A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
WILL BE HELD ON THURSDAY 17TH OCTOBER 2013 AT 3:00pm BOARDROOM, MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence: Prof. Tom Craig, Shitij Kapur
2 Declarations of Interest
3 Minutes of the Board Meeting held on 10th September 2013 Attached
4 MATTERS ARISING

PRESENTATION
5 To receive a presentation on Future of Health Page 2 App A

QUALITY
6 To receive the Service Quality Indicator Report Page 21 App B
7 To receive the Infection Control Report Page 29 App C

PERFORMANCE AND ACTIVITY
8 To discuss the Finance Report Page 31 App D

GOVERNANCE
9 To receive a Report from the Chief Executive Page 40 App E
10 To receive an Update from the Council of Governors Page 45 App F
11 To receive an Update on Kings Health Partners Page 48 App G
12 To receive the Assurance Framework Report Page 49 App H
13 To receive the Risk Management & Assurance Strategy Annual Review Page 58 App I
14 To receive Key Points and Minutes from the Service Quality Improvement Sub Committee of the Board Page 88 App J
15 To receive the Audit Committee Minutes and Signed and Sealed Page 98 App K

INFORMATION
16 Director’s Reports Verbal
17 Forward Planners Page 108 App L
18 Any other business

To consider a motion that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public bodies (Admission to Meetings) Act 1960

Date of Next Meeting: Wednesday 6th November – 3:00pm, Boardroom, Maudsley Hospital, Denmark Hill, London, SE5 8AZ. Please send apologies to Alison Baker 0203 228 4763 alison.baker@slam.nhs.uk

web site: www.slam.nhs.uk
MINUTES OF THE SIXTY EIGHTH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 10TH SEPTEMBER 2013

PRESENT
Madeliene Long Chair
Dr Martin Baggaley Medical Director
Dr Patricia Connell-Julien Non Executive Director
Robert Coomber Non Executive Director
Nick Dawe Director of Finance
Harriet Hall Non Executive Director
Gus Heafield Acting Chief Executive
Kumar Jacob Non Executive Director
Prof Shitij Kapur Non Executive Director
Zoë Reed Director of Strategy & Business Development
Dr Jane Sayer Acting Director of Nursing and Education

IN ATTENDANCE
Alison Baker PA to Chair & Non Executive Directors
Lucy Canning Service Director, Psychosis CAG
Steve Davidson Service Director, Psych Medicine and MAP CAGs
Eleanor Davies Service Director, B&DP CAG
Roy Jaggon Head of Performance
Louise Hall Interim Director of Human Resources
Paul Mitchell Trust Board Secretary
Noel Urwin Vice Chair, Council of Governors

APOLOGIES
Mark Allen Service Director, Addictions CAG

DECLARATIONS OF INTEREST
Routine declarations were made:

- Madeliene Long declared an interest as a Lewisham Borough Councillor and an Honorary Fellow of King’s College London.
- Zoe Reed declared an interest as Chair, Society for Anglo-Chinese Understanding.
- Dr Patricia Connell-Julien declared an interest as a former employee of King’s College London and as a Trustee of Southside Certitude Support.
- Prof Shitij Kapur declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. Prof Kapur advises and consults with pharmaceutical companies periodically.

MINUTES
The minutes of the meeting held on the 23rd July 2013 were agreed as an accurate record of the meeting.

BOD 99/13 MATTERS ARISING

Page 1 of 5
There were no matters arising from the previous minutes.

**BOD 100/13 SERVICE QUALITY INDICATOR & INFECTION CONTROL REPORT**

Gus Heafield updated the Board on compliance with Monitor governance targets and confirmed that CAG progress was being monitored at the Chief Executive Performance Management meeting. The CPA 12m review was slightly below target for the month, CAGs had been requested to provide weekly reports, assurance had been received that CAGs would hit the target for Q2. The Trust remained compliant with delayed discharges and early intervention targets.

The Board of Directors noted the reports.

**BOD 101/13 FINANCE REPORT 2013/14 - JULY**

Nick Dawe explained that in the previous month the overall position had improved, largely due to the release of provisions which were limited and non recurring, taking account of income not previously built into the Plan for the AMH Transformation Programme and NHSE funded MSU/LSU placements. He confirmed that there had been no such benefit this month and the underlying CAG positions remain with acute overspill at its highest level since 2001 and the two major overspending CAGs, Psychosis and B&DP, now making up 71% of the current operational deficit.

The Trust’s financial position therefore continued to be a cause for concern with the retention of a financial risk rating of 3 at Q2 being an increasing challenge. If these activity pressures continued through September and resolution was not reached with the local CCGs the Trust would need to take difficult decisions in October to ensure services offered and delivered were of sufficiently high level of quality and affordable for the remainder of the year.

Lucy Canning explained that the CAG had reviewed the nursing costs by a review of rosters and bank expenditure.

Gus Heafield emphasised the importance of developing clear long term plans whilst dealing with the short term challenges.

The Board of Directors noted the report.

**BOD 102/13 REPORT FROM THE ACTING CHIEF EXECUTIVE**

Gus Heafield explained that Monitor had recently published a new risk assessment framework which set out their approach to making sure Foundation Trusts were well run and could continue to provide good quality services for patients. This would replace the Compliance Framework.

