

# Annual Plan 2008/09

South London and Maudsley  
NHS Foundation Trust

May 2008



## Annual Plan 2008 – 2009

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# 1. Past Year's Performance

## 1.1 Chief Executive's summary of the year

On 14<sup>th</sup> February 1908 Henry Maudsley wrote to the London County Council offering to contribute £30,000 towards the costs of establishing a "fitly equipped hospital for mental diseases." This letter set in motion the chain of events that led to the opening of the Maudsley Hospital.

100 years on, it is worth reflecting on three of the principles which lay behind Maudsley's mission: first, that we should aim to provide effective treatments for mental illness, just as we would for any other illness, in order to try to get people better, rather than simply removing them from society; second that there should be research into finding new and better treatments; and third that there should be centres for training people who are able to deliver those treatments.

There have been a number of developments in the course of the last year which are examples of the fulfilment of Maudsley's legacy. The most obvious example is the opening of our new Medium Secure Unit, River House. This 89-bed development at Bethlem Royal Hospital provides the opportunity for people to be treated locally, and as part of an integrated system of care, underpinned by the principles of recovery, which can help them return to a degree of independence as swiftly and as safely as possible. The unit exemplifies our commitment to raise the standards of inpatient care, both in terms of the quality of intervention and treatment and the environment. The opening of this Unit also enabled the final closure of Cane Hill Hospital, achieving the first stage of our plans for the consolidation of our acute inpatient sites.

Another important development in the course of this year has been our success - as part of a consortium with Care UK and the provider arm of Lambeth Primary Care Trust - in being awarded the contract to provide healthcare services at Brixton prison from May 2008. As well as delivering GP services and running the healthcare wing at HMP Brixton, the partnership will provide specialist treatments in mental health and addictions to address high levels of need in the prison population. There will, for the first time, be continuity of care, so that prisoners will have direct access to local community services on their release from prison. It is the first time that an NHS Foundation Trust has become responsible for the model of care in the prison healthcare wing.

We were pleased to host a visit to the Maudsley and Institute of Psychiatry, King's College London, by the Secretary of State for Health, Alan Johnson when he launched a major programme to train the new workforce of psychological therapists required to implement the Improving Access to Psychological Therapies programme. These therapists will provide high intensity therapy for people with moderate to severe conditions and low intensity therapy for people with mild to moderate conditions.

The Trust, in partnership with the Institute of Psychiatry, now manages the UK's only NIHR Biomedical Research Centre for mental health, providing a real opportunity to ensure that lessons from research feed directly into patient care - from 'bench to bedside' as it is sometimes described. Our involvement in plans to develop an Academic Health Sciences Centre (AHSC) takes this to another level. The AHSC - being developed in partnership with Guy's and St Thomas' NHS Foundation Trust, Kings College Hospital NHS Foundation Trust and King's College London - will be the first centre of its kind in the UK to harness clinical and research expertise in both physical *and* mental health.

The AHSC will work as a partnership and collaboration, and so will not alter our operation as an NHS Foundation Trust. It will however bring us into a more formal strategic alliance with one of the world's leading research led universities and two of London's most successful acute NHS Foundation Trusts. This will create a centre where excellence in research, teaching and clinical practice are brought together for the benefit of patients. The AHSC will bring real and lasting benefits to the local communities of south London, not only providing world leading healthcare experts and clinical services, underpinned by the latest research knowledge, but it will also benefit the local area in terms of regeneration, education, jobs and economic growth.

At the same time as competing on the international stage, our focus remains on providing local people with the very best that the NHS has to offer. The essence of our Trust is in its name – we are rooted in South London and grounded in the clinical reality of serving a local inner city community with high levels of mental health need. As custodians of the mission Henry Maudsley set out 100 years ago, we will remain focused on developing the best possible treatment, research and education for the benefit of service users.

### **1.1.1 Overall performance**

The Trust's track record for effective financial management was maintained during 2007/08, reflected in our 'excellent' rating by the Healthcare Commission for financial performance. In 2007/08, the Trust declared a surplus of £5.2m which was £0.2m above the Plan agreed by the Board at the start of the year.

In 2006/2007 the Healthcare Commission assessed the Trust's quality of services as 'good'. This assessment consists of three components:-

- a) Standards for Better Health (StfBH): The Trust 'fully met' compliance with the core (or basic) standards required of us as an NHS Trust. The Trust's declaration of compliance against these standards was supported by an assessment conducted by the Healthcare Commission (SLaM having been selected at random for an inspection). Comparison scores with other Trusts are; 1.4% not met, 7.2% partly met, 29.0% almost met and 62.4% fully met.
- b) Existing national targets: The Trust 'almost met' compliance with existing national targets although the Trust did perform well for many aspects of this assessment. The reason we did not receive a 'fully met' rating in this area was because of the way in which home treatment was configured in one part of the Trust. The criteria used by the Healthcare Commission for this rating changed from the previous year (when we were assessed as having 'fully met' the standard). We subsequently reviewed our arrangements to ensure that they are consistent with the assessment criteria used by the Healthcare Commission for 2007/2008. Comparison scores with other Trusts are; 9.1% not met, 0.0% partly met, 5.5% almost met and 85.4% fully met.
- c) New national targets: The Trust received a score of 'excellent' on our performance in the area of meeting new national targets to improve the health of the population. This covers issues such as increasing the proportion of users successfully sustaining or completing drug treatment programmes, suicide prevention, infection control and community mental health team integration. Comparison scores with other Trusts are; 1.8% weak, 10.7% fair, 17.9% good and 69.6% excellent.

#### *Health Care Commission Targets 2007/2008*

Our general statement of compliance for 2007/2008 was as follows:

“The Board of Directors has significant assurance that there have been no significant lapses in meeting the core standards during the period 1<sup>st</sup> April 2007 to 31<sup>st</sup> March 2008. South London and Maudsley NHS Foundation Trust is fully compliant with the Standards for Better Health core standards.”

### **1.1.2 Changes in Trust management arrangements**

The foundations have been laid for the implementation of Service Line Management (SLM) and Reporting through a comprehensive rolling programme across all clinical services to review baselines for service types, activity and budgets. The Trust is active in pan-London work to develop needs based clusters as the basis for future contracting and care pathways, and is participating in the Monitor sponsored pilot to develop SLM.

During the last year the Developing Organisation and Community Directorate has been refocused on Strategy and Business Development. A major part of this programme has been continued development work on the model contract template with local PCTs. This work is now increasingly being shared across the country with the Trust's national specialist commissioners in terms of specifications for services and agreed terms and conditions.

A review of the management structure of the Specialist Directorate [which covers Addictions, National Specialist services and Adults with Learning Disability] identified the need for additional senior management capacity for National Specialist services in view of the competitive environment in which they operate and the potential for growth. The management capacity has now been strengthened by the establishment of a new Director post with specific responsibility to lead those services.

Staffing levels across the organisation have remained reasonably stable over the last year. Whilst there has been a reduction in staffing in some directorates the opening of the new forensic inpatients services resulted in the creation of 68 additional posts. Job satisfaction across the organisation, demonstrated through the staff survey, is above average in comparison with other mental health trusts.

There has been significant progress with the implementation of the Trust Workforce Strategy with the centralisation of Human Resources (HR) transactional and advisory teams, and the implementation of clear human resource protocols and quality standards. The new HR Business Partner role is now embedded within the organisation.

The Electronic Staff Record [ESR] has been introduced and linked to NHS jobs. A comprehensive suite of electronic workforce reports have been initiated, providing managers with direct access to information about their staff at a local level.

### **1.1.3 Financial context and risks**

Following a period of financial instability and deficits in London, the Strategic Health Authority returned to surplus in 2007/08. The overall financial settlement, changes to RAB and the return of previous top slices to PCTs provided more stability in the system and in year investment opportunities. The major impact of this for the Trust was seen in the payment of £3m by Lewisham PCT which we had previously expected to be phased over 2008/09 and 2009/10.

Although the overall financial position improved across London, deficits were still incurred in the acute sector across outer South East London. The 'Picture of Health'

initiative to concentrate and rationalise acute services whilst expanding community services has been consulted upon during the last year [see 2.1.6] and will inform major service reconfiguration over the next three years.

For the future, one of the continuing risks faced by the Trust, despite our success in benefiting from the new national strategy, is the potential loss of R&D income as a result of national changes to the way this funding is allocated. This relates to the replacement of the previous levy received by individual NHS organisations by the new arrangements, which are more focussed on supporting the costs of direct research rather than the costs to services of supporting research activity. There continues to be uncertainty about the total size and nature of the new R&D income streams. In the absence of clear information from the Department of Health, we have updated our assumptions and will plan on the basis of losing a further £18m over the next two years.

Work continued during the year on developing an activity based contract with our four local PCTs. Much of this centred around improvements to data quality, updating service specifications, developing contract currencies and agreeing financial and activity baselines. This has provided an opportunity to review how and when we can progress their development using care clusters and care pathways rather than more traditional ways of counting activity. The Board of Directors will confirm the pace of change towards activity based contracts based upon national policy and the risks and resources involved.

2007/08 also saw a number of opportunities and threats emerge through the increased use of tendering of services. These opportunities and threats were considered by the newly created Strategy and Business Development Directorate, whose remit includes a marketing and business development function. Two early initiatives to be implemented by the Directorate have included creating a business development framework, and establishing a virtual rapid response tender team which has actively started to bid for new developments where they help reputation and strategic positioning for business success. To date this has included successfully tendering in partnership with Care UK and Lambeth PCT to provide healthcare services to Brixton Prison, collaboration with a local Trust to provide support and advice to the British Armed Forces in Germany and becoming a “preferred provider” for the provision of specialist beds to the Sussex PCTs.

## 1.2 Summary of financial performance

### 1.2.1 Income and expenditure

The performance of the Trust is shown below:

	2007/08 Plan £m	2007/08 Actual £m
<b>Income</b>		
Clinical Income	277.3	284.2
Non – Clinical Income	52.8	52.9
Total Income	330.1	337.1
<b>Expenses</b>		
Pay Costs	228.8	221.8
Non Pay Costs	80.8	91.1
<b>EBITDA</b>	<b>20.5</b>	<b>24.2</b>
<b>Net Surplus/(Deficit)</b>	<b>5.0</b>	<b>5.2</b>

This performance is set against a backdrop of:

- Internal investment in the Trust of £10m using non recurring funding and an in year generated surplus. Significant investment was made in ICT (development of infrastructure, EPJS and security/storage of information), estates and facilities (compliance work including asbestos removal), clinical directorates (to accelerate service quality and improvement, increase strategic capabilities, improve cleanliness and improve monitoring of the patient experience) and corporate (development of Service Line Management). In addition, internal non recurring financial support was given to Lambeth and Southwark Adult services following the loss of R&D income and disinvestment by local PCTs.
- Payment of £3m by Lewisham PCT and £0.25m by Lambeth PCT ahead of Plan.
- The full year effect of disinvestment in services by Lambeth and Southwark PCTs (£4m in 2007/8). The Trust implemented a number of agreed service changes following the decision by Lambeth and Southwark PCTs to reduce their contracts with the Trust in line with resources available to them.
- A reduction in R&D income (with no offsetting reduction in R&D costs) of £2.3m
- Internal support of £1.2m required to fund the transitional costs of opening River House (a new 89 bed forensic unit).
- Interest received of £2.7m due to both a higher interest rate and higher cash balance than expected.
- A wide ranging programme of cost improvements required to meet Government efficiency targets, cost pressures and re-investment into more efficient service delivery and other improvements.

Although the overall position was on target, there were areas of the Trust that did not meet their planned financial targets. With agreement, the Estates & Facilities Directorate spent £0.8m above Plan in order to progress compliance works by March 2008. The cost of forensic/complex placement costs were also higher than planned. Both issues are being addressed as part of the 2008/09 Annual Plan.

