Operational Plan 2014/16

1. Executive Summary

The South London and Maudsley NHS Foundation Trust is a founder member of King's Health Partners Academic Health Science Centre. It is an organisation with exceptional human and capital resource, located within an organisational system of tremendous strength and potential. This system is, however, facing unprecedented challenge with current models of healthcare delivery effectively unaffordable and unsustainable in the face of broader economic hardship, societal change and demographic shift. This two-year Operational Plan sets out how we intend to meet this challenge. The five-year Strategic Plan will set out the full transformation programme that will ensure we remain a sustainable, creative and dynamic contributor to a thriving health and care system in South East London securing the best of outcomes for local people, and contributing nationally and internationally as a centre of research, excellence and innovation.

This Operational Plan is informed by our knowledge that over the past two years we have experienced highly volatile levels of activity. 2013/14 in particular was an exceptionally difficult year in which we were required to consistently deliver significantly above contracted levels of activity. Whilst we were aware of the situation, and have worked collaboratively with our commissioners over the past nine months, this increased activity and demand has inevitably placed immense pressure on the Trust and subsequently on other parts of the local healthcare system. The result, coupled with suboptimal CIP delivery, inevitably impacted on our financial performance against plan.

Bearing these factors in mind, in order to ensure delivery against plan in 2014/15, we have taken a number of actions that are described in detail in this document. These include restructuring the Board to enable more rapid decisions and interventions in the future; strengthening our leadership with a focus on performance and delivery; clarifying lines of accountability and responsibility; improving governance arrangement from board to front-line; enhancing commercial capacity and capability; developing a new emphasis on strategy development and future vision; and ensuring greater alignment with local stakeholders. With quality in mind we have reviewed both the quality governance structures and our quality indicators that are used at ward through to Board level to enable early identification and assessment of any quality issues.

We know we need to make substantial changes in service delivery and we are mindful of the need to protect service quality and patient safety. In support of this we have worked with commissioners to agree shared transformational plans with appropriate risk share arrangements and contingencies, with a view to ensuring financial sustainability and stability during a period of unprecedented system-wide pressure. Further details on this are set out below.

Underpinning this plan is a recognition that we need to rethink how we deliver mental health services to meet such rapidly changing need and context. Care needs to move further out of hospitals towards lower cost settings that also meet the demand to provide care and support as close to home as possible. Our relationships with primary care and local communities need to be much closer, and our professional staff need to work towards developing and supporting capabilities in existing and potential service users that enable people to stay well, and to self-manage effectively when unwell within strong peer support networks.

We need now to build on recovery models, moving from tertiary towards secondary and primary prevention. In so doing we also need to harness the potential of technology and digital innovation to empower service users, facilitate effective communication and support people in understanding and managing their own conditions. Our services need to join up physical and mental health care much more effectively, integrating support around people

with complex lives and conditions. Our hospitals, both acute and mental health, need to be seen as sites of specialist care with acute admission in itself being seen as a specialist intervention to be used only when care cannot be delivered elsewhere, or when the outcomes associated with admission generate real value. The management of our work and service development and transformation need to be supported by high quality information. Partnership between organisations, professionals and local people will be key with our local services bringing together a mix of community facing specialisms, organisations and assets. In effect, we know that we need to work in different ways, from different locations, and with different people.

Pursuing an explicitly value-based approach will involve a relentless focus on improving outcomes that matter to people for every pound we spend. We will work closely with other local providers focusing on what we can best contribute to improve value, building partnerships with people who do things better than us at lower cost and who can enhance our offer. Where we identify activities that increase costs and add no value to the people we serve, we will stop doing them.

Ultimately, our purpose is to improve the lives of the people and populations we serve and to ensure that the benefits of the academic health science centre flow across the entire system, through:

- King's Health Partners [KHP], one of the world's premier Academic Health Sciences Centres [AHSCs];
- An international centre of clinical excellence committed to local people and communities;
- Our relationship with the Institute of Psychiatry, an international centre of academic excellence focused on translation into practice;
- Our local partnerships, leading together in truly integrated and preventative health and care;
- Capturing the richness of Croydon, Lewisham, Lambeth and Southwark and the populations that we serve;
- Contributing to a flourishing and sustainable health and care system in South East London and beyond.

Summary of key financial data

In 2014/15 we are facing an unmitigated challenge of £47m. The following summarises our approach to meeting this challenge.

The EBITDA target for the two years is £16m in order to generate sufficient return for investment and sustainability and results in I&E breakeven before exceptional items. We are continuing to treat service restructuring as a non-operating post-EBITDA expense. This is consistent with 2012/13 and 2013/14. This means that we are planning to make a net surplus of £0.9m in 2014/15 and net deficit of £1.6m in 2015/16. The main driver for the difference in the net surplus between the two years is the charity capital grants in operating income.

Our capital expenditure shows an increase in 2014/15 resulting from the impact of the major work streams agreed by the Trust Board. The schemes are funded by cash reserves accumulated from past capital receipts and I&E surpluses. The full costs of this capital investment and the impact on operating costs and CoSRR are built in as appropriate over the period.

For the period of the operational plan we have a continuity of service risk rating of 3 in Q1 and 4 in Q2 - Q4 in 2014/15 a service risk rating of 3 in Q1 – Q2 and 4 in Q3 - Q4.

We have successfully negotiated much more robust downside risk sharing agreements with commissioners. We have built the potential costs for the Trust into the plan to mitigate the

impact of potential increases in activity which has, as mentioned above, had such an impact on performance in 2013/14. We will be driving our commercial strategy and new income streams will be expected to increase revenues and margins in the period of the plan but significant growth has not been built in at this stage. We have adopted a new approach to the delivery of efficiency and productivity which will have an impact in this year, delivering higher performance against our CIP plan and also via a rolling ongoing programme of initiatives to flex the programme to accommodate downside risks.

For 2014/15 we have set ourselves the target of achieving a £16m cost improvement programme [CIP] including revenue generation. In previous years we have underachieved on our CIPs. Within the current climate, however, effective delivery and implementation are key. With this in mind we have taken steps to strengthen our leadership and implement a system of clear personal accountability. The creation of a Chief Operating Officer provides for the first time a single accountability for performance and delivery of all operational services. Beyond this we have streamlined our governance arrangements around quality, safety, performance and commercials. Significant service transformation is a key element of our planning but we will ensure that in so doing we improve patient care and satisfaction.

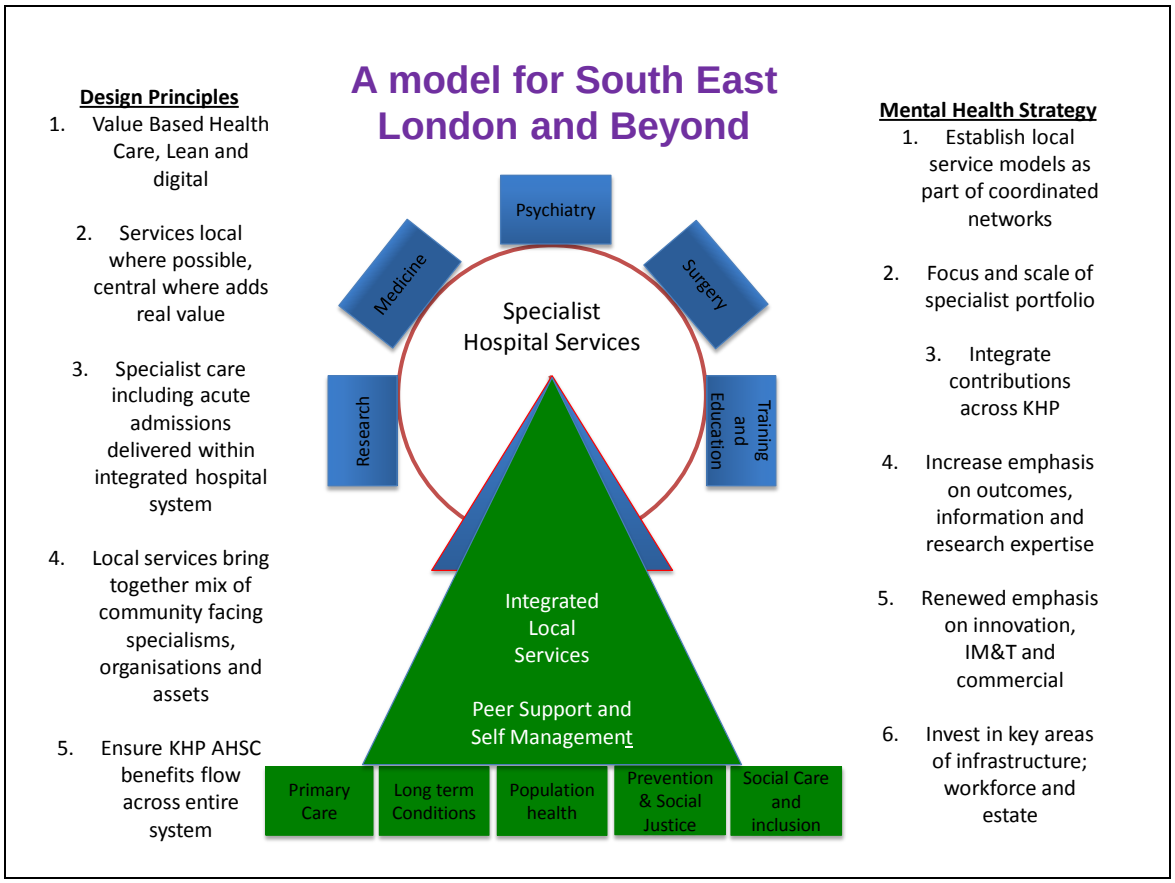
In working with stakeholders across the local health economy [LHE] we have signalled our clear understanding of the issues our commissioners, other providers and the voluntary sector are also facing, and consequently the importance of aligning our plans so that we can best respond to local need. Our voluntary sector stakeholders are pleased to hear of our commitment to move services to lower cost settings, and our service user and carer stakeholders support the move to care closer to home and a focus on relapse prevention and wellbeing.

