the past three years we have increased the number of people we have seen by 12% overall since 2011/12 to reach 35584 people this year.

1.2.1 Our Beds

Our bed profile has been successfully reduced over since 2009 from 543 beds to 332. To be able to cope well with the peaks and troughs of our unplanned admissions we need to achieve an optimum occupancy level of 85% which is the recognised safe level. For the majority of time this is being achieved on a monthly basis for most of our specialities. However this can mask day to day fluctuations.

Benchmarking data shows that we have relatively high average Lengths of Stay and relatively low levels of readmissions in particularly our adults of working age beds. This profile suggests a potential for increased efficiency in the use of and therefore potential further reductions in beds across our current portfolio, with corresponding further development of our care pathways to support people better at home and to keep people well for longer so they prevent crises.

1.2.2 Our Staff

An analysis of our staffing capacity highlights the following key features:

- The majority of our staff are over 45 years old. A high number of our current staff will be eligible for retirement at 55
- Our staff are from more diverse backgrounds than the local population we serve (2/3rds of our staff are from BME backgrounds) particularly in our inpatient services
- We have a low sickness absence rate compared with similar other trusts

- We have achieved year on year improvements in our staff's experience (as measured by the national Staff Survey)

Our staff have delivered significant changes to their practice over the last 10 -20 years to deliver the transition from the old institutional models of care. But our staff will need to transition their skills further from the secondary care into community and individual/personalised care; and from our current emphasis on treatment models to deliver earlier interventions, diagnosis and advice and consultancy support to people and the wider system.

This will impact differentially on our different staff groups as we try to ensure we have the optimal skill mix within our largely multi-disciplinary teams to offer quality services (safe, effective (good outcomes), experience and value for money) for people.

1.2.3 Our Property (Estates)

Over the next ten years we will see an exponential increase in the availability of diagnostic and treatment technologies and consumer and commissioner expectations. This will raise expectations regarding the quality and appropriateness of our facilities. Increasing use of technology to deliver services will also mean that we require less bed based services and ultimately less sites and buildings.

As a result of this our focus continues on radical rationalisation of the remaining estate portfolio from 63 to 25 sites together with development of improved 24 hour and community environments. The aim is to meet the expectations and improve the experience of our staff and public by providing where appropriate, fit for purpose, well maintained 'healing environments'. The emphasis is on leased (rather than owned) community property and radical improvement in space utilisation enabled by mobile technologies.

If we project the above service scenarios forward to 2022 we would require:

- A few sites that are purpose designed for 24 hour care
- Multiple community sites that provide high quality consulting environments
- Base(s) for the provision of virtual care and 24/7 call centre(s) which offer services in the UK and internationally
- A significant increase in home and remote working for both business units and corporate services

1.3 A funding analysis, based on historic trends and likely commissioning intentions

1.3.1 Historic funding patterns and delivery

Over the period 2007/08 – 2012/13 we delivered the following financial reductions for the local health economy:

- Income: Reduced by 23%;
- Clinical Expenditure (Direct & Indirect): Reduced by 11%;
- Asset Costs: Reduced by 28%;
- Corporate Costs: Reduced by 33%.

Historic funding decisions for our services through the block contract show that Commissioners have not funded parity of esteem as investment in our contract has fallen in real terms against a rise in funding for services which attract tariff.

This has been achieved through the delivery of Cost Improvement Plans (CIPs) totalling more than £64million over the last 8 years. During this period, total NHS spending has risen from £76.4bn in 2005/06 to £104.3bn in 2011/12 (a rise of 36.5%). In this period of significant growth in health spending, our income has reduced by £24m (prior to the transfer of the Specialist Commissioning budgets) – while the closure of the SCCP Homes accounts for ~£12m of this decrease, our comparative baseline turnover has decreased by a further £12m.

1.3.2 Commissioning intentions

Whilst some health commissioners have expressed a desire to invest in increased mental health, particularly for the frail elderly, our Local Health Economy (LHE) remains challenged by the financial pressures.