The main differences between the planned income and expenditure and actual were:

- The Trust agreeing a payment by Lewisham PCT of £3m which we had previously expected to be phased over 2008/9 and 2009/10. The Trust also agreed a similar payment of £0.25m from Lambeth PCT. This was agreed as part of the context for the financial negotiations for 2008/09.
- In year investment (£1.8m) on a variety of schemes by Lambeth, Southwark and Croydon PCTs.
- Over performance on variable income streams linked to activity.
- Various in-year grants and successful bids for income that were not anticipated in the Plan.
- Budget underspends in some directorates due primarily to vacancies.
- Continued overspends on external placements due to high activity and delayed discharges.
- In year investment decisions particularly in areas of non pay (compliance and other estate works and ICT).

As a result of the significant increase in income highlighted above, EBITDA was higher than Plan although the net surplus remained on Plan. This was due to the impairment and write down of two assets – River House and Oaks. The cash from these impairments has been retained and has contributed to the overall improvement in the cash position.

## 1.2.2 Cashflow

	2007/08 Plan £m	2007/08 Actual £m
EBITDA	21	24
Non Cash Operational I&E Items	(1)	(1)
Movement in Working Capital	(3)	7
Net Capital Expenditure	(17)	(20)
Interest Receivable	2	3
Other – PDC	10	12
Other – Dividend paid	(9)	(9)
<b>Net Cash Inflow</b>	<b>3</b>	<b>16</b>

The Trust has no short-term or long-term loans and during the period it was not required to make use of the committed working capital facility with Lloyds TSB bank. There was no draw down of funds against the Prudential Borrowing Code of £71.4m.

Net capital expenditure of £19.2m was £13.5m below plan (cash £21.8m, £14.3m below plan). £2.8m of slippage occurred on works to expand beds at Lambeth Hospital to facilitate relocation from St Thomas'. This was due to negotiations with the P21 partner over the GMP. The need to address the asbestos removal mentioned previously has also had some knock-on impact on the delivery of some of the capital schemes.

The Trust Board approved new-build developments in Croydon across two sites totaling £15m. The buildings will provide accommodation for CAMHS and AMH services and also PCT services, and are funded from property disposals. A P21 partner has been appointed to progress to design and planning through to FBC and construction should commence towards the end of 2008/9.

## 1.2.3 Financial risk ratings

Metric Used	Criteria	2007/08 Plan	2007/08 Actual	Rating Given
EBITDA margin	Underlying performance	6.2%	7.2%	3
EBITDA, % achieved	Achievement of plan	97.3%	118.4%	5
Return on Assets	Financial efficiency	4.3%	5.8%	4
I&E Surplus Margin	Financial efficiency	1.5%	3.1%	5
Liquid ratio	Liquidity	54.9 days	64.1 days	5
Weighted Average		3.6		4.3
<b>Overall Rating</b>		<b>4</b>		<b>4</b>

The Trust achieved an overall financial risk rating of 4, in line with the 2007/8 Plan. The main variances occurred on financial efficiency and achievement of plan and came about through the underlying surplus being above Plan.

There were no one-off exceptional I&E items (Income and Expenditure) as defined by the UK GAAP (i.e. FRS3 'reporting the substance of transactions').

### **1.3 Other major issues**

There were no major financial risks in 2007/08 including unplanned reductions in income or increases in costs. Discussions with external auditors have not revealed any issues of concern. Furthermore there have been no investments that could affect the Trust financial risk rating. The Board of Directors has not been made aware of any other significant issues which might materially affect the risk ratings of the Trust or suggest material weaknesses in financial governance systems and controls.

There was no loss of accreditation for mandatory services and the Trust did not vary mandatory services provision or dispose of assets contrary to the terms of authorisation.

The capital development of the Estate portfolio remains a challenge. During 2007/08 the River House development was completed on budget and on programme. However this was in contrast to the number of smaller projects which suffered slippage - resulting in a significant under spend on the Capital Programme. Whilst some of the programme slippage was due to service specification changes the scale of the non-client related poor performance was sufficient to trigger a full review. The Department reviewed all practices, in line with ISO 9001:2000 and re-scheduled the overall capital programme. The Board has been given assurance that performance will improve and that the revised Capital Programme will now be delivered.

The maintenance function of the Trust has focused on compliance issues over the past year. This is now to be more closely performance managed to assure the Board that expenditure will be controlled.

Where services had overspent on nursing budgets a number of measures have been put into place to help tackle the underlying problems, and nursing costs will continue to be monitored through reports/information presented monthly to the Board and at the CEO Performance Review meetings.

### **1.4 Changes to the Board of Directors**

The re-appointment of Madeliene Long as Chair and the appointment of Prof Eric Taylor as a Non Executive Director, which were reported in the 2007/08 Annual Plan, were formally ratified at the meeting of the Members' Council held in May 2007.

The Trust had one Non Executive Director vacancy at the start of the financial year. Sue Harvey subsequently resigned as a Non Executive Director of the Trust in August 2007. The Trust advertised to fill the two vacancies and the Members' Council agreed the recommendation of the Nominations Committee to appoint Professor Christopher Clare as a Non-Executive Director of the Trust for a period of three years.

Prof Clare, until his recent retirement, was the Executive Dean for Business, Computing and Information Management at the London South Bank University. He undertakes IT consultancy work for a number of organisations.

The remaining Non Executive Director vacancy will be advertised within the next couple of months. An initial discussion about the skills and experience required took place at the December meeting of the Members' Council.

Following a recent meeting of the Trust Remuneration Committee Zoë Reed's portfolio has been extended to undertake additional functions and her post is now titled Director of Strategy and Business Development.

## 2. Future business plans

### 2.1 Strategic overview

#### 2.1.1 Trust vision and statement of strategy

The Trust Strategy was launched at the Trust AGM in September 2005 and following extensive consultation the final amended Strategy was approved by the January 2006 meeting of the Trust Board. It was included in our Foundation Trust Application. It is currently being updated to reflect the changing context and priorities.

Our strategic objectives are:

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

Our core value is:

- Everything we do is to improve the experience of the people using our services and to promote mental health and well-being for all

It has as its central guiding principle:

- Treat others as you would have them treat you

This guiding principle ensures that all our actions as individuals and as an organisation are consistent with our values-driven commitment to team work, mutual respect, improvement and learning.

Over the next few years we plan to drive strategic implementation plans which set out how our three objectives will be achieved in practice and how they relate to the Trust's progress in its competitive and market environment.

#### 2.1.2 Academic Health Sciences Centre

In April 2008, the Trust, together with King's College Hospital and Guy's and St Thomas' NHS Foundation Trusts and King's College London declared a combined intent to establish ourselves as the UK's largest Academic Health Sciences Centre.

Our Mission is to be one of the world's leading centres for basic, translational and clinical research. That is applying world-class medical science research to deliver better clinical care and patient outcomes.

We will achieve this through:

- The seamless integration of clinical care, research and teaching.
- Harnessing our collective expertise to promote health in mind and body.
- Building on our experience of outstanding healthcare delivery and research in a world city with over 300 diverse communities.
- Working with our diverse local communities to research and develop new treatments in a wide range of diseases and conditions.
- Bringing a unique perspective to the world stage – based on the breadth of our clinical expertise, the depth of our academic research and the length of our history.
- Building our reputation as a major force in healthcare delivery, teaching and research, helping us to attract the highest calibre health care professionals, academics and researchers as well as the best and brightest students.

- Working together to maximise new funding and charitable opportunities, including research grants, commercial partnerships and ambitious fundraising initiatives that will complement our existing income streams.
- Exploiting the advantages of the breadth of expertise brought to the AHSC by the unique strengths of each of our partners.
- Continuing to develop our hospitals as highly rated clinical and academic centres.
- Playing an active part in the development of health services in London, including working with other partners and local communities to improve health outcomes.

### **2.1.3 The Trust Board**

The Trust Board of Directors provides the leadership of the organisation. It sets strategic aims, allocates resources, monitors implementation of strategy and reviews management performance. The Board, led by the Chair, is collectively responsible for the exercise of the powers and the performance of the NHS Foundation Trust. It provides active leadership of the Trust within a framework of controls which enables risk to be assessed and managed.

The Trust Board has continued to meet in public on a monthly basis. Discussions in private are restricted to confidential items related to staff, patients, business development or consideration of draft submissions to regulators. A successful Annual General Meeting was held in September at the Brit Oval.

Seminars have been held to raise Board awareness on specific topics. In October the Board spent a day, the first of two and a half days over a six month period, devoted to the annual planning process. At the October 2007 seminar the Board developed the Investment for Improvement programme. Building on this approach a programme of half day seminars is being developed and will be implemented during 2008-09.

Board members have worked closely with colleagues in our partner organisations in the development of the Academic Health Sciences Centre. Further activity will take place in 2008/09 in the development of Workstream activity.

The Chair is a stakeholder representative on the Members' Council of the Guys and St Thomas NHS Foundation Trust and the Chief Executive is a representative on the Kings College Hospital Board of Governors.

Board members have provided support to FT applicant Trusts and have been actively involved in the Foundation Trust Network. The Chair has addressed a number of conferences on Board development in Foundation Trusts.

Prior to the passing of the Mental Health Bill 2007 and subsequent amendment to the Trust constitution in September 2007, Non Executive Directors were devoting significant time to attending hearings under the Mental Health Act. Although the activity is less than prior to the constitutional change, the Non Executive Directors continue to sit as hearing panel members along with their Associate Hospital Manager colleagues.

### **2.1.4 Engagement with Members' Council**

During 2008 the Members' Council has been alerted to opportunities to influence the future direction of the Trust through the annual planning process. The Members' Council has established three workstreams on:

- Improving the Patient Experience.
- Promoting Mental Wellbeing.
- Promoting Social Inclusion - to ensure the social inclusion of people with mental health problems, including employment and vocational opportunities, housing, access to physical health care, social networks and community participation, stigma and discrimination.

Funding was allocated to the Members' Council to establish an innovative programme where members could bid for funding relating to the three workstreams. The response rate was very good with 300 bids received. Panels were established to shortlist the bids against a clear and brief criteria. One important aim of this process has been to identify the themes emerging from the bids so that they can inform the next business planning process.

The Members' Council have also identified that membership development is another area which needs to feed into the business planning process [see Section 5.2 for membership commentary].

### **2.1.5 Service developments and use of surplus and cash balances**

The following section describes the service development plans, mapped onto the Members' Council workstreams. These service developments will help guide decision making on the use of resources over the coming year.

- **Improving the patient experience**

The national patient survey provides good feedback on the patient experience; however this is only one feedback mechanism, limited to a defined and relatively small sample of patients on a yearly basis.

In light of this, the Trust is developing and implementing an action plan which during 2008/09 aims to explore options for systematically collecting and acting on feedback from patients about their experiences, using a number of mechanisms to effect change. The larger samples, giving team level results, will give more informed feedback and enable problem areas to be targeted. The real-time data allows for much more immediate change, and more in-depth qualitative data from focus groups enables a better understanding of what longer-term actions are needed.

The Trust has also invested in an initiative to improve and enhance inpatient care. The 'All Inpatients Quality Improvement Programme [AIQUIP] is a five year programme, which commenced in October 2007, and which will enable all inpatient services in the future to achieve a recognised external accreditation.

- **Promoting well-being**

The Trust's mental health promotion strategy aims to promote mental well-being in communities by working in partnership. We will achieve this by:

- Influencing both internally and externally to ensure that mental well-being is core to service delivery.
- Working with organisations, communities and individuals to build their understanding knowledge and capacity and to promote mental well-being.
- Providing innovative well-being services.

This will include contributing to a range of partners' strategies and meetings, robust measurement of mental well-being, action learning sets, training and events. One key strand will be developing work around positive psychology and happiness, and workstreams are designed to reflect the broad diversity of our service users.

- **Promoting social inclusion**

We are focusing on social inclusion, rehabilitation and recovery (SIRR) and working to develop stronger partnerships with social services and local authorities in areas of housing and leisure, schools and faith groups in terms of combating stigma and opportunities for partnership working with the voluntary sector.

The themes identified in the SIRRs strategy that was developed last year are:

- Recovery orientated practice – adopting the proposed Recovery Charter and Principles as the foundation for our services, and ensuring that staff are trained and supported to work with a recovery focus.
- Work and employment – supporting people who are using our services to access a range of socially inclusive employment and vocational opportunities, e.g. employment, training, education or voluntary work.
- Housing – improving the access to appropriate housing for people with mental health problems.
- Physical health – ensuring that people using our services have the opportunity and are given support to obtain good physical health and well being as part of their recovery journey.
- Access to community resources – improving access to community resources and opportunities for participation for people using mental health services.