The Chair and new Chief Executive have, together, engendered a renewed energy in strategy development with our staff, Council of Governors and stakeholders across the system. This has generated a clear high level strategic plan which will be the organising framework for our five-year Strategic Plan [submission to Monitor in June this year]. The two-year Operational Plan bridges into the Strategic Plan and ensures implementation of programmes designed to deliver high quality and cost effective services, e.g. the adult mental health [AMH] changes already underway, in preparation for a much more radical transformation to deliver our five year vision.

The Organising Framework for our five-year Strategic Plan is set out below and recognises that our future lies as an embedded part of both KHP and a much wider system. Ensuring whole system sustainability is key to ensuring our own; contributing to and co-ordinating, where appropriate, local services as part of an integrated health and care system and offering a range of high quality specialist services both nationally and internationally.

Central to this model is delivery of integrated local services. For us this means a commitment to develop integrated care solutions across our four local boroughs, contributing to a shift in how care services are delivered so that they are well coordinated and provide holistic care that is centred on people's needs. Our SLIC programme is a vital part of our learning in this new way of working and will, we believe, help us to address the challenges experienced across the local health economy as we work collaboratively with partners to design and deliver integrated care solutions.

Our relationship with our Academic Health Sciences Partners gives us valuable advantages in this work, as does our lengthy and strong association with the Institute of Psychiatry, King's College London, which is renowned for the quality of its research and which is the most cited research centre outside the US, and the second most cited in the world as ranked by Thomson ISI Essential Science Indicators.



2. Operational Plan

Context

South London and Maudsley NHS Foundation provides the widest range of NHS mental health services in the UK, and we also provide substance misuse services for people who are addicted to drugs and / or alcohol. We have more than 230 services including inpatient wards, outpatient and community services, and have around 4,800 staff working for us. Locally we serve a population of 1.1 million people, and we treat more than 45,000 patients in the community across Lambeth, Southwark, Lewisham and Croydon as well as providing inpatient care for approximately 5,300 people each year. We work closely with the Institute of Psychiatry, King's College London and are part of King's Health Partners Academic Health Sciences Centre.

King's Health Partners offers a strong combination of clinical specialities, including mental health, which, through closer working and better alignment of research and development with services will deliver real benefits to patients and staff. We continue building on our position as Europe's lead provider in health education, and to strive for international academic and research excellence to improve the delivery of patient-centred care. An ambitious programme of work for the next two years includes: treating the whole person, and delivering improved patient experience and value across the patient pathway.

The Southwark and Lambeth Integrated Care [SLIC] programme is a movement for change that seeks to genuinely shift how care services are delivered, so they are co-ordinated around the needs of people. Treating mental health, physical health and social care needs holistically. We are currently working as part of the roll out for Older People and the

development of the Long Term Conditions programme. As part of the infrastructure development around these programmes of work the potential for even closer integration is being explored, including different organisational forms. We are committed to the development of integrated care and will be actively engaging in these developments to ensure that mental health is strongly and fully represented alongside physical health in both community and acute settings.

The Health Innovation Network [HIN] is the Academic Health Science Network for South London. We will work with the HIN on a small number of clinical priorities, alcohol screening, dementia and diabetes, which will enable implementation at scale and influence a wide cultural change. This will be achieved through strong collaboration with partner organisations and by spreading local innovation. Further information about the future of KHP and our collaborations are described in Appendix 1.

Engagement across the local health economy [LHE]
We have been working closely with partners from our LHE on our developing vision and strategy. We have done this through hosting roundtable events, including a '4-way' event that brought together Commissioners, Local Authorities and third sector representatives from the four boroughs of Croydon, Lambeth, Lewisham and Southwark together with staff and Council of Governor representatives from the Trust.

In addition, as an integral part of KHP, we have been participating in regular meetings of the Lambeth and Southwark Planning Approach Group which enables the three health providers [Guy's and St Thomas', King's College Hospital and ourselves] to work collaboratively with the local CCGs and the Commissioning Support Unit.

In the coming year the CCGs and Boroughs are renegotiating agreements and applying existing initiatives against the fund. We have not been invited or requested to come forward with new proposals but will be considering our position in respect of 2015/16 in July.

We have also worked closely with our Council of Governors' through a specific Forward Plan and Strategy Group. Members of this group facilitated a series of membership engagement events in each of the four boroughs [Croydon, Lambeth, Lewisham and Southwark] during November 2013, where participants identified the areas that they wanted us to focus on. The priorities identified were: improving early intervention services, crises services and care on discharge; more training and support for carers; greater integration of services; increased working with, and training of GPs; more preventative focus on physical health; continued work on recovery and choice and empowering staff. The Council of Governors Forward Plan and Strategy Group meets regularly to continue the dialogue and to contribute to the developing strategic plan.

We have listened to our patients, carers, governors, members and commissioners and what we have heard has informed our vision of the future of mental health services.

Our ambition, as set out above, is perhaps the most far reaching it has been for the Trust and necessary because of the unprecedented times.

As we concentrate our efforts on delivering value based healthcare we will be taking the cost element of the value equation seriously. We will take a strategic approach to deciding what we do and don't do in the future, focusing on what we are really good at and concentrate volume while seeking opportunities to expand our excellent services to other locations.

We are building commercial leadership and capability to make the most of opportunities. Recruitment of a new Commercial Director is underway [see also 'Strengthening Leadership' below] who will sit in the Senior Management Team. The Director will set up a central team

and appropriate infrastructure [templates, processes and content] with a wide remit to develop the Trust's business into new markets and to support our leaders to develop new products and services. New markets include the wider NHS [i.e. beyond South London], the private sector and international buyers. New products and services may include, for example, digital education products [for patients and staff], information sharing technologies [e.g. to increase mobile working] or innovative pathway methods to embed more out-of-hospital working.

In addition to new business development, the Commercial team will partner with our Finance and Operations teams to embed more commercial practice in to day-to-day thinking and doing of operating Clinical Academic Groups [CAGs]. This will include practical support with business cases, tenders and contract management. They will also lead commercial discussions with partner organisations in KHP to progress our shared ambition to deliver holistic patient care across mental and physical health and to expedite the translation of academic research and teaching into clinical practice.

Our developing strategic workforce plan will help us to prepare for and manage the workforce costs and capability required to deliver our strategic objectives effectively and efficiently. This includes a review of the workforce structure, components and future requirements, supported by Staffside and key stakeholders, as a key element of the transformation programme.

