South London and Maudsley NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

South London and Maudsley NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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Date	**31st May 2013**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three 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.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Madeliene Long**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Gus Heafield**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Nick Dawe**

Signature

Context

The South London and Maudsley NHS Foundation Trust provides the widest range of services in the United Kingdom for people with mental health problems or an addiction to drugs or alcohol.

We provide care and treatment for children, adults and older people living in South London as well as Tier 4 Child and Adolescent Mental Health services [CAMHS] in Kent, and specialist services for people from across the country. We aim to offer high quality clinical care and treatment and to improve mental health and well-being for all. We work in partnership with the Institute of Psychiatry, King's College London, on research to improve patient care and treatment and we are one of four organisations that make up 'King's Health Partners', an Academic Health Sciences Centre, with a vision to pioneer better health and well-being for people with physical and mental health care problems, locally and globally, through integrating excellence in research, education and training, and patient care. This is reflected in one of the KHP strategic objectives - *we will ensure our mental and physical health services work collaboratively to treat the entire individual*. This aspiration acknowledges the importance of treating the whole person in recognition that people with mental health problems have higher rates of physical ill health and die younger than the general population; and that people with long term physical conditions often have a psychological component to their health needs which if attended to would improve both experience and outcomes of their condition. Furthermore, the Mandate from the Government to the NHS Commissioning Board [now NHS England] sets out the importance of *treating mental and physical health conditions in a coordinated way and with equal priority* – working towards full "parity of esteem" is a crucial issue for the business development of SLaM as well as the outcomes and experience for its patients and local people.

Two examples of recent achievements, that illustrate both our wish to provide new services that meet the needs and wishes of our service users and our innovative approach, are:

- We were one of just two Trusts nationally to become a demonstration site for Improving Access to Psychological Therapies for Severe Mental Illness. This means providing cognitive behavioural therapy and family intervention to people with psychosis as part of the Government's four year plan for expanding access to talking therapies. The benefits for service users and their carers are improved access to NICE recommended psychological therapies for psychosis across all four boroughs we serve, with clear referral pathways, including self-referral, reduced waiting times and regular assessment of progress to ensure that therapy is helpful.
- MyHealthLocker gives people using mental health services electronic access to their health records for the first time using a free resource accessible online. We consulted extensively with service users, staff and local GPs to ensure that MyHealthLocker addressed the needs and concerns of those who would be using it. Service users have secure access to their care plan from the Trust as well as information stored by their GPs. This facilitates collaborative care and decision making with clinicians – putting patient choice at the centre of the care relationship.

Our mission is:
To treat mental illness effectively
To work in partnership to promote well-being
To support others by sharing our clinical expertise and knowledge

Our strategic goals are:

1. **Providing high quality safe and innovative clinical care and treatment** that meets the expectations of service users and their carers and the requirements of commissioners and regulators.
2. **Developing care pathways** in collaboration with key stakeholders that will deliver efficient and effective services, with a focus on the interface between mental health care and physical care.

Focus on the care pathway [not the component parts in isolation] and address gaps, overlaps and inconsistencies from the users' perspective.

3. **Promoting recovery, social inclusion and mental wellbeing** for the benefit of service users and the wider population.
4. **Maintaining financial sustainability** by increased operational efficiency and actively developing commercial skills so that the organisation is able to thrive in a more competitive and challenging market.
5. **Contributing to the delivery of King's Health Partners vision and objectives** – to identify and develop opportunities to address the inequalities and unique needs of our local population through provision of early intervention and personalised intervention to help people to maintain improve and enhance their health.

The components of our delivery plan continue to be:

A. Delivery of clinical service operational plans including CIPs and QIPPs, and the on-going development of our care pathways
B. Implementation and delivery of our Quality Strategy
C. Improved responsiveness and cost effectiveness – through enabling transformation programmes that focus on estate, workforce and processes/technology and which will support the delivery of both components A and B through supporting reduction in our cost base with a focus on enhancing our capability to respond rapidly and flexibly.
D. Seizing business development opportunities including through partnerships and organisational forms

Our Strategic Goals were used as the framework for an extensive strategy development programme from Spring to December 2011 to produce the Trust Strategic framework 2012-15. The Trust employed a multi-layered engagement process and developed from that process the 4 components A-D of our Delivery Plan as set out above.

To create the 2013/14 Annual Plan refresh, we have used this Trust Strategic Framework 2012-15 as our baseline for further engagement over the last year. This engagement has included ongoing conversations with the Trust Board, Executive and Members Council [Board of Governors], Trust-wide staff events; round table events in collaboration with Local Authorities and voluntary organisations and a series of open conversations, sponsored by our Members Council Planning sub-group, held in the four boroughs of Lambeth, Southwark, Lewisham and Croydon, specifically to engage our wider membership. However, during the period since the submission of our 2012-15 plan the context for our annual planning has changed substantially with two significant new developments in our local health economy which are described below [see local health economy section].

Forecast health, demographic and demand changes

The population in all local boroughs that we serve is projected to grow, particularly among children in the 0-10 year age range and in working age adults, while there is likely to be a relatively small growth in the over 65 year old population over the next five years although as people live longer the incidence of dementia is likely to increase. Based on the current projections, demand for mental health services are likely to increase as a result of these particular increases in the population.

The boroughs we serve are amongst the most diverse in London with Black African, Black Caribbean and Black other forming a significant ethnic minority group in some boroughs. This has a particular importance for severe mental illness as studies indicate that black and minority ethnic communities are up to nine times more likely to have psychosis than in an average English borough [Havant].

Incidence of psychosis, particularly in the boroughs of Lambeth, Lewisham and Southwark, is higher than the London average which in turn is higher than the national average. This increase in incidence has led to a demand for our services which equates to approximately 400 new cases of psychosis each year across the four boroughs.

There are a number of social risk factors that need to be taken into account when considering population demand for mental health care including employment, income, educational achievement, housing density

and alcohol and drug misuse. Whilst employment is projected to increase in all the boroughs the rate is lower than for England over all. In addition most boroughs have areas where there are high levels of poverty, that is, around 20% of workers are paid less than the London living wage.

The four boroughs served have higher rates of opiate and crack cocaine use than the England average, and the number of admissions for alcohol attributable conditions has increased over the past five years.

Poor quality of life through physical illness is known to be closely related to mental health status. People with chronic physical health problems such as heart disease are at high risk of developing depression. Whilst people with mental health conditions are up to twice as likely to report experiencing a long term illness or disability.

The local health economy

Local services are funded through contracts with Lambeth, Southwark, Lewisham and Croydon Clinical Commissioning Groups. We also have contracts with local authorities that support the provision of integrated health and social care teams. The demographic and social issues as described above are leading to increased need and demand, particularly in Lambeth and Croydon. The level of financial challenge we face is high and likely to continue for the foreseeable future.