The published headline priorities of our Commissioners currently are:

- **Promotion and Prevention:** Aim: Improve health and reduce health inequalities for people with MH or LD
- **Early Diagnosis and Intervention:** Aim: To prevent unscheduled admissions and secondary care appointments and to promote independence. Improve the diagnosis, treatment and care of people with common mental health problems and dementia and the co-morbidity of MH & LTC.
- **Improve Quality and Efficiency:** Aim: Improve service user experience, improve care pathways and their integration and deliver care closer to home. To increase efficiency and innovative approaches to integration and partnership working across health, social care and the voluntary sector to improve patient care.
- **Social and Individual:** Aim: Address the social determinants and consequences of mental health.

We know the socio-economic forecast for publically funded services is reducing. Currently these sources account for c75% of our total income. To thrive we need to diversify our income base – locally, nationally and internationally i.e. non-NHS from local authorities and voluntary sector buyers and private payers.

We know we need to deliver more service with less resource. We can do this by working differently and partnering with others whose expertise complements ours. We want to also offer new responses to the growing public health challenges if we are to realise our ambitions as a public benefit organisation.
We need to provide services which help prevent people becoming ill to make the best use of the resources available to us all.

To deliver our potential to improve public health and well-being and meet the challenges of population demands locally we need to find substitute income to support earlier intervention, diagnosis and prevention and promotion activities. Potential sources of this new income for us are the Better Care Fund to support Public Service transformation in Surrey e.g. our inclusion in the Blue Light initiative, the Better Care Fund and new markets for our existing expertise e.g. IAPT expansion, neurodevelopmental disorders including FASD, to other areas nationally and internationally.

Achieving the required level of income growth will only be possible by creating a culture of innovation and a readiness to explore new ideas, techniques and methods.

1.4 Our competition

A new health and care ecosystem is emerging in the wake of major social and political change. This new landscape includes:

- Major cost pressures for public sector providers;
- Changing consumer demands and needs;
- Development of new technology-based approaches;
- Opportunities to develop new services in new markets;
- Rise of new competitors in the market place.

The key is the fact that the market which was once niche and localised is now opening up to national and international competition. However it should also be noted that such a period of great change brings discontinuity to the market which in turn brings opportunity alongside potential threat.

Our competition is changing as our strategy grows and our intended reach for our services extends beyond our traditional base. Our competitive landscape can be best viewed within the local/national markets and internationally.

Increasingly we are seeking our most significant competition from independent and voluntary sector organisations, plus more active and acquisitive NHS providers, including Foundation Trusts. However our recent experience reflects the reality that our biggest threat is increasingly from consortium bids arising from collaborations between partners drawn across sectors and which combine each of these sectors' individual strengths.

1.5 What happens if we do nothing

The amount of taxpayers' money available to fund public services, including the National Health Service (NHS), is reducing in real terms. We need to deliver more service with less resource. We can do this by working differently and partnering with others whose expertise complements ours. We need to provide services which help prevent people becoming ill to make the best use of the resources available to us all.

In order to sustain our level of income we must find other people who want to buy services from us to substitute the income we will lose from our traditional NHS commissioners.

If we "do nothing" to secure substitute income in this context our income will reduce to c£133m by 2018/19 as a result of year on year efficiency expectations without growth. As a result our organisational will be unsustainable in its current form. A "do nothing" option is not therefore viable.

If we are unable to secure additional substitute income through achievement of our Plans we will need to review our Strategy e.g. look for a different organisational vehicle than that currently offered by NHS FT.

