

# **OPERATIONAL PLAN**

**2016/17**

**Monitor Submission 15<sup>th</sup> April 2016**

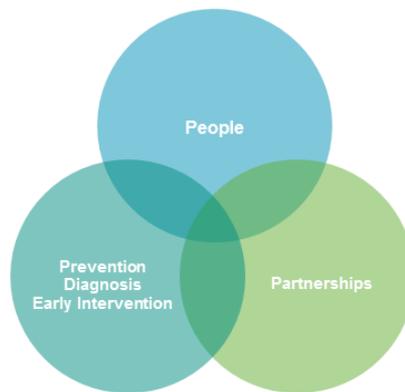
# OUR PLAN 2016/17

## 1.0 Introduction

We are entering our 9<sup>th</sup> year as a NHS Foundation Trust. Our Strategy was reviewed and refreshed in summer 2015 by the Board. Each year our annual Operational and Strategic Plans set out how we will implement our Strategy over the next 1 – 5 years.

### 1.1 Our Strategy

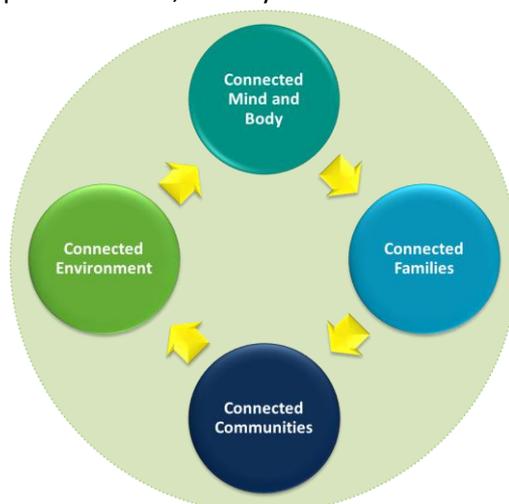
What is most important to us is people; the people we serve - **people** who use services, families and communities. We find our strength in doing all things in **partnership** with others and what we do well is **promotion and prevention, early detection and intervention, consultancy, diagnosis and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



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***

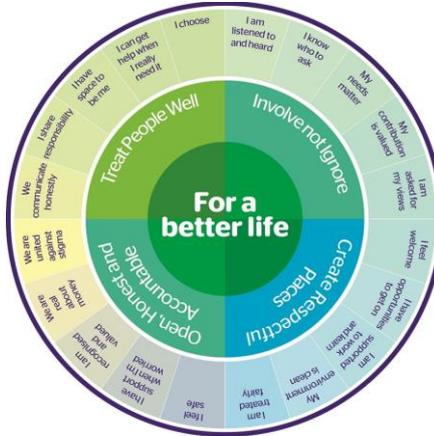
We aim to achieve for people **one plan** of care and support through our partnership working with others. Everything we do aims to keep people connected, so they can live better lives.



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Our approach is to collaborate both formally and informally. We work hard and aspire to create efficient and integrated mind and body care networks with our partners that are tailored to both the health and social needs of the people and communities we serve.

Our values compass describes what people told us they want from us and how we want people to experience us.



### 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.

Our Strategy drives our Service Plans and is underpinned by our enabling strategies and milestones:

**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, owning up 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, retaining and developing good staff and planning our workforce and their support to meet the needs for the future including driving increased productivity and effectiveness.

**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

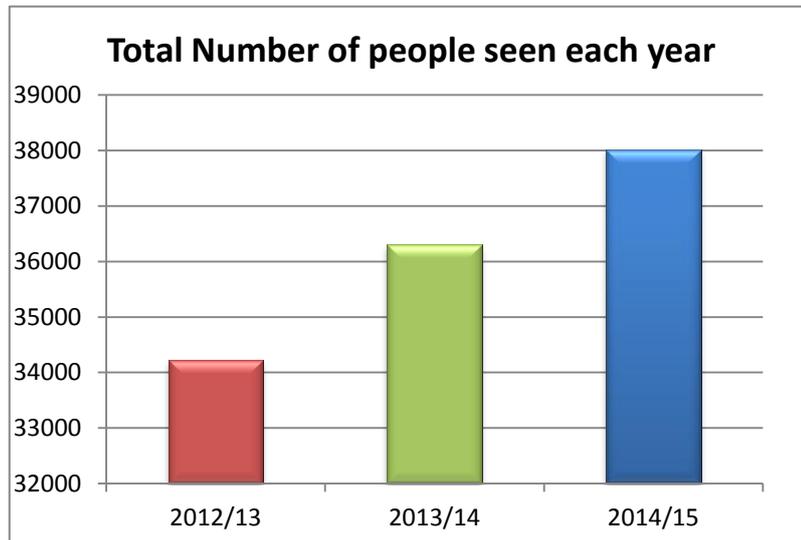
**Property** – investing to ensure all our environments are therapeutic and well maintained and provide environments we would be happy for our families and friends to be treated within; including integrating our space requirements with those of our partners to enable our teams to work alongside one another

**Innovation and Development** – sustaining our level of income and making the best use of the resources available to us all by working differently and partnering with others whose expertise complements ours

## 2.0 Our Approach to Activity Planning

### 2.1 Our Activity Plan (demand and capacity)

We continue to deliver our clinical strategy to see more people year on year. We are ambitious to reach as many people as we can with the resources we have available to us.