The DoH had awarded £9m to fund the National Institute for Health Research (NIHR) Collaboration of Applied Health Research and Care (CLAHRC) South London. The CLAHRC would also receive £9m of matched funding from the local partners taking the total to £18m over five years. The Board thanked the team who led the bid for all their hard work.

The Care Quality Commission revisited Bethlem Royal Hospital following a visit in February 2013 where they had found the environment on the wards visited to be
stark, unclean and the furniture had been damaged. At the follow up visit the assessors found that improvements had been made to the environment. Draft feedback had been received and the issues were now closed.

Dr Matthew Patrick would be taking up the position of Chief Executive on Monday 14th October 2013, the Board offered Matthew a warm welcome and were looking forward to working with him.

Dr Jane Sayer currently Acting Director of Nursing and Education was leaving the Trust at the end of October 2013 to take up the post of Director of Nursing, Quality and Patient Safety at Norfolk and Suffolk NHS Foundation Trust. Jane had worked at SLaM and its predecessor Trusts for 26 years. She was thanked for her contribution over these years.

The Board welcomed Louise Hall who had been appointed as the new Interim Director of Human Resources and Organisational Development.

Gus Heafield confirmed that this would be his last report as Acting Chief Executive. He said that he had been very proud to take up the role in October 2012, it had been a real privilege leading such a prestigious and high performing organisation, working with so many talented, experienced and hard working people. Gus Heafield thanked Madeliene Long and the Board for giving him the opportunity, and all his colleagues for their support, commitment and enthusiasm.

The Board of Directors noted the report.

**BOD 103/13 UPDATE FROM THE COUNCIL OF GOVERNORS**

Noel Urwin reported that the results of the elections to fill vacancies on the Council of Governors had been announced on 26th July. Five new governors had been elected, two of whom were in attendance today Chris Anderson and Dr Tom Werner. Dr Dele Olajide would be meeting with the SLaM local CQC Manager Jane Brett with a view to her making a presentation at a future Council of Governors meeting.

The Quality Group had met on 20th August where there were discussions around the Mental Health Act and how it was applied and interpreted across the Trust, there had been helpful guidance from Kay Burton.

The Bids Steering Group meeting had taken place on 5th September, where there were a few new Governors in attendance. There was also a visiting programme scheduled to assess some of the successful bids.

Madeliene Long reported that she had met some of the new Governors during the previous week.

The Board of Directors noted the report.

**BOD 104/13 UPDATE ON KINGS HEALTH PARTNERS**

Madeliene Long explained that Professor Sir Robert Lechler would be attending the Council of Governors meeting where he would be presenting an update on KHP. Gus Heafield reported considerable activity was taking place in the
development of the full business case. Madeliene Long confirmed that there would then be further discussions at each of the subsequent Board meetings.

The accreditation process would be taking place on 29th October.

The Board of Directors noted the verbal report.

**BOD 105/13 COMPLAINTS AND PALS ANNUAL REPORT**

Dr Jane Sayer explained that there had been 551 complaints recorded from 1st April 2012 to 31st March 2013, this was slight decrease from the previous year. Throughout the year Psychosis CAG had received the highest number of complaints, with a continued reduction in complaints from acute inpatients services and reconfiguration of community services.

This year there had been an introduction of the PALS surgery piloted on wards within River House, from February 2013 nine surgeries had been held with the main topics raised being lack of activities, request for talking therapies and clarification wanted regarding taking leave under the Mental Health Act. The issues and themes raised in the surgeries were monitored and reported through the regular reporting structures along with complaints to ensure effective analysis.

The Board of Directors noted the report.

**BOD 106/13 MINUTES AND KEY POINTS FROM THE SERVICE QUALITY COMMITTEE**

Harriet Hall explained that this report presented a brief summary of the key points discussed at the meeting of the Service Quality Improvement Sub Committee meeting held on 23rd July 2013.

The committee reviewed the initial results of the gap analysis between the Trust’s existing arrangements and those set out in Monitor’s Quality Governance Framework. In many areas work was already underway to address the gaps and remaining areas work were due to commence shortly. The formal assessment would be taking place in November 2013.

The Board of Directors noted the report.

**BOD 107/13 DIRECTOR’S REPORTS**

There were no Director’s reports noted

**BOD 108/13 FORWARD PLANNERS**

The Forward planner was noted.

**BOD 109/13 ANY OTHER BUSINESS**

No other business was considered.

**BOD 110/13 MOTION TO EXCLUDE THE PRESS AND PUBLIC**

The Board of Directors agreed that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on
which would be prejudicial to the public interest (Section 1(2) Public bodies (Admission to Meetings) Act 1960.

The date of the next meeting will be: **Tuesday, 29th October 2013 – 3:00pm Maudsley Board room, Maudsley Hospital, Denmark Hill, London, SE5 8AZ**

(Post meeting note – this was subsequently changed to Thursday, 17th October 2013).

Chair
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 17th October 2013

Name of Report: Future of Health

Heading: - (Strategy, Quality, Performance & Activity, Governance, Information) Presentation

Author: Dr Matthew Patrick

Approved by: Dr Matthew Patrick

(name of Exec Member)

Presented by: Dr Matthew Patrick

Purpose of the report:
To introduce the Board to the work of the pan London Strategic Clinical Network and the links between mental health and long term conditions.

Action required:
For discussion.

Recommendations to the Board:
For noting.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The presentation describes the socio-economic factors which are causing activity pressures for all mental health service providers. There are proposals described which if taken forward could help to provide services in a different way and reduce the pressure on current services.