### **2.1.6 The local health environment**

The Trust's assessment of the local PCT's financial position is that 2008/09 is more stable than in the previous years and in some cases, such as with Lambeth PCT, there has been additional non recurrent investment to support service redesign. However this is offset by the fact that as the PCTs repaid previously agreed brokerage from the Trust early [because they had larger cash balances than expected at the end of 2007/08] this has had an adverse impact on the planning assumptions for 2008/09 by approximately £3m.

The Trust also has close relationships with local authorities and PCTs which is reflected in a number of Section 75 agreements. There is active participation by all three parties in Partnership Boards which facilitates work on social inclusion and well being. In Addictions Services there is a plurality of service provision and complex funding streams. All three partners [the Trust, PCTS and Local Authorities] are working together to ensure delivery on National Treatment Agency (NTA) targets.

As mentioned in Section 1, the Trust is now part of an Academic Health Sciences Centre alliance, along with Guy's and St. Thomas's and King's College Hospital NHS Foundation Trusts and King's College London.

We continue to collaborate with NHS London in a number of strategic areas including the provision of education and training of future workforce as well as national developments including:

### *Healthcare for London*

The Trust is committed to the framework proposed in the Healthcare for London programme. The Trust responded to the 'Healthcare for London consultation: A Framework for Action' jointly with its AHSC partners. The organisations are supportive of the aims of the high level proposals in the consultation and have outlined in their response the significant contribution that collectively an AHSC in South London can make to improving the health of Londoners.

The Trust hosted a conference on the implications of Healthcare for London for mental health and Professor Graham Thornicroft, the Trust's R&D Director, led the continuation of the mental health workstream of Lord Darzi's review to develop three clinical care pathways.

### *A Picture of Health*

The four AHSC partners also responded jointly to the consultation 'A Picture of Health' which contains proposals for improving and ensuring the sustainability of local health services in outer South East London. The partners see the future AHSC as having a major role in the sector both in working with provider trusts and the Picture of Health project team to shape and develop the service reconfiguration proposals, and also in the continuing delivery of service provision across outer SE London in terms of tertiary, outreach and networked services. As part of this work the partner organisations will explore the relationships with our SE London Trusts as we believe that we can make a significant contribution to future plans.

## **2.1.7 Contracting Strategy**

- The Trust has signed a new contract with each of its major PCTs for the next two years. This allows for the introduction of a 12 month termination clause should the new DOH mental health contract be introduced, but on the basis that developments and commitments agreed for 2009/10 during the next year are carried forward.
- The Trust has successfully agreed to put both CAMHS Tier 4 and Adult National Specialist services onto cost and volume arrangements with all its commissioners and will be operating high cost/low volume activity on the basis of expected demand.
- The Trust participates in sector and local PCT specialist consortium meetings, and adult mental health clinicians from each borough are also active in local tertiary panels with each of the four main PCT commissioners to support clinical decisions about use of funding.
- This year saw the introduction of risk shares in forensic and complex placements with Lambeth and Southwark PCTs. The risk of high volumes of placements has been reduced by the opening of River House which has significantly increased our Forensic/MDO provision and will reduce MDO/overspill placement cost pressures.
- Embedding service line management in the context of local, London-wide and National work on needs based clusters / care pathways is a priority in 2008-09. We have invited our key commissioners to engage with the Trust on this development, which is part of a London-wide programme.
- The contract portfolio for the Trust remains largely unchanged except at the margins, although the number of PCTs has reduced due to amalgamation outside London. We intend to focus next on a review of expenditure contracts [contracts

where the Trust sub-provides care] to gain greater efficiencies over the next two years.

### **2.1.8 Marketing proposals, innovations and development of commercial opportunities**

During last financial year the Trust developed its capacity and shaped its approach to Business Development.

A number of early tendering ventures provided useful learning that have shaped the current arrangements. This includes the creation of a Business Development Framework and tender completion support website which is now being promoted across the Trust and the formation of a Business Development and Innovations Forum.

The work last year has established the necessary infrastructure to enable the Trust to respond to business opportunities. This includes leading the work across England to establish a network of mental health trusts able to respond to the recent MOD tendering for the provision of mental health in patient services. This process is currently underway and the work provides a basis from which bids for other national work could be made.

The Trust also undertook a number of marketing initiatives including appointing consultants to review the positioning of the National Specialist business in particular, and the Trust overall. Appropriate structures and resource changes are being put in place locally and centrally.

### **2.1.9 Research and development proposals**

We are strongly committed to maintaining the quality and breadth of our research portfolio and to maximising our position within the new funding climate that follows the launch of Government's research strategy for the NHS, *Best Research for Best Health, 2006*. Through the Trust's cost improvement plans we have so far continued to accommodate all of our research activity in a context of considerably reduced NHS R&D income. We have continued to work in close partnership with the Institute of Psychiatry (IoP), King's College London, the partnership having been successful in securing funding and taking forward activity under several new R&D funding developments including a specialist NIHR Biomedical Research Centre in mental health, NIHR Technology Platform funding for neuroimaging and six NIHR programme grants for applied research. For 2009/10 the biggest financial risk for the Trust is the expected further substantial loss of R&D income and the challenge that this will bring in terms of continuing to support our research portfolio.

The Trust is a member of the intellectual property hub, NHS Innovations London, with which it is working to encourage staff to develop the potential of their innovative ideas including through business development and commercialisation.

### **2.1.10 Relationships with healthcare stakeholders**

Our key healthcare stakeholders are the four South London PCTs and Local Authorities and we continue to build and maintain effective relationships with them at all levels. We also work closely with local acute care providers.

### **PCTs**

The concept of core contract teams who are led by an Executive Director both from the PCT and the Trust has become embedded and these meet monthly to provide an overview of all contract issues. In addition the Trust meets all the four major PCTs as a group on a quarterly basis to engage on common contract and strategic commissioning issues such as the development of the model contract. There are also a number of sub-groups to look at technical issues such as information flows and finance. In addition local service directorates engage with Commissioners via care group meetings and Partnership Boards to discuss clinical and service development issues.

### **Local Authorities**

The Trust has close relationships with local authorities, as mentioned earlier this is reflected in a number of Section 75 agreements, and we are active participants on all Partnership Boards.

The Trust engages with our four local Overview and Scrutiny Committees (OSCs) within Croydon, Lambeth, Lewisham and Southwark on specific clinical service changes including older adults day care in Southwark. Information about specific consultations is published on our website [www.slam.nhs.uk](http://www.slam.nhs.uk). We also attend local OSCs on request to provide a broader overview of service provision within local Borough services.

### **LINKs (Local Involvement Networks)**

Currently each Local Authority (LA) is in the process of setting up their LINKs. Under legislation, each LA has set up transitional arrangements from 1 April 2008, while they tender for and appoint a host organisation to support the LINKs. Once in place the host organisation will recruit LINKs members and work with those members on organisational structures. Such structures will possibly contain mental health forums and the local mental health services within SLaM will liaise with the appropriate forums. It is also possible that eventually the mental health forums in Lambeth, Southwark, Lewisham and Croydon may wish to set up a forum which relates directly to SLaM. Corporately, the Strategic Lead for PPI and Community Connections within SLaM will keep an overview and liaise with all the relevant local LINKs, addressing Trust-wide issues as they arise.

### **King's College Hospital and Guy's and St Thomas' NHS Foundation Trusts, King's College London and the Institute of Psychiatry**

The Trust has a good working relationship with these organisations, which has been strengthened by the more formal strategic alliance of becoming an AHSC. This development offers many opportunities for joint working including securing greater efficiencies and effectiveness in clinical care and research delivered within a sustainability framework.

### **University Hospital Lewisham NHS Trust**

The Trust continues to work closely with University Hospital Lewisham, particularly where one organisation requires the clinical expertise of the other for people who experience both mental and physical health problems. As outlined in section 2.1.5 the AHSC partners responded jointly to the consultation on configuration proposals for health services in South East London, "A Picture of Health for Bexley, Bromley, Greenwich and Lewisham" and we look forward to further collaborative work with colleagues on how we can best support the needs of people with mental health problems who also use acute hospital services.

### **Mayday Healthcare NHS Trust**

The Trust has a good working relationship with Mayday Health Care Trust and maintains a formal strategic alliance through membership of the Healthy Croydon

Partnership Executive. This offers opportunities to plan together health improvements and secure service efficiencies for local residents

## 2.2 Service development plans – activity and finance

### 2.2.1 Overview

The four major income contracts have been signed [see Section 2.6 for details].

### 2.2.2 Growth and activity assumptions

The 2007/08 planned activity profiles were based on a capacity model and included in the model contract for that year. During 2007/08 the Trust reviewed and revised the currencies in discussion with the PCTs. This means that some of the Trust's activity in 2008/09 has moved from one currency definition to another. This largely explains the difference in profiles between the two years. It is important to note, however, that this activity is contained within block contracts so changes in currency allocation and/or numbers do not affect income.

Additional variation in the OBDs for cost and volume contracts reflects the full year effect of forensic service developments in particular River House (89 bed unit).

	<b>2007/2008 Content</b>	<b>2008/2009 Content</b>
<b>Admission</b>	All acute inpatient activity (adult, MHOA), continuing care and rehabilitation services	MHOA acute and Lewisham acute where variation is low and data quality is high
<b>Referrals</b>	New referrals for all community teams and inpatient liaison.	New referrals for all community teams
<b>OBDs (block)</b>	Not previously used as a currency in the block contract	Acute inpatient activity (adult, MHOA), continuing care and rehabilitation services
<b>OBDs (cost and volume)</b>	National adult and CAMHS	National adult and CAMHS and forensic services
<b>Outpatients</b>	National adult and CAMHS	National adult and CAMHS
<b>Liaison</b>	A/E attendances	A/E attendances and inpatient referrals

2007/2008 planned and actual performance:

	<b>PLAN</b>	<b>ACTUAL</b>
	<b>2007-08</b>	<b>2007-08</b>
Admissions	4054	4002
Referrals	29446	30600
OBDs	95950	102144
Outpatients	33368	35254
Liaison	8325	8259

The only significant variation for the year is in Occupied Bed Days. The increase in activity of 6.4% is a reflection of increases in adult and CAMHS national services which are part of cost and volume contract and therefore represent an increase in income for the Trust. Forensic activity also contributes to this increase in performance as the Plan is based on 95% bed occupancy and the actual a reflection of 100% occupancy.

## 2008/2009 Plan

<b>CURRENT PLAN</b>			
	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>
Admissions	1443 <sup>1</sup>	1443	1443
Referrals	21763 <sup>2</sup>	21785	21785
OBDs (block)	175852 <sup>3</sup>	158862	155741
OBDs (cost and volume)	147577 <sup>4</sup>	147577	147577
Outpatients	30016 <sup>5</sup>	30016	30016
Liaison	11724 <sup>6</sup>	11724	11724

1. This includes acute admissions for those areas of low variation and high data quality
2. This includes new referrals to community based teams and no longer includes inpatient liaison
3. This includes acute services and long stay services such as rehabilitation and continuing care in a block contract arrangement
4. This includes activity in a cost and volume agreement i.e. national adult and CAMHS, addictions and forensic services
5. This includes national adult and CAMHS services
6. This includes inpatient liaison and A/E attendances

As mentioned above, during 2007/2008 the Trust undertook extensive work in preparing for an activity based contract approach. This involved reviewing activity over the previous three years and comparing this to previous activity targets based on capacity assumptions. The Trust worked closely with our local PCTs in considering this information to produce an activity profile for 2008/2009. Key decisions on the choice of currency for activity included in a block contract arrangement were based on the robustness of the data i.e. minimum variation and high data quality. The significant change from last year is the use of OBDs, not only for services that have a long length of stay / low throughput, but also for many of the Trust's acute services. We will continue the development of contracts that link activity and finance through needs based clusters and the care pathway approach.