Over the past three years, you can see that we have increased the number of people that we have seen by 11% overall since 2012/13 to reach 38,022 people in 2014/15. In 2015/16 though the full year numbers are not yet available we believe that the number of people seen would have been consistent with previous year trends. We expect this trend to continue in 2016/17 as we further implement our strategy to move increasingly to new ways of working with partners and move to earlier intervention, prevention and diagnosis across our services.

Over the same period our bed profile has been reducing as we consolidate services and reduce demand for inpatient care through developing alternative models of care; from a total of 543 beds in 2009/10 to 251 by the end of 2015/16 across our portfolio. We do not anticipate any further significant bed reductions in 2016/17.

In 2015 we jointly commissioned a demand and capacity analysis by Mental Health Strategies with our CCGs to support our 24/7 Review into our future hospital facilities requirement. This considered likely future demand for inpatient care e.g. taking into demographic changes and planned and potential new models of working. This suggests a further consolidation of our mental health hospital sites (from 3 to 2 subject to consultation and engagement planned for in 2016) and maintenance of our current overall bed numbers with investment in complementary service model changes some of which are already planned and in train and others which are in line with commissioning intentions. These include:

- Implementation of safe haven (joint with CCG)

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- Single Point of Access (joint with CCG)
- Implementing Personality Disorder Strategy
- Acute Care Project Model Implementation
- Developing Home Treatment Team (Intensive Support Team) for Older People
- Audit of Long Stayers in Inpatient Wards (joint with CCG)

### 2.2 Planning assumptions and growth rates

Our activity assumptions for 2016/17 form part of our contract negotiations with our health commissioners. They focus on the following:

- Parity of esteem in line with national expectations and guidance
- How any additional demand will be recognised and managed
- The approach to meeting new targets e.g. IAPT
- The nature and scope of QIPP initiatives
- Local response to the new contracting framework, Mental Health Taskforce, Sustainable Transformation Footprint plans and new ways of working e.g. Vanguards and ICOs, partnerships with voluntary sector.

Our commissioning discussions have identified the following assumptions which we have reflected in our draft activity plan:

- Reduced growth in activity but a focussed impact associated with new MH targets e.g. EliP, IAPT and local commissioning intentions, in particular early onset dementia. The financial impact of this is subject to our contract negotiations.
- Increase in CAMHs activity associated with the mobilisation of our new model of care
- Reflection of investment in our Eating Disorders service (Transformation Fund)
- Reduction in our supported living (social care) for people with learning disabilities (Loddon Alliance)

## 3.0 Approach to Quality Planning

### 3.1 Overview

Our ambition is to demonstrate excellence everywhere. We want people who use our services and their families to be delighted about their experience. We want staff to be highly satisfied and recommend us as the employer of choice and we want to have an exemplary safety record.



Our Quality House provides our framework. The metrics for each pillar are constructed to provide incremental continuous quality improvements that over time actualise our Values and Quality Ambitions:

- **Experience** – to provide the best reported experience for people who use our services, their carers and families and staff
- **Effectiveness** – for people to have outstanding care plans that they were involved in writing and who have a recognised and accessible copy
- **Safety** – to provide the safest care, treatment and support for people
- **Value for money** - to offer good value for money for the taxpayer

#### 3.1.1 Care Quality Commission

We have now delivered 100% of the actions for our healthcare services following the CQC's inspection of our services in July 2014 (as part of their pilot) from which we received no enforcement notices; sustaining and embedding actions is our challenge. We were re-inspected by the CQC week commencing 29<sup>th</sup> February 2016.

Our social care services new regime inspections have flagged a number of concerns for us for some of our homes. We were issued with a Warning Notice (s29a) for our Ashmount services for people with learning disabilities in August 2015. Our action plan was submitted on 13<sup>th</sup> November in response to the Ashmount report. Many of these actions were already complete. The warning notice remains in place and will not be removed until a follow up inspection is completed. This inspection took place on 30<sup>th</sup> March. No significant issues have been escalated to date. We await the draft report. Action plans are being progressed and a Circle of Support is operating to share learning and improvement across our social care services. To help support this we are having an observational focus to ensure they are caring, safe and effective. We also commissioned an external expert review of our residential social care homes. This has been completed and actions proposed are being taken forward as part of our Plan.

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### 3.1.2 Monitor

We have maintained a GREEN Governance rating and achieved a COSRR 4 for Quarter 4.

### 3.1.3 Well-Led Independence Governance Review 2015

We commissioned PWC to return to us in Dec-Feb 2016 to review our progress against their 16 recommendations (3 high priority) in March 2015. That review rated us as Green (4) and Amber-Green (6) across the 10 domains. As a result of their Review PWC have commented positively on our progress and improved our rating to Green (9) and Amber-Green (1). They have made some further recommendations of how we can further improve our practice and we will now consider and develop an action plan to implement these.

## 3.2 Approach to Quality Improvement

Our Quality Improvement Plan is reported through our Quality Account and led by our Director of Quality/Deputy Chief Executive (Nurse Director). It provides a road map to enable Divisions, services, teams and individuals to develop their own Quality House to set out their local quality improvement plans that contribute to achieving our high level priorities. Quality improvement and learning is sustained and protected by assurance and good governance. Through a systematic approach of gathering evidence and data, not just description, we assure ourselves that we are all focused on the same things through a two way process from front line services to our Trust Board and back.