Summary of Financial and Legal Implications:
Detail includes national costs of mental health, long term conditions and medically unexplained conditions.

Equality & Diversity and Public & Patient Involvement Implications:
The presentation provides details disparity in the number of people with mental illness in contact with services.
Dr Matthew Patrick

Future of Health

NHS England (London Region)
Mental Health Strategic Clinical Network
03 October 2013
The London Mental Health SCN will take a whole system approach

Aim: To work in partnership to improve mental health outcomes that matter to Londoners

Mental health through more than one lens

Networks
- Maximise synergies
- Share knowledge & learning
- Develop models of best practice
- Implement of change

Partnership focused on Londoners
Patients, carers, clinicians, commissioners, social care, voluntary sector, PHE, AHSNs, HEE, CJS, Royal Colleges, etc.

Strategic Prioritisation
- Clarity of focus
- Large & lasting
- Clarity of aims and outcomes

Value based approach
- Condition specific integrated care pathways
- Outcomes measures that matter to people
- Measurement of cost
- Clinical standards for high quality care
- Informatics & data
London Mental Health SCN Priorities 2013/14
Strategic work plans & desired outcomes

- **Prevention** of mental illness in the early years. Building resilience in young people
- **Psychosis & urgent care pathways**
- **Mental health in Primary Care** (depression, anxiety)
- **Integration** of mental health into physical health care pathways. Support those with long term conditions who also have mental health conditions
- **Primary care commissioning.** Working with AHSN (UCLP) to support London CCG MH Network
- **Support Health in the Criminal Justice System**

Evidenced based best practice │ Needs assessment │ Care pathway profiling │ Referral & access protocols │ Patient assessment guidelines
Benchmarking │ Measurement │ Informatics & Analytics │ Training │ Redesign modelling │ Service model recommendations │ Standards
## Prevalence of mental health & its impact on outcomes

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Conditions</th>
<th>Outcome impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care:</strong></td>
<td>Depression &amp; anxiety</td>
<td>Premature mortality : 15-25 years</td>
</tr>
<tr>
<td>30-50% of daily workload</td>
<td>Substance misuse</td>
<td>Quality of life in LTCs</td>
</tr>
<tr>
<td></td>
<td>Children's conditions</td>
<td>Recovery from illness</td>
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<tr>
<td></td>
<td>Psychosis</td>
<td>Patient safety</td>
</tr>
<tr>
<td><strong>Acute care</strong></td>
<td>Alcohol &amp; drugs</td>
<td>Premature mortality</td>
</tr>
<tr>
<td>40% of A&amp;E in London</td>
<td>Depression &amp; self harm</td>
<td>Quality of life for LTCs</td>
</tr>
<tr>
<td>40% acute beds in London</td>
<td>Depression</td>
<td>Recovery from illness</td>
</tr>
<tr>
<td>50% acute outpatient clinics</td>
<td>Dementia</td>
<td>Patient safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient experience</td>
</tr>
<tr>
<td><strong>Prisons &amp; offenders</strong></td>
<td>ADHD, ASD</td>
<td>Premature mortality</td>
</tr>
<tr>
<td>70-80% especially young men</td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance misuse</td>
<td></td>
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<tr>
<td></td>
<td>PD</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist mental health services</strong></td>
<td>Psychosis</td>
<td>Premature mortality : 15-25 years</td>
</tr>
<tr>
<td></td>
<td>Neurodevelopmental</td>
<td>Quality of life</td>
</tr>
<tr>
<td></td>
<td>Substance misuse</td>
<td>Recovery from illness</td>
</tr>
<tr>
<td></td>
<td>Personality disorders</td>
<td>Patient safety</td>
</tr>
<tr>
<td></td>
<td>Complex multi axial</td>
<td></td>
</tr>
</tbody>
</table>
The overlap between long term conditions & mental health problems

- Long term conditions: 30% of population of England (approximately 15.4 million people)
- Mental health problems: 20% of population of England (approximately 10.2 million people)
- 30% of people with a long-term condition have a mental health problem (approximately 4.6 million people)
- 46% of people with a mental health problem have a long-term condition (approximately 4.6 million people)

The Kings Fund and Centre for Mental Health, 2012
Mental health raises costs in all sectors

- Overall, international research finds that co-morbid MH problems are associated with a **45-75% increase** in service costs per patient (after controlling for severity of physical illness).

- Between 12% and 18% of all expenditure on long-term conditions is linked to poor mental health & wellbeing – at least **£1 in every £8** spent on long-term conditions.
What physical healthcare clinicians treating people with DIABETES need to know

- Depression is common
- Diabetics have 2 – 3 times the rate of depression than the general population
- 24% of people with diabetes are estimated to be suffering from depression
- People with diabetes and depression have lower levels of self care & greater loss of work days
- Co-morbid depression is associated with 2x health care costs & increased health care utilisation
- More likely to be poor hyperglycaemic control with the severity of depression
- More likely to be admitted to hospital beds & other health services

What clinicians treating SMI need to know

- 1 in 5 people with a SMI has diabetes
- Premature deaths in people with SMI are up to x3 higher than the general population
- On average, those with SMI die between 10-15 years earlier
- Impact of some medicines can increase risk of diabetes
- Managing people with SMI & diabetes requires expertise & without that length of stay in mental health hospital beds is significantly extended
- People with SMI registered on primary care QOF registers must be assessed for diabetes as part of the annual physical health check
Heart disease