Strengthening Leadership
The Chair and Chief Executive have, together, reviewed the leadership structure to best meet the inevitable challenges of the next 2-5 years. Following this review we have implemented a number of changes. Specifically, we have restructured the Executive team resulting in the establishment of new posts to strengthen and build on the work of the Senior Management Team and to ensure successful delivery of the Trust's values and operational and strategic plans. The newly created posts are:

- Chief Operating Officer; an Executive Director post
- Commercial Director
- Director of Organisation and Community

We will run the major transformation programmes using a programme management process, with clear leadership in place to ensure that delivery is achieved.

In addition, we have created a leaner Board committee structure. The committees now concentrate on key strategic issues and have a dedicated focus on performance. We have also moved away from committee responsibility to a system of personal accountability for delivery.

Furthermore, the Board has established a new Business Development and Investment Sub-Committee to provide assurance on the development and implementation of the commercial strategy, evaluate major investment and disinvestment decisions and to provide assurance on the strategy for the improvement of efficiency and productivity across the Trust including the CIP programme.

The Chair has reviewed the Non-Executive Director capabilities and the skills required for a strong, balanced board. This has led to a re-shaping of the Board with the imminent appointment of two new Non-Executive Directors, one with a focus and expertise in quality and safety and the second with marketing and commercial expertise. We expect to be able to confirm these appointments, which will complement the current Non-Executive Director strengths, in April 2014.

We will also be recruiting new Head of the Biomedical Research Centre, to ensure continued excellence in leadership, in this organisation that is run in partnership with the Institute of Psychiatry, King's College London. The BRC was awarded increased funding of £49m over five years to support a new portfolio of experimental medicine and translational research. The increase in funding was awarded specifically to build upon our successful informatics strategy which we believe is key to the transformational changes we will be pursuing over the next five years.

In summary, to deliver our two-year operational plan, and provide a sound basis for achieving our five-year strategy, we are planning to invest resources [of time, energy, passion and money] in the key areas of:

1. **Changing service models / transformation** – on establishing local service models as part of co-ordinated networks and on the focus and scale of our high quality specialist services.
   All our workstreams will be carried out using a value based healthcare approach, with a focus on improving outcomes that matter to people for every pound we spend.

2. **Innovation** – increased emphasis on outcomes, information and research, including further development of the Biomedical Research Centre and its contribution to front line service transformation; digital innovations that will enhance service offers; and bringing together physical and mental health care more effectively, particularly across the KHP community, so that we provide integrated support to people with complex conditions.

3. **Infrastructure** – we consider the following workstreams are critical to our success and will be wrapped around service models to enable our clinical services to deliver the scale of transformation that we are planning:
   - **IM&T**
     To include mobile working technologies, cloud-based productivity applications and MyHealthLocker supporting service transformation and improved management reporting that informs decision making.
   - **Workforce**
     To engage, support and develop the workforce to enable people to work to the top of their skill set, enabling us to respond and adapt to the constantly changing economic climate and system requirements. This will include training and education to promote positive service change, patient choice and increased collaborative working.
   - **Estate**
     That is fit for purpose, provided in partnership, situated appropriately and that is cost effective and cost efficient on a whole life basis.
   - **Commercial**
     Embedding commercial practice and cost awareness into the day-to-day thinking and doing of operating Clinical Academic Groups [CAGs].
     We will seek to reduce the cost of infrastructure, including opportunities to work across KHP, where it does not impact on quality of service provision. This may include co-location and integration of transaction services or outsourcing.

a. The short-term challenge

Financial Baseline

- We have delivered services for which we have not been paid by up to £14m in 2013/14. This is causing an operational deficit of £8m and a bottom line net deficit of £6m.
- Our current contracts do not adequately reflect current activity baselines. There are some services where operating margins do not cover the full costs (overheads, capital depreciation, and dividend payment). There are particular pressures in some of the infrastructure services, particularly in Estates.
- Our financial performance has been supported by a positive average cash balance in 2013/14 of approximately £68m, however supporting the operational over performance have meant the underlying cash position has deteriorated by £8m.

Two-year financial outlook

- NHS demand for our local services, linked to demographic demand, is forecast to increase over the next two years by around 2%.
- Increased demand puts stress on our levels of staff and beds.
- NHS contracts need to reflect appropriate activity and funding.
- Local Commissioners have identified QIPP targets of £9.8m over the next two years.
- The Trust will be expected to deliver efficiency targets of 4% per annum with the breakdown between our commissioners as follows: Lambeth CCG (£2.2m), Southwark CCG (£1.8m), Lewisham CCG (£2.2m), Croydon CCG (£1.5m) and NHSE (£1.7m).
- This means our total cost challenge is estimated at £15m-£30m in 2014/15 and £15m in 2015/16 respectively before taking account of capital investment required

We have worked with Local Health Economy partners on the short term challenges within the LHE, and there is a shared ambition for integrated health and care, moving care out of hospitals into primary care and communities and towards supported self-management and peer support.

We will play our part in placing a greater emphasis on keeping people well and this will support the LHE vision of developing stronger, more resilient communities. We are already working on significant programmes that deliver on these elements, and which are described in this document, including the Southwark and Lambeth Integrated Care programme and the Adult Mental Health programme.

To achieve our shared ambition of truly integrated and preventative health and care we will need to contribute to a flourishing and sustainable health and care system in South East London and beyond. This transformation has implications for our workforce. Our purpose inspires some staff who are natural innovators and early adopters to embrace change. However, it will be critical to support the majority of our staff who aren't early adopters through a period of transformational change that means changes to jobs and threat to job security. As we have set out elsewhere in this Plan we will need to invest additional funding in staff, technology, estates and marketing to transform the future, while we continue to run the existing system.

b. Quality Plans

National priorities

National expectations have been set out in the "Everybody Counts 2014/15" operating framework. We have noted the following guidance which we are supporting local CCGs to consider within their operational plans:

- Parity of esteem and convenient access to mental health services.
- The continued uncertainty around the differential between acute and mental health tariff deflators.
- Consideration of funding for mental health demand management from the reinvestment of 70% of A&E tariff adjustment.
- Use of 2.5% non recurrent investment fund including 1% for transformation to support mental health schemes.
- 2014/15 s256 transfer from health to social care to fund services/schemes to benefit health (in advance of the Better Care Fund from 2015/16).
- The NHS Constitution pledges a universal waiting time maximums of 18 weeks with a zero tolerance of waits that are 52 weeks plus. In terms of parity of esteem, our expectation is services will be commissioned in line with these waiting times (where shorter times haven't already been agreed for some services).
- Local primary care strategic plans including specific actions around care coordination, holistic care, responsive access, prevention, self-care and quality of care and how secondary MH planning should complement primary care plans.
- The Better Care Fund national conditions and performance measures against which progress is expected by April 2015, including providing 7 day services to support patients being discharged, preventing unnecessary weekend admissions, progress against delayed transfers of care [DTOC] and avoidable emergency admissions, admissions to residential and care homes, and effectiveness of reablement and patient experience.
- Identification of the impact of Better Care Fund on our services, with reference to the commitment that changes in the acute sector should not have a negative impact on level and quality of MH services.
- National Quality Board guidance requires comprehensive reviews and actions to be taken to ensure Safe Staffing in all clinical services.

We continue to operate clustering and reporting against the MH tariff structure in shadow form.

Local CCG priorities for secondary care services

Commissioning discussions since September 2013 have focused on the management of excess demand on adult mental health services, which have caused significant amounts of overspill of patients into independent sector providers. We took the decision to re-open an unused ward of 25 beds from December 2013 in order to repatriate patients and to deliver better quality of care and patient experience consistent with our services.

Contract negotiations for 2014/15 have concentrated on agreeing an on-going level of commissioned in-patient activity which meets the current levels of demand in each of our four local CCGs and will enable work to reduce the additional in-patient capacity as the system rebalances during 2014/15.

In addition to the factors driving excess demand nationally, the growth in population in our boroughs is expected to continue to rise. With a higher percentage of people coming into the area from overseas having a greater susceptibility to mental illness.

Other local commissioning priorities focus primarily on the transformation of adult mental health services in order to shift the emphasis of provision further from in-patient beds into the community and primary care. Plans are being developed appropriate to each CCG's current configuration of services. The CCGs have identified local incentivisation support for the implementation of these transformation plans via the CQUIN scheme.

Improving Access to Psychological Therapies (IAPT) services are commissioned at different levels across the four CCGs but all broadly continue to try to achieve the national targets around access and recovery. Innovative applications of the IAPTs model have been implemented for patients with serious mental illness and users of CAMH services. Southwark are intending to tender their IAPTs during 2014/15.