We have a range of tools and techniques which we use to deliver quality improvement checks and quality assurance. We also look to share lessons learnt from complaints and serious incidents through: Clinical risk alerts, Reflective practice, Quality Assurance Groups, Complaints reports, Lessons learnt sessions led by the clinical risk and safety team, Lessons learnt papers issued by the clinical risk and safety team and Service improvement programme sessions.

### 3.2.1 Clinical Quality Priorities Indicators for 2016/17

Whilst usually incremental we are aiming to make a step change in the following priorities in 2016/17- carer's satisfaction; people's involvement; 'one person one plan'; accessible information; our Safe CARE outcomes. Our **Clinical Quality Priority Indicators** for 2016/17 are:

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<b>Experience</b>	
<b>1. For people who use services</b>	To retain the percentage of people, reported through Your Views Matter, who are satisfied with the services they received?
<b>2. For people who are carers</b>	To retain the percentage of carers, reported through Your Views Matter, who are satisfied with the services they received?
<b>3. For people who are carers</b>	To ensure that at least 60% of people identified as carers have had or been offered a carer's assessment.
<b>4. For our staff</b>	To have a response rate of 80% to the national staff survey
<b>5. For our staff</b>	To improve our staff satisfaction/engagement rating
<b>Effectiveness</b>	
<b>6. Involvement in your care plan</b>	To improve the percentage of people who in 'Your Views Matter' question: "Do you think your views were taken into account when planning your care?"
<b>7. One person one plan</b>	To establish a baseline of the numbers of people who are supported by more than one team from different divisions and who have "one [care] plan"
<b>8. Connected body and mind (Physical Health)</b>	People who are receiving services (not including assessment services) will have a physical health check within 3 months of assessment
<b>9. Connected Communities (Equality)</b>	Each division and corporate service has a targeted plan to improve their information to ensure it is in accessible formats for people who use services
<b>Safety</b>	
<b>10. Safe CARE</b>	To demonstrate we have fewer people who are harmed year on year by Falls, suicide, AWOLs and face down restraint and when benchmarked against national data (if available) be better than mean performance
<b>11. Serious Incidents</b>	Reduce the number of Serious Incidents reported where severe or extreme harm resulted from 2012 - 2013 totals of 70.
<b>12. Abuse of staff</b>	To reduce the number of incidents of abuse (including discriminatory abuse) experienced by staff in the workplace

Our Clinical Quality Priorities Indicators for each of these are an integral part of our Key Performance Indicators (KPIs).

### 3.2.2 Risks to Quality 2016/17

Potential Risks and our planned mitigations are identified in Appendix 2. Our current top three risks to quality are highlighted in red.

### 3.3 Seven Day Services

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We are contributing to the development of seven-day working through our system-wide working on public sector transformation and new models of care. In particular the following service plans which are already being delivered and will continue to be a focus in 2016/17

- Implementation of the Crisis Care pathway (with partners e.g. Surrey County Council, Surrey Police, SECAmb, NHS111 and CCGs) which includes - Safe Haven roll out completion, Single Point of Access development (urgent care - Working Age Adult -WAA) and Emergency Duty Team (EDT) development
- North East Hampshire and Farnham system Vanguard
- Integrated Care Organisations (ICO) delivery - Surrey Heath, Surrey Downs and North West Surrey to date
- Mobilisation of our new CAMHS model with partners - including co-designed extended hours

We are also keen to work with commissioning and acute colleagues to enhance psychiatric liaison services to achieve 24/7 coverage across all acute hospitals in our area.

### 3.4 Quality Impact Assessment process

We use a Programme Office Approach template to support our development of CIP projects and to monitor their delivery. Within this framework, individual Directorates and Divisions develop individual schemes, ensuring that clinicians have been closely involved as members of the multi-disciplinary directorate team. A quality assurance checklist is completed for each plan and these are reviewed and signed off by the Director of Quality / Deputy Chief Executive (Nurse Director) and Medical Director(s).

Cost Improvement Programmes requiring significant change are subject to engagement and consultation (as necessary) with those directly affected including people who use services, carers and staff, and their representatives; or business case processes. They are also supported by Equality Analysis. Each of these significant consultation and business cases is signed off individually by the Executive Board before they proceed. The planning and phasing of the overall Financial Plan is reviewed and delivery is monitored by the Chief Finance Officer and reported through to the Executive and Trust Boards.

### 3.5 Triangulation of Indicators

Our Quality House provides our framework for triangulating data. Our Key Performance Indicators (KPIs) have been developed through discussions between the Board and Council of Governors. They use the framework of our Quality House pillars and focus on those areas of performance where we know we must succeed to deliver our Strategy and realise our potential for the people we serve. They are used by the Executive (monthly), Board and Council (each time they meet) to monitor our performance throughout the year. Our indicators for 2016/17 are provided in [Appendix 1](#).

In addition we use the following: our weekly Safety Huddle reviews our top risks recorded on our risk register (DATIX); our Surge and Escalation system provides daily sitreps (hospital services) to help us with our early warning

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and response to emerging high risks such as bed shortages and staffing; our early warning indicators are identified and reviewed monthly by the Quality Directorate and trigger consideration for a Circle of Support.

Since the publication of the Mazars report into the sad events at Southern Heath (December 2015) we have been reviewing how we scrutinise, investigate and report on the deaths of people who are using our services. Feedback during our CQC inspection has also informed the development of our new approach. We have made the following changes: developed a new way of recording people's death on our clinical and risk systems, introduced a new weekly review led by the Co-Medical Director to support decision making on investigating the deaths of more people, agreed we will investigate all deaths of a person with a learning disability, created a new Mortality Surveillance Group and changed our reporting to the Board (from March 2016).