What cardiac services treating people with HEART DISEASE need to know

- They are more likely to suffer from depression
- They have an increased risk of death following myocardial infarction compared to those who are not depressed
- Low levels of emotional support have been reported to increase the risk of cardiac mortality 3 fold over 5 years following myocardial infarction

What primary care & mental health services treating MENTAL HEALTH need to know

- People with depression are at greater risk of developing heart disease
- A significant ‘dose related’ relationship has also been reported between anxiety disorders & sudden cardiac death
- Prospective epidemiological studies report that hopelessness more than doubled the risk of coronary heart disease
- Depression is a predictor of 1 year cardiac mortality but very high levels of support appear to buffer the impact of depression
What stroke clinicians treating people with STROKE need to know

- Depression occurs in **10-27%** of stroke survivors & usually lasts for about one year
- An additional **15-40 %** of stroke survivors experience some symptoms of depression within two months after the stroke
- Post stroke depression is associated with later mortality
- Untreated post stroke depression is likely to have a negative impact on functional outcome including activities of daily living & quality of life

What primary care & mental health clinicians treating DEPRESSION need to know

- Middle-aged men are **3x** more likely to suffer a fatal stroke if they are depressed
- The 14 year follow up study found a strong positive association between depression & fatal stroke in middle aged men
- Individuals reporting five or more depressive symptoms have more than a **50%** risk of mortality due to stroke in the subsequent 2-3 years
- Although the complex relationships between depression & stroke & cardiovascular mortality are not completely understood, treatment for depression has been shown to enhance quality of life, to improve physical, social & emotional functioning
Cancer

What services treating people with CANCER need to know

- 30% of patients with cancer have significant psychological morbidity
- 1 in 4 people with cancer also suffer from clinical depression
- Depressive symptoms can be mistakenly attributed to the cancer itself, which can also cause appetite and weight loss, insomnia and loss of energy
- Addressing mental health problems in people living with cancer does not pathologise a normal grieving process; it enables people to manage their health and improves quality of life.

What primary care & mental health clinicians treating DEPRESSION need to know

- Serious mental illness also increases the risk of cancer:
- People with schizophrenia are:
  - 3-4 times more likely to develop bowel cancer.
  - have a 52% increased risk of developing breast cancer.
- People with alcohol problems are more likely to develop head and neck cancers.
- Smoking rates are much higher among people with mental health problems so lung cancer will be more prevalent.
Medically Unexplained Symptoms

- **10-20%** of GP consultations
- **50%** of out patient attendances in acute specialist care
- Associated with increased health care consumption
  - Consultations in primary and secondary care
  - Increased use of medication
- Associated with increased dissatisfaction in the consultation
  - Both patient and GP

### Prevalence of MUS in Consecutive attendees at a UK teaching hospital

<table>
<thead>
<tr>
<th>CLINIC</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest</td>
<td>59</td>
</tr>
<tr>
<td>Cardiology</td>
<td>56</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>60</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>58</td>
</tr>
<tr>
<td>Neurology</td>
<td>55</td>
</tr>
<tr>
<td>Dental</td>
<td>49</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>57</td>
</tr>
</tbody>
</table>
MUS

- MUS costs the Exchequer around £18 billion p.a.
- MUS account for £3 billion of direct NHS costs pa
- £1.2 billion spent on top 10% (in-patient care)

- RAID Liaison model saves £4 for every £1 spent
The % of children with a mental disorder by type of physical complaint

Mental health of children & adolescents in Great Britain, 2000
The physical conditions which lead to premature mortality

Prevalence of physical health conditions among people with schizophrenia or bipolar disorder

- People with schizophrenia
- People with bipolar disorder
- People without schizophrenia or bipolar disorder

Percentage

Ischaemic heart disease: 4.0%
Stroke: 1.7%
Diabetes: 4.1%
High blood pressure: 9.7%

(Source: Hippisley-Cox and Pringle 2005)

These figures are similar to those found internationally.
Disparity in care

There is a disparity in the number of people with mental illness in contact with services, compared to physical health, yet it is a major cause of premature death.

<table>
<thead>
<tr>
<th>Broken down by condition....</th>
<th>% in treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety and depression</td>
<td>24</td>
</tr>
<tr>
<td>PTSD</td>
<td>28</td>
</tr>
<tr>
<td>Psychosis</td>
<td>80</td>
</tr>
<tr>
<td>ADHD</td>
<td>34</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>25</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>23</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>14</td>
</tr>
</tbody>
</table>

Mental health problems are estimated to be the commonest cause of premature death.

Largest proportion of the disease burden in the UK (22.8%), larger than cardiovascular disease (16.2%) or cancer (15.9%).

People with schizophrenia die 15-25 years earlier.

Depression associated with 50% increased mortality from all disease.
Futures of Health

- We all know that LTC and mental illness coexist
- But perhaps not aware of is the scale of the problem
- Allowing such comorbidities and health inequalities to go unrecognised and untreated is unacceptable
- When we talk about integration, however, we often get confused about what we are talking about – vertical, horizontal, three dimensional
- Why don’t we follow the principle of integrating services around people and needs
- Locate support and services where people want them, often as close to home as possible
Futures of Health

- Provide information, support, digital platforms and financial control to empower and enable self management and peer support
- Follow people into primary care, social care, the voluntary sector and ultimately home settings
- Design teams assuming comorbidity
- Work in partnership with people and offer guidance through service pathways
- Over recovery training and support to those with physical health conditions
- Use commissioning strategies to incentivise providers in doing the right thing
- And lets not forget that children and young people have LTCs and comorbid health difficulties as well.
Beyond Liaison Psychiatry?