## 2009/2010 and 2010/2011

The planned figures for this period have been adjusted to reflect service changes over the same period as contained in the Trust Estate Strategy.

See Section 3.1 (4) regarding infection control measures, including reference to MRSA bacteraemia and C. difficile infections.

## 2.3 Operating resources required to deliver service developments

Operating costs are analysed in the Plan over 5 categories, pay, drugs, clinical supplies and services, secondary commissioning and other non pay operating costs.

The table below compares the historic achievement for operating resources against the current Plan.

<b>Operating Expenses</b>					
<b>£m</b>	<b>Plan</b>	<b>Actual</b>	<b>Current Plan</b>		
	<b>2007/08</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>
Pay	229	222	242	234	233
Drug Costs	11	11	11	10	10
Clinical Supplies	1	1	1	1	1
Secondary Commissioning	25	32	32	32	32
Other Non Pay	44	47	43	41	41
<b>Total</b>	<b>310</b>	<b>313</b>	<b>329</b>	<b>318</b>	<b>317</b>

Operating costs have been adjusted for the forecast changes arising from service development plans and are shown net of forecast cost reductions described below. Details of the assumptions on inflation and other cost pressures within the Plan are provided in the section on “summary of key assumptions” below.

Total costs increase in 2008/09 due to inflation and additional investment by local PCTs. However, in 2009/10 costs will be required to fall or income increased in order to offset the loss of R&D income.

The focus on workforce over the next financial year will continue to be increasing capacity and continual quality improvement. The provision of temporary staff will transfer to NHS Professionals to improve clinical governance and the quality of temporary staff provision. We are also considering proposals to introduce an electronic rostering programme across the organisation.

We will be developing our managers through the Trust’s “Developing Leaders, Developing Performance” programme, whilst all management appointments will be supported by recruitment assessment centres. Working with our Academic Health Centre Partners we will be undertaking more in-depth analysis and research of the area of concern in the staff survey in relation to bullying and harassment.

### 2.3.1 Cost improvement programme

A summary of the Trust’s cost improvement programme is provided in the table below:

<b>Cost improvement plans</b>					
<b>£m</b>	<b>Plan</b>	<b>Actual</b>	<b>Current Plan</b>		
	<b>2007/08</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>
Pay	4.0	3.7	4.0	11.5	5.7
Drugs	0.5	0.5	0.4	0.5	0.2
Other	3.0	2.2	5.0	3.5	1.8
<b>Total CIP</b>	<b>7.5</b>	<b>6.4</b>	<b>9.4</b>	<b>15.5</b>	<b>7.7</b>

The increase in the CIP required over the next 3 years results from a higher national efficiency target (3%), the impact of capital investment and loss of R&D income. In particular in 2009/10, the Trust will experience the full impact of the final phase of R&D changes. The Plan assumes no additional income (beyond what has already been agreed) to offset R&D losses, and targets the surplus available for internal investment

at measures to improve our income/cost position. The levels of CIP have also been established to enable the Trust to maintain its financial risk rating of 4.

In addition to its 2008/9 programme of savings, the Trust intends to make progress in the following areas over the coming year to help it address the increasing CIP in 2009/10:

- Transfer inpatient services from St Thomas' Hospital.
- Transfer inpatient services from Guy's Hospital.
- Review all adult acute and MHOA inpatient provision.
- Improve management of ward staffing.
- Seek improved value from contracts for goods and services.
- Dispose of surplus assets.
- Maximise income in areas subject to activity based contracts or where the potential to increase income has not been fully realised.
- Continue discussions with local PCTs on how to deal with the reduction in R&D income and its potential impact on local services.
- Continue discussions with the DoH about changing the R&D funding formula so that it better reflects the fact that NHS support costs in mental health are higher than in other specialties.

The Trust used the performance management tool, developed by Ernst and Young, to help progress its 2008/9 CIP. The tool will help local service teams to check on the delivery of individual steps within each element of the CIP, with progress also being routinely monitored at Board level. In this way key risks which require intervention can be identified early on so that, if appropriate, the impact can be mitigated.

### 2.3.2 Inflation and technical assumptions

#### *NHS income inflation*

The 2008/9 NHS generic uplift of 2.3% is based upon the following national breakdown with forecast NHS uplifts also provided in the table below:

	2008/09		2009/10	20010/11
<b>Increase In Pay &amp; Prices</b>	<b>Actual</b>		<b>Forecast</b>	<b>Forecast</b>
	<b>%</b>		<b>%</b>	<b>%</b>
Pay	2.80		2.08	1.95
Non Pay (price inflation)	0.55		0.55	0.55
Clinical Negligence Costs	0.35		0.30	0.30
Secondary Care Drugs	0.65		0.65	0.65
Revenue cost of capital	0.35		0.20	0.20
Less Efficiency Saving	(3.00)		(3.00)	(3.00)
<b>Net Pay &amp; Price Increase</b>	<b>1.70</b>		<b>0.78</b>	<b>0.65</b>
<b>Reform &amp; Quality</b>				
Various	0.60		0.50	0.50
<b>Total Reform &amp; Quality</b>	<b>0.60</b>		<b>0.50</b>	<b>0.50</b>
<b>Overall Uplift</b>	<b>2.30</b>		<b>1.28</b>	<b>1.15</b>

For all other non NHS income, inflation after 2008/09 is assumed at NHS generic levels.

The application of this inflation funding will vary according to the actual circumstances and cost base of the Trust, as modified by the Trust Board of Directors to address particular priorities.

### ***Expenditure inflation***

The following assumptions have been made regarding inflation from 2008/09 to 2010/11:

<b>Expenditure Type</b>	<b>Inflation To Apply 2008/09</b>	<b>Inflation To Apply 2009/10</b>	<b>Inflation To Apply 2010/11</b>	<b>Notes (re 2008/09)</b>
<b>Pay</b>				
Consultants	2.20%	2.40%	2.25%	As per pay review body
Junior Doctors	2.20%	2.40%	2.25%	As per pay review body
AfC Bands	2.75%	2.40%	2.25%	As per pay review body (3 year deal from 1/4/08)
AfC Bands	0.58%			Full year effect of the 2007/8 pay award
AfC Bands 1-3	Change to unsocial rates			As per agreement with NHS Employers
<b>Non Pay</b>				
Drugs	2.30%	3.00%	3.00%	As per overall NHS uplift
Energy	5.00%	10.00%	10.00%	Uncertain sector
NHS external contracts	2.30%	1.28%	1.15%	As per NHS uplift
Non NHS external contracts (placements)	2.30%	2.50%	2.50%	Target inflation funding
All other non pay	1.50%	2.50%	2.50%	Target inflation funding set for Trust

Provisional agreement has been reached between the DoH and unions on a 3 year pay deal covering all AfC grades. The Plan assumes that the pay uplifts implicit in this deal will go ahead.

### **2.3.3 Phasing of income and expenditure**

The phasing of income and expenditure in the Plan for 2008/09 is detailed below:

- Income – the majority of contract income is spread equally across the year.
- Ring fenced income – some budgets are funded on actual expenditure as it is incurred. For these services the budgets are profiled equally across the year and any underspend is offset by income under-recovery.

- Investment – budgets are profiled according to when expenditure is planned to be incurred.
- Pay expenditure – spread equally across the year.
- Utility expenditure – the profile is based upon historic cost information which weights the budget for the winter months.
- Other non pay expenditure – spread equally across the year.
- Cost improvement programme – budgets are profiled according to when savings are expected to take effect.

### 2.3.4 Investment Decisions

In November 2007, the Board of Directors approved a programme of new revenue investment covering 2007/8 – 2009/10. The themes covered were:

- Responding to patients and the patient experience.
- Improving the environment.
- Improving baseline knowledge for SLM.
- Improving clinical and management information.
- Responding to business development opportunities.

and these are reflected in the 2008/9 Plan as follows:

Investment	Recurrent	Non - Recurrent
	£'000	£'000
Patient experience	97	190
Improving the environment	100	
Implementing SLR		814
Improving clinical/management information	252	886
<b>Total Investment</b>	<b>449</b>	<b>1,890</b>

As part of the Business Planning process, a number of additional areas had investment confirmed by the Board of Directors. These included the full year effect of implementing NICE guidance, improvements to the Care Programme Approach, continuing turnaround support to Lambeth Adults and the transitional costs of implementing the estates strategy.

Additional investment in 2008/9 is subject to review, in the light of the forecast reduction in R&D income and the challenges that this will present. There is limited planned additional revenue investment in 2009/10 – 2010/11 bar any agreed investment from PCTs and the full year effect of supporting the R&D programme.

## 2.4 Investment and disposal strategy

The Trust has a large and complex estate which requires regular review. The Estates Strategy objectives are:

- **Consolidate inpatient services to four main hospital sites**  
In addition to the closure of Cane Hill Secure Unit – achieved in February 2008 following the opening of River House MSU – this will be achieved through:

- Relocation of Lloyd Still Ward from St Thomas' in December 2008 to Lambeth Hospital
  - Relocation of John Dickson and Ruskin Wards from Guy's Hospital back to the Maudsley Hospital in summer 2009
  - Creation of accommodation at Bethlem Royal Hospital for CAMHS inpatient services in summer 2009
  - Consolidation of MHOA services into Aubrey Lewis House, achieved as part of the redevelopment of the Maudsley Hospital.
- **Outsource staff accommodation**  
To be achieved by April 2009.
  - **Undertake major developments to provide modern facilities to improve the patient experience**  
Major schemes identified include:
    - Maudsley Hospital: redevelopment plans to be developed by June 2008
    - Bethlem Royal Hospital: includes relocation of inpatient services at Westways Resource Centre to Wickham Park House, and refurbishment of Fitzmary I ward
    - Lambeth Hospital: development of Oak House to provide new 18 bed ward which will facilitate the relocation of Lloyd Still ward from St Thomas' and AL3 ward from the Maudsley, remodelling of vacant ward space to facilitate relocation of ES3 ward from the Maudsley
    - Ladywell Unit, University Hospital Lewisham: business case being developed for remodelling of all remaining original wards.

The strategy ensures full consideration of privacy and dignity and single sex accommodation, along with safety and security of service users and staff.

During the previous year a number of properties were identified by the Trust as surplus to requirements. Many of the properties were subsequently sold, however a number of those identified did not become vacant within the originally predicted timeframe and will go for disposal in the coming year. These disposals will provide funding for major planned developments and others will be sold during the forthcoming year to further support new projects.

#### Comparison between historic achievement and current plan

	Plan	Actual	Current Plan		
	2007/08	2007/08	2008/09	2009/10	2010/11
	£m	£m	£m	£m	£m
Investment in fixed assets [non-maintenance]	28.2	19.2	21.2	32.9	18.2
Investment in fixed assets [maintenance]	7.9	2.6	9.1	4.5	2.1

#### Asset disposal

Protected	-	-	-	-	-
Mixed use	-	-	-	-	-
Unprotected	19.4	1.9	18.2	2.0	7.8

<b>Protected asset declassifications</b>					
Protected to unprotected	-	-	-	-	-

## 2.5 Financing and working capital strategy

Based on the current financial projections as set out in this Plan, the Trust's working capital requirements over the next three years can be funded from internal sources. The cash balance at 31 March 2008 includes £7m PDC drawn but where the capital outlay is just to occur. The current projection of the cash balance at 31 March 2011 is £28m. The lowest quarterly cash balance within the Plan is £39m.

The Trust has a £25m committed working capital facility from Lloyd's TSB which expires at 31 October 2008. The original agreement includes for the facility to be rolled forward and this has been recently agreed in principle with Lloyds.

The Trust's Plan is compliant with the Prudential Borrowing Code (PBC) ratios as per the table below:

<b>PBC Ratios</b>	<b>Value</b>	<b>Compliant</b>
Maximum Debt/Capital Ratio	0%	Yes
Minimum Dividend Cover	2.0x	Yes
Minimum Interest Cover	0	Yes
Minimum Debt Service Cover	0	Yes
Maximum Debt Service To Revenue	0%	Yes

The Trust is forecasting PDC of £1m in 2008/9 resulting from a share of the sale proceeds of a PCT owned property on which the Trust holds a long-term lease.

