Birmingham and Solihull Mental Health NHS Foundation Trust

Strategic Plan Document for 2014-19

Birmingham and Solihull Mental Health NHS Foundation Trust
Public

Strategic Plan Guidance – Annual Plan Review 2014/15

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

The strategic plan must cover the five year period for 2014/15 to 2018/19. Guidance and detailed requirements on the completion of this section of the template are outlined in Section 5 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good strategic plan should cover (but not necessary be limited to) the following areas, in separate sections:

1. Declaration of sustainability
2. Market analysis and context
3. Risk to sustainability and strategic options
4. Strategic plans
5. Appendices (including commercial or other confidential matters)

As a guide, we would expect strategic plans to be a maximum of fifty pages in length.

As a separate submission foundation trusts must submit a publishable summary. While the content is at the foundation trust's discretion this must be consistent with this document and covers as a minimum a summary of the market analysis and context, strategic options, plans and supporting initiatives and an overview of the financial projections.

Please note that this guidance is not prescriptive. Foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

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

1.1 Strategic Plan for y/e 31 March 2015 to 2019

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

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Date	**30/06/2014**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five 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 Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic 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 Strategic 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;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Sue Davis

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	John Short

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Sandra Betney

Signature

1.2 Declaration of sustainability

The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.	***Confirmed***

Birmingham's population is due to increase by 14% by 2030 (JSNA 2012). The disproportionately younger and extensively diverse population will need mental health services that are innovatively and sensitively designed. Our Solihull population is also forecast to grow 7.6% by 2020 with a disproportionate increase in the >85 year population.

This forecast growth is against a background of flat health care funding generating a forecast gap of £30b by 2021. Commissioners are increasingly using the procurement route in an attempt to re-design care pathways across traditional provider functions (Procurement, choice and competition in the NHS: documents and guidance 2013, Monitor). Our financial plans are prudent and assume 1.8% deflator and no funded growth over the period of the plans. We expect to retain our existing services going forward. This cautious approach provides headroom against any commissioner plans for growth across the LHE.

Our plan provides a strategic assessment of local and national competitors. It reviews our strengths, weaknesses opportunity and threats and using a strategic analysis tool and prioritises our contracted service lines. As a result we have identified the following critical schemes that will ensure that we continue to deliver excellent clinical, quality driven sustainable and adaptive services.

- **Provide Community and Inpatient Mental Health Services – Children and Young Adults 0 up to 25 years of age**
- **Redesign Community and Inpatient Mental Health Services –Adults above 25 years of age**
.
- **Develop Emotional Well Being and Mental Health for Children and Young People in Solihull**
- **Align contractual and service configuration for Solihull– Adult Mental Health Service**
- **Review adult inpatient beds capacity**
- **Acute Day Centre- feasibility across LHE**

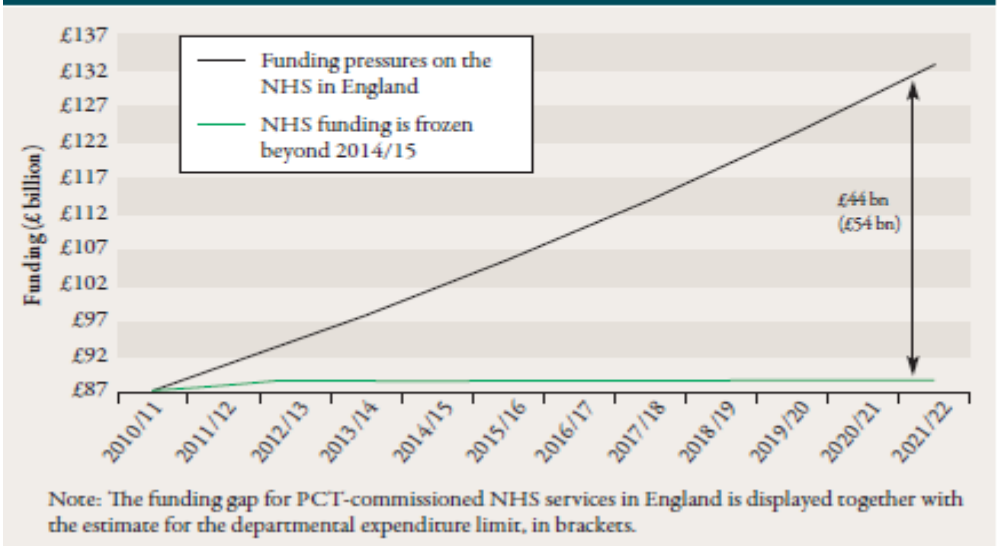
1.3 Market analysis and context

1.3.1. Health care needs assessment

Since the NHS was founded in 1948, its spending has increased on average by 4% a year in real terms. It is expected that funding will fall despite budgets remaining flat over the coming years. The Institute for Fiscal Studies warning that the impact of an ageing and growing population means spending per patient will fall by 9 per cent by 2018. Recent projections from the Nuffield Trust and NHS England suggest this gap could grow to £30 billion a year by 2021. (Call to Action)