We continue to work closely with health and social care commissioners, acute care providers and the independent sector to facilitate mental health and substance misuse whole system development.

As mentioned above, there have been two significant developments over the past year that we need to take into account in future planning. These are:

1. The agreement on the 20th February 2013 by King's Health Partners Board [KHP] to proceed with the next stage of developing a Full Business Case [FBC] to create a single academic healthcare organisation. The process, which is under way, will consider various organisational models to achieve the KHP vision, including a possible merger of the three Foundation Trusts who are partners in the Academic Health Sciences Centre. In recognition of the changed environment since the Strategic Outline Case was developed in July 2012, the partners are clear that the FBC programme must acknowledge and respond to recent developments, particularly when scoping the shape and governance of possible new organisational forms, and are committed to strong local stakeholder engagement throughout this process. A dedicated delivery team has being established, led by a high level Programme Director and overseen by the King's Health Partners Board and the FBC Steering Group, a subset of the Partners Board. The FBC is expected to conclude in late Autumn 2013.

This is the most significant possible change facing the Trust since it became a Foundation Trust in 2006. As with all major plans it presents both opportunities and challenges and, in common with all Partners in KHP, we are exploring how best to secure the most benefit for our patients, carers and key partners, as well as enhancing our reputation going forward.

2. The conclusions of the Unsustainable Provider Regime conducted by the Trust Special Administrator [TSA] for South London Healthcare Trust [SLHT] which has focused on the 'optimal delivery of safe, high quality, affordable and sustainable health services for the people of south east London for the long term'. The recommendations of the TSA were not limited to services provided by SLHT and as a result there will be an impact on all six boroughs in south east London.

Within the boroughs where there will be significant changes to healthcare provision we will be working closely with key stakeholders to ensure that there is no negative impact on the quality of mental health services that we provide.

In the light of these two major developments we have devoted a significant amount of time:

- In consideration of the next steps towards a KHP integrated academic healthcare organisation
- Ensuring we take account of the views and feedback from a range of stakeholders during our business planning, and

- Purposefully preparing for the large scale change management task which will be required as we implement the outcomes of the KHP FBC development work, our commissioners' QIPP and our CIP plans and the SLHT TSA recommendations.

Whilst we deliver a sizeable proportion of mental health services within Lambeth, Southwark, Lewisham and Croydon we also provide a number of specialist services [see below]. We recognise that the market is becoming increasingly competitive and that commissioners will be looking for opportunities to tender out services. Whilst this brings potential threats it also offers opportunities and we believe that, in addition to offering services that evidence good outcomes, the combination of our clinical, educational and research expertise enables us to continue to develop and offer innovative services that will be attractive to commissioners, and valued by service users and their families.

Key competitors include other NHS Trusts, particularly those bordering our area of service provision, along with non-statutory organisations (private, social enterprise and third sector) e.g. Care UK, Priory Group, Virgin, Turning Point; Together. Conversely, we are successfully working in partnership using the skills and expertise of each organisation to best advantage to provide high quality services [see partnership working below].

In relation to our key competitors we believe that our key strengths are our reputation; we are known as a centre of excellence around the world and as a result we have a global mental health brand that we can exploit. Our current approach to market making and market shaping needs to be improved and refined, and we will be addressing this over the coming year in order to maintain and improve market share.

The National picture

In addition to our local services we have a long history of providing specialist mental health services both nationally and internationally, and all of these are operating in an increasingly competitive market.

Since April 2013, NHS England [NHSE] has had responsibility for directly commissioning all prescribed specialised services. Whilst a lower number of our services are transferring than was originally envisaged, we have now received confirmation that forensic services along with parts, but not all, of our Adult services for Eating Disorders, Perinatal, Neuropsychiatry and Affective Disorders Residential Unit will fall within the remit of NHSE.

There are some specific risks relating to those services where the whole care pathway has not transferred. These are:

- Increased unnecessary length of stays
- Negative impact on service users and carers if there are delays in authorisation between the NHSE and the CCG funding/ panel arrangement

Further potential impact of services transferring to NHSE includes:

- Organisational – the new system presents a very different way of working for in-patient teams and this will take time to embed.
- Financial – dependent on a decision from NHSE on the occupied bed prices [which will be inclusive of all observations] this may have a significant impact on the services we provide where acuity levels often require one to one observation.
- Reputational – the NHSE have no formalised gate keeping arrangements in place, which may result in delayed discharges and subsequently increase the risk of serious incidents and complaints.
- As the NHSE work to bring parity in specialist services across London we are mindful that we need to ensure that our status as a lead for both the UK and world is not lost.

The remaining services we deliver will be commissioned by CCGs, including some that have previously been commissioned as specialist services rather than via our block contract arrangement. The potential risks to this arrangement are:

- Reduced access to care pathways that have traditionally been provided as specialist services due to the new funding arrangements.

- Ability to remain in the market if our prices are considered too high, thus impacting long-term on the continued development of specialist clinical services, world class research and the ensuing educational opportunities.

We will continue to be alert to market forces, and with the reduction in the barriers to market entry we expect to see a growth in competition from new external providers. This has been experienced by our Addictions CAG which, along with other NHS providers, works within a well developed market environment that has been in place for the last ten years. As a result of this model, within the local Boroughs we serve there are over forty organisations offering similar services to our community drug and alcohol services. Competition for residential services is also high although our Acute Admission Unit sees the most complex clients that most non statutory providers are unable to treat.

In order to strengthen our approach to increasing business opportunities a Business Development Support Group was established in November 2012 – chaired by the Medical Director, with the support of the Executive Director Strategy and Business Development. The primary purpose of this group is to support the development of a Business Development and Marketing Strategy that includes more effective and commercial business practice and marketing techniques, an active approach to income generation through developing, managing and maintaining constructive external and internal partnerships and networks leading to the development of new projects and tender submissions across the Trust. The primary objectives of the group are to:

- Provide a mechanism to ensure that regular business development reports are received by the Trust Executive enabling appropriate oversight and sign-off.
- Support the development of new projects and tender submissions.
- Help reduce any overlap and duplication that exists in business development activity.
- Support the increase in income generation and achieve a more cohesive approach to business planning, practice and development.
- Support the development of new care pathway partnerships.
- Support the management of partnerships and associated reputational, financial or regulatory risk.
- Provide business and tender planning, practice and training support, to ensure both the effective and efficient use of SLaM resources and finance**.**

Threats and opportunities from changes in local commissioning intentions

Detailed plans for the delivery of QIPPs are currently being drawn up with commissioners, with certain schemes being dependent on a preliminary joint review, e.g. rehabilitation services for Lambeth. Risk share arrangements are in place for QIPPs however there remains risk in delivering many of the changes as they assume contracted activity levels will fall over the coming year where current information indicates that activity levels are still rising.