In Lambeth there are well developed discussions around the commissioning of an alliance of providers of adult mental health rehabilitation services, with a proposed start date in-year.

We await clarification of the guidance on choice in mental health services before we and local commissioners can assess the potential impact of the change in policy. We continue to support the development of personal budgets in health and social care.

The CQUIN scheme across our four core boroughs of Lambeth, Lewisham, Croydon and Southwark CCGs incentivises:

- Adult mental health transformation
- Improving physical health care (the national CQUIN)
- Implementation of the patient recovery and support plan
- Interfaces with primary care - communications on discharge
- Development of the mental health tariff

The implementation of the Friends and Family Test [FFT] and feedback to CCGs on outcomes relating to aggregated HoNOS clinical outcome scores have been identified as a priority service development plans, as well as reviews of older adult services, whole system reviews, reviews of services with long waits, development of local ADHD services and CAMHS services.

London Boroughs of Lambeth and Southwark priorities for addictions services
In Lambeth we are lead provider across a consortium of providers.

In Southwark commissioners have expressed their intention to decrease expenditure in some areas of addictions services.

NHS England priorities for prescribed specialist services
Discussions continue with NHSE London co-ordinating commissioners which at this point indicate:

- Implementation of a “London Average Price” for secure forensic services could render the delivery of a quality therapeutic model of treatment unviable financially.
- The commissioning of previously highly specialised Obsessive Compulsive Disorder services on a roll forward basis, which does not recognise the patient waits currently experienced and which we expect to increase to over 18 weeks during 2014/15, nor the unintended consequences of commissioning incentives which are impacting on the viability of OCD residential services.
- A delay to the publication of the NHSE’s review of CAMHS tier 4 capacity issues which is delaying decisions around potential service developments that would ease the current situation in London.
- The potential commissioning of additional secure forensic capacity.
- Commissioning of liaison and diversion services in support of the clinical justice system.
- Commissioning a range of services on a block basis that may not provide funding to enable our services to flex to meet demand pressures.
- Non-recognition of the gender dysphoria services we provide consistently with the interim national specification.

NHSE CQUINs for 2014/15 include the following:
Secure forensic services:

- The provision of an education training package for patients and qualified staff around collaborative risk assessment and management. Service users having active involvement in their risk assessment and management.

Eating Disorders:

- The collection of outcome measures on admission and discharge to aid qualitative understanding of the effectiveness of interventions within inpatient care.

Perinatal:

- The implementation of trained clinical personnel to deliver psychological and/or psychosocial interventions and ensure that these interventions are offered to all mothers

CAMHS:

- A multi-agency review of unplanned admissions within 5 days of admission

All (excluding highly specialised services):

- The quarterly submission of clinical data; includes training and supervision figures, complaints, Patient Experience Data Intelligence Centre [PEDIC] Serious Incidents etc.
- Plus, the national CQUIN on Improving Physical Healthcare to reduce premature mortality in people with severe mental illness.

Our quality goals, as defined by our quality strategy and quality account
Our quality strategy 2011-14 has run its course and a new strategy is in development. Strategy drivers include the three cornerstones of Kings Health Partners – clinical services, academic excellence and research into practice, as well as ensuring a robust response to the new regulatory framework of the CQC. Patients, staff and stakeholders remind us that our quality ambitions should include; service designed around the patient, artificial service boundaries removed for the benefit of a seamless service for patients, a focus on things that really matter to patients – i.e. benefits, work, relationships, feeling better about themselves, and a continued emphasis on combating the stigma of mental illness. Since 2011 the local health economy landscape has changed, and as the full scale of the funding gap becomes clearer, the need for a radical transformation in the way we meet the increasing demands on services with diminishing resources comes more sharply into focus.

Once our overall strategic goals have been agreed, the annual quality priorities (published in our quality accounts) will year on year be aligned with the longer term strategic targets.

Delivery Framework
Through the new quality strategy, we will set out a delivery framework that will ensure clear, effective and open communication and governance around implementation, and the identification, assessment, measurement and mitigation of impacts and risks to quality. This delivery framework will be based on the seven steps approach, borrowed from; High Quality Care for All. NHS Next Stage Review Final Report – DH 2008

Quality Priorities for 2014-15
The quality priorities for 2014/15 have been identified through a number of sources and a process of consultation with stakeholders and staff. They are:

	What we will commit to	Target	How we will do it	Source

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1	We will reduce the fear and threat of violence and aggression in our in-patient units	Increase the number of people who feel safe in our services	By implementing our violence reduction strategy, and ensuring that staffing levels and skill mix on all wards is right	Top Clinical Risk
2	We will improve the quality of the environments within our in-patient wards	Improvement in PLACE environmental audit scores by 5%	A full review of all wards areas will been complete, and an estate condition priority list used to allocate resources.	CQC inspection reports theme
3	We will ensure that a programme of improvements identified by users of in-patient services continues	Local targets set by local services users	Agreeing a programme of improvements with service users. Review and redesign of ward processes. Using Quality Improvement techniques	Patient surveys
4	We will continue to improve our screening of patients for cardio-vascular and metabolic disease	Improve the physical health of all our patients	Audit, and feedback to clinicians, continue to publicise the rationale for this work and use audit results in supervision and performance management	NICE guideline
5	We will help patients to quit smoking and move to no smoking in all clinical environments	Increase the number of smokers offered intervention NRT or counselling	Improve take up of Nicotine Replacement Therapy, and psychological interventions, through staff training and work with Pharmacists. Plan to go no smoking across all Trust sites by November 2014	Value Based Health Care 13/14 Quality priority
6	We will improve GP access to SLaM assessments, so that more patients are seen quicker for first assessment at home and in the GP surgery	See more patients at home and in primary care settings for first contact	GPs will be able to discuss and make referrals during surgery hours. This will improve access between 5-7 p.m. each week-day evening and Saturday mornings	Patient feedback Easy In Easy Out Strategy
7	We will stop the transfer of acute patients to private sector hospital beds outside the Trust	Stop the transfer of acute patients to private sector hospital beds outside the Trust	In-house overspill provision. Live bed management control. Active management of admissions. Adult Mental Health transformation project	Clinical risk Patient feedback
8	We will make it easier for patients to access help in a crisis	No one should experience being turned away when in a crisis	Adult Mental Health transformation plan and review of Home Treatment Team function.	Patient survey PALS
9	We will improve the	Improve survey	Through training and positive	Patient survey

	What we will commit to	Target	How we will do it	Source
	way we involve patients in their care planning	scores, in this area.	publicity. Audit of health records and feedback to services throughout the year	finding

Quality concerns (raised by CQC or other parties) and plans to address them
CQC inspections of our services in 2013/14 were largely positive. Compliance issues with minor and moderate impact on patients have been identified in the area of safety and suitability of premises on four in-patient units. Concerns are about the maintenance of the fabric of wards, their décor, furniture and fittings. The Estates strategy includes an estate condition priority review which will be used to allocate resources to clinical areas most in need of attention on a rolling year on year improvement programme. Estates and facilities teams will be working to new targets for bringing back into commission damaged bedrooms, toilets and washroom facilities.

Mental Health Act specific CQC reviews have identified:

- Place of Safety facilities are often unavailable because of damage to the suites, staffing levels or infection control issues. The Trust is reviewing its staffing support to the Places of Safety, and is working towards consistent standards of Place of Safety build, furniture and fittings, repair and maintenance.
- Care plans do not reflect patient and carer involvement or up to date risk assessment information and mitigation. Services are addressing this through training, audit, spot checks. This will be a quality priority in 2014/15

As requested by Monitor, during 2013/14, KPMG conducted a stage two review of our Annual Plan, with a particular focus on the areas of quality, governance and estates. Their report identified a number of areas of risk and recommended actions. As a result we identified:

- The actions that were already in hand prior to the KPMG review
- Further actions to respond to the recommendations, along with timescales, and
- How assurance will be delivered

The key actions can be summarised as:

1. A review of quality governance structures has been conducted and significant changes made to the terms of reference of the Quality Sub-Committee of the Board. These changes will begin in April 2014.
2. The Trust Estates strategy is being developed and key Estates and Facilities management posts are being filled.
3. The Trust is reviewing the quality indicators that are used at ward through to Board level with the aim of producing a single set of quality indictors which can be used at each level.
4. Quality Impact assessments will be completed for all CIP and QIPP schemes for 2014/15 onwards.