Over the same period, demand for NHS health care is expected to rise as people live longer, have more complex health problems and more advanced treatments become available.

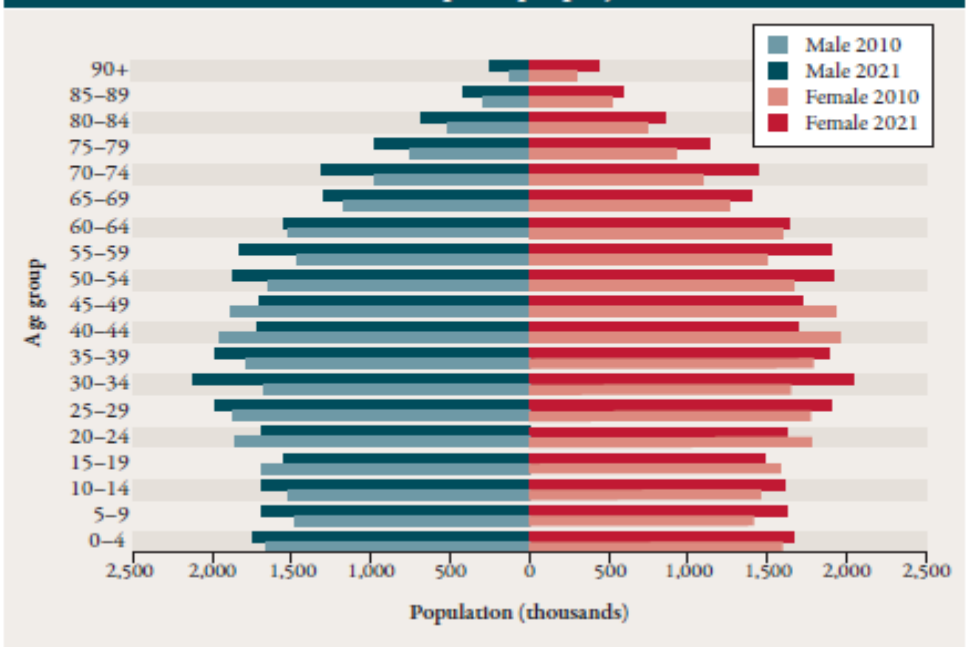
Figure 3.1: The funding gap by 2021/22, assuming English NHS funding rises as set out in the 2010 Spending Review to 2014/15 and is frozen in real terms after, and without the effect of QIPP savings



Note: The funding gap for PCT-commissioned NHS services in England is displayed together with the estimate for the departmental expenditure limit, in brackets.

Population growth and demographics are a key driver in forecasting health needs. The growth in the underlying population specifically the greater proportion of the elderly will have an amplified need for health care. Using principal ONS projections from 2008 for population, mortality and fertility to create a projection estimates to 2021/22 as shown in figure (b). The overall population is projected to grow across England from 52.1 million in 2010 to 56.4 million in 2021, which is the greater than the current total population of Wales (Nuffield Trust)

Figure 2.5: Population change in England between 2010 and 2021, by age and sex, based on the 2008 ONS principal projections



Over the projected period of time the number proportion of working age population will decrease with a corresponding increase in the elderly population.