1.6 Our Local Health Economy Partners' Plans

The relative immaturity of commissioning structures and the block contract arrangement for our services currently makes it difficult to analyse fully the intentions for LHE partners over the next five years. However what we know from the intelligence shared to date that we will look to build further on our successes and partnerships to play our part in delivering the health and social care system-wide priorities to tackle their challenges which may be summarised as:

- **reducing avoidable hospital admission and facilitating earlier discharge** – particularly for the physically frail elderly and those with dementia, and the acute care pathway for people with mental ill health to reduce inappropriate A & E attendance for mental health crises
- **earlier intervention and diagnosis** – shifting the focus of our expertise to contribute to earlier interventions and promotion and prevention of ill-health and diagnosis to help increase the length of time people can live well and independently before needing services
- **delegated commissioning (non-prescribed services)** – continuation of delegated responsibility to lead the commissioning of non-prescribed specialist mental health services to ensure people are supported in the least restrictive environment as close to home as possible
- **Better Care Fund integrated system-wide solutions** – contributing our expertise and already formally integrated approaches with social care, voluntary and wider public services e.g. police, as

a platform for new partnerships and pathways to tackle other system priorities e.g. alcohol related admissions, pain management and other long term conditions such as cancer care. This includes Public Sector Transformation in Surrey.

2.0 Risk to sustainability and strategic options

2.1 External Impacts

Our market analysis and context assessment as part of our Strategy development took into account external factors summarised above which we anticipate will impact on the need and demand for our services and how we need to operate to achieve our potential for the people and communities we serve over the next 10 years. They are summarised in the table below:

External Impact	**Priority Actions**
• Increased Competition • Economic climate for public services • Changing Health and Social Care system • Growing population needs and demands • Increased expectations and potential for eHealth	Clear specifications Clear focus on quality experience Capital development – management and alternative funding sources Partnerships and Public Service Transformation Business opportunities focus and practice

2.2 Risks to sustainability

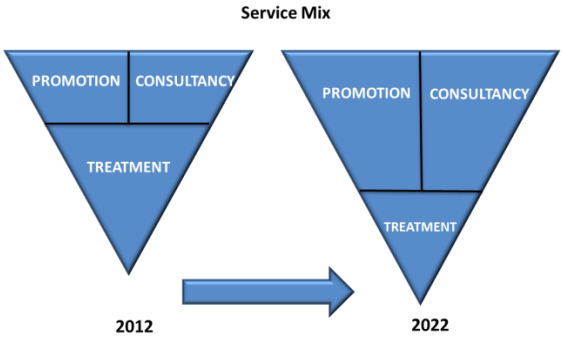
Through our analysis of the external environment and our internal capabilities we have identified the following risks to our sustainability.

- Failure of commissioners to develop strategic intentions for our services
- Failure to engage staff and stakeholders in our transformation programme
- Failure to manage our finances effectively in the economic climate and failure to deliver increases in productivity and efficiency
- Failure to grow our market share and diversify our services to respond to market changes
- Failure to achieve our focus on quality and safety
- Failure to engage and manage our staff effectively
- Failure to work in partnership with health and social care partners, including commissioners, to integrate to make the best use of collective resources available to us
- Failure to improve our reputation

2.3 Our Strategic Options

We have a track record of delivering value for money for local commissioners through transformational change.

Over the next five years we will need to manage the transition for our services, the people who use our services and carers and our staff, as we transform our services into an increasing focus on early intervention, prevention, promotion and diagnosis with inpatient care for short periods when people are most unwell and away from more traditional models of care. This shift is illustrated in below



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We need to provide services which help prevent people becoming ill to make the best use of the resources available to us all.

In order to sustain our level of income we must find other people who want to buy services from us to substitute the income we will lose from our traditional NHS commissioners.

We know we do our best for people, including the wider local health and social care system overall, when we work in partnership with others. We have therefore already begun to consider thoughtfully how we best compete for business development opportunities including through collaboration where we believe we have something to offer. This includes the development of key strategic partnerships and collaborations on product development and specific tender opportunities.