## 4.0 Our Approach to Workforce Planning

### 4.1 Our Workforce Strategy

Our Workforce Strategy is focused on continuing to enhance our culture, leadership, membership and equality, ensuring the consistent availability of excellent staff, developing the flexibility we can offer staff, recruiting, retaining and developing good staff and planning our workforce and their support to meet the needs for the future including driving increased productivity and effectiveness. It is shaped by the following key themes:

#### Key Themes

- Improve staff experience
- More community less secondary
- More partnership working
- Early intervention
- More family designed services
- Consultants and experts within a care pathway
- Less site based more remote working
- More personalised care less group provision
- New markets include private and international opportunities

It is an enabler of our clinical strategy which requires a new range of skills and technical competencies within our workforce and new diagnostic capability leading to the consideration of new roles. Our partnership models of delivery will mean less health care support staff directly employed by us.

This year we have deployed over 2,000 health and social work staff (including 200 social work/care staff assigned from Surrey and Hampshire County Council) to provide increased integrated, expert and consultancy services.

### 4.2 Impact on Workforce profile

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Overall our Strategy will lead to a reshaping of the workforce with different and less expensive employees allowing for a decrease of 82wte over next year across our current portfolio. 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 for people. This is shown in the table below:

		WTE
2015/16	Substantive people in post	2190
	Vacancies	515
	Total Funded WTEs	2705
2016/17	Total Funded WTEs	2623
	Decrease in WTEs	82

To support this, our integrated education and development strategy and function has commissioned additional places through our arrangements, with the LETB, to ensure our workforce supply needs are met.

### 4.3 Key Workforce Programmes

The following workforce programmes are being taken forward to support workforce change in 2016/17:

- **CARE<sup>+</sup> - Culture, Leadership and Morale** – including our **CARE<sup>+</sup>** movement, designed by our staff, to help staff teams do the right thing every time, Changing Futures programme, our Leadership work including talent and succession planning, new appraisal co-design and staff survey action plans
- **Workforce Planning** – using our Leadership Definition work, our learning and development programmes to support care pathway skills development e.g. early intervention and detection, acute care pathway, people with personality disorder, body and mind, early detection and intervention and including our partnership with Surrey University and health partners to develop a medical school proposal
- **Recruitment and retention** – focusing on recruiting to our vacancies, (building on our assessment centres for selection), planning for our potentially high retirement levels, retaining good staff and flexible contracts – within national frameworks
- **Reducing temporary workforce** - where target reductions (in line with cap) are not yet achieved and further reductions in line with national expectations

Our workforce plan over the next 5 years will need to invest in the following key priorities:-

- Reducing our vacancy percentage of 18% - by retaining staff and recruiting more quickly into vacancies and reducing our reliance on bank and agency staff
- Increasing our WTEs for areas of business development e.g. Surrey CAMHS, Surrey IAPT (therapists) and Safe Haven (nurses)
- Making sure our systems support managers to manage their workforce well

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- Investing in support, through our productivity programme, to help staff identify where they could gain back time to focus on what is important by stopping waste and duplication
- Invest in the leadership capacity and capability to support the transformational change and mobilisation requirements for services and staff
- Invest in the leadership capacity and capability to ensure focus on quality improvement

### 4.4 Quality Assurance and Monitoring

Our priority Workforce Indicators are included within our Key Performance Indicators (KPIs) and monitored by the Executive, Board and Council. All workforce CIPS are subject to our quality assurance process and data triangulation outlined in Sections 3.4 and 3.5 of this Plan.

## 5.0 Our Approach to Financial Planning

Our financial focus will continue to be on long term financial sustainability rather than simply the delivery of short term targets.

### The key assumptions underpinning our Plan currently are:

- Pay inflation of 2.2% for 2016/17 and 1% for the next 4 years;
- NHS inflation of 1% reflecting the cost of drugs and medical equipment;
- Efficiency and productivity requirement of 3% in 2016/17 and 3% or 4% thereafter
- Investment from our commissioners in line with parity of esteem

Our final settlement has been dependent upon the following:

- Impact of the Autumn Statement on NHS allocations, along with commissioning items within the national planning guidance which was released in December.
- Outcome of our contract negotiations with our commissioners. In particular Surrey Downs where our negotiations have concluded on their proposed QIPP, now set at a £275k reduction in our contract value for their population.
- Agreement with commissioners for new income as a result of parity of esteem, new ways of system working and innovation.

**To optimise the potential of 2016/17 - 2017/18 to make the stepped change in our Strategy implementation it is proposed that the key priorities shaping our Financial Plan for the next 1 – 5 years are:-**

- £0.1m target surplus in 2016/17
- Maintenance of a contingency in 16/17
- Development of a project development fund to support internal business cases for productivity improvement or strategic change programmes

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- Investment in transformation programmes to support productivity and strategic change
- The management of our capital plan to:
  - prioritise essential expenditure over developmental priorities
  - deliver funding to support the investment needed in our inpatient facilities to achieve an equivalent high quality environment as that at the new Farnham Road Hospital
  - deliver our disposals programme
- Success in contract negotiations for growth and parity of esteem
- Continuity of Service Risk Rating of 4 is likely to be sustained

The headlines of the proposed Financial Plan are provided in the tables which follow.