In our older adult and forensic secure services we have been working on decreasing the length of stay and managing pathway demand through the provision of alternative services during 2011/12 and 2012/13 which has enabled the decommissioning of empty beds in these services. Within older adult services this is supported by planned developments in home treatment services that will enable people to stay in their own homes whenever possible.

The new specialist commissioning arrangements have led to a significant increase in income and activity risk. The risk is attributable to a variety of causes including, unrecognised activity and cost information from the commissioner, a late start to contract discussions and a naïve approach to commissioned contract activity requirements and the costs of delivering effective specialist services.

Our adult mental health services are planning a fundamental redesign of community and inpatient services during 2013/14 in order to meet the scale of savings that are required. Local commissioners are amongst the stakeholders involved in this redesign.

The process of transition to CCGs has produced little evident change in our contacts with local commissioners and therefore no loss of history relating to the commissioning of our secondary services. Local contracts continue to be funded on a block basis, however we are working with commissioners on the underlying data quality and processes needed to support the implementation of Mental Health

Payment by Results [MHPbR], which is currently planned for April 2014. The complexity of MHPbR cannot be under-estimated and the lack of national resources available for its implementation, including a financial payments system and the mental health information analysis resources available to commissioners, combined with its introduction at a period of financial challenge, presents additional risk. There also appears to be a lack of consideration of the application of PbR to integrated health and social care teams.

In addition, it is unclear how the policies and payment regimes required for the concurrent introduction of personal health budgets and the removal of patient choice exception for mental health services will align, as well as the potential impact of patient choice on the funding of integrated teams.

The tighter financial management necessary in the current climate is highlighting the need to be very clear about commissioner responsibilities, in particular their responsibilities for external demand and for the demand for services from patients whose needs fall outside the local specifications agreed with us. This less flexible approach has the potential to impair our relationship with local commissioners.

The CCG commissioning of non-prescribed specialist services within the reduced CCG allocations is likely to be based on very tightly controlled management of referrals and is a potential threat to the sustainability of some services.

Collaboration, integration and patient choice

As described above our adult mental health [AMH] services are planning a whole system approach to deliver a different type of service in order to secure a reduction in the rate of psychotic relapse, increase the quality of care and help manage demand into secondary care. The drivers for this are solving the issues of a sharply increasing demographic pressure, areas of historic underfunding in the system and the significant national and local savings requirements. Initially, we will roll out the AMH plan in two boroughs. The principles behind the AMH plan are fully aligned with commissioner aspirations in that they seek to move patients from secondary care to primary care, shift care into community settings, improve patient experience and outcomes and reduce inpatient capacity.

We have embarked on a number of partnerships and collaborations with other providers that have provided learning opportunities around how we might work differently, whilst still enabling our services to continue to develop and grow. Examples include:

- In 2010 the Lambeth Living Well Collaborative was formed with SLaM playing a central role alongside commissioners, service users, carers, peer supporters, primary care GPs, social care, voluntary provider organisations and community capacity building groups. As part of the radical change to the whole health and social care system for adults with severe and enduring mental health issues, a Provider Alliance Group has been formed to realign resources and introduce wholesale cultural change so that coproduction becomes the underpinning operating system.
- Lead role for delivering the Lambeth Substance Misuse Treatment Consortium which is a partnership between us, Foundation 66, Blenheim CDP and Mainliners, providing integrated care between the NHS and the third sector.
- Provision of an ADHD satellite clinic in Kent to deliver a service to their local population along with commencing a one year pilot being delivered for another Commissioner.
- Our Child and Adolescent Mental Health Service [CAMHS] provides clinical supervision for the National Society for the Protection of Cruelty to Children.
- An integrated Memory Assessment Service with Kings College and Guys and St Thomas's hospitals which will operate a single access service for anyone requiring an assessment for dementia is in development. This will bring the previous memory services operated by these different NHS Trusts into one service and provide a consistent model of service delivery with improved outcomes for patients.
- We are part of the Southwark and Lambeth Integrated Care (SLIC) programme. This programme is developing integrated service delivery for older people in collaboration with Kings College and Guys and St Thomas's Hospitals, Lambeth and Southwark Social Services, primary care services and community health services. One of the aims of the programme is to deliver integrated services for people with dementia between these agencies and to see more people cared for in line with the National Dementia Strategy and the Prime Minister's Dementia Challenge.

As a member of Kings Health Partners Academic Health Sciences Centre we work with King's College and Guy's and St. Thomas' Hospitals and King's College London to improve the services we provide to our local communities and beyond. In the year ahead we will participate in the Department of Health's competition process for Academic Health Science Centre designation. If successful, we will retain AHSC status for a further five years from 1 April 2014.

In addition, as mentioned above, we will also continue exploring the possibility of establishing a new integrated academic healthcare organisation. This could involve an organisational merger between the three NHS partners and a strengthened partnership with academic partner King's College London.

We are clear that any kind of organisational change is only worth doing if it improves our ability to bring clinical services, research and education more closely together for the benefit of the patients and local communities we serve. We want to test the case for change in order to decide whether it is a good idea to take the idea of an NHS merger any further, if there are other options worth looking at or whether we should leave things as they are. This will be explored in the Full Business Case which we will produce by Autumn 2013.

Once the Full Business Case is completed, each of the NHS Foundation Trust Boards and the equivalent body within King's College London (the College Council) will decide whether to proceed with exploring the idea formally with regulators. With this exception we have no current plans that may require to be addressed under the provisions of competition legislation.

We will continue to actively explore opportunities to work collaboratively with our partners, other mental health providers and the third sector to improve the care that can be offered to our local communities and beyond.

Approach taken to Quality

Over the past twelve months we have had CQC inspections of the arrangements for detaining people under the Mental Health Act as well as four full essential standards inspections of quality and safety [further details in Appendix 4].

The emphasis we have long placed on the importance of quality as users of our services experience it will continue to be central to our approach. In engaging and agreeing our quality priorities for the next year we have been mindful of the work we have done so far, as well as taking into account a number of national frameworks and guidance and local priorities on quality. In addition, in the light of the tragic failures at Mid Staffordshire Hospital and the Francis Report we will be re-committing to and additionally resourcing the work that ensures the Strategic Goals are fully embedded throughout all levels of the organisation and this will ensure that we exhibit a 'culture of compassion'. Furthermore, a high-level action group has been convened to ensure an appropriate Trust response to the issues raised in the Francis Report, including identifying where a review of processes is required. The group is tasked with reporting back to the Trust Board in September.