It is possible that PDC drawn down but not spent in 2007/08 will have to be repaid to the DH. In a worst case scenario this could mean up to £7m of PDC funding being repaid with a risk that none will be returned back to the Trust under the revised PDC process. This is not considered a material threat to liquidity. In all cases the Trust has reaffirmed the commitment of the DH leads for the projects and kept them informed of the delays. £2m related to R&D is contractually committed the remainder is uncommitted.

## 2.6 Summary of key business assumptions

### Income

The Trust is currently forecasting total income of £348m in 2008/9. This income level is based upon the following factors/assumptions:

#### 2.6.1 PCT income

##### ***Main PCT income***

Around 80% of Trust income is derived from contracts with PCTs, of which 90% is earned from our four key contracts with Lambeth, Southwark, Lewisham and Croydon PCTs.

With the exception of Specialist services, the main PCT agreements have remained under a block contract arrangement. The move to full activity based contracts in local

services was delayed from April 2008 whilst work is undertaken to define and agree care clusters and care pathways. The Plan therefore assumes:

- no change to block PCT funding (2008/9 – 2010/11) beyond that already contractually agreed
- income levels increase under cost and volume arrangements due to an increase in capacity and transfer out of three year rolling average contracts

### **Other PCT income**

The Trust has negotiated to move all its specialist contracts on to a cost and volume basis or a named patient agreement basis. The baseline targets will be set at outturn for Adult Specialist and on a three year rolling average for CAMHS and Addictions. The proposed baselines would result in an increase of c£1.3m (excluding inflation) across these services. However, income will be tied to actual activity performed.

By moving away from block payments all specialist services will now be under activity based contracts where financial performance will be as much about achieving income targets as it is about control of costs.

## **2.6.2 Other main sources of income**

The other main sources of Trust income are via Department of Health central allocations and through Local Authority allocations:

### **R&D income**

A new government strategy for research in the NHS, *Best Research for Best Health*, was launched in January 2006. The impact of this has been to remove R&D levy funding to Trusts over a three year transitional period starting in the 2006/07 financial year, at the same time bringing in several new income streams that are competitively sought for under the umbrella of the National Institute for Health Research (NIHR). We have succeeded in securing competitively allocated funding for a NIHR Biomedical Research Centre, NIHR Technology Platform funding in Neuroimaging and six NIHR programme grants for applied research.

Whilst we have been successful in receiving funding through the new NIHR schemes, we are expecting to lose significant R&D income. Not only are we expecting to receive less funding through the new schemes compared with our R&D levy allocation but much of the new funding is for direct research rather than NHS support costs.

The final funding levels for two key streams (Flexibility and Sustainability and Comprehensive Research Network funding) are still unknown and so these can only be estimated. Flexibility and Sustainability funding levels have been confirmed for 2008/9 but not 2009/10. Funding for the Comprehensive Research Network is channelled through the London (South) Network and was only announced on 31<sup>st</sup> March. The national allocation basis has been amended. This has resulted in a shift of funds to other parts of the country and has left the London (South) Network with less funding than originally forecast. Of the £6.3m allocated to London (South), we are estimating that £947k will come to the Trust (based upon the latest activity data). The final allocation will not be known until June when the London (South) Network Board confirms its spending plans.

The Trust has been informed that it will receive around 42% of its original R&D levy allocation as transitional funding for the 2008/09 financial year, which is a higher proportion than anticipated because of a delay nationally in launching other funding streams under NIHR. This change to transitional funding provides more assurance

than was previously the case. However, by 2009/10 transitional funding will cease, the expectation being that all of the new NIHR schemes will be fully operational.

The annual and overall estimated R&D income position can be summarised as:

Source of Income (at same price base)	2007/08 £'000	2008/09 £'000	2009/10 £'000
<b>Original R&amp;D Income 06/07</b>	<b>27,231</b>	<b>27,857</b>	<b>27,857</b>
Transitional Funding	22,534	10,712	0
Biomedical Research Centre	1,250	2,672	2,672
Technology Platform – Original Bid	367	184	0
Technology Platform – Additional Projects	250	250	0
6 Programme Grants - Indirect Costs	349	358	358
NIHR Flexibility & Sustainability (faculty)	0	2,254	3,600*
Comprehensive Research Network	190	947*	947*
<b>Total Forecast Income</b>	<b>24,940</b>	<b>17,377</b>	<b>7,577</b>
<b>Forecast Shortfall In R&amp;D Income compared to 2006/07</b>	<b>2,291</b>	<b>10,480</b>	<b>20,280</b>
<b>Year On Year Forecast Reduction</b>	<b>2,291</b>	<b>8,189</b>	<b>9,800</b>

\* estimated values based upon previous share of national/local allocations

In addition to this loss of income, additional expenditure is being incurred in implementing new programmes of work (estimated at £2m by 2009/10). The net impact to the Trust will therefore be a combination of loss of income and additional costs. In the 2007/8 Annual Plan this net impact was put at £19.8m by 2009/10. Changes to income/expenditure streams have meant this net impact is now forecast to be £22.2m.

The Trust is working locally and nationally to identify the impact and to make the case that the NHS support costs in mental health are higher than in other specialties. The Trust has raised awareness with those local PCTs most significantly affected (Southwark and Lambeth) and will be hosting a senior officer workshop with local PCTs in June to help address the issues that result from this loss of income.

## Other income

This includes:

- **NMET/MADEL** (education and training) – funding confirmed and SLA provisionally signed off subject to further discussion /agreement around junior doctor numbers and support to faculty development and assessment activity
- **FITPS** (forensic intensive psychological treatment service) – funding confirmed with NHS London
- **NSCAG** – funding confirmed for Adolescent Forensic Unit and OCD services
- **PTB** (Pooled Drug Treatment) – the allocation of PTB funding is changing in line with national policy over the next 3 years. The impact of this is being addressed by the Addictions Directorate with each of their respective commissioners
- **CAMHS Grant** - funding is no longer ringfenced to mental health services. Again, the impact of this is being addressed with respective Commissioners as different approaches are being adopted by Local Authorities and their partner PCTs

### 2.6.3 Non recurrent income

The Trust non recurring brokerage position can be summarised in the table below –

Source	2008/09 £'000	2009/10 £'000	2010/11 £'000
Lambeth PCT	250	250	250
Southwark PCT	100	300	0
Lewisham PCT	900	450	0
<b>Total</b>	<b>1,250</b>	<b>1,000</b>	<b>250</b>

This is a change from the 2007/8 Annual Plan due to the early payment of funding by Lewisham PCT in February 2008. It will mean that £2m anticipated in 2008/9 and £1m anticipated in 2009/10 will no longer contribute to the I&E position. This funding was to be used to offset the impact of the loss of R&D funding.

### 2.6.4 Expenditure

#### *Generic increases*

Besides inflation, there are a number of other areas where expenditure will change and which are covered within the NHS generic uplift:

- Beyond inflation and new unsocial rates, the current Plan assumes no further budgetary uplift for incremental drift. This has been funded since 2004 and it is assumed that movement up the incremental scale will now be balanced out by turnover and appointments made at points below the funded level.
- An increase in capital charges due to estimated investment in capital projects and impact of the interim valuation. The cost increase within the capital charges return to the DH has been estimated at £2.2m, of which £1.8m relates to the interim valuation. This includes the full year capital charge impact of opening the River House medium secure unit in February 2008, for which additional funding has been secured.
- Clinical negligence and other insurance premiums have remained within the 2007/8 funding levels.
- No funding has been set aside within this Plan for the potential impact of new equal pay claims occurring in 2008/09 (arising out of the change from Whitley/local to AfC bandings). A provision is carried in the balance sheet for any claims received up to 31/3/08.

#### *Revenue costs of capital*

Although the revenue costs have increased, these are less than were forecast in the 2007/8 Plan. This is primarily due to:

- Slippage on the capital programme in 2007/8.
- An interim revaluation of the estate which resulted in lower building values than estimated (with an associated fall in depreciation charges).
- Impairment of some assets.

Elements of the Estates Strategy such as the transfer of services from Guy's and potential redevelopment of the Maudsley Hospital have been factored into the capital charge assumptions. However the full revenue consequences will need to be accounted for once detailed business cases have been developed. Certainly in the case of the former we would assume that it will contribute to our CIP programme in 2009/10.

FT Accounting policy requires certain devaluations to be charged to I&E as an impairment (after EBITDA). Such devaluations may occur on the first valuation of a new build where valuation is below cost and will occur for any demolition. This may also occur as a result of major refurbishments and general falls in property value. The first valuation of River House resulted in a £3.8m impairment in 2007/8. Additional outstanding works of £2m will be impaired in 2008/9 as these are unlikely to alter the assessment of building valuation.

### ***Deferred expenditure from previous generic uplifts***

The full cost implications of Agenda for Change have yet to be borne by the Trust. In particular:

- The cost of the nurse/admin bank will increase through bringing both the rates of pay and terms and conditions in line with AfC. Bank rates have not been increased since 2005/6 and are not commensurate with AfC rates. At current rates of usage, the bank will cost an additional £1.6m in 2008/9. In addition, the transfer of the bank to NHS Professionals will increase costs above the existing in-house service. However the budgets for all established ward posts were uplifted in 2005/06 and 2006/07 in line with the relevant AfC bandings (including vacant posts). The funding to cover this additional cost has, therefore, already been included within the existing ward budgets.
- Paying our contracted out catering and domestic staff the equivalent of AfC rates. The backdated and recurring payment to ISS staff transferring to AfC pay rates is still to be confirmed. A provisional sum has been set aside in the Plan pending the outcome of negotiations with the contractor.

### ***Decrease in expenditure***

The Trust is planning to reduce its costs [or replace lost income] by £18.1m [or 5.2%] in 2008/09 based upon targets agreed at the November 2007 meeting of the Trust Board of Directors:

<b>Area</b>	<b>Recurring Reduction £'000</b>
Non recurring investment in 07/08	8,763
Cost Improvement Plan	9,422
<b>Total</b>	<b>18,185</b>

- The costs of any non recurrent investment in 2007/08 are planned to cease in 2008/09.

- The cost improvement (including R&D) targets were issued to all directorates in November and form part of the overall cost improvement programme that Directorates are working to.
- All directorates are expected to breakeven on the Plan set.

### **2.6.5 Summary**

The overall impact of these key business assumptions on our financial projections can be seen in the tables in Section 6.

The forecast financial performance for 2008/09 shows an EBITDA of £18.4m and a surplus overall for the year of £0.1m. The difference in net surplus from the 2007/8 Plan is largely accounted for by the decision to invest part of this surplus non-recurringly in 2008/9. In addition, the impairment of works at River House will mean an exceptional cost of £2m being incurred post EBITDA. Liquidity remains strong with the quarterly cash balance not falling below £39m.

Over the following two years the net surplus increases although the cash balance falls in 2009/10 as the Trust implements the major part of its estate strategy. The key risk will be the implementation of a projected £16m CIP in 2009/10 following the final phase in reduction of R&D income and increase in capital charges. By 2010/11, the Trust's cash position has stabilised and the CIP has come down by 50%.

## 3. Risk Analysis

### 3.1 Governance risk

Below is the Trust's response on its performance in the seven governance elements, as defined in the Compliance Framework:

#### 1. Legality of Constitution

The Board continues to consider that the constitution is legal and is compliant with good practice for a Foundation Trust.

The Trust has agreed one change to the constitution which has been authorised by Monitor. This has been necessary as a consequence of the passing of the Mental Health Bill 2007 so that hearings under the Mental Health Act can be heard by Hospital Managers. The revised paragraph 3 now reads:

##### "Powers

- 3.1 The powers of the Trust are set out in the 2003 Act, subject to any restrictions in the terms of Authorisation.
- 3.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.
- 3.3 Subject to paragraph 3.4 below, any of these powers may be delegated to a committee of Directors or to an executive director.
- 3.4 (a) Where the Trust is exercising functions under the Mental Health Act 1983, the Trust may delegate a function under that Act in accordance with provision made by or under that Act;  
  
(b) Without prejudice to the generality of subparagraph (a) above, where the Trust is exercising the functions of the managers referred to in Section 23 of the Mental Health Act 1983 (as amended), those functions may be exercised by any three or more persons authorised by the Board of Directors, each of whom must be neither an Executive Director of the Board of Directors nor an employee of the Trust."