### 5.1 Income and Expenditure

Income & Expenditure (£000's)	FOT 2015/16	Projected				
		2016/17	2017/18	2018/19	2019/20	2020/21
Income	149,766	158,733	165,082	171,686	178,553	185,695
Pay	(109,924)	(111,728)	(116,932)	(123,224)	(130,050)	(136,946)
Non Pay & Contingency	(31,883)	(37,553)	(37,854)	(37,778)	(37,703)	(38,004)
<b>EBITDA</b>	<b>7,959</b>	<b>9,452</b>	<b>10,297</b>	<b>10,684</b>	<b>10,801</b>	<b>10,745</b>
Depreciation & Capital Charges	(7,803)	(9,237)	(9,152)	(8,939)	(9,056)	(9,000)
Other Financing Costs	(90)	(115)	(145)	(145)	(145)	(145)
<b>Surplus / (Deficit) before Exceptional Items</b>	<b>67</b>	<b>100</b>	<b>1,000</b>	<b>1,600</b>	<b>1,600</b>	<b>1,600</b>
Profit on Disposal	1,008	2,641	0	0	0	0
Impairment	(7,971)	0	0	0	0	0
<b>Surplus / (Deficit) after Exceptional Items</b>	<b>(6,896)</b>	<b>2,741</b>	<b>1,000</b>	<b>1,600</b>	<b>1,600</b>	<b>1,600</b>

### 5.2 Income Growth

The current baseline proposes a gross £27m increase in income over the next five years. This is subject to ongoing Board consideration of reasonable judgements and assumptions which take into account our strategy implementation, new ways of working and implementing the Five Year Forward View (5YFV) and our innovation and development.

### 5.3 Cost Improvement Plans

CIP Target	16/17	17/18	18/19	19/20	20/21	Total
	£'000	£'000	£'000	£'000	£'000	£ '000
Productivity CIPs						

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Community Hubs	0	tbc	tbc	tbc	tbc	0
IT Transformation – iCARE	0	1,300	975	238	0	2,513
24/7 programme	tbc	tbc	tbc	tbc	tbc	0
<b>Trust Wide Transformational CIPs</b>						
Service Redesign	532	200	tbc	tbc	tbc	616
Workforce Redesign	1,648	1,000	tbc	tbc	tbc	2,893
Temporary Staffing	300	200	100	0	0	600
<b>Divisional CIPs</b>	<b>1,948</b>	<b>2,148</b>	<b>5,475</b>	<b>6,336</b>	<b>4,951</b>	<b>21,028</b>
<b>Total CIP Target</b>	<b>4,428</b>	<b>4,848</b>	<b>6,550</b>	<b>6,574</b>	<b>4,951</b>	<b>27,651</b>

#### The key features of the Cost Improvement Programmes over the next 1-5 years will be

- Implementation of our strategy to move to earlier intervention in partnership
- Trustwide focus on workforce redesign to deliver new ways of working
- Trustwide focus on temporary staffing expenditure reductions and rigorous establishment management in those where target reductions (in line with cap) are not yet achieved and further reductions in line with national expectations
- Investment in transformation programmes to support productivity and strategic change - including explicit efficiency expectations on all priority transformation projects – notably 24/7 programme, iCARE, community hubs and acute care pathway

#### 5.4 Capital Plan

Capital Plan	2016/17	2017/18	2018/19	2019/20	2020/21	Total
	<b>Plan</b>	<b>Plan</b>	<b>Plan</b>	<b>Plan</b>	<b>Plan</b>	<b>Plan</b>
	<b>£m</b>	<b>£m</b>	<b>£m</b>	<b>£m</b>	<b>£m</b>	<b>£m</b>
Development	11.8	7.7	1.8	2.7	2.7	26.7
Maintenance	4.2	3.2	3.2	3.3	3.3	17.1
Other	0.0	0.0	0.0	0.0	0.0	0.0
Disposals	7.9	3.3	8.2	2.9	0.0	22.3

Our capital plan over the next 1-5 years will need to invest in the following key priorities:-

- Creation our community hubs
- Implementation of recommendations from the 24/7 Review North West and East and Mid Surrey (Hospital Facilities) and investment in our current facilities to improve environments pending this development

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- Further Investment in technology – the development of an infrastructure to support mobile working and telehealth
- Continued investment in maintaining the quality of our environments and updating our ICT infrastructure and equipment

It currently does not identify the capital and revenue costs we will need to support the outcome of our 24/7 Review of our hospital facilities for North West, East and Mid Surrey. Developing our funding options for this will be considered through the Strategic Outline Case (SOC) we will be developing during 2016/17. This will clearly have a significant impact.

### **5.5 Continuity of Services Risk Ratings (COSRR)**

We aim to maintain a CoSRR of 4 for 2016/17 - 2020/21.

## **6.0 Link to the Emerging “Sustainability and Transformation Plan (STP)”**

### **6.1 Sustainability and Transformation Plan Footprints**

We will be part of the following Sustainability and Transformation Plan footprints:

1. Surrey Heartlands STP including Surrey CC, G&W, NW Surrey and Surrey Downs.
2. Frimley STP including all the Vanguard partners in North East Hampshire and Farnham plus those in Berkshire
3. Sussex STP including the East Surrey CCG with the other Sussex local authority and CCG partners.