If we are unable to secure additional substitute income through achievement of our Plans we will need to review our Strategy e.g. look for a different organisational vehicle than that currently offered by NHS FT

3.0 Our Strategic Plans

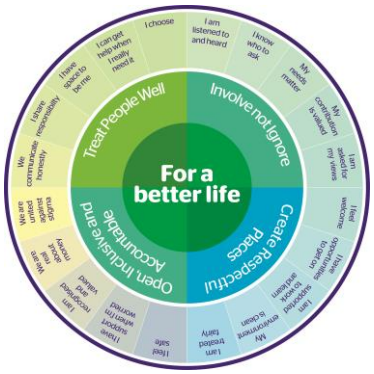
3.1 Our Strategy

Our **core purpose** is:

To work with people and lead communities in improving their mental and physical health and well-being for a better life; through delivering excellent and responsive prevention, diagnosis, early intervention, treatment and care

The services we provide help people to develop, maintain, sustain and recover independence and better lives by helping them to achieve better health and well-being. Our approach is focused on managing factors which build resilience and support health and well-being as well as identifying and managing factors which cause disease.

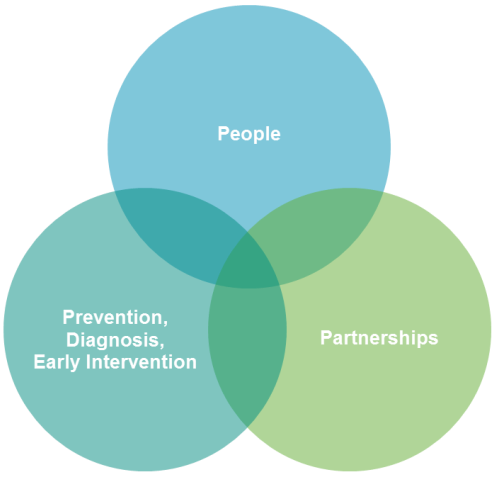
Our **Values** are very important to us. They act as our compass, guiding the way we do things and how we want our relationships with people to be. They are the code by which we behave. We know that if we stick to them they will help us make sure we do the right things.



- Involve not ignore
- Creating respectful places
- Open, inclusive and accountable
- Treat people well

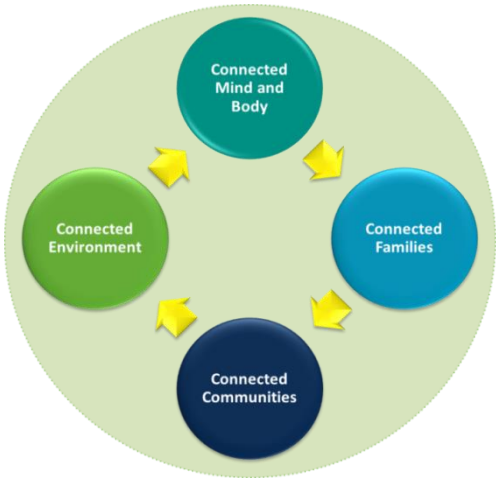
Our belief in equality and human rights is the fundamental pre-requisite for all we do and together with all of our employees we are tasked to conduct business in this spirit.

What is most important to us is people; our staff, the people we serve - people who use services, families and communities. We find our strength in doing all things in partnership with others and what we do well is promotion and prevention, early detection and intervention, consultancy, diagnosis and treatment. We are increasingly shifting to focus on prevention, diagnosis and early intervention.



What we offer

We aim to achieve for people **one plan** of care and support through our partnership working with others. Everything we do aims to keep people connected, so they can live better lives.



Our services will offer:

- Earlier intervention **and** prevention and **health promotion**
- Mind **and** body approach
- **Targeted** expertise
- Training and equipping **others**
- Consultancy and advice, **as well as**, treatment
- **Ready access** to experts when needed

We will serve:

People are looking increasingly for different models of care which fit better with the way they want to live their lives e.g. technology assisted, more control, more choice. We believe our expertise could be of benefit to a wide range of people who currently cannot have access to it. We want to expand our reach to include more people who could benefit from them locally, nationally and internationally.

3.2 Our Service Plan priorities over the next 5 years

Our Strategy drives our Service Plans. The following priorities underpin each of these:

Clinical Strategy – investment in the development of our prevention and early intervention, diagnostic and therapeutic services delivered in the community, supporting more people in out of hospital settings with a continued decrease in our use of inpatient hospital services

Customer Quality - The improvement in the quality (safety, effectiveness, experience and value for money) we offer to people with a particular emphasis on responding quickly to people's feedback on how we are doing and putting things right when they fall short of the standards we expect

Workforce – continuing to enhance our culture, leadership, membership and equality, ensuring the consistent availability of excellent staff, developing the flexibility we can offer staff, recruiting and developing good staff and planning our workforce and their support to meet the needs for the future.