#### 2. Growing a representative membership

The Trust has continued implementing the strategy to develop its membership by using existing networks and meetings to generate and sustain membership. Details of current membership and plans for increasing the membership base are set out in Section 5.

#### 3. Appropriate Board Roles and Structures

The Board roles and structures are kept under review and revised as necessary.

The Board maintains its register of interests and confirms that there have been no material conflicts of interest.

Changes to the Board have been reported in Section 1.3.

The membership and terms of reference of the Board Committees are now being reviewed along with the Scheme of Delegation.

The Trust's Assurance Framework is reviewed regularly by the Clinical Governance and Risk Management Committee and the Governance Executive. South Coast Audit is concluding a review of the operation of the Framework within the Trust.

A new post of Trust Board Secretary was appointed to in July 2007. The postholder is ensuring that the Trust's governance arrangements are being assessed as fit for purpose. The membership and terms of reference of the Executive Team were reviewed and agreed by the Board in October 2007. This has led to the creation of the Strategy Executive and Service Quality Executive which both meet on a monthly basis.

#### **4. Service performance [targets and national core standards]**

The Trust has a robust performance management framework in place that builds on processes established as part of becoming a foundation trust and on progress made last year. The Trust performance management processes are structured to deliver the following:

- Terms of Authorisation (March 2008)
- Compliance Framework (May 2008)
- HCC Existing and New Targets (2007/2008)
- HCC Existing and New Targets DRAFT (2009/2010)
- HCC Standards for Better Health
- Trust internal targets:-
  - HoNOS paired scores
  - Infection control – e-Learning
  - Data Quality (MHMDS and HES returns)
  - PCT targets (including LDP)
  - Complaints
  - 18 week wait for psychological therapies

All standards and targets deriving from the above are set and agreed by directorates, both clinical and infrastructure. The above list is not considered to be exhaustive and Trust is mindful of other data sources that reflect the quality of services being delivered, including MHAC visits and reports and all other third party reports.

A detailed list of all standards and targets that the Trust will deliver in 2008/2009 has been developed. Whilst the list includes targets that will be monitored on a monthly basis the Trust is also mindful of those targets which are part of an annual return, for example the Estates Return Information Collection and the Emergency Preparedness Continuity Business.

The Trust has fully implemented the Hygiene Code of Practice. The Board has approved the collective responsibility for minimising the risks of infection and the means by which it prevents and controls such risks. The Trust has a Director of Infection Prevention and Control, accountable to the Board, who oversees the Infection Control Strategy, education and training and a programme of audit to ensure key policies and practices are implemented. The Trust has ensured that the risks of healthcare associated infections have been significantly reduced. This has been achieved by the implementation of a range of systems, and is monitored at the monthly Chief Executive's Performance Management Review, where data relating to incidents of Clostridium Difficile and MRSA and general infection control incidents are reported. This data is now reported monthly to the Board.

The patient environment is a Trust priority and comprehensive reviews are conducted throughout the year. Reviews consist of PEAT (Patient Environment Action Teams)

visits to all wards and community sites in addition to visits from the Trust Nursing Directorate which reviews clinical and professional practice as well as policy implementation. The results of reviews are considered at the Chief Executive performance management meetings with the clinical teams of the Trust as well as at the Client Environment Board.

Standards for Better Health are now managed together with National Health Service Litigation Authority [NHSLA] standards and Essence of Care. This ensures a more coordinated and cohesive approach to the management of systems and standards. With one team overseeing these processes there are additional benefits particularly in the reduction or duplication of effort.

A 'Delivering Business Knowledge' project is under way. This is scheduled to deliver mid-year, a monthly KPI reporting capability as part of the Trust data warehouse/integrated reporting system. In the interim the Trust has a stand alone monthly reporting tool that enables review of targets on a monthly basis and, where relevant, on a weekly basis.

The Trust is also developing Service Line Management (SLM) and is a Monitor pilot site. The Trust will be looking to extend SLM across the organisation.

In recognition of the concerns of our local PCTs, regarding the NTA's decision to link treatment targets to annual funding, the Trust is establishing working groups across the seven boroughs where Addictions Services are provided. The groups will deliver improved data quality, ensure that NTA targets are met and reduce the risk to future funding. In addition to these work streams the Addictions Directorate will be meeting with the Director of Strategy and Business Development and the Director of Finance to establish a Trust-wide approach and to oversee the individual work streams.

## **5. Clinical quality**

Clinical quality is measured through systematic, structured audit, as illustrated by the arrangements for meeting Standards for Better Health. The patient experience is measured through the Service Quality Executive, which meets monthly to ensure continuous and measured improvement in the quality of care and service delivery across the Trust.

The Client Environment Board, which is overseen by the Director of Estates, Facilities and Planning and Capital Projects and the Director of Nursing and Education, monitors the patient environment across the organisation. As mentioned in section 2, there is a process in place for external accreditation of in-patient wards [See Section 2.1.5 - AIQUIP].

## **6. Effective risk and performance management**

The Trust has effective arrangements for monitoring and improving the quality of the services it provides. The processes for incident reporting and management are well established and the Trust is continuously developing the system for learning and applying lessons from incidents. Serious incidents are subject to a full structured investigation as required by the National Patient Safety Agency [NPSA], and there is a secondary process of Board level scrutiny of investigations. External scrutiny takes the form of multi-agency review of child safeguarding and complies with the external investigation as required under HSG 94[27] and chapter 8 of Working Together to

Safeguard Children. The Trust developed an integrated system in 2007 for these serious case reviews involving children.

A Trust-wide committee for safeguarding adults was established in 2007. Membership includes Local Authority representation. Child safeguarding arrangements are well established. A strategy and action plan is in place from 2007 to 2009. This is reviewed regularly within the Trust committee. The integrated system for serious case reviews involving children embeds the process within existing incident procedures and clinical governance systems for learning from incidents involving children.

The Trust-wide Police Liaison group has successfully strengthened links with a number of key partners. It has also identified a number of policy developments around police liaison, post-incident management, security and safety in hospital premises. The focus for the coming year is embedding policy change to practice and continuing to develop better ways of working with our partners in the Metropolitan police. Security management issues will continue to be developed through this committee.

In December 2008 the Trust will be re-assessed for NHSLA Level 2 [previously known as CNST]. The promotion of good risk management, governance and assurance are integral components of the NHSLA scheme. The NHSLA Risk Management Standards are designed to address organisational, clinical and non-clinical / health and safety risks. There are a single set of risk management standards for each type of NHS health care organisation: acute, ambulance, mental health and learning disability and primary care trusts.

The Trust reported it is fully compliant for 2007/08 on all Standards for Better Health. Areas of work to be prioritised during 2008/09 include improving information to patients and carers on mental health issues and strengthening the implementation of recommendations and action plans arising from serious incidents. In addition the Interim Deputy Director of Patient Safety and Assurance will be meeting with the Members' Council on a bi-monthly basis to work on gathering evidence and further developing the Standards for Better Health.

A Statement of Internal Control ["SIC"] is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the SIC.

## **7. Co-operation with NHS bodies and local authorities**

The Trust works with a wide range of partner organisations both at a corporate level and at individual service level and is committed to maintaining and developing these important relationships. Colleagues from the Trust participate in the local Partnership Boards and relevant integrated budget groups and there is representation from most of the key stakeholders on our Members' Council, including representatives from the Local Authorities. Further examples of effective working are set out in Section 2.1.10 – relationships with healthcare stakeholders.

### **3.1.2 Significant governance risks**

The Trust has assessed the factors that could impact on effective governance of the organisation and have identified the following:

- Achievement of compliance frameworks/targets
- Improving clinical quality
- Improving patient safety

- Managing security and custody
- Security of information / information sharing / information use
- Management and leadership capability and succession planning

#### **Achievement of compliance framework / targets**

There are a number of risks associated with the Compliance Framework/National Targets which could result in the Trust not achieving its targets. The Trust is confident that its effective performance framework and management systems including the CE performance management meeting and reporting to the Board, means that any potential underachievement of targets can be quickly identified and addressed.

#### **Improving clinical quality**

There are arrangements in place to ensure clinical quality and the Trust is identifying measures to ensure continuous improvement in its services. Good quality clinical information that is accessible to services will provide a sound basis for continuing improvement. Targets have been set for paired outcome measures and external accreditation will be achieved through AIQUIP. Further projects such as reviewing the CPA, the development of care pathways and SLM, and Patient Experience Tracking are under way.

#### **Improving patient safety**

A number of areas are planned for improvement including physical healthcare, drug administration, hospital acquired infections and implementing lessons from serious untoward incidents on a system wide basis.

#### **Managing security and custody**

The Trust has increasing and increasingly complex responsibilities for the management of custody. The Trust is taking a number of steps to minimise this risk, including the appointment of security advisors to ensure the latest expertise is applied to services users in custody, including whilst in transit.

#### **Security of information / information sharing / information use**

The Trust is mindful of recent high profile national events relating to personal information and recognises that there needs to be a balance between breaching confidentiality versus failure to share information appropriately and promptly that can result in failures of patient care or risk to public safety. The Trust has responded to this risk in a number of ways including reviewing policies and practices and awareness raising through IT systems.

#### **Management and leadership capability and succession planning**

To respond to the increasing complexity of the tasks, management and leadership capability and capacity needs constant attention and improvement. A new leadership development programme addresses this agenda. There is an increasing use of assessment centres for selection for key posts.

### **3.2 Mandatory service risks**

There are no planned material changes to mandatory services in 2008-09, and the Trust is not contemplating any significant change to its protected asset base in 2008/09.

See investment and disposal strategy, section 2.4

## 3.3 Financial risk

### 3.3.1 Commentary on financial risk rating

The Trust believes that it should be assigned the following financial risk ratings based on the financial projections included in this Plan and the metrics used by Monitor to assess risk.

Metric used	Criteria	2008/09 Plan	2009/10 Plan	2010/11 Plan
EBITDA margin	Underlying performance	5.3%	6.2%	7.3%
EBITDA, % achieved	Achievement of plan	118.4%	118.4%	118.4%
Return on assets	Financial efficiency	3.3%	3.5%	4.2%
I&E surplus margin	Financial efficiency	0.6%	0.6%	1.2%
Liquid ratio	Liquidity	60.9 days	60.0 days	35.1 days
Weighted average		3.5	3.5	3.7
<b>Overall Rating</b>		<b>4</b>	<b>4</b>	<b>4</b>

### 3.3.2 Significant financial risks

The Trust has assessed the factors that could be a risk to achieving the financial targets, these are listed below:

- Management of R&D
- Achievement of CIPs over the course of the Annual Plan
- Development of the AHSC
- Management of the contractual framework
- Management of the Trust's position in a market context
- Managing the estate
- Managing major capital projects

#### Management of R&D

The Trust is suffering a major loss of income as a result of the national R&D strategy [see under CIPs] but at the same time we are performing well against all the criteria for success under the strategy. Negotiations are underway with local PCTs and at a national level with the R&D Directorate of the Department of Health.

#### Achievement of CIPs over the course of the Annual Plan

Maintaining progress on CIPs in this year's Plan, and much increased CIP target for 2009/10 will be essential as a consequence of R&D changes. The strategic approach includes formal recovery processes for areas struggling financially and early planning for 2009/2010 CIPs. Strategies to reduce revenue costs include reducing leased space and improved procurement and rostering.

#### Development of the AHSC

The Trust along with its partners, KCH, GSTT and KCL is committed to creating a successful AHSC. This strategic collaboration will enable us to harness our collective expertise in research, teaching and clinical practice to promote health in mind and body. 2008/09 is the start up year and it is likely additional expenditure will be incurred

as the organisations align in preparation for accelerating 'bench to bedside to population' research findings leading to improvements in patient treatment and care

#### **Management of the contractual framework**

The lack of PbR in mental health means there is limited opportunity to generate additional income. Formal account management approaches will minimise local risks.