Following this review we have also commissioned Deloittes to do further work with us so that we can be sure we are in the best shape possible to deliver high quality services in a time of unprecedented challenge.

The key quality risks and how these will be managed

Key risks to achieving our strategic aims on quality are identified within the assurance framework. Key operational risks are logged on the service and corporate risk register. The following table summarises key quality risks and mitigations.

Risk Description	**Mitigation / contingency**
Potential risk of high levels of violent and aggressive behaviour by patients on patients and by patients on staff.	Full implementation of a Violence Reduction Strategy throughout the Trust. Development of the Care Delivery System as a clinical toolkit to reduce violence. Appropriate workforce planning to address the problem of an aging/less fit workforce and their capability to use and train in PSTS techniques. Implement improved alarm system. Ensure compliance with current Department of Health policy including: Positive and Proactive Care: reducing the need for restrictive interventions
The Trust's workforce potentially lacking the correct skills, in the correct numbers, to ensure that services are provided in line with best practice.	Develop programmes that reflect agreed best practice. Develop a 3-year workforce plan based on the skills required to implement future service requirements. Carry out six-monthly Safe Staffing reviews and act on any recommendations identified. Ensure that quality implication statements appear on all decision papers at CAG, Executive and Board level. Ensure that all CIP/QIPP schemes over £0.5m in value have accompanying quality impact assessments and a set of early warning indicators.
Potential failure to provide the quality of service that service users require and/or deserve or is contracted.	Ensure issues are identified promptly and responded to appropriately. Empower service users to have more input into the way they are treated.
Potential that demand for services exceeds capacity and contracted levels beyond the parameters of the agreed risk share.	Improve capacity and demand management and forecasting and introduce flex capacity and work with commissioners to ensure they can satisfactorily discharge their prime gate keeping responsibilities: Key metrics: • Profiled activity and capacity plan • Risk share arrangement monitoring • Length of admission and discharge delays • Other productivity measures, e.g. average length of stay, case mix, delayed discharges, non-clinical stay days Maintain the bed management office Bed Trajectory project. Benefit from service models such as street triage and RAID in acute accident departments.

Risk Description	Mitigation / contingency
Potentially high levels of vacant, acting and interim posts, coupled with high levels of organisational change, including the advent of the Kings Health Partnership.	Identify and manage gaps proactively. Identify and develop leadership skills. Recruit to key Director and other senior posts.
The estate is not functionally suitable for key services. (Condition of premises stock and backlog maintenance need) Source of Assurance: • Capital Report to Board • Programme Reports • Statutory compliance	Sign off revised estate strategy. Initiate rapid response arrangement and create buffer stock of key estate components and decant facilities. Re-launch and retarget ward refurbishment and ward redecoration programme. Continue to strengthen operational, programme and project management arrangements. Maintain our proactive approach to statutory testing and delivering the remedial works programme.

Board assurance on the quality of its services and patient safety
In 2013 our quality governance arrangements were subject to external review against the Monitor Quality Governance Framework. This Monitor review was conducted by KPMG. An improvement plan signed off by the Board, is being followed through, with regular reports of progress to the Board Quality Sub Committee.

The approach the Trust Board takes to assuring the quality of our clinical services is to continuously strive for robust assurance. Assurance is provided by:

- **Performance data and management reports**. The Board receive a Service Quality Indicator dashboard each month. Performance and quality indicators are used at the monthly CEO Operational Performance Review Meetings, and include performance and progress against quality targets and priorities.
- **External inspection**, assessment and investigations reports including those from: the CQC. We have robust processes to follow through actions resulting from CQC inspections [including Mental Health Act reviews]. Internal audit have reviewed arrangements for responding to CQC reports on Trust services.
- **Clinical audit** [this includes a detailed annual clinical practice assessment of each clinical team]. The annual clinical audit programme is prioritised according to risk in three areas of patient safety, clinical effectiveness and patient experience. The Quality Effectiveness Safety Trigger Tool (QuESTT), which monitors key indicators that may impact on quality, has been tested on all wards within the Psychosis CAG and clear escalation procedures from ward to board has been developed.
- **Board members and Governors visit clinical settings**, talk to service users individually and at organised events, and listen to what staff have to say, about the services that they provide.
- **The assurance framework**, and Clinical Academic Group/departmental risk registers and mitigation plans, identify key risks and progress updates of mitigation action being taken. Quality is one domain within the assurance framework. The Assurance Framework is reviewed at Executive and Board level committees.
- **System for receiving and responding to, formal complaints and serious incidents**. The Board are briefed about very serious incidents and complaints by email as soon as practical and when essential minimum information has been obtained. Investigation of the most serious incidents is overseen by Board Directors. Investigation reports and updates of reports of very serious incidents are received at Part II of the Board.

- **Quality Improvement (QI) programmes** are designed to achieve improvements in areas defined by our quality priorities, and areas where improvement is required. Quality improvement activity is supported by a central bespoke team who deploy QI models, techniques and expertise, to support transformation projects and clinical QI programmes.

What the quality plans mean for our workforce
We have linked the results of the annual staff survey to the people plan that will be delivered in 2014, also incorporating the organisational development activities that will be prioritised during this year.

These activities furthermore link the actions and cultural changes that have emerged from the Francis report to how we communicate with and involve our staff in these focus areas to ensure a co-ordinated and consistent message about how we are making SLaM a better place to work and receive care.

The organisational development strategy is primarily focused on:

- Our culture
- Leadership capability and behaviours
- Engagement of staff
- Ensuring supporting systems and processes are aligned, transparent and a shared organisational strategy is in place

Our response to Francis, Berwick and Keogh
A Trust response to the Francis report was agreed at the February 2014 Board. This response was developed over a year and took into account the Keogh, Cavendish, Berwick, Clwyd/Hart reports, as well as the 2012 National Nursing strategy (Six Cs). The essential messages in these have been incorporated into our Francis response.

Our Strategic Framework provides a sound foundation for our Francis response and includes clear values statements and expectations of staff behaviour, and the authority to embed within the Trust, aspects of culture which would protect against any future widespread failure of care.

Since the Francis report was published there have been many conversations and events within the Trust, where members of staff have had the opportunity to discuss the implications of the Francis report for themselves, their services and the Trust. The Trust's Francis working group distilled all this thinking into a simple model for change. There are four essential elements to the model and these are in line with the key messages from the Francis report:

- Creating the right culture for positive challenge and positive action. Staff will not challenge poor or unacceptable practice if the belief is that nothing will be done to change it.
- Working with service users in a spirit of co-creation and co-production. Increasingly over recent years mental health services have acknowledged the importance of working collaboratively with service users as individuals and groups.
- Looking after staff, each other and ourselves. The key principle here is to fix the faults which lie within the organisational culture, systems, structures and processes, rather than blaming individuals.
- Assuring the quality of patient care in every corner of the Trust. This is about ensuring that the right metrics are chosen, the chosen metrics are presented in a way which they can be understood, and the information is used to monitor, challenge and drive quality improvement.

These elements are being woven into the developing organisational development strategy and an action plan has been generated from this model. Within the action plan there are

actions for the Board, Trust Executive, Senior Managers and CAGs. Progress against the plan will be monitored by the Board Quality Sub-Committee and the Forward Planning Delivery Group which will receive regular updates from CAGs every month, and push forward on the Trust wide actions within the plan.

The Board agreed the actions at the February 2014 meeting. Actions for the Board and Senior Management Team include:

- Hearing patient stories routinely at the Board
- Evaluating the behaviour and dynamics of the Board and impact of these on the culture of the organisation
- Promoting and marketing SLaM values, five commitments and expected behaviours
- Developing of the organisational development strategy [Due summer 2014]
- Developing a live quality indicator dashboard capable of reporting at Board, CAG and team level
- Developing a comprehensive annual forward plan of all assurance reports to Board and Quality sub-committee
- Reviewing sub-Board governance committee structure and arrangements to ensure robust and rigorous assurance, scrutiny and escalation
- Considering how the Governors and membership can become involved in supporting the Board in its assurance and scrutiny activity

c. Operational requirements and capacity

Activity levels

We carry out an annual analysis of need and demand for our inpatient, outpatient and community services, involving clinicians and managers, which is based on the following approach:

- The activity delivered in previous years is analysed for geographical, case-mix and other shifts.
- A demographic uplift is applied, based on research work carried out for the Trust.
- The implications of commissioners' plans for investment and disinvestment are taken into account.
- Changes arising from our service transformation and efficiency initiatives are applied.