Population	**2010**	**2021**
Working Age 20-64	24%	23%
Elderly 65+	16%	19%

The Local perspective

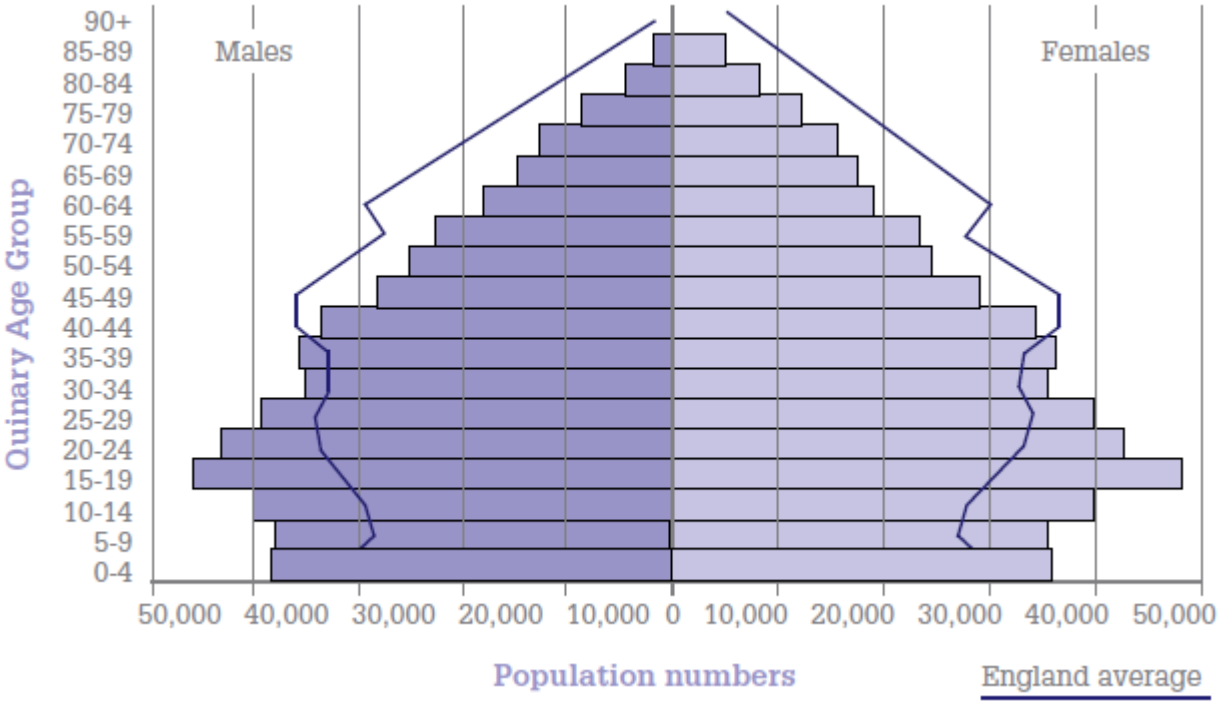
Birmingham is 267.8 square km in size, and divided into 40 electoral wards. Most of the area is urban, and the city centre accommodates some of the most high profile financial, legal, and retail centres outside of London.

Birmingham has reinvented itself over the last 15 years to become a vibrant city with many leisure attractions and quality urban spaces. Despite the success of the City as a whole there are still unacceptable inequalities within it. It is ranked the 9th most deprived Local Authority in England out of 354. Like most large urban cities we have areas that are wealthy and thriving and other areas that suffer from high levels of multiple deprivations. Life expectancy for Birmingham (76.8 for males and 81.6 for females) is below the England average (78.6 for males and 82.6 for females)

Birmingham is the most ethnically diverse city in the United Kingdom. People of White, Asian and Black ethnicity represent 68%, 20%, and 7%, respectively.

Birmingham's population in 2011 was 1.073 million. It is a young population with 66% being under 44 years old. The 20-29 age group represents around 19% of the total population (see Figure 1). The population over 65 years old represents about 13% (136,617) of the population. It is estimated that the

population will increase by 14% to reach 1,183,200 by 2030. The population pyramid is steeper compared to the national picture due to the young local population.



(JSNA Overview 2012)

Solihull is mostly urban, the population being concentrated in the western half of the borough where it borders Birmingham. It neighbours rural areas within Worcestershire, Warwickshire and Coventry. The population of around 205,000, unlike Birmingham is overwhelmingly white, 95%, with a significantly elderly population. Solihull's population forecast projected to increase by 7.6% to 220,900 by 2020. Population projections indicate that between 2006 and 2020, the over 65 population is predicted to increase by 26% and the over 85's by 58%.

	2006		2020		2006-2020	2006-2020
Age band	persons	age band as % of total	persons	age band as % of total	% increase in number in age band	change in age band as % of total
under 20	51.2	25.2	53.4	24.2	4.3	-1.0
20-49	77.5	38.2	79.1	35.8	2.1	-2.4
50-64	39.0	19.2	44.1	20.0	13.1	0.8
65-84	31.0	15.3	37.5	17.0	21.0	1.7
85+	4.3	2.1	6.8	3.1	58.1	1.0
All ages	203	100	220.9	100	8.8	

Data source: ONS 2006 based population projections

Solihull is regarded as an affluent borough however there are significant areas of deprivation in three wards in the north of the Borough. One indicator of affluence is the number of owner occupied houses in the region, which is 78% of the housing stock compared to a regional average of 69%.