Furthermore a number of initiatives around Patient Experience are planned throughout the year including:

1. Working to implement the 'Friends and Family Test' (FFT) across all our inpatient wards. Whilst the FFT is only mandatory in acute hospitals we believe that this will enable us to further improve patient experience.
2. To re-develop the qualitative feature of patient experience information through the collection of patient stories and focus groups and cultivate action service improvements with staff collaboration.
3. To develop both strong and constructive working relationships with our external partners including local Healthwatch, Overview & Scrutiny Committees, Clinical Commissioning Groups and third sector agencies.

There have been many successes and developments during 2012/13, but there are areas where we need to do better and during the coming year we will be focusing our attention on the following areas:

- Violence and aggression on inpatient wards, continues to be our biggest obstacle to ensuring that all patients benefit from a safe and therapeutic stay in hospital. Whilst we have succeeded in

reducing the overall number of violent incidents, other indicators show that there is clearly more to do to help patients feel safer. We are putting in place a package of measures which are designed to reduce violence and aggression and improve communication between staff and patients. We call it our 'care delivery system'.

- Our patient survey results indicate that many patients are unable to access quickly the support and advice they need when in a crisis or emergency. To improve this we will be increasing the number of service users with crisis plans, which will be a key component of the new Support and Recovery Care plan.
- People with mental illness are more likely to suffer from serious diseases such as diabetes and coronary artery disease. We will be taking steps to improve the routine screening of inpatients and those prescribed anti-psychotic medication. This builds on quality priorities from previous years.
- For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms. Recovery planning is key to ensuring progress towards recovery. During 2013/14 we will focus on supporting patients to develop their support and recovery plans, and a pilot is underway for delivering brief team based training on the use of the new support and recovery plan.
- Helping to stop people smoking is a national health priority, and around two-thirds of people with psychosis smoke, a much higher proportion than in the general population. The Trust is moving towards a totally smoke free environment for patients and staff. To support the new policy we are improving the availability of advice and support to patients who smoke, both in the community and when admitted to hospital. We will provide smoking cessation level 1 training for staff to identify all patients who wish to quit, and offer patients support and interventions - nicotine replacement therapy or smoking cessation counselling.

The key quality risks inherent in the plan and how these will be managed

As required by national guidelines all savings schemes have been reviewed and approved by both the Medical Director and the Director of Nursing.

The identification and management of risk forms a key part of the production and delivery of the Annual Plan. By the very nature of the services that we provide and the reputation, scale and complexity of the Trust, the number of risks is sizeable, with several of the risks being significant. We recognise the importance of identifying these significant risks, and to have a realistic risk appetite that supports innovation, change and the capacity and capability to manage and mitigate risks. The Trust's risk appetite is currently set at 12, and as a result all Trust-wide strategic risks rated 12 and above will be regularly reviewed by the Trust Executive and progress towards mitigating them will be monitored jointly by the Audit Committee and the Service Quality Improvement Sub Committee.

The Trust Board have agreed a list of principal risks, particularly the need to strengthen the focus on the quality of care in light of the Francis Report. These risks relate to the following three primary objectives and risk areas:

1. **The service user is the centre of all we do:**
   - Insufficient attention is given to quality issues in strategic and operational decision making and practice.
   - Heightened levels of violent and aggressive behaviour.
   - Unexpectedly high levels of Serious Incidents and Complaints.

2. **Provide effective and efficient services that meet the needs of our service users:**
   - Failure to deliver the Forward Plan (CIPs and QIPPs).
   - Demand for services exceeds capacity and contracted levels.
   - Insufficient capacity & capability to deliver the AMH transformation programme.
   - Insufficient capacity & capability to deliver the Forensics transformation programme.

3. **Retain the position of a leading MH Trust, with proven clinical and business success:**

- High levels of vacant, acting and interim posts, coupled with high levels of organisational change, including the advent of the Kings Health Partnership.
- The estate is not functionally suitable for key services.
- Lack of timely and accurate performance information (clinical, contractual, bed, etc.)
- Failure to develop robust relationships with CCGs, SCGs and Local Authorities.

Below are the risk descriptions relating to the first objective 'the service user is the centre of all we do'. Further risks relating to finance, some of which are associated with, and could potentially impact on, quality are set out in key financial risks section.

Objective	Risk area	Risk description	Management of risk
The service user is the centre of all we do	Offer people the quality of service they require / deserve	Insufficient attention is given to quality issues in strategic and operational decision making and practice	Trust's Quality Plan for 2013/14 to contain specific quality targets and baselines Disseminate the Quality Strategy throughout the Trust Ensure mechanisms for patient, carer and staff satisfaction are regular and robust and respond appropriately Ensure that quality implication statements appear on all decision papers at CAG, Executive and Board level
	Inadequate focus on patient safety	Heighted levels of violent and aggressive behaviour	Address the problem of an aging/less fit workforce and their capability to use and training PSTS techniques. Implement improved alarm system
		Unexpectedly high levels of Serious Incidents and Complaints	Develop agree benchmarks and a mechanism to raise awareness and respond appropriately

Overview of Board Assurance on Patient Safety and Quality

Quality is integral to, and embedded in, the Trust's Strategy. We have a clear organisational structure that cascades responsibility for delivering quality care from Board down to team level and back.

The approach that the Trust Board takes to assuring the quality of our clinical services is to continuously strive for robust assurance. Assurances are sought that standards and targets are met, including all national standards and targets (CQC essential care standards, NHSLA risk management standards, targets set by the NHS outcomes framework, professional standards), local commissioning standards and targets (CQUIN targets, core contract quality schedules), Trust policy standards and quality priorities.

Assurance is provided by:

- The Assurance Framework, and Clinical Academic Group/departmental risk registers and mitigation plans - where key risks are identified and progress on mitigating actions is regularly updated and reviewed.