- Network of providers working together across traditional boundaries
- MH integrated into wider healthcare delivery
- Single care plan approach
- Delivered by integrated teams
- Around condition specific care pathways
- Spanning primary and secondary care
- With system navigators
- Enhanced skills within all teams – ‘on every ward round’
- Secondary care models in primary and social care
- Primary care and MH models in secondary care
TRUST BOARD OF DIRECTORS
SUMMARY REPORT

Date of Board meeting: 17th October 2013
Name of Report: Service Quality Indicator Report
Heading: Quality
Author: Roy Jaggon
Head of Performance Management
Approved by:
(name of Exec Member) Gus Heafield
Presented by: Gus Heafield

Purpose of the report:
To present to the Board the monthly service quality indicator report.

Action required:
To review, the service quality indicator report, and note the planned way forward in development over the coming months.

Recommendations to the Board:
The Board are asked to accept the service quality indicator report and the planned work streams in progressing this further.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The report provides quality indicator data for each CAG, and therefore provides a source of assurance of service quality.

Summary of Financial and Legal Implications:
Quality targets written into the core contract quality schedules this year include; seven day follow-up post discharge, and copies of care plans given to patients.

Equality & Diversity and Public & Patient Involvement Implications:
There are no immediate or direct implications to equality & diversity or public and patient involvement.
SERVICE QUALITY INDICATOR REPORT

This is a monthly Quality Indicator report consisting of targets from both Monitor and the Trusts Quality Account. Performance is by CAG as well as providing an overall Trust position.

Month Commentary 6 (Quarter 2)

1. Patient experience

This segment of the quality strategy illustrates a consistent picture for patient surveys i.e. that all teams in the Trust are in the process of undertaking a patient experience survey. The patient experience question: ‘Do You Feel Safe?’ is a Quality Account indicator for this year and reported quarterly. For Q2 performance has improved from 77.10% to 80.27% against a target of 90%. In the June 2013 we described a number of violent reduction action plans / programmes being implemented across the Trust and we will report on progress next month. The ‘copy of care plan’ indicator has consistently illustrated performance of circa 93% for this financial year. This month performance has decreased slightly to 92.23% and will be progressed through CEO PMR.

CPA 12m, the Trust has met this target with performance of 95.91%

2. Access

The Trust remains compliant with delayed discharges, and early intervention targets.

HTT gate keeping: performance to date is 95.01% and therefore meets the target. However the comments of last month (below) remain to be the case. Clinical staff need to change their practice to ensure the administrative elements of recording are complied with.

‘Following the implementation of the Quality Account audit recommendations there is a period of transition as we adapt fully to the Monitor definition and make the technical changes to the way information is captured and reported on. We have implemented the Monitor exclusions and removed all non-compliant items. Current Insight reports no longer meet these new requirements. In the interim, while a new Insight report is developed, a manual extract of all admissions is analysed to provide a measure of performance. We are currently reviewing the change in reporting and implementing actions to ensure full compliance for this quarter.’

3. Patient safety

Overall the Trust has met the 7 day f/u target which is applicable to all adult services (AMH, MHOA and specialist services). There are some CAGs that are below the target of 95%. However given that we are providing this report earlier in the month than usual, we would anticipate seeing improvements in this area.

The Trust continues to meet the Brief/Full risk screen targets. However Child Need Risk Screen remains at 93.60% and will be progressed through the CEO PMR.
In future months we will be looking at how we might improve reporting on incidents for example looking at particular types of incidents. In addition we shall provide a more detailed analysis of RIDDOR reported incidents.

4. **Patient Outcomes**
The Trust continues to deliver on paired outcome scores across all CAGs.

5. **Inpatient and Community Contextual Information**
This information is similar to previous months and shows no significant variations in activity. Over the coming quarter we will look at how we can represent this data graphically to support a better our understanding of these activity profiles.

6. **Future Developments**
Over the next quarter we will be progressing further development of this report. In part this will be to ensure alignment with the Monitor Quality Governance Framework. This work will include enhancing the section on patient experience, improved reporting on violent incidents, developing a section on safeguarding and including some elements on physical healthcare.

Roy Jaggon
Head of Performance Management
Strategy and Business Development Directorate
### Patient Experience & Access Indicators