### **6.2 Key Features influencing the STP**

The key features of the current external and internal environment influencing the refresh of our Plan and which we expect to influence the STP for the next 1-5 years are summarised below:-

### **6.3 National and Policy context**

- Collaboration and Competition
- Economic climate for public services
- Evolving health and social care system – Five Year Forward View and political climate
- Growing population needs and demands
- Increased expectations and technological potential
- Devolution
- Early Intervention and Children and Young People

### **6.4 Local External Environment**

- Deficits

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- Vanguard and Follow On Vanguard
- Integrated Care Organisations
- Mergers & Acquisitions
- Devolution

And more specifically:-

- Public Sector Transformation – e.g. Crisis Concordat
- Mental Health and Well Being Strategy
- CCG Collaborative commissioning intentions
  - Crisis concordat – crisis pathway, enhanced Home Treatment Team, potential for realignment of resource from beds to fund
  - Single point of access and CAMHS “One Stop”
  - Integrated Care Organisations - Integration of MH into primary care integrated hubs
  - Adult neurodevelopmental service
  - Young onset/ “ageless” dementia care pathway development
  - People with Learning Disabilities – decommissioning of Bramdean and development of our intensive support team
  - Delegated commissioning
  - Parity of esteem
  - New Mental Health Contract - moving towards capitation budgets (whole population budgets)
  - New Mental Health targets - e.g. EIIP and IAPT
  - Local responses to psychiatric liaison development and specialist commissioning redesign
- Sustainable Transformation footprint plans

### 6.5 Our Service Plans

To deliver our system contribution to [close the health and well-being gap](#), [close the care gap](#) and [close the finance and efficiency gap](#) over the next 1 - 5 years our focus will be on our:

- Citizen-led design
- Family focus
- Partnerships & System working
- Innovation
- Productivity

Our key service plans will be to implement the:

- North East Hampshire and Farnham system Vanguard
- Integrated Care Organisations

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- Crisis Care pathway including Single Point of Access, Acute Care Pathway and Safe Havens
- Internet of Things Test Bed collaboration
- 24/7 review – NW, E & Mid Hospital facilities
- CAMHS new model mobilisation
- Older people's services pathways including development of our Intensive Support Team
- Community Hubs
- Residential social care for People with learning disabilities strategic review implementation

Development of our Intensive Support Team for people with learning disabilities - further reducing our number of beds for people with learning disabilities

## **7.0 Membership and Elections**

### **7.1 Our Council of Governors Current Status and Elections**

Our Council currently has no vacancies (as at 31<sup>st</sup> January 2016). We have held one by-election during 2015/16 to fill our Staff Governor - Administration, Facilities and Managerial seat; our new Governor joined us following a contested election in December 2015. The majority of our Governors' 3 year Terms of Office will expire on 30<sup>th</sup> April 2017. Some Governors will not be eligible for re-election at this time due to reaching their 9 year maximum. Our campaign to attract new members to the role will commence during 2016/17.

### **7.2 Governor Training and Development**

The following training and development for Governors has been delivered since 1<sup>st</sup> April 2015:-

- Refresher / Update module delivered x2 sessions
- Induction - Understanding Foundation Trusts & Understanding our Performance modules + Individual
- Joint Board and Governor development - summer away day; bespoke GovernWell Effective Questioning
- External courses attended by some Governors - NHS Providers Governor Focus Conference; GovernWell Membership module; GovernWell Accountability module.

The programme will be repeated next year following positive feedback.

### **7.3 Membership Recruitment**

Our strategy is to achieve a targeted, active and involved membership of 7,000 by March 2017. Our current membership is 6139 (public, people who use our services, carers and families). Currently females and those whose race is not white British are over-represented when compared with the population of Surrey. We have

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delivered a diverse range of membership engagement and recruitment events across our catchment area over the last 12 months. Some examples include:-

- Community events e.g. 16 May: Get Moving, Walk 4 Life 2015, Ewell, 10 October: Farnham Road Hospital Community Open Day, FoCUS area groups
- Partner events e.g. 25 June: Surrey Independent Living Fayre, 9am-7pm, Epsom Race Course, Epsom
- Member events e.g. 7 July: Mental Health Matters, 10am-1pm, Princes Hall, Aldershot; 30 September: SABP Member's Day, Reigate Hill Golf Club; 9 November: Young People's Mental Health, Redhill; 28 January: Supporting Carers, Ebbisham Centre, Epsom

A similarly diverse programme is being developed currently for the coming 12 months, informed by feedback from events (our most popular event in Aldershot was attended by 82 people) but with a focus on those communities newer to our services who are not yet well represented e.g. our communities in Hounslow and Brighton.