Healthcare Trends- Mental Health

The national population profile over the next 10 years demonstrates that there will be not only natural population growth but this will be accelerated for the elderly population. However for Birmingham we do have a disproportionately younger population that will require mental health services covering the next five years.

Mental health services will need to radically change the way they deliver services to meet not only the financial, quality and capacity challenge.

Mental health is expected to remain high on the political agenda over the next few years as it remains a focus of government policy. The mental health impacts of austerity, the public health challenge of dementia, the 'mortality gap' between those living with mental illness and the general population and the drive to achieve parity of esteem with physical health will require a concerted effort to achieve integration across social and health care.

The main theme in the national intelligence picture is a need to integrate services to improve patient care and increase efficiency. A report from the Mental Health Foundation 'Crossing Boundaries: Improving integrated care for people with mental health problems' suggests that mental and physical health needs must be integrated and that key factors in achieving this are the commitment of leaders and frontline staff to cross-boundary working. There has also been a call for the relevant leaders in each local health and social care economy to come together to form a single, integrated, strategic leadership team to enable vertical and horizontal service integration. However, integration may be difficult to deliver in an environment where competitive commissioning can drive ever-greater fragmentation of services.

Recognising this need for integration Birmingham City Council is one of the first to propose pooling its entire adult care budget with the NHS, potentially releasing £80m from the government's Better Care Fund. The City's three commissioners have agreed to add some of the elderly care spend once they establish their overall spend on older people. Some concerns have been raised that such pooling could result in NHS funds draining into other non-health local authority services. Given the interest of independent providers in delivering community services, and their seemingly increasing success at winning contracts, this process could locally accelerate the transfer of NHS funding to independent providers.

A recent report from the King's Fund suggests that radical change is needed in the NHS, and particularly community services, to realise the ambition of moving as much care as possible to the community setting. We consider that the drive towards a greater proportion of care being delivering in the community will create opportunities for the independent care sector and will be a threat to the business models of NHS providers; this risk could be greater for providers of secondary and tertiary care.

Our local strategy for Birmingham is largely defined in 'Better Mental Health for Birmingham: An overarching strategic direction for Mental Health Services for adults 2011-2016'. In February 2014 briefing paper was published setting out the challenges faced by the Joint Commissioning Team Mental Health in commissioning services for the 2014/15 period. Broadly these align with the priorities seen nationally:

•Capacity management with a focus on community care

•Service developments including the development of Young Peoples' services, Older Adults provision, the improved performance of IAPT services and the development of primary mental health services

•Primary Care and Community Mental Health Services – with a plan to consider how service delivery can

be restructured to maximise mental health wellbeing at the primary care level

• Community and Inpatient Mental Health Services – Children and Young Adults 0 up to 25 years of age– This tender provides significant opportunity and risk to the Trust. We are currently working with partner agencies to develop an innovative and viable model for Birmingham.

•Dementia – the Dementia Strategy for Birmingham and Solihull 2013-16, 'Give me something to Believe in' is now undergoing formal consultation prior to launch in May 2014. Again the focus is on community support to reduce admissions to acute hospitals and premature entry to care homes. This strand links to the pooled funding proposal referred to above

Capacity analysis

Our 5 year monitor activity submission is based on no inpatient bed growth over the next 5 years as shown in the table below:

Bed Numbers	2014/15	2015/16	2016/17	2017/18	2018/19
Bed Numbers - Adult - (excluding High/Medium/Low Secure)** see comment below	350	350	350	350	350
Bed Numbers - Adult - Medium Secure	217	217	217	217	217
Bed Numbers - Adult - Low Secure	30	30	30	30	30
Bed Numbers - CAMHS	26	26	26	26	26
Bed Numbers - Older People	116	116	116	116	116
Total Bed Numbers	739	739	739	739	739

While there is recognition and evidence by the commissioner that out of area placements remain above their historic levels there has been no firm commitment to re-invest resources to develop local solutions with the Trust. ** These are subject to feasibility discussions with commissioners.

Any developments are expected to be cost neutral if they materialise.

We are continuingly investing in our estate in order to bring our community 'hubs' fit for purpose to ensure that we improve productivity and relocating our inpatient units to meet local demand.