- Performance data [which is used at the monthly Chief Executive's Performance Review Meetings]. This includes data on aspects of patient safety, clinical outcomes scores, patient satisfaction surveys and access to services such as waiting times. A summary of issues raised at the monthly performance management reviews is reported back to the Board by the Chief Executive.
- Clinical, internal and external audit [this includes a detailed annual clinical practice assessment of each clinical team]. The Audit Committee has a key role in determining non-clinical audit plans and monitoring improvement plans generated as a result of audit.
- National quality accreditation schemes, such as AIMS. These schemes enable a comparison of our services and practice against other Trusts across the country. They provide assurances that our services are meeting the highest standards set by the professional bodies, and give a framework for quality improvement for the participating services.
- Quality improvement programmes - designed to achieve improvements in areas defined by our quality priorities. Quality improvement activity is founded on our successful 'productives' programme, and draws in other models, techniques and expertise.
- Progress against the quality priorities for 2013-14 - monitored and performance managed at a monthly review. The Board Service Quality Improvement Sub Committee reviews all priorities which are embedded within the Trust's quality strategy (domains include safety, outcomes, experience, access) each quarter.
- Board management reports from Trust governance committees, and professional groups within the organisation.
- Compliance with NHSLA risk management standards. The Trust has been NHSLA Level 3 since it achieved compliance in December 2011.
- External inspection, assessment and investigation reports - including those from the CQC (both Mental Health Act specific and full essential standard inspections), Deanery inspection of Post Graduate medical training, Ofsted reports, and independent investigations into serious incidents commissioned by NHS England.
- Board members visits to clinical settings - talking to service users individually and at organised events, and listening to what staff have to say about the services they provide. Our Non Executive Directors and Members' Council have a key role in supporting the Board to reflect on the quality of our services and assimilate the information we need in order to make judgements about the quality of our services.
- The established Members' Council Quality sub group - which has been active in contributing to the identification of quality priorities and the production of the Quality Account. The group has identified a work programme of key quality issues, including detention of patients under the Mental Health Act.
- Sign off of all formal complaints by the Chief Executive or his deputy.
- Procedure for serious incidents - notified to Senior Managers of the service and Executive Directors with 48 hours of them being reported. The Board are briefed about very serious incidents by email as soon as practical and when essential minimum information is obtained. The most serious incidents are subject to Board level Inquiry. Investigation reports and updates of reports of very serious incidents are received at Part II of the Board. The Trust wide Serious Untoward Incidents and Complaints Governance committees are chaired by the Trust Chair and the CEO, Medical Director and Director of Nursing attend.

Clinical Strategy

Through our extensive engagement as described in the context section above, we have heard that people would like more alternatives to inpatient care, and they are concerned that if they need support they want to be able to get it rapidly; easy-in and easy-out of all parts of the system has become a common theme. Without this assurance patients, their families/carers and clinicians are reluctant to discharge the patient to primary care – a crucial planning assumption in the CCGs' resourcing contacts with the Trust. We will continue to develop and refine our care pathways and to work with our partners to provide services that meet the needs of our service users and to develop our services so that alternatives to in-patient care are more readily available wherever this is possible. This aligns with our approach to the transformation of our Adult Mental Health care services, which is described further in Appendix 5.

Another important aspect for many people, and fully supported by our Members Council Planning sub-group, reflects our strategic priority around recovery, which in mental health does not always refer to the

process of complete recovery from a mental health problem in the way that we may recover from a physical health problem. It is about focusing care on supporting recovery and building the resilience of service users. The guiding principle is hope, the belief that it is possible for someone to regain a meaningful life despite serious mental illness. As reported last year our Social Inclusion and Recovery [SIR] Strategy 2010-2015 continues to be an important cornerstone of this work and provides the simple definition: 'Recovery involves living as well as possible'. The workstreams set out in the Strategy are co-ordinated by the SIR Board who report annually to the Trust Executive.

As part of this initiative we are exploring how we can develop recovery focused learning through Recovery Colleges. The colleges use a recovery based approach to provide a range of educational courses and resources for people with lived mental health experience, their friends, family and Trust staff. It runs on college principles, providing education through courses and workshops on a range of topics as a route to Recovery, not as a form of therapy. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals. We have recently secured three years Trustees funding that enables us to develop this initiative. Planning is now under way and we aim to start with a pilot prospectus of courses and workshops this summer with a launch of the College in the autumn.

We will continue with our enabling transformation programme, as set out in our last Forward Plan, to improve our ability to be agile and flexible, to enable us to respond and adapt rapidly to changes in demand, and at the same time supporting the delivery of QIPP and local business plans. We recognise the requirement for rapidly changing service models for both inpatient and community care, and to the continued development of partnerships where they offer the best solution for the provision of high quality patient care.

As part of our transformation programme we are looking to develop more flexible and agile ways of working through improving the technology available for staff and using a hub and spoke system. This will enable us to continue the rationalisation of our estate, providing services from fewer buildings and the more concentrated use of buildings through extending the hours of usage.

To ensure the most effective, efficient and economic use of Trust resources in the delivery of patient care we will be using a zero based budgeting approach alongside service line budgeting in parallel with the annual planning exercise for 2014/15. This will be done in conjunction with a drive to delegate accountability and responsibility to individual managers and Clinical Academic Groups to deliver service line reporting.

Clinical Workforce Strategy

In the era of the Francis Report our ability to create an environment which promotes the wellbeing of our staff and enables them to flourish and be resilient and creative in a time of challenge and change is vital to future success. In recognition of this we are creating a three year programme to promote the wellbeing of staff at individual, team and organisational levels. This will build on a number of recent successful initiatives to promote mental wellbeing including the learning from a four year lottery funded programme to promote mental wellbeing in 20 communities across London, the continued success of the King's Health Partners staff health and wellbeing pilot and the innovative wheel of wellbeing framework that is gaining national and international interest.

The psychiatry medical workforce strategy is under a national special strategic review and there are conflicting ideas as to how it should and will develop. A number of our senior clinicians are participating in this strategic review. Once the national strategy is clearer we will develop a local strategy.

For psychiatry, recruitment is a national concern and we are addressing this by working in collaboration with the South Thames Foundation School to develop taster weeks or placements in psychiatry. We are also hosting a National Summer School for psychiatry societies in medical schools, with the aim of fostering recruitment into the specialty generally and to us specifically.

We are developing skills within the non-medical workforce to minimise the use of doctors in training on routine tasks such as phlebotomy. In addition a review of streamlining paper and electronic record keeping is being undertaken to maximise face to face contact.

Across London a review of medical training posts is being undertaken and this may have an impact on the number of such posts that we are able to offer. In the first instance we will be carrying out a review of medical posts across the Trust.

We have implemented systems for appraisal and in the last year have appraised 301 out of 302 doctors and this year will aim to appraise 100% of our doctors within the year. We will be obtaining external quality assurance of our appraisal system to make sure that all our processes are in order and of a sufficiently high quality. We will also have 76 of our Consultants and SAS doctors revalidated, which will include all doctors who hold senior leadership positions within the Trust.

We are developing a system of team level reporting for incidents and complaints that will provide the Consultants and SAS doctors with monthly reports. In the future we are planning on developing these systems in conjunction with the Clinical Directors to give the Doctors information about the quality of the work that they perform. Over the next year we will also have a trained group of senior doctors who will be able to carry out case investigations where questions of performance have been raised. We will be standardising the process for investigating and responding to concerns and to developing remediation plans where required for doctors working in our services.

Last year we implemented Job Planning via the Zircadian system, and during 2013/14 we will be working to ensure that every doctor has a job plan recorded on the system. We will also be standardising the process of job planning across the Trust and move towards objective setting for doctors within job planning aimed at further improving performance.

We will consider how best to utilise occupational therapy core skills within the community setting to support the Trust workforce development.

Peer support systems and the release of capacity within services users, their families and friends is a core component of the Lambeth Living Well Collaborative and will greatly enhance the resources available within the system – albeit not within our employment responsibility.