The results of the above exercise produce an activity expectation by service line by commissioner plus an indicator of the probability of the activity varying from target.

Commissioners are encouraged to purchase activity at realistic levels during the contracting process, to ensure; choice, access and where relevant, static or reducing waiting times. Implications of other parts of the health system, e.g. accident and emergency waiting times, are also taken into account.

It should be noted that during 2013/14 there was an unprecedented increase in activity and significant effort was made during the year to discuss changes in need and demand with commissioners.

Capacity levels

Once the activity levels and the tolerance around these levels is agreed, capacity requirements are derived using a standard methodology, e.g. average length of stay and occupancy levels converts episodes and inpatient day numbers to an inpatient bed requirement. Likewise for outpatients and community work, previous work on productivity

allows the activity requirement to be converted via caseloads and contact rates to the number of clinic and staff sessions required by service line.

These requirements are then matched against estate and workforce plans to form a balanced operational plan.

A summary of the activity and capacity plan is provided in Appendix 2.

Activity and Capacity Risks and Contingencies
In view of the highly volatile levels of activity seen in the two previous years a risk and contingency plan associated with the activity and capacity plan is drawn up.

Although there has been significant progress this year in agreeing with commissioners realistic activity levels, financial constraints and competing priorities mean that not all commissioners will purchase the Trust advised level of activity at the start of the year.

To protect service quality and patient safety, appropriate risk share arrangements are agreed with commissioners and contingency plans are drawn up. The risk share arrangements vary by commissioner. For commissioners purchasing advised levels of activity the Trust will commonly bear all operational risk and the first 2% of the financial risk associated with additional activity.

At the other extreme where the commissioner purchase significantly below the advised levels of activity we will require the CCG to take the operational and financial risk of over performance.

In view of our short term estate and workforce limitations the risk and contingency plans assume that a plus/minus 2% activity and capacity variance can be accommodated within business as usual and up to a plus/minus 5% activity and capacity variance can be managed operationally and financially without disadvantaging the Trust.

Workforce Implications
Workforce costs are 60% of our overall expenditure and sustaining the current costs and level is an increasing financial challenge, so it is vitally important to have a strategic workforce plan that helps us to prepare for and control both workforce costs and capability whilst supporting effective and efficient delivery of our strategic objectives.

Traditionally, organisations have used a range of methods including: across the board cuts, programmatic cuts, decreasing administrative tasks, reducing headcount, consolidating or centralizing functions, re-engineering, investing in IT and outsourcing. These changes can have short term beneficial financial effects however better outcomes are often achieved when a strategic approach to efficiencies is taken rather than top slicing. Headcount cuts also have a demoralizing effect on the culture and workforce and in turn provide challenges to recruit and subsequently retain new skills and people.

Our strategic aim is to ensure we have an agile, flexible workforce which is able to respond and adapt to the constantly changing economic climate and system requirements. As we press forward with our strategy to make partnership, integration and collaboration our primary organising principles we recognise that staff will need a different skill set. They will need to be able to work at the margins of organisations, sharing their skills and expertise and creating the context within which the assets of every other player in the system - including patients and their family and friends - can be released and utilised. We are developing our Workforce Plan to enable us to predict, manage and respond to these changing health and care requirements and have robust processes in place to enable the

detail to be described in the five year Strategic Plan. See extract of draft HR Strategy 2014-16 Appendix 3.

Estate Implications
Our estate is substantial and we recognise it is a key priority workstream for us. Our buildings need to be fit for purpose, situated appropriately and be cost effective and efficient. Where we provide inpatient services they should offer a therapeutic environment. Where there is opportunity, we will work in partnership sharing accommodation where it makes economic sense and where it enables us to provide higher quality, more accessible services to our communities.

We are finalising completion of a new Estates Strategy that reflects the above approach. The Strategy is due for approval by the Trust Board in May 2014. A brief summary of our plans to date is set out in Appendix 4.

Operational Initiatives
Despite increasing need and demand and the increased expectation of patients and carers in respect of choice and quality, all commissioners are making net disinvestments in secondary and tertiary mental health services through the CIP and QIPP mechanisms.

To maintain our class leading reputation and to help mitigate or counter the impact of the commissioner disinvestment decisions, we are engaged in an extensive range of service and organisational improvement initiatives. The top transformation and service improvement initiatives are listed below:

Changing service models:

- Changing service models**:** including further development of the AMH Transformation Programme [see appendix 5] in Croydon, Lambeth, Lewisham and Southwark, which includes work on reducing in-patient bed capacity, implementing evidence based interventions within community settings to prevent relapse and readmission, and developing local partnerships to offer alternative delivery such as working with housing; improved community working with GPs and Social Care to prevent relapse; Review of Continuing Care Services for Older Adults.
- Development of our specialist portfolio; including Addictions and forensic service transformation, redesigning how inpatient services are delivered; responding to NHSE, Child and Adolescent Psychiatry additional capacity tender.
- Southwark and Lambeth Integrated Care programme, breaking down the boundaries between health and social care organisations to provide targeted and joined up care for patients [see Appendix 1 for details]. This work includes a pilot of contracting forms and Alliance contracting for rehab services.
- Kings Health Partners, building upon the academic health science network to improve patient care across Trusts and reinforce research and education strengths, including mind and body development. More detail in Appendix 1 – see section on Health Innovation Network
- Workforce review of the structure, components and future requirements, including specific work around nursing levels.

All the above will be carried out using a value based healthcare approach.

In addition we have reviewed and reshaped our performance management framework to ensure it fully supports the delivery of our operational forward plan, from individual team level through to the Board.

The main changes are bringing together all aspects of the Trust's performance and delivery into one framework, blending quality and outcome, resource and infrastructure, programmes

and projects and operational delivery together. This approach allows full drill down from Trust wide objectives and priorities to individual tasks and actions by service team. In addition to this performance pyramid approach there is a stronger concentration on the pace of performance improvement (vectors) and the comparative position of the Trust (benchmarks).

The performance framework is broadly structured as follows:

Programmes

- Transformation programmes (local services and specialist services)
- Infrastructure strategies
- Innovation (including IMT, digital innovation and value based approaches)

Resources

- IMT
- Estates
- Manpower
- Finance

Quality

- Quality account
- Quality strategy
- National requirements

Operations

- Productivity (CIPs/QIPPs)
- Regulatory/Compliance/Legal requirements
- Contracts (activity/capacity management)

There will also be an increasing focus on continuous improvement and action planning based on accurate, immediate and relevant performance information and intelligence.

By taking this more integrated approach to performance management we will deliver our Forward Plan in full by being a high performance organisation.

National and local commissioning priorities

The following section analyses the key commissioning priorities that are reflected in our contract discussions and the operational plan.

NHS England

A deliberate policy of essentially rolling forward activity levels and prices has been followed by NHS E other than in forensics where a fifteen per cent price reduction is being sought with no loss of activity but significant ramifications for quality and outcome. CAMHS services are due for national tender mid-year with the aim of commissioning additional capacity.

Croydon CCG

The CCG is recovering from a systemic whole health economy overspend but has signalled mental health as a priority for investment in 2014/15. The CCG wishes to purchase sufficient inpatient capacity but work with us and GPs to shift resources and effort, over time, to primary care and the community.

Lambeth CCG

The CCG wishes to purchase sufficient inpatient capacity but work with us and GPs to shift resources and effort, over time, to the community via its “Hub” and “Alliance Contracting” initiatives.

Lewisham CCG
The CCG also wishes to purchase sufficient inpatient capacity but work with us and GPs to shift resources and effort, over time, to the community. In addition the CCG are keen to complete the MHOA continuing care review.

Southwark CCG
The CCG likewise also wishes to purchase sufficient inpatient capacity but work with us and GPs to shift resources and effort, over time, to the community. In addition the CCG are keen to complete the MHOA continuing care review and improve the urgent care system across Southwark and Lambeth.

The implications of the commissioning intentions on operations are significant with considerable risk associated with the forensics service and an increase in bed capacity followed by rapid service transformation and an increased community focus for the four main CCG commissioners.