Our Estate

Our estates strategy is based on the following aim "An estate which efficiently, effectively and economically supports the delivery of safe, high quality service's and of the Trusts service, business and financial strategies and plans".

It supports the development of Inpatient Cluster sites and Community Hubs as shaping the future configuration of the estate recognising that limited resources will require investments to be prioritised. Our data intelligence is driving our estates prioritisation.

Emerging themes can also be identified in terms of the structure and design of the estate, which suggests

that the Trust estate will be developed around:

- A number of “Inpatient Cluster” sites and “Community Hubs” each delivering safe, high quality services, supporting, the redesign/integration of services & teams.
- “Core” estate (for which a medium/long term need exists), and “Non-Core” estate (for which no more than short term need exists) can be identified. A current version of the core and non-core is attached at the end of section 2.
- A desire to work in partnership more effectively with other service partners, promoting the possibility of services being provided from their estate rather than the Trusts and other such initiatives which may enable more effective community services to be developed.
- New ways of working, specifically mobile working for community staff. This will require Estates and ICT investment strategies, to be aligned, to provide a technically and environmentally functionally suitable Estate/ICT infrastructure.
- Greater evidence based assurance with regard to the performance of the estate and its ability to meet and support the needs of services, service user and staff will be required to support effective management of the estate and ensure assessment criteria standard of regulators are met.

Our Workforce

Workforce Demand (Establishment FTE)

	14/15	18/19	Change	% Change
Medical	292	280	-12	-4.1%
Nursing	1388	1407	19	1.4%
Allied Health Professionals	135	132	-3	-2.2%
Scientific, Therapeutic & Technical Staff	302	282	-20	-6.6%
HCA & Support Staff	1482	1489	7	0.5%
Infrastructure Support	561	401	-160	-28.5%
Total	**4160**	**3991**	**-169**	**-4.1%**

Medical Workforce Strategy

Our longer term strategy is to minimise numbers of locum doctors while maintaining flexibility in our medical workforce. We intend to develop and increase the numbers of Physician Associates (formerly Physician Assistants) and Nurse Prescribers, ensuring that they are a key part of our multi-disciplinary teams, relieving pressure on medical staff to allow them to focus on more complex patient care.

Non-Medical Workforce Strategy

Widening participation will be a central feature of our workforce strategy over the next ten years, driven by the need to recruit more young people into the organisation and to make the workforce more reflective of the population it serves. In addition the strategy will improve the retention of our workforce and the use of bank and agency workers therefore ensuring the long term financial sustainability of the organisation. The strategy will focus on three areas:

a) Access – Develop effective work experience opportunities for 14-16 year olds across clinical and non-clinical areas. This will need to include robust engagement strategies with local schools and colleges across Birmingham and Solihull.

b) Apprenticeships – There are two types of apprenticeship framework :

I. Intermediate and advanced level apprenticeships at levels 2 and 3 which include specific mandatory components in mental health. Ideally this could be an established route into Healthcare Assistant and other Support roles, with cohorts being initially supernumerary and rotating around the Trust before being slotted into substantive roles.

II. Higher apprenticeship for Assistant Practitioner roles at level 5 which could be used as a progression route into qualified (band 5) roles and be a central element of the new roles approach to our long-term workforce planning.

An additional element to this agenda, being considered by the Mental Health Institute Local Education and Training Council in the West Midlands, is the expanding the role of former and current service users in the delivery of services. We have already developed roles particularly in substance misuse services with former service users being employed on a voluntary basis as Recovery Coaches. Mental health is particularly well placed to lead on this work, and the success we've had with existing roles will be built on and expanded into other service areas

Funding analysis

	Annual Plan 2014/15 £000s	Annual Plan 2015/16 £000s	Annual Plan 2016/17 £000s	Annual Plan 2017/18 £000s	Annual Plan 2018/19 £000s
Healthcare Income	233,469	249,960	245,589	241,297	237,082
Other Income	14,668	7,566	7,609	7,653	7,525
Total Income	**248,136**	**257,526**	**253,198**	**248,950**	**244,607**

Our income assumptions are based on no activity funded growth and continued application of a deflator of 1.8% over the next 5 years. We have no formal plans with local commissioners at this stage to suggest these assumptions will differ significantly. We assume that we will retain our current portfolio of business going forward by winning contracts for services out to competitive tender.