#### Year to Date 2013/14

<table>
<thead>
<tr>
<th>Indicator</th>
<th>PEDIC Survey in Progress Year To Date - 2013/14</th>
<th>Q3 Do you feel safe? 2013/14 as at end of Q2 (30th September 2013)</th>
<th>CarePlan Copy Given Year To Date - 2013/14</th>
<th>CPA - 12 Month Review As at 4th October 2013</th>
<th>Complaints MG - September 2013 YTD vs MG - September 2012 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>95.00%</td>
<td>Q3 90.00%</td>
<td>95.00%</td>
<td>95.00%</td>
<td>2013 / 14                                             2012 / 13</td>
</tr>
<tr>
<td>%</td>
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<td>%                                               %</td>
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<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>100.00%</td>
<td>N/A</td>
<td>N/A</td>
<td>3                                               +1</td>
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<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>85.00%</td>
<td>90.14%</td>
<td>4.86%</td>
<td>96.00%                                          1.00%</td>
</tr>
<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>70.57%</td>
<td>95.00%</td>
<td>0.00%</td>
<td>96.35%                                          1.25%</td>
</tr>
<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>80.36%</td>
<td>92.69%</td>
<td>2.21%</td>
<td>94.50%                                          -0.50%</td>
</tr>
<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>80.00%</td>
<td>91.85%</td>
<td>3.15%</td>
<td>92.35%                                          -3.15%</td>
</tr>
<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>82.35%</td>
<td>92.86%</td>
<td>2.14%</td>
<td>94.31%                                          2.31%</td>
</tr>
<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>81.93%</td>
<td>92.97%</td>
<td>2.71%</td>
<td>95.92%                                          0.92%</td>
</tr>
<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>81.93%</td>
<td>92.97%</td>
<td>2.71%</td>
<td>95.92%                                          0.92%</td>
</tr>
<tr>
<td>100.00%</td>
<td>5.00%</td>
<td>92.30%</td>
<td>92.33%</td>
<td>2.77%</td>
<td>95.93%                                          0.91%</td>
</tr>
<tr>
<td>Totals</td>
<td>5.00%</td>
<td>82.37%</td>
<td>92.97%</td>
<td>2.77%</td>
<td>95.93%                                          0.91%</td>
</tr>
</tbody>
</table>

**Please Note:** The results for "Do you feel safe?" are reported quarterly for 2013/14. This information comes from the PEDIC/Freedom data source - which is where the CAGs upload their survey submissions. Addictions are currently submitting their surveys on a bi-annual basis. The "Do you feel safe?" target is taken directly from the Quality Account 2012/13 document with a definition of "At least 90% of patients will respond positively."

#### Access Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Delayed Discharges Year To Date - 2013/14</th>
<th>HIT Gatekeeping Year To Date - 2013/14</th>
<th>Early Intervention: New Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>7.50%</td>
<td>95.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Days Lost</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>1,442</td>
<td>0.00%</td>
<td>N/A</td>
</tr>
<tr>
<td>0</td>
<td>24,759</td>
<td>0.00%</td>
<td>N/A</td>
</tr>
<tr>
<td>62</td>
<td>10,211</td>
<td>0.61%</td>
<td>N/A</td>
</tr>
<tr>
<td>37</td>
<td>10,633</td>
<td>0.54%</td>
<td>N/A</td>
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<td>0</td>
<td>2,686</td>
<td>0.00%</td>
<td>N/A</td>
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<tr>
<td>0</td>
<td>14,463</td>
<td>0.00%</td>
<td>95.01%</td>
</tr>
<tr>
<td>3,978</td>
<td>22,383</td>
<td>0.50%</td>
<td>N/A</td>
</tr>
<tr>
<td>0</td>
<td>142,709</td>
<td>2.94%</td>
<td>95.01%</td>
</tr>
</tbody>
</table>

**Please Note:** The Home Treatment Team figure reflects new current practice as per the Monitor definition implemented for 2013/14.
# September 2013 - Month 6

## PATIENT SAFETY INDICATORS

### Year To Date - 2013/14

<table>
<thead>
<tr>
<th>CPA 7 Day Follow-Up %</th>
<th>CPA 7 Day Follow-Up Numbers</th>
<th>Brief/Full Risk Screen</th>
<th>Child Risk Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>Total Discharges</td>
<td>Achieved</td>
<td>Not Achieved</td>
</tr>
<tr>
<td>Behavoural and Developmental Psychiatry</td>
<td>N/A</td>
<td>42</td>
<td>19</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>90.48%</td>
<td>+ 4.52%</td>
<td>101</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>N/A</td>
<td>92</td>
<td>80</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>91.12%</td>
<td>+ 3.31%</td>
<td>25</td>
</tr>
<tr>
<td>Psychosis</td>
<td>95.18%</td>
<td>+ 0.18%</td>
<td>174</td>
</tr>
<tr>
<td>Totals</td>
<td>95.35%</td>
<td>+ 0.35%</td>
<td>1165</td>
</tr>
</tbody>
</table>

The following applies to both CAG and through breakdown for CPA 7 Day Follow-Up.

For the CPA 7 Day Follow-Up % - the percentage is calculated by the achieved figure divided by the total discharges minus any exemptions.

### 12 Month Rolling Figures - Comparison from 2012/13 to 2013/14

<table>
<thead>
<tr>
<th>Violent S’s</th>
<th>RIDCOR Reported Violent Incidents</th>
<th>Patient Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 11 to Sep 12</td>
<td>Oct 12 to Sep 13</td>
<td>Oct 11 to Sep 12</td>
</tr>
<tr>
<td>Addictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>14</td>
<td>288</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>51</td>
<td>30</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Psychosis</td>
<td>32</td>
<td>56</td>
</tr>
<tr>
<td>Totals</td>
<td>763</td>
<td>746</td>
</tr>
</tbody>
</table>

This table shows the figures for Violence & Aggression. There is a RAG rating used, based upon the comparison between two periods of 12 month rolling average - September 2012 to October 13 vs. September 2011 to October 12 (last year). For Patient Falls the comparison is based on September 13 vs. September 12 (last year).

Green highlights where there is no change or a reduction in the figure recorded when compared to last year.

Amber highlights where the figure recorded is not greater than 5 when compared to last year.