Within the **Nursing** workforce:
Pre-Reg: There has been a reduction in overall commissioned student numbers, in line with forecast workforce requirements, and an increase in the numbers of student nurses undertaking two year PG Dip programmes, now at all three universities. The quality of students graduating has improved our ability to recruit to the registered nurse workforce, and we have led several pieces of work across London to improve the quality of our processes to recruit into Band 5 posts.

Qualified Staff: We know that many senior nurses are able to retire in the next five years, and a priority is managing succession planning more robustly, in order to ensure we have strong leadership in the future. Changes to strategy in the Adult Mental Health Clinical Academic Groups will require community staff to work in new ways. This is an area where we have historically struggled to fill community posts at Band 6 and therefore will require a robust workforce development strategy (at a time when our CPD funding is reducing). We would like to explore a dual RN training (mental health/physical) to meet service user needs within our Mental Health of Older Adults and Dementia and Psychological Medicines CAGs.

HCAs: We are currently piloting a skills-tutor led package of training and support to develop Band 2's and 3's. If we are instructed to implement pre-training experiences within the HCA group we will have to consider the implications on potential redundancies, supervision and management requirements, selection processes and, most importantly, patient safety.

A reorganisation of psychology and psychotherapy (P&P) is proposed that will integrate the two professional groups into a single structure of professional leadership for psychological therapists in SLaM. This will enable more effective governance of psychological therapies as all the practitioners whose main role is to practice psychological therapy will be brought together - this will involve individuals from a range of professional backgrounds including psychology, psychotherapy, arts therapies, family therapy, medical psychotherapy, CBT nurses, IAPT workers etc.

The new structure will have a number of advantages. It will be a simpler, leaner, structure enabling CAGs and others to access advice and support more easily. It will be more representative of the body of expertise in the Trust. It will be fairer to the staff concerned who will have equal access to support and career development opportunities. It will assist with workforce planning, skills training and service development relating to the full range of psychological therapies.

There are substantial service redesigns and developments planned, as referred to in this document, and the integration of P&P is timely to provide advice on the most appropriate psychological therapies in the relevant services, to facilitate the up-skilling of staff and to support staff through difficult transitions.

Clinical Sustainability

The issue of having services that could potentially lack critical mass or having consultant cover below those recommended is not applicable in our case.

Examples of innovations in care that we are working to develop/continuing development, are:

- The Medically Unexplained Persistent Physical Symptoms [MUPPS] service, previously referred to as medically unexplained symptoms. The aim of this programme of service development and evaluation is to transform the care of patients with MUPPS in Lambeth and Southwark by taking a whole systems approach and developing and piloting new care pathways and services which transects traditional barriers between primary and secondary care and between physical and mental health care. The pilot will focus on referrals from primary care practices and frequent users of acute hospital services.
- A tailored clinical medical liaison service where Acute Medicine Physicians and nurse practitioners attend our inpatient wards. The goal is to meet the profound physical health needs of mental health inpatients in the setting most suited to their overall health priorities and so reduce the high levels of morbidity and mortality. We also wish to evaluate the effectiveness, cost-effectiveness and palatability of this service and to develop a business model for optimal service provision and funding to meet this clinical need in the future. The project has been designed in collaboration between Clinicians in Psychosis, Liaison Psychiatry and Acute Medicine and with a health economist.
- The eMpowerment programme has created and piloted myhealthlocker; a patient website where service users can view different parts of their clinical record from SLaM and their GP, gather and record their own information and feedback through structured outcome measures. The next stage is to roll out and implement the patient website across the rest of the Trust so that all service users and clinical teams can benefit.

Productivity and Efficiency

We have convened a Productivity Group to support CAGs in having conversations with clinical teams about productivity, to make comparisons between like teams and agree priorities and best practise that delivers improvements in productivity and in particular increases contact with service users. To achieve this CAGs have been provided with activity data by team. We are currently gathering data on clinical staff (wte) to determine the number of patients per staff member seen per week. This will enable CAGs to have a discussion with teams about whether the figures are a good reflection of their practise and whether the figures are representative of what they would wish to deliver. This will also enable comparisons between similar teams. The plan for the Productivity Group is for the conversations with clinical teams to have taken place by M6 and for the group subsequently to decide on improvement plans.

We are aware that that in certain areas of the Trust there are a high number of DNAs, and consequently areas of poor productivity. As a result we have implemented the technical ability to use SMS messaging to alert service users of impending appointments. All CAGs are engaged with this project, but are at different stages given the different client groups and therefore different aspects that need to be considered. Many services have started or are about to start pilot schemes that will last up to four weeks. This enables technical issues to be identified and resolved but in particular allows for service user feedback. At the end of the pilot period it is anticipated that SMS messaging will be rolled out to those teams that have significant DNA rates initially with other teams to follow. We would expect to see the impact of SMS messaging half-way through the year.

Within our CIP plans we have a number of schemes planned and in progress to delivery efficiency and productivity gains. These include initiating drug controls, establishment reviews, improved flexibility of staffing to enable optimum use of this resource, measures to reduce sickness and new bank controls.