Competitor Analysis

We have a number of service competitors and recognise that different competitors operate in different markets, requiring us to understand our service-level market position, Broadly there are NHS and independent providers that may compete against us for different services, see map below. The current national thinking is that fewer providers will provide services over larger and not-necessarily contiguous geographic areas. This is likely to result in provider consolidation.

The independent sector's Healthcare Industry Barometer considers that opportunities will continue to evolve for independent providers, especially in community services, and a number of leaders in the independent sector predict an increase in business as a result of NHS changes. There is some evidence that the independent sector is gaining market share. However, the market may be becoming more challenging for them; the National Audit Office has criticised public sector contracts with independent providers saying that they lack transparency and are won by a small number of firms. Furthermore, they

have questioned how the market operates and whether contracts are sufficiently competitive. There is still some public scepticism about independent providers and any criticism of their service provision or quality tends to be well reported. Some have also experienced issues with staff dissatisfaction over working conditions, including strike action.

Independent and NHS providers are also working together with various balances of power. For example BUPA has announced a three-year partnership with South London and Maudsley and Tavistock and Portman foundation trusts. Bidders for the older adult community contract in Cambridgeshire and Peterborough have also included a number of NHS and independent provider partnership bids. This will create opportunities for independent providers to move into market areas traditionally occupied by NHS providers.

Corporate Strategy Review

The Trust is planning to refresh its corporate strategy 2013-2016 in the late autumn of 2014 given changes in the NHS and in the Trust leadership. As part of the Board/Governors strategy seminar the Board agreed to strengthening the commitment to research and innovation with an emphasis on co-design in order to drive better services for the diverse populations of Birmingham, Solihull and the wider West Midlands conurbation.

Recognising the macro economic NHS position, the Trust will continue to seek collaborative working and pursuing opportunities to grow through tenders as well as exploring opportunities for mergers and acquisitions in order to achieve this aim within the financial constraints likely to be in force during the life of this plan.

Financial Resilience

Our financial plans are risk averse and do not factor in any growth income however we understand that our commissioners may forecast 1% growth. This headroom will offer an opportunity to mitigate unforeseen risks.

Assumptions

- “Do nothing” means inflation assumptions remain per original submission, but any new developments and revenue generation CIPs are removed from the plan;
- Other CIPs are achieved each year;
- Capital Expenditure plans remain as is.

By removing income generation assumptions in the 5 year strategic financial plan, surplus is reduced in each financial year. As the capital programme is dependent on achieving a surplus each year rather than utilising borrowing, the capital programme is under funded by £5m over the 5 year period, resulting in the need to use additional cash balances.

This in turn reduces the liquidity ratio within the COS ratings and would reduce the Trust to an overall rating score of 2 from 2016/17 onwards.

The resulting 5 year forecast for I&E, SOFP, cash flow and COS ratings are shown below:-

Income & Expenditure Forecast

	Annual Plan 2014/15 £000s	Annual Plan 2015/16 £000s	Annual Plan 2016/17 £000s	Annual Plan 2017/18 £000s	Annual Plan 2018/19 £000s
Healthcare Income	233,469	249,960	245,589	241,297	237,082
Other Income	14,668	14,718	14,761	14,805	14,677
Total Income	**248,136**	**264,678**	**260,350**	**256,101**	**251,759**
Pay Costs	(180,873)	(175,088)	(170,795)	(166,702)	(162,865)
Drug Costs	(7,697)	(7,629)	(7,434)	(7,250)	(7,015)
Clinical Supplies and Services	(90)	(90)	(88)	(86)	(84)
Other Costs (excl Dep'n)	(34,781)	(54,604)	(54,261)	(52,986)	(51,883)
PFI Specific Costs	(7,210)	(6,871)	(6,773)	(6,685)	(6,592)
EBITDA £'000	**17,485**	**20,396**	**20,999**	**22,393**	**23,321**
EBITDA Margin %	7.0%	7.7%	8.1%	8.7%	9.3%
Capital Financing	**(15,219)**	**(16,083)**	**(17,161)**	**(17,657)**	**(18,437)**
Surplus / (Deficit) before impairment	**2,266**	**4,313**	**3,838**	**4,736**	**4,884**
Surplus / (Deficit) Margin %	0.9%	1.6%	1.5%	1.8%	1.9%
Savings Target Assumed in year	**13,524**	**11,647**	**11,200**	**11,500**	**11,700**