## KEY PERFORMANCE INDICATORS 2016/17

QIP	KPI Number	Ambition	Target
EXPERIENCE	KPI 1	To retain the percentage of people, reported through Your Views Matter, who are satisfied with the services they received? (where 10 is extremely satisfied and 0 is not at all satisfied, we will include all people who scored 10,9 or 8)	< 55% Inadequate ≥55% Requires improvement ≥ 70% Good ≥ 85% Outstanding
	KPI 2	To retain the percentage of carers, reported through Your Views Matter, who are satisfied with the services they received? (where 10 is extremely satisfied and 0 is not at all satisfied, we will include all people who scored 10, 9 or 8)	< 55% Inadequate ≥55% Requires improvement ≥ 70% Good ≥ 85% Outstanding
	KPI 3	To ensure that at least 60% of people identified as carers have had, or have been offered, a carers' assessment	< 30% Inadequate ≥ 30% Requires improvement ≥ 60% Good Outstanding: TBC
	KPI 4	Percentage of staff with an up-to-date appraisal.	< 75% Inadequate ≥75% Requires improvement ≥ 85% Good ≥ 93% Outstanding
	KPI 5	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.	Inadequate: TBC Requires improvement: TBC Good: ≥ 50% Outstanding: TBC
	KPI 6	Improving Access to Psychological Therapies: People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral.	Inadequate: TBC Requires improvement: TBC Good: ≥ 75% Outstanding: TBC
	KPI 7	Improving Access to Psychological Therapies: People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	Inadequate: TBC Requires improvement: TBC Good: ≥ 95% Outstanding: TBC
EFFECTIVENESS	KPI 8	To improve the percentage of people, reported through Your Views Matter, who said they were involved in planning their care.	< 50% Inadequate ≥ 50% Requires improvement ≥ 66% Good ≥ 85% Outstanding
	KPI 9	To establish a baseline of the numbers of people who are supported by more than one team from different divisions and who have "one [care] plan"	Green / Red
	KPI 10	People who are receiving services will have a physical health check within 3 months of assessment.	< 40% Inadequate ≥ 40% Requires improvement ≥ 60% Good ≥ 75% Outstanding
	KPI 11	Each Division and corporate service has a targeted plan to improve information to ensure that it is in formats that are accessible for people who use services.	Deliver against agreed milestones
	KPI 12	Support our adherence to the Equality Act 2010 by improving the data collection of the protected characteristics of people who use our services.	< 40% Inadequate ≥ 40% Requires improvement ≥ 80% Good ≥ 90% Outstanding
	KPI 13	To reduce the duration of untreated psychosis of people entering our Early Intervention programme for first time.	To achieve a DUP median of under 90 days for people who use services > 120 days Inadequate > 90 days Requires improvement ≤ 90 days Good ≤ 30 days Outstanding
S A F E	KPI 14	Through the Safe Care programme demonstrate we are the safest, in	<-5% reduction : Inadequate

QIP	KPI Number	Ambition	Target
		relation to suicide prevention, AWOL, face down restraint and self-harm benchmarked against other mental health organisations.	0% reduction : Requires improvement > = 10% reduction : Good > 20% reduction : Outstanding
	KPI 15	To increase the numbers of incidents reported and reduce the number of patient safety incidents resulting in severe harm or death from the number in 2012/13.	No of monthly cumulative SIs where severe or extreme harm resulted is less than 70 at year end, including SIs where a fractured neck of femur resulted.
	KPI 16	To reduce the number of incidents of abuse (including discriminatory abuse) experienced by staff in the workplace	Decrease of > 5% = Inadequate Decrease of 1%-5% = Requires improvement Increase of 0%-5% = Good Increase of >5% = Outstanding
	KPI 17	Achieve an outstanding level of compliance of staff being up to date with their statutory training	< 80% Inadequate ≥ 80% Requires improvement ≥ 90% Good ≥ 95% Outstanding
	KPI 18	Achieve a good level of compliance of staff being up to date with their mandatory training	< 80% Inadequate ≥ 80% Requires improvement ≥ 90% Good ≥ 95% Outstanding
	KPI 19	Good retention of staff	Inadequate = Below current status Requires improvement = Current status Good = National benchmark Outstanding = Above national benchmark
VALUE FOR MONEY	KPI 20	To reduce agency spend as a % of total pay bill	> 12% Inadequate ≤12% Requires improvement ≤10% Good < 8% Outstanding
	KPI 21	Continuity of Service	1 Inadequate 2 Requires improvement 3 Good 4 Outstanding
STAFF SURVEY - ANNUAL	KPI 20	To have a response rate of 80% to the national staff survey	< 50% Inadequate: > 50% Requires improvement: > 60% Good > 80% Outstanding =
	KPI 21	To improve our staff satisfaction / Engagement rating	< 3 Inadequate: ≥ 3 Requires improvement: ≥ 3.81 Good ≥3.93 Outstanding