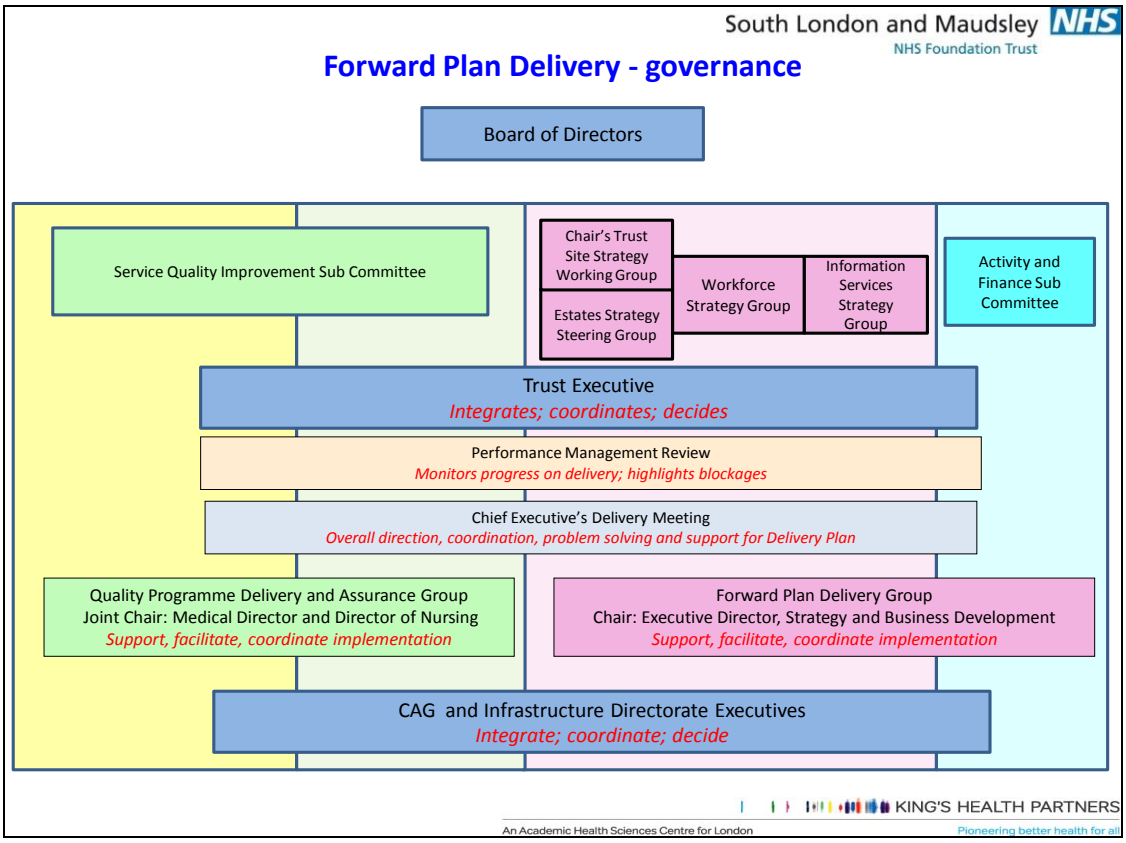
Bank and agency spend has been a significant cost for us, and the centralised booking system that was in place did not cater for all temporary staff. Following a procurement exercise from April 2013 the new service will provide us with a fully managed temporary staff booking service, and the consolidation of all bookings for temporary resources will allow for the introduction of e-Time sheeting and e-Billing which will generate both financial and non-financial efficiencies that have the potential to deliver in excess of £500,000 over a three year period

CIP governance

We have developed a detailed system for tracking progress with the delivery of the Cost Improvement Programme on a monthly basis, which picks up on clinical and quality issues and key dependencies and inter-dependencies as well as the level of savings achieved against plan.

The Medical and Nursing Director have reviewed the qualitative and quantitative impact on services of the CIP proposals and consider the programme to be acceptable provided risks are continuously reviewed and responded to.

The Board has considered each scheme in detail and have requested monthly progress reports on an exception basis.



The diagram above illustrates the governance arrangements that are in place to ensure delivery of both Quality Programme and the delivery of the Forward Plan. The structure continues to be supported by strategy, steering and task and finish groups although since first introducing this arrangement we have reviewed and revised the terms of reference of the two groups that 'support, facilitate and coordinate

implementation' so that there is now a clearer delineation between the Quality Programme Delivery and Assurance Group and the Forward Plan Delivery Group.

The Quality Programme Delivery and Assurance Group is responsible for:

- The delivery of the programme of quality targets/priorities as set out in our quality account. These are expressed under three broad headings which put together provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience.
- Ensuring that there are robust arrangements for the delivery of the quality priorities.
- Ensuring that there are robust arrangements for the delivery of each domain of the quality strategy.
- Ensuring that robust information flows support assurance for the Board and Executive.
- The group is accountable to the Trust Executive and reports up to the Board subcommittee for QI – SQISC as set out above.

The Forward Plan Delivery Group is responsible for:

- Co-ordinating and implementing plans designed to support delivery of the Forward Plan
- Reviewing delivery of the transformation programme to support the delivery of CIPs and disinvestment. The three streams supporting this work are
    - Transformation Workforce
    - Transformation Estates
    - Transformation Processes and technology
- Identification and resolution of blockages
- Providing a forum for co-ordinating plans to review and develop models for joint work with corporate/infrastructure departments in respect of services.
- Providing an opportunity for sharing information between CAGs and infrastructure on service models, development plans and implementation problems
- The FPDG is accountable to the Executive, and will provide the Executive with monthly progress reports
- Any major variations will be reported to the Board

During the course of last year the frequency of the Chief Executive's Delivery meeting was changed to a weekly basis and the organisation of monthly Performance Management Review [PMR] changed to a two part process. In Part 1 the performance team has detailed discussions with each CAG, which enables the Part 2 main PMR to be focussed on the priority issues identified. This happens on a monthly basis.

Following publication of the Francis Report and in the light of the issues this highlighted, in April this year we held a special PMR event with the objective of considering how we might ease the burden of bureaucracy and reduce the data entry burden on clinicians, whilst at the same time having a specific focus on quality and ensuring governance and assurance principles apply. This event enabled identification of a number of recommendations, to achieve the event objective, based on three themes:

1. Indicators
2. Improvements in efficiency and
3. Focus on quality

CIP enablers

The totality of the detailed proposals within the CIP programme has originated from the clinical and operational heart of our organisation and therefore "ownership" of the programme is very good.

The heart of the programme is service transformation both in terms of clinical change such as the Adult Mental Health initiative or through Trust wide and corporate initiatives such as agile working.

Finance, estates, HR and IT input into the programme of savings is considered essential and there is a strong correlation between the objectives of the CIP Programme and the priorities within the Estates and IT strategies, e.g. estates rationalisation, agile working, IT decision support tools and improved contract management and procurement.

Quality Impact of CIPs

As part of the local business planning process all CIP plans were assessed and signed off by the Medical Director and Nursing Director. Where there were any concerns, the plans were not signed off until all questions were satisfactorily answered and plans were quality assessed. In addition all plans have been equality screened and where relevant equality impact assessments have been conducted.

As our stated intention in our last Forward Plan, we brought the business planning process forward with submission required in December 2012. Initially a detailed evaluation of all risks to the delivery of plans was undertaken, along with assessment of the controls and assurances to mitigate or eliminate risk. Following this preliminary evaluation all CIP and QIPP proposals have been required to have SMART plans that include information on key dates, enabling them to be monitored, along with identification of the responsible manager for each plan. The progress is then included in a brief integrated monthly business report that brings together finance, performance, quality and HR information along with relevant additional contractual performance detail.

CIP profile

Within the CIP Programme there are two particular schemes of significant scale and these are: The transformation of adult mental health (AMH) Services across all four boroughs over a three year period and a fundamental redesign of the medium term secure unit services.

Both projects are about optimising the level and quality of care in order to meet the CIP challenge and commissioner disinvestment in these services. For the AMH project the key change is about moving resources from hospital care to community and primary care to ensure higher levels of targeted intervention and support that results in a reduction in the admission and readmission rates for inpatient care. For the medium secure services the key driver is to ensure the right type and numbers of skilled staff are available to provide a safe and efficient service and improve management capability whilst reducing management costs.

Beyond these major transformation programmes there is a raft of other operational savings that fit into the following categories.