Red highlights where the figure recorded is greater than 5 when compared to last year.
<table>
<thead>
<tr>
<th>%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HNOS REPORTING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CGAS REPORTING</td>
<td>97.74%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start</td>
<td>99.64%</td>
<td>98.51%</td>
<td>Exit</td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Outcomes**

**September 2013 - Month 6**
<table>
<thead>
<tr>
<th>Family</th>
<th>Physical</th>
<th>Psychosocial</th>
<th>Social</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>129</td>
<td>117</td>
<td>113</td>
<td>112</td>
<td>112</td>
</tr>
<tr>
<td>105</td>
<td>102</td>
<td>100</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>84</td>
<td>80</td>
<td>78</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>62</td>
<td>59</td>
<td>56</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>37</td>
<td>35</td>
<td>33</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>12</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>15</td>
<td>14</td>
<td>13</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

Table: Inpatient Contextual Information

September 2013 - Month 6 (YTD)
### September 2013 - Month 6

**Community Contextual Information**

<table>
<thead>
<tr>
<th>CAGA</th>
<th>Case Load M06 - September 2013</th>
<th>Discharges (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>3,485</td>
<td>1,417</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>2,988</td>
<td>934</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>6,007</td>
<td>2,608</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>4,659</td>
<td>2,326</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>5,857</td>
<td>2,611</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>4,756</td>
<td>4,653</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7,910</td>
<td>817</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>36,306</strong></td>
<td><strong>15,426</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community</th>
<th>12 month rolling - October 2012 to September 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Seen</td>
</tr>
<tr>
<td>Addictions</td>
<td>4,798</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>2,010</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>7,721</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>6,487</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>8,816</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>11,944</td>
</tr>
<tr>
<td>Psychosis</td>
<td>8,333</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>50,092</strong></td>
</tr>
</tbody>
</table>
### TRUST BOARD OF DIRECTORS – SUMMARY REPORT

<table>
<thead>
<tr>
<th>Date of Board meeting:</th>
<th>17 October 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heading: - (Strategy, Quality, Performance &amp; Activity, Governance, Information)</td>
<td>Quality</td>
</tr>
<tr>
<td>Author:</td>
<td>Karen Taylor – Assistant Director of Nursing – Infection Control</td>
</tr>
<tr>
<td>Approved by: (name of Exec Member)</td>
<td>Dr Martin Baggaley</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Dr Martin Baggaley</td>
</tr>
</tbody>
</table>

**Purpose of the report:**
To inform the Trust Board of Directors of: Infection Control data, with particular reference to MRSA and *E. coli* bacteraemia, *C. difficile* and outbreaks.

**Action required:**
To note the report

**Recommendations to the Board:**
To note the report

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**
Compliance with Outcome 8 and the Health & Social Care Act [HSCA].

**Summary of Financial and Legal Implications:**
None

**Equality & Diversity and Public & Patient Involvement Implications:**
The report positively supports diversity issues
1. Surveillance report of Blood borne viruses, alert organisms and outbreaks

<table>
<thead>
<tr>
<th>MRSA</th>
<th>There has been a colonised* case in a ward on the Maudsley Hospital site. Nil cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMRSA, PVL</strong></td>
<td></td>
</tr>
<tr>
<td>Antibiotic resistant infections, e.g. ESBL***</td>
<td>There has been one case in a urine sample from a patient on a ward at the Ladywell Unit. Information on the patient’s symptoms was obtained and advice was given on appropriate treatment.</td>
</tr>
<tr>
<td>E. coli bacteraemia</td>
<td>Nil cases</td>
</tr>
<tr>
<td>C. difficile</td>
<td>Nil cases</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>For the month of September 2013, 1 of the 30 patients screened for Hepatitis C antibody was positive.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>For the month of September 2013, 30 patients were tested for HepBsAg. Following further tests, none were found to be HepBeAg positive.</td>
</tr>
<tr>
<td>HIV</td>
<td>For the month of September 2013, 30 Inpatients and 3 Community patients were tested for HIV. All results were negative.</td>
</tr>
<tr>
<td><strong>Diarrhoea and vomiting Outbreaks:</strong></td>
<td>Nil outbreaks</td>
</tr>
</tbody>
</table>

* Colonisation – the presence of microbes on or in the body, growing and multiplying without invading the surrounding tissues or causing damage
** Panton Valentine Leucocidin
*** Extended spectrum beta-lactamases; Vancomycin Resistant Enterococcus

2. Progress on the Annual Infection Control audit strategy.

3.1 Infection Control dashboard

Work on the annual audit strategy continues, to demonstrate that policies have been implemented. Ward Managers [WMs], Modern Matrons [MMs] and Clinical Service Leads [CSLs] continue to complete hand hygiene, commode and decontamination of patient equipment audits on a quarterly basis. The results of the audits for each ward are included in an IC dashboard which is presented at CEOPMR.

3.2 Infection Control visits to Clinical areas

“Spotlight” checks in Clinical areas continue to be carried out by the ICT, ensuring compliance with key drivers, including those set by the CQC, and that IC is part of embedded into all aspects of clinical practice.

The tool has been reviewed to include more waste and sharps standards and availability of: Waste [colour coding] management and inoculation posters; Retractable phlebotomy equipment and: Colour coded equipment to deal appropriately with body fluid spillages.

All Waste Management critical issues are escalated to the Estates & Facilities Department.

All findings are fed back to WMs, MMs and CSLs.