Preparation for Payment by Results
We will continue to be involved in both national and local groups and have key areas of work planned for 2014/14 [these are set out in Appendix 6]

Preparation for Choice
We have a project on choice that includes actions related to improving connection and communication with patients and GPs, refreshing contracting and business arrangements and applying for IT connectivity with the national Choice System.

Implications of Commissioners Decisions on the Trust's Operations
The implications of national policy and the specific preferences and priorities of commissioners result in the following operational priorities:

- Organise around patient's clinical needs not organisation and professional specialties.
- Integrate care to maximise continuity and safety for patients across separate facilities and organisations.
- Expand geographic/population reach for highly specialist services to ensure clinical and financial sustainability.
- Measure costs and outcomes for each patient and develop local pricing where possible to reflect value based healthcare.
- Build enabling information flows and IT platforms to maximise efficiency and continuity of care.
- Work together effectively, openly and transparently in best interests of patients and public.
- Maximise focus on prevention and anticipatory care to avoid unnecessary admissions and costs.

d. Productivity, efficiency and CIPs

- The Trust Board sees the operational improvements in efficiency and productivity and the transformational programmes to deliver fundamental changes to the nature quality and cost of service delivery as core to our strategy and achievement of improved outcomes.

- We have already embarked on a strategic transformation of the adult services and the major elements of the plan for each service and for the infrastructure are described in the

Appendices. The nature of the transformation programmes is that there is a requirement for investment up front and then the delivery of the significant benefits only begins towards the end of the two-year operational plan period. These financial implications have been factored into our two and five-year financial plans.

- We recognise that we have only achieved 78% of our CIPs in 2014, similar to previous years, therefore we are revising the programme management for the delivery of ongoing productivity and efficiency gains in the organisation.

- The Board has agreed an overall governance structure including:
  - Programme approach to Efficiency and Productivity (CIPs); and Transformation programmes
  - Senior Management Team accountability and oversight for the programme
  - Integrated performance reporting by 1 May 2014.
  - Centralisation of certain expenditure lines to achieve better value for money consistency, and efficiency.
  - Regular challenge meetings weekly plus performance review and Executive Operations meetings.
  - Board Investment Sub-Committee oversight quarterly.
  - Review of programme to agree process, information and reporting proposals by 1 April 2014.
  - Rolling Programme to identify possible schemes including scoping and implementation.
  - Quarterly reporting to the Board on performance and two and five year planning to support Monitor declarations.
  - Commercial Team focus internal and external opportunities to be developed into stretch targets although only limited impact assumed within the plan to provide the baseline.

Traditional CIPs

- The schemes built into the plan are set out below.
- They are grouped into broad headings of staffing productivity, estates utilisation, improved use of technology to improve efficiency and reduce bureaucracy and some incremental service change.
- Some schemes improve productivity using existing resources (e.g. CAMHS national and specialist outpatient services to improve financial return)
- Several CIPs underway which deploy technology to automate certain process steps and/or improve tools for decision making and analytical capability and improve staffing productivity (e.g. introducing digital dictation)
- Individual procurement projects to reduce prices in technology, bank and agency (such as the LPP programmes and managed print services)
- Specific proposals are under development to deliver benefits by rationalisation of processes internally between teams, centralise operational management of key expenditure items such as legal costs and work with our KHP partners on opportunities for shared or managed service contracts subject to business case

CIPs by Type	2014/15 Value assigned by CAG £000	2015/16 Value assigned by CAG £000
Staffing Productivity	6,204	6,303
Estate Utilisation	99	1,984
Improved use of Technology	267	433
Service Transformation	165	1,495
Contracts and Sales (Rev Gen)	7,003	380
Procurement	722	479
Capacity management	924	667
Incremental Service Change	562	17
TOTAL	15,946	11,718

Transformational CIPs:

- **Changing service models:** reducing in-patient bed capacity and developing local partnerships to offer alternative delivery, including further development of the AMH model.
- **IMT:** including mobile working technologies, improved management reporting, cloud-based productivity applications.
- **Workforce:** including review of staffing, new skills.
- **Estate**: including the development of sites, development of local partnership presence with GPs and community groups.

IM&T Objectives

- We are in the process of recruiting for a new CIO. Whilst the recruitment for the substantive replacement is underway we have established interim leadership arrangements to ensure we implement the operational and strategic programmes underway.
- We recognise the need for investment in our core services to move towards industry benchmarks of investment. The plans incorporate potential additional revenue investment of £3m per annum and capital investment of £1.5m per annum from 2014/15, subject to business case.
- We are refreshing our IMT strategy in line with the five year strategy and has commissioned a series of service reviews to inform priorities in the period and maximise benefits from the investment. These including exploring appropriate managed service/outsource contracts for key elements of the technical and support infrastructure where there is potential for significant improvements and consequent productivity and efficiency gains across the Trust.

The key priorities for the initial period of the plan are to drive efficiency, facilitate better information for clinical teams and improve responsiveness of the ICT services. Specifically these are:

- Implementing an improved 1st line ICT service model to deliver a high "fix at first contact rate" to improve customer satisfaction and productivity in line with industry best practice.
- Roll out of further self-service capability to improve productivity and reduce bureaucracy.
- Continuing delivery of informatics and analytical tools to help support remote working, particularly for clinical teams in the community and thereby improve productivity, quality of clinical information to support decisions and more efficient use of the estate.

- Focus on Research and Development so that the latest technology can be deployed where it brings benefit to the Trust and enables us to provide high quality services.
- Continuing improvements to the ICT architecture to benefit from developments such as Cloud services.
- Exploring with KHP opportunities for collaboration to improve efficiency such as shared services; improved information sharing with our acute partners and GPs to support service delivery and access to more effective and efficient technical solutions for example cloud services.

The first stage will be a review of governance processes for future ICT developments and alignment of priorities with a detailed implementation plan prepared by the end of Q1.

We have not participated in the National Programme contract as we have our own clinical system ePJS, procured independently and therefore it is not affected by the October 2015 contract end. We will be reviewing options during the first quarter of 2014/15 to agree an appropriate procurement route for the clinical systems as the current contract expires at the end of April 2016.

e. Financial plan

The principle income and expenditure assumptions in the operational plan and for the five year period are set out below.

Business Planning 2014/15 - ASSUMPTIONS

		2014/15	2015/16	
Income	NHS Efficiency	-4.00%	-4.50%	
	NHS Inflation	2.20%	2.50%	
	NHS Deflation	-1.80%	-2.00%	
	NHS Deflation	-1.40%	-2.00%	on 3 local contracts
	Inflation for all Other income	0.00%	0.00%	
	By exception:			
	Annual reduction in R&D income	£1,697k	£1,120k	
Expenditure	Pay Costs - pay awards and drift	1.00%	1.00%	
	Additional pension related costs		0.70%	
	Gross pay cost inflation	1.00%	1.70%	
	Drugs	5.00%	5.00%	
	Other Non-pay	2.00%	2.00%	
Other	QIPP (or percentage reduction)	£5.9m	2.00%	
	CQUIN (at 100% of targets achieved)	2.50%	2.50%	
	Target EBITDA	£16m	£16m	
	Contingency	£2.9m	£2.9m	
Post EBITDA	Restructuring/redundancy costs	£2m	£2m	

- The assumptions on NHS Efficiency requirements and NHS inflation are as published in the Monitor and NHS England guidance but subject to local negotiation. Inflation for all other income sources is neutral with 0% uplift overall.
- Specific potential changes as notified are built into the plan such as reduction in income from R&D in the Comprehensive Local Research Network CLRN
- We have engaged with individual CCGs and local health economies and across the four Boroughs as well as specific engagement opportunities with commissioners and providers within the LHEs in South East and South West London.
- That the impact of Payment by Results is neutral overall within the period of the operational plan. We have been working to prepare for PbR in mental health as per Appendix 6). There is a potential upside as in reality the activity we have historically carried out for local services has been consistently above contracted levels and is expected to rise further during the period, albeit more modestly than in 2013/14.
- That any changes to the DSPD services which are due to be tendered in 2014/15 by NHS England are net cost neutral.
- Any loss of income through commissioning of services to a lower volume or specification will be offset by a reduction in costs.
- That from year 2 of the Plan, we will begin to offset overall income reductions in our current NHS portfolio by extending our catchment through specific tenders, competing for specialist contracts and by further diversifying into social, community and primary care areas. The Trust is building its commercial capability including the appointment of a Commercial Director and Team and we expect this to begin to payback through additional NHS, non-NHS and international income streams and margins towards the end of the two-year plan. No significant growth or additional margin is assumed in 14/15 and 15/16.
- The plan assumes we will achieve 2.5% CQUIN over the 2 years of the plan (less some investment for delivery of the targets - up to £700k non recurrent in both years 1 and 2 – but taking account of a risk factor re achievement of the 100% CQUIN target).
- The following are the key issues that are driving the contracting process:
  - Realistic levels of activity being commissioned in relation to need and current service models.
  - Realistic risk share arrangements for activity variances beyond contract limits.
  - Support and investment for key transformation programmes.
  - Transparent and deliverable QIPPs.
  - Transparent and deliverable CQUINs.
  - An overall target of securing income at levels after QIPP and investment that is no less than the national deflator impact.