#### **Management of the Trust's position in a market context**

If the Trust is unable to respond effectively to customer requirements in an increasingly competitive healthcare market this could result in a loss of business. The Trust has developed a marketing strategy and is consolidating its approach particularly with regard to Specialist Services. The Chair and Chief Executive are actively engaged in London wide discussions and local relationship maintenance is a priority for the Trust. A specific project has been established to improve service user experience.

#### **Managing the estate**

The scale and diversity of the Trust's Estate has led to problems in delivery of minor capital schemes. The capital programme and delivery systems have been reviewed and the Audit Committee is reviewing risks to the achievement of the capital programme.

#### **Managing major capital projects**

The Trust has successfully delivered major capital projects in 2007/08 however they require significant investment of time, effort and resources. In 2008/09 there is another major complex project that is active and two more in development. Sound project management is in place, and Gateway Reviews are used to measure performance.

### **3.4 Risk of any other non-compliance with Terms of Authorisation**

The Trust is not aware of any risks, other than those covered in the three categories above that may threaten compliance with the Terms of Authorisation.

The Board has thoroughly reviewed all the issues identified as risks within the Annual Plan submission and has concluded that whilst there are significant risks and challenges facing the Trust they are not of sufficient severity or likelihood to threaten the Terms of Authorisation upon which the Trust was established.

## 4. Board Statements

### Clinical quality

The Board of Directors confirms that:

- The Board is satisfied that, to the best of its knowledge and using its own processes [supported by Healthcare Commission metrics and including any further metrics it chooses to adopt], the Trust has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

### Service performance

The Board of Directors confirms that:

- The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets [after the application of thresholds] and national core standards and with all known targets going forwards;
- The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* (including the Hygiene Code).

### Risk management

The Board of Directors confirms that:

- Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;
- All recommendations to the Board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
- The necessary planning, performance management and risk management processes are in place to deliver the annual plan;
- A Statement of Internal Control ("SIC") is in place, and the NHS Foundation Trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see <http://hm-treasury.gov.uk>); and
- All key risks to compliance with its Authorisation have been identified and addressed.

### Compliance with the Terms of Authorisation

The Board of Directors confirms that:

- The Board will ensure that the NHS Foundation Trust remains compliant with its Authorisation and relevant legislation at all times;
- The Board has considered all likely future risks to compliance with its Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and
- The Board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with its Authorisation.

## Board roles, structures and capacity

The Board of Directors confirms that:

- The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;
- The board is satisfied that all the directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;
- The selection process and training programs in place ensure that the non-executive directors have appropriate experience and skills;
- The management team has the capability and experience necessary to deliver the annual plan; and
- The management structure in place is adequate to deliver the annual plan objectives for the next three years



Signature  
In capacity as Chief Executive and  
Accounting Officer



Signature  
In capacity as Chairman

Signed on behalf of the Board of Directors, and having regard to the views of the Members' Council

## 5. Membership

### 5.1 Membership report and headline analysis:

#### 5.1.1 Membership size and movements

Public constituency [local authority electoral areas]	2006/07	2007/08	2008/09 [Estimated]
At the year start [1 <sup>st</sup> April]	92	358	556
New members	363	210	580
Members leaving	4	12	24
At year end [31 <sup>st</sup> March]	359	556	1112
<b>Public constituency – national</b>			
At the year start [1 <sup>st</sup> April]	47	375	515
New members	372	178	591
Members leaving	0	38	76
At year end [31 <sup>st</sup> March]	372	515	1030
<b>Staff constituency</b>			
At the year start [1 <sup>st</sup> April]	350	1582	2307
New members	1584	750	1194
Members leaving	3	25	40
At year end [31 <sup>st</sup> March]	1581	2307	3461
<b>Service User constituency</b>			
At the year start [1 <sup>st</sup> April]	52	603	701
New members	603	119	726
Members leaving	2	21	25
At year end [31 <sup>st</sup> March]	601	701	1402
<b>Carer constituency</b>			
At the year start [1 <sup>st</sup> April]	17	169	215
New members	169	53	225
Members leaving	0	7	10
At year end [31 <sup>st</sup> March]	169	215	430

#### Analysis of current membership

Public constituency [local – Croydon borough]	No. of members [124]	Eligible membership [2001 national census shown as %]
<b>Age [years]</b>		
0 -16	1 [0.8%]	[21.9%]
17 – 21	4 [3.2%]	[10.8%]
22+	97 [78.2%]	[67.3%]
Unknown	22 [17.8%]	No comparison*
<b>Gender</b>		
Male	40 [32.3%]	[48.1%]
Female	82 [66.1%]	[51.9%]
Unknown	2 [1.6%]	No comparison

Public constituency [local – Croydon borough]	No. of members [124]	Eligible membership [2001 national census shown as %]
<b>Ethnicity</b>		
White	51 [41.2%]	[73.7%]
Mixed	7 [5.6%]	[2.1%]
Asian	7 [5.6%]	[9.5%]
Black	19 [15.3%]	[13.7%]
Other	4 [3.2%]	[1.1%]
Unknown	36 [29.1%]	No comparison

\*Please note that 'No comparison' applies when there is no comparable information for the relevant field.

Public constituency [local – Lambeth borough]	No. of members [134]	Eligible membership [2001 national census shown as %]
<b>Age [years]</b>		
0 -16	0 [0%]	[19.2%]
17 – 21	2 [1.5%]	[12.7%]
22+	112 [83.6%]	[68.1%]
Unknown	20 [14.9%]	No comparison
<b>Gender</b>		
Male	46 [34.3%]	[49.3%]
Female	86 [64.2%]	[50.7%]
Unknown	2 [1.5%]	No comparison
<b>Ethnicity</b>		
White	70 [52.3%]	[57.3%]
Mixed	7 [5.2%]	[5.5%]
Asian	4 [3.0%]	[13.4%]
Black	19 [14.2%]	[12.8%]
Other	7 [5.2%]	[11%]
Unknown	27 [20.1%]	No comparison

Public constituency [local – Lewisham borough]	No. of members [137]	Eligible membership [2001 national census shown as %]
<b>Age [years]</b>		
0 -16	0 [0%]	[21.1%]
17 – 21	5 [3.7%]	[12.1%]
22+	114 [83.2%]	[66.8%]
Unknown	18 [13.1%]	No comparison
<b>Gender</b>		
Male	52 [37.9%]	[48.2%]
Female	83 [60.6%]	[51.8%]
Unknown	2 [1.5%]	No comparison
<b>Ethnicity</b>		
White	73 [53.3%]	[68.4%]
Mixed	4 [2.9%]	[4.1%]
Asian	3 [2.2%]	[2.6%]
Black	36 [26.3%]	[23.8%]

Public constituency [local – Lewisham borough]	No. of members [137]	Eligible membership [2001 national census shown as %]
Other	2 [1.4%]	[1%]
Unknown	19 [13.9%]	No comparison

Public constituency [local – Southwark borough]	No. of members [161]	Eligible membership [2001 national census shown as %]
<b>Age [years]</b>		
0 -16	1 [0.7%]	[20.3%]
17 – 21	3 [1.9%]	[13.6%]
22+	132 [81.9%]	[66.2%]
Unknown	25 [15.5%]	No comparison
<b>Gender</b>		
Male	67 [41.6%]	[48.9%]
Female	92 [57.2%]	[51.1%]
Unknown	2 [1.2%]	
<b>Ethnicity</b>		
White	73 [45.4%]	[66.7%]
Mixed	7 [4.4%]	[1.9%]
Asian	3 [1.8%]	[2.8%]
Black	30 [18.6%]	[27.5%]
Other	8 [4.9%]	[1.1%]
Unknown	40 [24.9%]	No comparison

Public constituency - national	No. of members [515]	Eligible membership [2001 national census shown as %]
<b>Age [years]</b>		
0 -16	0 [0%]	[20.2%]
17 – 21	13 [2.5%]	[10.9%]
22+	384 [74.6%]	[66.2%]
Unknown	118 [22.9%]	No comparison
<b>Gender</b>		
Male	203 [39.4%]	[48.7%]
Female	301 [58.5%]	[51.3%]
Unknown	11 [2.1%]	No comparison
<b>Ethnicity</b>		
White	266 [51.7%]	[92.1%]
Mixed	8 [1.5%]	[1.1%]
Asian	31 [6.0%]	[4%]
Black	54 [10.5%]	[2%]
Other	23 [4.4%]	[0.8%]
Unknown	133 [25.9%]	No comparison

Please note in the following tables – percentages are shown for all categories [including ‘not stated’] as comparative data was available.

Service User constituency	No. of members [701]	Eligible membership*
<b>Age [years]</b>		
0 -16	1 [0.1%]	[14.9%]
17 – 21	6 [0.8%]	[5.5%]
22+	328 [46.8%]	[79.6%]
Not Stated	366 [52.3%]	No comparison
<b>Gender</b>		
Male	321 [45.8%]	No comparison
Female	354 [50.5%]	No comparison
Unknown	26 [3.7%]	No comparison
<b>Ethnicity</b>		
White	202 [28.9%]	[54.8%]
Mixed	5 [0.7%]	[2.5%]
Asian	16 [2.2%]	[3.7%]
Black	45 [6.5%]	[19.6%]
Other	7 [0.9%]	[3.0%]
Unknown	426 [60.8%]	[16.4%]

\*Eligible membership statistical information was gathered from the Trust's internal patient records.

Carers constituency	No. of members [215]	Eligible membership*
<b>Age [years]</b>		
0 -16	0 [0%]	No comparison
17 – 21	1 [0.5%]	No comparison
22+	167 [77.7%]	No comparison
Not Stated	47 [21.8%]	No comparison
<b>Gender</b>		
Male	89 [41.4%]	No comparison
Female	123 [57.2%]	No comparison
Unknown	3 [1.4%]	No comparison
<b>Ethnicity</b>		
White	82 [38.2%]	No comparison
Mixed	9 [4.2%]	No comparison
Asian	9 [4.2%]	No comparison
Black	31 [14.4%]	No comparison
Other	9 [4.2%]	No comparison
Unknown	75 [34.8%]	No comparison

Staff constituency	No. of members [2307]	Eligible membership [% 's from workforce E&D report 06/07]
<b>Age [years]</b>		
0 -16	0 [0%]	0%
17 – 21	5 [0.3%]	0.9%
22+	1933 [83.8%]	99.1%
Unknown	369 [15.9%]	No comparison
<b>Gender</b>		
Male	809 [35.2%]	33.66%
Female	1429 [61.9%]	66.34%
Unknown	69 [2.9%]	No comparison

<b>Ethnicity</b>		
White	1057 [45.8%]	52.07%
Mixed	63 [2.7%]	3.60%
Asian	162 [7.1%]	5.34%
Black	394 [17.1%]	23.43%
Other	78 [3.4%]	10.81%
Unknown	553 [23.9%]	4.75%

<b>Socio-economic sub grouping1</b>	<b>Members*</b>	<b>Members</b>
<b>ABC1</b>	407	773327
<b>C2</b>	0	0
<b>D</b>	146	335922
<b>E</b>	0	0
<b>Unclassifiable</b>	3	3

\*Please note: profiling only includes public members within the four catchment areas; Public members in the Rest of England and Wales cannot be accurately profiled.

## 5.2 Membership commentary

### 5.2.1 Current numbers and projections

<b>Constituency</b>	<b>March 07</b>	<b>March 08</b>	<b>Annual Increase (%)</b>
Public	731	1,071	46.5
Service user	601	701	16.6
Carer	169	215	27.2
Staff	1,581	2,307	45.9
<b>Total</b>	<b>3,082</b>	<b>4,294</b>	<b>39.3</b>

Action taken to increase membership in the previous year includes recruitment at events such as the Bethlem 'Sunfayre'.

Despite an increase of nearly 40%, the membership base remains comparatively small compared to other NHS Foundation Trusts. In particular, the Trust intends to focus on increasing the number of service user members over the year ahead.