Statement of Financial Position Forecast

STATEMENT OF FINANCIAL POSITION	31 Mar 2015 £000	31 Mar 2016 £000	31 Mar 2017 £000	31 Mar 2018 £000	31 Mar 2019 £000
Total non-current assets	**199,624**	**204,561**	**208,822**	**209,611**	**210,368**
Inventories	413	413	413	413	413
Trade and other receivables	6,496	6,496	6,496	6,496	6,496
Cash and cash equivalents	30,981	26,566	22,351	22,506	22,840
Assets held for resale, current	0	0	0	0	0
Total current assets	**37,889**	**33,475**	**29,260**	**29,414**	**29,749**
Trade and other payables	(19,769)	(19,773)	(19,776)	(19,779)	(19,783)
Tax payable	(3,310)	(3,310)	(3,310)	(3,310)	(3,310)
Other liabilities	(10,149)	(10,149)	(10,149)	(10,149)	(10,149)
Total current liabilities	**(33,228)**	**(33,232)**	**(33,235)**	**(33,238)**	**(33,242)**
Total assets less current liabilities	**204,285**	**204,804**	**204,846**	**205,787**	**206,875**
Borrowings	(101,571)	(97,779)	(93,987)	(90,195)	(86,403)
Provisions	(1,074)	(1,074)	(1,074)	(1,074)	(1,074)
Total assets employed	**101,640**	**105,950**	**109,785**	**114,518**	**119,398**
Total taxpayers' equity	**101,640**	**105,950**	**109,785**	**114,518**	**119,398**

COS Ratings Forecast

	Forecast 2014/15	Forecast 2015/16	Forecast 2016/17	Forecast 2017/18	Forecast 2018/19
	Risk Rating	Risk Rating	Risk Rating	Risk Rating	Risk Rating
Liquidity (Current Assets and Current Liabilities less inventories and assets held for sale / Operating Expenditure x No of days in financial year to date)	4	3	3	3	3
Capital servicing (EBITDA for year to date / capital servicing costs)	2	2	2	2	3
Rounded average	**3**	**3**	**3**	**3**	**3**

Wider Health Economy

The key findings from our strategic analysis and their wider national evidence in outlined below:

Key Themes	Wider Health Economy- National Evidence
Inpatient bed capacity – waiting times	CCG Out of Area placement/ Parity of esteem/ Closing the Gap 2014/ A call to action – 7day working
Move care into community settings	NHS England 2014/15-18/19 -Everyone Counts: Planning for Patients
Increasing competition /pathway fragmentation	Monitor Procurement, choice and competition in the NHS: documents and guidance 2013
Opportunities to enter new markets	NHS England 2014/15-18/19 -Everyone Counts: Planning for Patients Transformative ideas for the future NHS: A call to action 2014
Working in partnerships	NHS England 2014/15-18/19 -Everyone Counts: Planning for Patients- Better Care fund Transformative ideas for the future NHS: A

	call to action 2014

Risk to sustainability and strategic options

Our Approach

Financial

A risk profile has been developed for our contracts in the absence of accurately disaggregating historic block contract lines. Wherever possible the contractual income for 2013-14 and expenditure lines have been analysed on a service level to give an initial perspective of financial sustainability of services.

Each contract has been given a financial rating based on the previous Monitor threshold for surplus margin.

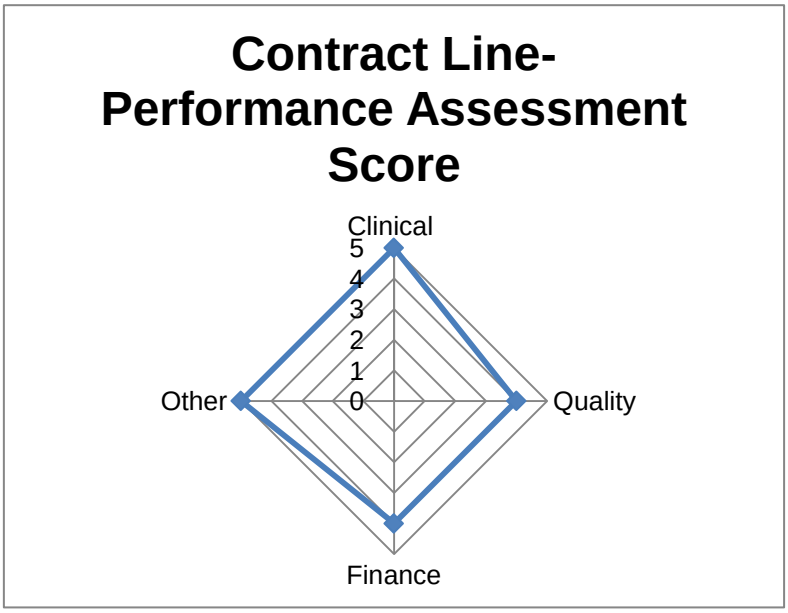
FR	5	4	3	2	1
% Surplus	3%	2%	1%	-2%	<-2%

Performance Assessment

Each contract has assigned a range of scores that provide a framework for a mix of financial and non – financial appraisal. This is outlined below and is developed using available evidence, eg contractual performance, risk register, quality concerns etc.