- Contracts with local CCGs are well advanced and the we expect to finalise and sign these in the next four weeks. The latest income and activity assumptions are built into the plan and will be adjusted to reflect the final values once these are agreed. At this stage local CCGs are expected to invest c£7m additionally into the contract to reflect baseline pressures and proposed developments in 2014/15.
- Contract discussions with NHS England are not as far advanced as with the local CCGs. NHS England have set a very challenging QIPP target of 6% on top of the 4% efficiency requirement. We are in discussions about the financial sustainability of the Forensic services at the Board in this context.
- The Plan includes latest figures of £1.7m of CCG proposed investment into the new transforming Adult Mental Health service model. This funding has been earmarked within the CCG plans but is subject to further discussion and finalisation in the contracts. It is possible that additional transformation funds will be secured from

CCGs to support this change. The Trust has identified the full costs of implementation in the plan this year.

- No final QIPP targets have been given by the CCGs for future years but the plan assumes that they will continue to be required at 2% of contract value. Further discussions with CCGs will be on-going during 2014/15 and as part of the 2015/16 contracting round to agree schemes.
- Approximately 86% of our income is stable and relatively secure and comprises block contract income or non-clinical operating income such as rental income and charitable donations. However £45m of our income (14%) is cost and volume and cost per case where income varies with activity.

Expenditure

- The significant assumptions are set out in the template.
- The full consequences of the pay awards are modelled into the plan
- We are planning to invest up c£700k of CQUIN funding to enable CQUIN targets to be met and we have also factored a risk of underachievement of CQUIN 90% for CCGs and 75% for NHS England into our plans.
- CIP and QIPP plans are met or mitigated against.
- The Trust's internal investment programme includes:
  - Start-up costs of the new AMH service model
  - Continuing revenue investment in the Estate
  - Additional investment of capital £1.5m p.a.in ICT and informatics services to deliver improved decision support, analytics and clinical systems developments over the period of the plan
- An overall contingency of £2.9m is available to provide cover against activity in excess of contract (CCG risk shares), to act as a general contingency against unexpected costs and/or slippage on savings schemes and to provide support to CAGs that are in turnaround.
- The costs of acute overspill, above those built into the Plan, will be met through the implementation of local CCG risk share agreements and have been recognised in the contingency fund to meet any Trust elements of the risk shares which have been capped at 2.5% and 5%. This is still subject to finalisation of the contracts with the CCGs.
- Any loss of service resulting from re-tendering exercises will be offset by a corresponding reduction in expenditure.
- A redundancy provision of £2m in 2014/15 and 2015/16 is built into the plan. The contributions to KHP have yet to be finalised.

EBITDA

- The EBITDA target for the two years is £16m in order to generate sufficient return for investment and sustainability and results in I&E breakeven before exceptional items

Net Surplus

- We are continuing to treat service restructuring as a non-operating post - EBITDA expense. This is consistent with 2012/13 and 2013/14. These two items mean that we are planning to make a net surplus of £0.9m in 2014/15 and net deficit of £1.6m in 2015/16. The main driver for the difference in the net surplus between the two years is the charity capital grants in operating income.

Capital Expenditure

- Capital expenditure shows an increase in 2014/15 resulting from the impact of the major work streams agreed by the Board. The schemes are funded by cash reserves

accumulated from past capital receipts and I&E surpluses. The full costs of this capital investment and the impact on operating costs and CoSRR are built in as appropriate over the period.

- Other capital expenditure includes service refurbishments, estate capital maintenance and ICT renewal and investment.

- The summary of the plan with descriptions of the schemes are included in Appendix 4 Estate

- The Croydon Community hub project is the first of the borough community estate reviews and is targeted to provide appropriate, cost effective facilities for the next ten years. Croydon has been chosen at the first borough based on need and due to the existing multi-organisational Croydon Social Infrastructure partnership. The expenditure shown may involve a number of smaller schemes but for the purpose of the APR these are shown as new-build. It is planned to start on site in July 2014 and complete in 2015 to 2016. The project is funded by existing cash reserves originating from property disposals in Croydon.

- Lewisham Community Strategic Development Scheme will ultimately be a developer scheme for community premises with revenue rent and charges (more than) off-set by consolidation savings. Initial capital sum and credit indicates, construction finance, repaid by developer on scheme completion. Ladywell would be vacated.
- 6 x £500k major ward / department improvement schemes per year, mainly on Maudsley and Bethlem sites

Cash
- The overall liquidity in the Trust over the period of the plan is as set out in the table.

Continuity of Service Risk Rating
- For the period of the operational plan we have a continuity of service risk rating of 3 in Q1 and 4 in Q2 - Q4 in 2014/15 a service risk rating of 3 in Q1 – Q2 and 4 in Q3 - Q4
- The increase in the asset base, from the development of new facilities and the reduction in cash, result in an increase PDC dividend thereby making the debt service cover a higher target to meet.
- Upward valuations of the fixed assets which have been particularly driven by increasing inflation in land in London, although they do not reflect changes in the underlying performance of the Trust, upwards valuations drive up capital charges and dividends, and therefore have an impact to reduce the debt cover ratio.

Contingencies to safeguard risk rating:
- Within the current climate effective delivery and implementation are key. With this in mind we have taken steps to strengthen our leadership and implement a system of clear personal accountability. The creation of a Chief Operating Officer provides for the first time a single accountability for performance and delivery of all operational services. Beyond this we have streamlined our governance arrangements around quality, safety, performance and commercials. Significant service transformation is a key element of our planning but we will ensure that in so doing we improve patient care and satisfaction.
- We have successfully negotiated much more robust downside risk sharing agreements with commissioners. We have built the potential costs for the Trust into the plan to mitigate the impact of potential increases in activity which has, as mentioned above, had such an impact in on performance in 2013/14. We will be driving our commercial strategy and new income streams will be expected to increase revenues and margins in the period of the plan but significant growth has not been built in at this stage. We have

adopted a new approach to the delivery of efficiency and productivity which will have an impact in this year, delivering higher performance against our CIP plan and also via a rolling on-going programme of initiatives to flex the programme to accommodate downside risks.

- The basecase has been based on outturn from 2013/14 in order to ensure that the starting budgets and plan are realistic. We expect there to be some upside potential in this starting point but it gives in our assessment a prudent and realistic basis for the plan. The Trust has modelled a number of scenarios in its assessment of sensitivities and these are summarised in the template.
- The scenarios we have modelled are:
    - Additional activity pressures in year 1of 10% above the reset baseline and a further 5% in year 2. Given the investment and restatement of the baseline in 2014/15 this should be more than sufficient to reflect anticipated activity pressures.
    - Whilst we have strengthened our programme management and accountability for CIPs we have modelled a potential slippage of 20% against our plan. The internal Trust target is to achieve >90% of our plans.
    - QIPP plans have yet to be agreed with our commissioners. The contracts require the commissioners to bear the risk of non-delivery but we have modelled some risk falling indirectly to the Trust.
    - Potential slippage or non-delivery of the AMH programme.
    - Loss of a smaller contract for clinical services such as a local addictions community service – mitigation is that we would remove the costs – there may be some small phasing issues but these are unlikely to be material for the whole Trust.
- The Trust has retained a contingency reserve of £2.9m to mitigate impact of these risks. We expect to drive our commercial strategy to deliver some return over the two-year period although we have not included an increase in revenues or margin within the basecase.
- The Trust has developed some stretch targets in the CIP programme which are not built into the basecase but which we expect to contribute upside benefits and to mitigate the risks