### 5.2.2 Plan of action

Communication with membership has been enhanced through production of a quarterly newsletter and monthly e-bulletin. A re-launch of the website will take place in the coming year and seminars for members are being planned for summer 2008. Action planned to increase membership includes targeted mail shots.

#### **Membership development team**

The Trust is in the process of establishing a cadre of staff and members to be responsible for membership development activity. This will consist of using their roots in local communities to raise the profile of the Trust, explain the benefits of membership and to extend the membership base of the organisation. The initial plan is that the team will consist of around 50 people.

### 5.2.3 Targets

The combination of mail shots and more membership developmental work should make a doubling of the public constituencies achievable. A combination of new joiners to the organisation plus the implementation of an opt-out arrangement for current staff to join should make a 50% increase achievable. The combined impact would be as illustrated in the table over.

<b>Constituency</b>	<b>March 08</b>	<b>Target Annual increase (%)</b>	<b>Target Membership March 09</b>
Public	1,071	100.0	2,142
Service user	701	100.0	1,402
Carer	215	100.0	430
Staff	2,307	50.0	3,461
<b>Total</b>	<b>4,294</b>	<b>73.1</b>	<b>7,435</b>

## 6. Financial projections

Income and Expenditure Account	07/08	08/09	09/10	10/11
	£m	£m	£m	£m
<b><u>Clinical Income</u></b>				
HCLV Activity - Cost & Volume Contract Income	35.3	37.6	38.1	38.5
Block Contract - 1: Lambeth	74.4	82.2	80.1	81.0
Block Contract - 2: Southwark	54.2	59.8	61.6	62.7
Block Contract - 3: Lewisham	52.4	53.8	54.3	54.5
Block Contract - Other: Croydon, BBG, MSW	37.4	41.9	42.4	42.9
Clinical Partnerships (including S31 agreements)	2.9	3.0	3.1	3.1
Other clinical income from mandatory services	27.6	28.5	28.8	29.2
<b>Sub -total</b>	<b>284.2</b>	<b>306.8</b>	<b>308.4</b>	<b>311.9</b>
<b><u>Other income</u></b>				
Research and Development	25.3	19.8	10.1	9.9
Education and Training	10.7	10.5	10.2	10.3
Other income*	16.9	10.4	10.5	10.6
<b>Sub -total</b>	<b>52.9</b>	<b>40.7</b>	<b>30.8</b>	<b>30.8</b>
<b>Total income</b>	<b>337.1</b>	<b>347.5</b>	<b>339.2</b>	<b>342.7</b>
<b><u>Expenses</u></b>				
Pay Costs	(221.8)	(242.4)	(234.0)	(233.2)
Drug Costs	(10.7)	(10.6)	(10.2)	(10.3)
Clinical supplies & services	(1.3)	(1.4)	(1.3)	(1.3)
Secondary commissioning costs	(32.0)	(32.3)	(31.3)	(31.5)
Other Costs (excl. depreciation)	(47.1)	(42.4)	(41.2)	(41.4)
<b>Total costs</b>	<b>(312.9)</b>	<b>(329.1)</b>	<b>(318.0)</b>	<b>(317.7)</b>
<b>EBITDA (operating Surplus/(Deficit))</b>	<b>24.2</b>	<b>18.4</b>	<b>21.2</b>	<b>25.0</b>
Total Depreciation	(7.1)	(8.2)	(9.7)	(10.8)
Total interest receivable/ (payable)	2.6	1.8	1.4	1.0
PDC Dividend	(9.4)	(10.0)	(10.8)	(11.1)
Exceptional Cost (impairment)	(5.3)	(2.0)		
Profit on disposal	0.2	0.1		
<b>Net Surplus/(deficit)</b>	<b>5.2</b>	<b>0.1</b>	<b>2.1</b>	<b>4.1</b>
<b>EBITDA Margin</b>	<b>7.2%</b>	<b>5.3%</b>	<b>6.3%</b>	<b>7.3%</b>
<b>Net I&amp;E Margin</b>	<b>1.5%</b>	<b>0.0%</b>	<b>0.6%</b>	<b>1.2%</b>

## Balance Sheet

	07/08 £m	08/09 £m	09/10 £m	10/11 £m
<b>Fixed Assets</b>				
<b>Total Fixed Assets</b>	<b>345.6</b>	<b>348.4</b>	<b>374.8</b>	<b>374.0</b>
<b>Current Assets</b>				
Stocks & Work in Progress	0.3	0.3	0.3	0.3
NHS Trade Debtors	7.2	6.6	5.9	5.4
Non NHS Trade Debtors	7.0	6.3	5.7	5.2
Other Debtors	0.0	0.0	0.0	0.0
Accrued Income	(2.5)	(2.2)	(1.9)	(1.7)
Prepayments	0.5	0.5	0.5	0.5
Cash at bank and in hand	52.9	47.2	26.4	28.9
<b>Total Current Assets</b>	<b>65.4</b>	<b>58.7</b>	<b>37.0</b>	<b>38.7</b>
<b>Current Liabilities (amounts due in &lt; 1 year)</b>				
Bank Overdraft	0.0	0.0	0.0	0.0
Drawdown in Committed Facility	0.0	0.0	0.0	0.0
Trade Creditors	(8.0)	(6.8)	(6.8)	(6.8)
Other Creditors	(7.2)	(7.4)	(7.7)	(7.9)
PDC dividend creditor	0.0	0.0	0.0	0.0
Capital Creditors	(4.2)	(5.5)	(6.4)	(3.9)
Interest payable creditor	0.0	0.0	0.0	0.0
Payments on Account	(0.7)	0.0	(2.5)	(2.5)
Accruals	(18.7)	(15.7)	(15.7)	(15.7)
Deferred Income	(4.4)	(3.5)	(3.5)	(3.5)
<b>Total Current Liabilities</b>	<b>(43.2)</b>	<b>(38.9)</b>	<b>(42.6)</b>	<b>(40.3)</b>
<b>Net Current Assets (Liabilities)</b>	<b>22.2</b>	<b>19.8</b>	<b>(5.6)</b>	<b>(1.6)</b>
Long term Debtors	1.1	1.1	1.0	1.0
<b>Total Current Assets Less Current Liabilities</b>	<b>368.9</b>	<b>369.3</b>	<b>370.2</b>	<b>373.4</b>
<b>Creditors: Amounts falling due &gt; 1 year</b>				
Finance leases	0.0	0.0	0.0	0.0
Provisions for liabilities and charges	(6.3)	(5.9)	(5.8)	(5.6)
<b>TOTAL ASSETS EMPLOYED</b>	<b>362.6</b>	<b>363.4</b>	<b>364.5</b>	<b>367.8</b>
Public dividend capital	179.3	180.3	180.3	180.3
Income and expenditure reserve	(0.1)	0.0	2.1	6.2
Revaluation reserve	163.0	163.5	163.3	161.3
Donated asset reserve	20.3	19.6	18.8	19.9
<b>TOTAL TAXPAYERS EQUITY</b>	<b>362.5</b>	<b>363.4</b>	<b>364.5</b>	<b>367.8</b>

## Cash Flow

	07/08 £m	08/09 £m	09/10 £m	10/11 £m
<b>EBITDA</b>	<b>24.2</b>	<b>18.4</b>	<b>21.2</b>	<b>25.0</b>
Excluding non cash operational I&E items	(1.1)	(0.7)	(0.8)	(0.8)
<b><u>Movement in working capital:</u></b>				
Stocks & Work in Progress	0.1	0.0	0.0	0.0
NHS Trade Debtors	1.1	0.7	0.6	0.6
Non NHS Trade Debtors	0.0	0.6	0.6	0.5
Other Debtors	0.0	0.0	0.0	0.0
Accrued Income	(0.1)	(0.3)	(0.3)	(0.3)
Prepayments	0.1	0.0	0.0	0.0
Trade Creditors	2.1	(1.2)	0.0	0.0
Other Creditors	0.1	0.3	0.2	0.2
Payments On Account	0.6	(0.7)	2.5	0.0
Accruals	4.6	(3.0)	0.0	0.0
Deferred Income	0.1	(0.9)	0.0	0.0
Provisions & Liabilities	(1.2)	(0.5)	(0.2)	(0.3)
<b>CF from Operations</b>	<b>30.6</b>	<b>12.7</b>	<b>23.8</b>	<b>25.0</b>
<b><u>Capital Expenditure</u></b>				
Maintenance Capital Expenditure	(2.5)	(9.1)	(4.5)	(2.1)
Non Maintenance Capital Expenditure	(19.2)	(21.1)	(32.8)	(18.2)
Cash Exceptional items	0.0	0.0	0.0	0.0
Cash receipt from asset sales	1.9	18.2	2.0	7.8
Taxation paid	0.0	0.0	0.0	0.0
<b>CF before Financing</b>	<b>10.8</b>	<b>0.7</b>	<b>(11.5)</b>	<b>12.5</b>
<b><u>Interest</u></b>				
Interest (paid) on loans and leases	0.0	0.0	0.0	0.0
Interest (paid)/rec'd on cash balance & WC facility	2.7	1.9	1.5	1.1
<b><u>Loans</u></b>				
Drawdown of loans and leases	0.0	0.0	0.0	0.0
Repayment of loans and leases	0.0	0.0	0.0	0.0
<b><u>Other</u></b>				
Public Dividend Capital received	14.1	1.0	0.0	0.0
Public Dividend Capital repaid	(1.9)	0.0	0.0	0.0
Movement in Other grants/Capital received	0.0	0.8	0.0	0.0
Dividends paid	(9.5)	(10.0)	(10.8)	(11.1)
<b>Net cash outflow/inflow</b>	<b>16.2</b>	<b>(5.6)</b>	<b>(20.8)</b>	<b>2.5</b>
Opening Cash Balance	36.6	52.8	47.2	26.4
Net cash outflow/inflow	16.2	(5.6)	(20.8)	2.5
<b>Closing Cash Balance</b>	<b>52.8</b>	<b>47.2</b>	<b>26.4</b>	<b>28.9</b>

# Glossary

AfC	Agenda for Change
AHSC	Academic Health Sciences Centre
AIQUIP	All inpatients quality improvement programme
AMH	Adult mental health
CAMHS	Child and adolescent mental health services
CEO	Chief Executive Officer
CIP	Cost improvement programme
CNST	Clinical negligence scheme for Trusts
DH	Department of Health
EBITDA	Earnings before interest, tax, depreciation and amortisation
EPJS	Electronic patient journey system
ESR	Electronic staff record
FBC	Full business case
FITPS	Forensic Intensive Psychological Treatment Service
FRS	Financial reporting standards
GAAP	Generally accepted accountancy principles
GMP	Guaranteed Maximum Price [relates to P21 procurement]
GSST	Guy's and St Thomas' NHS Foundation Trust
HCC	Healthcare Commission
HES	Health episode statistics
HoNOS	Health of the Nation Outcome Score
HMP	Her Majesty's prison
HR	Human resources
HSG	Health Service Guidance
I&E	Income and expenditure
ICT	Information and communications technology
IOP	Institute of Psychiatry
KCH	King's College Hospital NHS Foundation Trust
KCL	King's College London
LDP	Local delivery plan
LINKs	Local Involvement Networks
MADEL	Medical and Dental Education Levy
MDO	Mentally disordered offenders
MHMDS	Mental health minimum data set
MHOA	Mental Health of Older Adults
MOD	Ministry of Defence
NHSLA	National Health Service Litigation Authority
NIHR	National Institute for Health Research
NMET	National Medical Education and Training
NPSA	National Patient Safety Agency
NSCAG	National Specialist Commissioning Advisory Group
NTA	National Treatment Agency
OBD	Occupied bed days
OSC	Overview and Scrutiny Committee
P21	Procure 21 [a method of tendering]
PBC	Prudential borrowing code
PbR	Payment by results
PCT	Primary Care Trust
PDC	Public dividend capital
PEAT	Patient Environment Action Teams
PPI	Patient and public involvement

PTB	Pooled treatment budget [re drug treatment]
RAB	Resource accounting and budgeting
R&D	Research and development
StfBH	Standards for Better Health
SIC	Statement of Internal Control
SIRR	Social inclusion, rehabilitation and recovery
SLM	Service line management