Scoring	Clinical	Quality	Finance	Other
1	Does not meet service specification and no pathway benefits	Serious quality concerns across > 2 categories	Serious budgetary concerns across expenditure and income	Significant capital and/or revenue costs. Not a commissioner priority
2	Does not meet specification but some pathway benefits	Serious quality concern	Serious budgetary concern across either income/ expenditure	Manageable capital and/or revenue costs. Not a commissioner priority
3	Partially meets specification and some pathway benefit	Some quality concerns	No current budgetary concerns.	Significant capital and/or revenue costs. Commissioner priority
4	Meets specification and some pathway benefit	Good quality performance	Good budgetary performance (2 years B/E)	Manageable capital and revenue costs. Commissioner priority
5	Meets specification and significant pathway benefit	Excellent quality performance	Excellent budgetary performance	Little capital and revenue costs. High commissioner priority

The combined scores provide each contract with a gross risk impact score and is presented in a radar diagram. Those services within the least surface area providing a visual perspective of most risk.



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Strategic Fit

Taking account of the key themes from arising from the FRR and risk impact contracts have been assessed for strategic fit realising a score between 1(Least) and 10 (most congruent) against our strategic aims.

Quality : Continuously improve quality by putting patients at the heart of everything.

People: To have a workforce that is innovative, empowered, engaged, fairly rewarded and motivated.

Stakeholder: Develop strong, effective credible, sustainable relationships with key stakeholders.

Sustainability: Achieve long term financial sustainability, top quartile for productivity, consolidate current business and growth

Strategic Ranking

The strategic ranking is based on a minimum performance score against the outcomes of the above analysis.

Where a contract service manages to meet all the criteria below :

- **Financial rating> 3**
- **Strategic Fit- 10**
- **Performance Assessment > 17**

It is assigned a ‘Gold’ ranking.

Where any of the criteria above are not achieved the service will be ranked a ‘Silver’ ranking if it meets :

- **Financial rating <3**
- **Strategic Fit >8**
- **Performance Assessment >13**

Where any of the above criteria are not met it will be ranked a 'Bronze' service.

Table: Summary of ranking.

Strategic Rank	Minimum Criteria
Gold	FRR>3, Strategic Fit >10. Risk Impact>17
Silver	FRR<3, Strategic Fit >8. Risk Impact>13
Bronze	FRR<3, Strategic Fit <7, Risk Impact<13

Strategic Options

Whereas each contractual service line is ranked across the above criteria this will lead to various strategic options that can be assigned. The following options were considered for all contracts.

1. Grow
2. Shrink
3. Exit
4. Stay same
5. Collaborate
6. Transform

Trust wide Strategic Ranking

The table overleaf outlines the Trust's summary position based on the analytical tool above. Whilst it offers a vehicle to inform the strategic thinking and derives themes for prioritising contract line initiatives, see section 1.4, it is not a tool for decision making.

The analytical tools will require further detail and development to include other factors such as :

- Local Demographic
- Quality Metrics
- Staff Metrics
- Local Market Intelligence
- Future Demand/Capacity Forecast
- Stakeholder perspective
- Impact of PbR

These will be developed alongside the re-fresh of the new Corporate Strategy during Autumn 2014.

1.4 Strategic plans

Alongside the above analysis and methodology used by the Board and Governors' to review contract lines we have identified key strategic contract line initiatives.

Key Service Line Initiatives	Strategic Option
Community and Inpatient Mental Health Services – Children and Young Adults 0 up to 25 years of age	GROW/TRANSFORM
Solihull–Emotional Well Being and Mental Health for Children and Young People	GROW
Solihull– Adult Mental Health Service	TRANSFORM
Adult Inpatient Bed Capacity	GROW
Acute Day Centre	TRANSFORM
IAPT	GROW
Forensic services	GROW/TRANSFORM
Rapid, Access, Interface and Discharge	TRANSFORM
25+ Adult Mental Health Services	TRANSFORM