## RISKS TO ACHIEVEMENT OF PLAN (STRATEGIC OBJECTIVES) - 2016/17 Top Risks highlighted in Red

Category of Risks	Description of risk (including timing)	Potential impact	Key programmes of work / actions to mitigate risk
Failure to achieve our focus on quality value for money	Failure to deliver Financial Plan to secure a sustainable financial position	COSR reduced to less than 3	Financial plan delivery and monitoring
	Failure to develop services which meet the needs of our system(s) and make best use of resources available to us (commissioners and providers)	Loss of services and income – jeopardising sustainability and continuity of services Missed opportunities to secure new business and contribute to system-wide transformation – resulting in continued pressure on core services	Active membership of system transformation boards and activities Commissioning relationships activities – contract meetings/negotiations, individual relationships and networks Innovation and Development team activity
	Failure to develop effective partnership arrangements to do things differently together and have a strong voice for the people we serve	Missed opportunities to develop successful multi-agency arrangements for the benefit of people who use our services, their carers and families Loss of IP and missed opportunities to secure new business & learn from others' complementary skills	Approved governance arrangements for each partnership arrangement Formal partnership agreements - including s75, MOUs
Failure to achieve our focus on quality – effectiveness	Failure to demonstrate the value and benefit of our services for people	Commissioners withdraw contracts / do not value services delivered Missed opportunities to target resources where they can deliver greatest benefit for people	SytmOne and EIMS implementation and optimisation programme Assisted productivity programme (Meridian)
	Failure to develop services which allow the repatriation of specialist service contracts to improve quality of care pathway (safety/effectiveness/experience and value for money)	Missed opportunity to realise potential for savings and reinvestment in local services and more efficient and beneficial care pathways for people	Specialist commissioning governance arrangements delivery and monitoring Commissioning arrangements
	Failure to implement our strategy clearly for each of our services and deliver agreed Plan milestones for doing so to time	Ineffective and inefficient services which do not meet the needs of individuals and commissioners Financial instability resulting in short-term remedial action to recover position	Clear strategy implementation plans for each division Priority service plans identified in approved Plan with clear and realistic scheduling Annual Plan delivery and monitoring including priority service plans
Failure to achieve our focus on quality – safety	Failure to keep people safe	Increase in incidents and / or serious incidents and ensuing harm to people	Quality Improvement Plan programme - including Safe CARE programme, Positive CARE programme
	Failure to spot early if things are going wrong and do something about it	Increase in incidents and / or serious incidents and ensuing harm to people	Quality assurance and reporting processes - including CARE Accreditation, walkarounds, EXPERT, Complaints monitoring Incident and risk management reporting systems including DATIX, Safety Huddle
	Failure to manage change well	Increase in incidents and / or serious incidents and ensuing harm to people	Project Management arrangements for critical change programmes Annual plan delivery and monitoring
Failure to achieve our focus on quality – experience	Failure to focus on experience improvements	Missed opportunities to make a difference for people	Key Performance Indicator Dashboard delivery and monitoring Quality Improvement Plan programme - including EXPERT, surveys, Your Views Matter
	Failure to build confidence in our capability as an organisation, the services we offer and benefits people achieve from using our services	Damage to reputation leading to loss of existing services / income and failure to secure new business development opportunities	Communications and engagement programme
Failure to	Failure to achieve and evidence ongoing	Deregistration of services / loss of	Quality assurance governance - ward

<b>achieve our focus on quality – compliance</b>	<i>compliance with Registration and Licence requirements</i>	licence – impact of commissioner penalties; ineligibility for new business opportunities e.g. PQQs, AQP; reputational damage	<i>to Board and Council Quality improvement plan assurance and delivery - including CARE Accreditation, CQC action plan delivery Annual Plan delivery and monitoring Monitor standards delivery and monitoring Key Performance Indicators monitoring and delivery Contract (quality) reporting and monitoring</i>
	<i>Failure to harness the potential of our information systems and technology to improve our use of data to drive improvement</i>	<i>Missed opportunities to evidence the benefits of our work Missed opportunities to improve experience for people who use our services and their cares and families Missed opportunities to make sure our systems and processes enable good practice - at every level of the organisation i.e. corporate and clinical Inability to accurately monitor our performance and target performance improvements</i>	<i>SytmOne and EIMS implementation and optimisation programme Assisted productivity programme (Meridian)</i>
<b>Failure to achieve our focus on quality – Leadership, morale and culture</b>	<i>Failure to engage our communities, staff and stakeholders in our transformation programme and harness their energies to help achieve our overall purpose</i>	<i>Missed opportunities to improve our services through citizen-led design No improvement in stigma experienced by people who use our services No improvement in the mental health of the communities we serve Resistance to change prevents or slows progress needed on transformation</i>	<i>Internal and external communications and engagement activities Project management and governance of priority service change programmes</i>
	<i>Failure to motivate our staff and harness their energy and ideas for the benefit of the people we serve</i>	<i>Difficulties in recruitment and retention of high quality, capable and motivated staff – resulting in poor experience/ outcomes/ safety for people who use our services Missed opportunities to develop new ways of working and service improvements</i>	<i>CARE programme Leadership development activities Innovation and Development team activities - e.g. priority service change programmes Staff survey and action plans</i>

## UPSIDE AND DOWNSIDE SENSITIVITY ANALYSIS

### A3.1 Sensitivity Analysis - Downsides analysis

In downside scenarios, the following adverse variances from the base case have been included:-

- non achievement of income growth targets
- changes in national business rules
- system management

Potential downside scenarios have been developed to test our base-case assumptions to ensure our sustainability over the next five years.

Counter-balancing these potential downside scenarios are a number of upside opportunities. Uncertainty as to whether these will be achieved means they have not currently been reflected in the base-case assumptions. However, successful delivery against these opportunities would significantly improve our position over the next five years. These upside opportunities include:

- over-achievement of income growth target
- improved or early delivery of CIPs
- system management

	Full Effect		Probability		Net Value	
	Upside	Downside	Upside	Downside	Upside	Downside
	£m	£m	%	%	£m	£m
New business growth stronger than expected - net effect	0.200	(0.200)	20%	12%	0.040	(0.024)
Unutilised contingency	1.200		40%		0.480	
Increased rent costs from NHS Property services		(0.400)		80%		(0.320)
Increase in PDC due to revaluation of assets		(0.150)		50%		(0.075)
Increased usage in temporary staffing		(1.000)		10%		(0.100)
<b>TOTAL</b>	<b>1.400</b>	<b>(1.750)</b>			<b>0.520</b>	<b>(0.519)</b>