- Major service transformation, as described above
- Incremental service change, e.g. individual care pathway and team redesign
- Overhead reduction, e.g. estate rationalisation,
- Improved productivity, e.g. improving the management of absence,
- Inflation management, e.g. improved contract management and tendering.

An assessment of the Trust's current financial position

This year we reported a net surplus of £2.3m. This was £1.8m better than the plan agreed by the Board at the start of the year. The Trust EBITDA operating surplus of £16.9m was also £1.8m above plan. The variance from Plan was mainly due to the planned use of reserves and other non-recurrent income. In overall terms, the Trust performed well in difficult circumstances and taking account of continuing increase in demand and a reduction in funding in real-terms. Going into 2013/14 however, the Trust faces a number of financial challenges:

- In addition to the annual NHS efficiency target of 4%, our 4 main local PCTs continue to require additional savings as part of their QIPP programme to meet demands (largely non mental health) on local services. In 2013/14 these will amount to £6.2m (plus 12/13 carry forward) and are likely to result in some major changes to the way we are able to deliver services in future.
- The NHS Act has brought about a change in both general and specialist commissioning arrangements with prescribed specialist services now subject to London LAT average pricing rather than locally negotiated pricing arrangements. This could result in a destabilisation of some specialist services depending upon the outcome of on-going contract negotiations with London LAT (NHS England). We will not agree unrealistic contracts for services, i.e. where commissioners require a service at a cost that would jeopardise the effective delivery of that service.
- Actual levels of activity in mainstream services considerably exceeding contractually funded (block funded) levels of activity in many areas. Whilst more realistic activity ceilings and tolerances have been agreed in 2013/14 contracts and specifically reserved monies have been set aside to allow

the Trust to flex capacity in a managed way for in-year peaks and troughs of activity, the risk of over performance on acute beds, in particular, remains considerable whilst new models of care are introduced.

- In exceptional circumstances where activity levels have remained below target, mainly in some specialist areas the future of that service has been reviewed. Turnaround plans have been developed and backed up, if necessary, with transitional funding but only available for a maximum period of 18 months.
- The Trust has achieved significant levels of CIP and QIPP savings in previous years but has not always met its savings target in full. Significant under performance was recorded on some cost improvement plans in 2012/13 that, in part, will cause a financial pressure in 2013/14. This issue is being addressed by reviewing all proposals to ensure they are sound and realistic and more actively performance managing delivery on a scheme by scheme basis from April 2013.
- The Behavioural and Developmental CAG, in particular, is facing a number of challenges linked to reductions in income following a continuing contraction in the number of beds being purchased and revised commissioner prices. The CAG is working through a turnaround plan but the coming year is expected to be a challenging transitional period.

Key financial priorities and investments and how these link to the Trust's overall strategy

The Trust has restricted its revenue investment this year mainly to the support of the AMH and Forensics service transformation programmes, including programme management, organisational development support and the pump priming of extended community teams.

Some additional resources have been invested in estate maintenance and further resources have been set aside to potentially invest in additional ward capacity as reqired (in lieu of spending money on placements in the private sector).

There is also targeted revenue investment in projects and programmes that support the long-term strategy of the Trust including:

- Supporting a zero based budgeting programme.
- Enhancing service line management and removing unnecessary bureaucracy.
- Supporting organisational development activities.
- Supporting innovative practice, particularly that supported by IT.
- Developing opportunities offered by the King's Health partnership.

Key risks to achieving the financial strategy and mitigations.

The Trust has reviewed its approach to risk management and reconsidered the major risks that need to be managed and mitigated to ensure the Trust delivers the objectives within its Plan to Budget. These top-level risks and a summary of the action plans that address them are tabled overleaf:

Objective	Risk area	Risk description	Management of risk
Provide effective and efficient services that meet the needs of our service users	Forward Plan	Failure to deliver the Forward Plan [CIPs and QIPPs]	Improve 'SMART' monitoring of CIP and QIPP delivery. Manage performance of CIP and QIPP delivery, holding managers to account at Board meetings.
	Activity	Demand for services exceeds capacity and contracted levels	Improve capacity and demand forecasting. Establish bed management office and monitor performance.

Objective	Risk area	Risk description	Management of risk
			Agree how best to use £3m demand contingency monies set aside for additional capacity and/or placements.
	Adult Mental Health Services transformation	Insufficient capacity & capability to deliver the AMH transformation programme (due to its scale and experimental nature).	Produce SMART Business Case. Identify and train implementation project team. Monitor progress against plan and report to Board.
	Forensics transformation	Insufficient capacity & capability to deliver the Forensics transformation programme (due to its scale and experimental nature).	Produce SMART Business Case. Identify and train implementation project team. Monitor progress against plan and report to Board.
Retain the position of a leading mental health trust, with proven clinical and business success	Organisational and operational position	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.
	Estates responsiveness	The estate is not functionally suitable for key services.	Initiate rapid response arrangement and create buffer stock of key estate components. Improve operational, programme and project management arrangements. Ensure proactive approach to statutory testing and remedy.
	Decision support	Lack of timely and accurate performance information [clinical, contractual, bed, etc]	Identify information requirements, establish data supply (source and timetable) and monitor performance.
	Business retention	Failure to retain and develop our business (retain/expand market share, expand into new markets and respond to commissioner needs, policy and intentions).	Ensure that SLaM's models of care are seen to be innovative and credible. Identify prospective customers, review their requirements and provide appropriate response.

Objective	Risk area	Risk description	Management of risk
	New NHS	Failure to develop robust relationships with CCGs, SCGs and Local Authorities, in light of commissioning changes and the introduction of Payment by Results.	Refresh marketing strategy and commit to a market share defence / expansion plan. Improve relationships with key GPs, commissioners and boroughs through targeted contact, information provision and support. Review 4Ps (product, placement, price and promotion) approach to service offering to community, GPs and commissioners.

Membership commentary

The Trust continues to grow the membership base of the organisation and as at 31st March there were 12,184 members. Good progress was made on the recruitment of public members but there was a disappointing increase in our patient or service user and carer constituency. This will be the top priority in terms of membership development for 2013/14.

The Council of Governors (Members' Council) has established an active membership development and communications working group which has taken forward ideas for strengthening the membership base. The definition of the membership "offer" has been considered and refined by this group. The group has also helped in the development of a membership benefits scheme which will be launched in May 2013.

Communication with the membership has improved with the production of a more detailed monthly electronic bulletin which is sent to all members with access to e-mail.

The Council of Governors (Members' Council) has continued to support the bids scheme set up in 2007, this year titled "Make Me Smile Again". This continues to prove to be a unique way of engaging with the membership and has been quoted as an example of good practice.

The Trust confirms that all elections to the Council of Governors (Members' Council) were held in accordance with the election rules. By elections will be held in the summer to fill vacant positions on the Council of Governors.