Information and Communications Technology – transforming our services and the way we contribute our expertise to people's recovery and the wider system through innovation and enhancing our technical capability to support the frontline

Property – investing to ensure all our environments are therapeutic and well maintained and disposing of facilities that do not work well for people to reduce our overall footprint and make sure they provide environments we would be happy for our families and friends to be treated within

In the light of the above analysis we have identified the following priority plans for implementing our Strategy and enabling strategies over the next five years across our service lines and enabling programmes:

Our priority Service Plans for the implementation of our clinical strategy each year over the next 5 years are summarised below:

Clinical Strategy – implementation through Innovation and transformation

- **Mental Health Services for Adults of Working Age** - IAPT and Acute Care Pathway (urgent/unplanned care)
- **Mental Health Services for Older People -** Dementia Care Acute Care Pathway, Functional Acute Care Pathway and Dementia diagnosis, prevention and early intervention
- **Services for People with Learning Disabilities -** Supported Living (Loddon Alliance), Neurodevelopmental disorders, Short Breaks & Day Care and Low Secure in Partnership
- **Services for Children and Young People -** Early Intervention, CAMHS, TaMHS and Complex needs (e.g. HOPE, consultation)
- **Specialist Services -** Forensic and Prisons, Courts and Custody, Drug and Alcohol addictions and Liaison

The achievement of these Service Plan priorities isdependent on the implementation of the following key programmes over the same time period:

- **Customer Quality** – our Quality Improvement Plan and systematic, rigorous use of data
- **Workforce** – Leadership and skills to deliver new innovative models including use of technology

- **Property and IT** - Community hubs (including mobile working) and enhancement of our Inpatient facilities across Surrey in particular and innovative e-Health solutions and post 2014 clinical information system
- **Commercial** – establishment of our Wholly Owned Subsidiary and development of our business development and innovation capacity and capability

Our ability to deliver across all these will be underpinned by the continued development of our **Partnerships** across the independent, voluntary and statutory sectors.

3.3 Communication Plan

Our key stakeholders in making these changes are:

- People who use our services and carers and families and the public
- Staff
- Governors
- Regulators
- Commissioners, including Local Authorities
- Our Partner Providers and Innovation Partners

3.4 Strategy into Action - Monitoring Performance against our Strategic Plan

Our annual planning cycle engages the Board and our Council of Governors and operational divisions in refreshing and refining our Plans each year within our Strategic context each year. Our quarterly performance reporting regime to Monitor monitors delivery against the in-year Plan.

3.5 Our Financial Plan Headlines

3.5.1 Future income projections

In order to sustain our level of income we must find other people who want to buy services from us to substitute the income we will lose from our traditional NHS commissioners. As 'tax funded income' levels fall as a result of the national economic position, our sustainable financial viability will have to be achieved through:

- Generation of new income (from new customers and/or for new services).
- The reduction of current expenditure levels.

The key priorities shaping our Financial Plan over the next five years are:-

- The maintenance of existing business and income in services identified as of strategic importance
- The delivery of:
    - A gross £40m income growth target over the next five years of the Plan
    - The delivery of over £23 million Cost Improvement Plans in 5 years
    - The required recurrent Cost Improvements Programmes (CIPs) in Operational and Corporate services to ensure medium to long-term transformation of services and the delivery of year on year productivity improvements
- The redevelopment of Farnham Road Hospital site within the costs identified within the Full Business Case and finalising our inpatient facilities offer across the rest of Surrey
- The management of our capital plan prioritise essential expenditure over developmental priorities and deliver our disposals programme
- The management of risks to the financial plan through downside planning and mitigations
- The implementation of a commercial model to ensure all services remain financially sustainable while contributing to our strategic objectives