From 1 July – 30 September 2013, 41 Spotlight checks have been carried out by the ICT.

3.3 Infection Control environmental audits in the Community.

Audits on Community units have been completed.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 17th October 2013

Name of Report: Finance Report

Heading: Performance & Activity

Author: Tim Greenwood, Mark Nelson
Finance Directorate, BRH

Approved by: Nick Dawe
(name of Exec Member)

Presented by: Nick Dawe

Purpose of the report:

The Finance Report provides an update on the financial position of the Trust as at 31st August 2013 (month 5).

Action required:

To note the contents of the report and the financial pressures and for the members of the Board of Directors to satisfy themselves that actions are appropriate to address them.

Recommendations to the Board:

That the Trust Board of Directors approves the report on the financial position for August 2013.

Relationship with the Assurance Framework (Risks, Controls and Assurance):

The report is a key component of the assurance framework in terms of the effective and efficient management of resources.

Summary of Financial and Legal Implications:

The Trust must make the best possible use of public money and meet regulatory requirements and deliver to plan.

Equality & Diversity and Public & Patient Involvement Implications:

The report identifies activity and financial pressures that if not resolved may have implications on the Trust’s ability to deliver its equality, diversity and patient involvement commitments as set out in the Annual Plan.
1. **Headlines**

   - £1.9m net deficit (£1.5m adverse variance from plan) – see Table 1
   - £4.9m EBITDA (£2.3m adverse variance from plan) – an increase in the adverse variance of £0.8m in the month (£0.6m in month 4)
   - If this variance was to continue, a risk rating of 2 would be achieved in Q2 under the current rating system
   - There has been little overall change from the previous month:
     - Psychosis and B&D overspent by £1.1m (£1m in month 4)
     - Acute overspill utilised 41 beds (40 beds in month 4)
     - Ward nursing costs fell slightly but more than offset by a reduction in C&V activity over the August period
     - CIPs remain off target by 26% - a similar position compared to previous months
   - A forecast position has been included in Table 1 this month. The forecast is subject to further discussion with the CAGs but is currently indicating an overall variance from our EBITDA Plan of £9m. This does not take account of:
     - Further releases of provisions
     - Additional income from local CCGs for over activity including the cost of the BRH Triage
     - Any slippage on Trust funded programmes such as AMH Transformation, maintenance and CQUIN schemes
     - Any HCAS funding (£0.5m) or Lewisham CCG AMH Transformation funding
     - Further CIP schemes

However, it also assumes:

   - All CQUIN targets are achieved
   - No sanctionable KPI fines are imposed
   - Lambeth CCG pay £750k towards the AMH Transformation and management of QIPP
   - CCG income is not reduced if neutrality cannot be achieved with NHSE over the transfer of funding
   - QIPP schemes such as the Lambeth Rehab Review, Lambeth acute bed reduction and reduction in older adult continuing care beds are cost neutral to the Trust
## 2. Financial Summary

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Variance</th>
<th>Variance</th>
<th>Variance</th>
<th>Variance</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month 1</td>
<td>Month 2</td>
<td>Month 3</td>
<td>Month 4</td>
<td>Month 5</td>
</tr>
<tr>
<td>Pschosis</td>
<td>(0.69)</td>
<td>(1.28)</td>
<td>(1.86)</td>
<td>(2.40)</td>
<td>(2.93)</td>
</tr>
<tr>
<td>Behavioural &amp; Dev.</td>
<td>(0.68)</td>
<td>(1.46)</td>
<td>(2.30)</td>
<td>(2.80)</td>
<td>(3.38)</td>
</tr>
<tr>
<td>Mood, Anxiety &amp; Personality</td>
<td>(0.08)</td>
<td>(0.22)</td>
<td>(0.29)</td>
<td>(0.39)</td>
<td>(0.46)</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>(0.14)</td>
<td>(0.38)</td>
<td>(0.44)</td>
<td>(0.70)</td>
<td>(0.97)</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>(0.08)</td>
<td>0.06</td>
<td>0.26</td>
<td>0.35</td>
<td>0.38</td>
</tr>
<tr>
<td>Older Adults &amp; Dementia</td>
<td>(0.12)</td>
<td>(0.26)</td>
<td>(0.36)</td>
<td>(0.47)</td>
<td>(0.51)</td>
</tr>
<tr>
<td>Addictions</td>
<td>0.00</td>
<td>(0.10)</td>
<td>(0.12)</td>
<td>(0.06)</td>
<td>0.03</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>(0.22)</td>
<td>(0.57)</td>
<td>(0.56)</td>
<td>(0.79)</td>
<td>(1.05)</td>
</tr>
<tr>
<td>Corporate Income</td>
<td>(0.01)</td>
<td>(0.05)</td>
<td>0.14</td>
<td>0.05</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>Operational Deficit</strong></td>
<td>(2.01)</td>
<td>(4.27)</td>
<td>(5.55)</td>
<td>(7.22)</td>
<td>(8.75)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CAGs</td>
<td>(1,908)</td>
<td>(1,792)</td>
<td>(1,848)</td>
<td>(1,484)</td>
<td>(1,352)</td>
<td>(1,351)</td>
<td>(7,827)</td>
</tr>
<tr>
<td>Infrastructure Directorates</td>
<td>(37)</td>
<td>(217)</td>
<td>(358)</td>
<td>10</td>
<td>(224)</td>
<td>(259)</td>
<td>(1,048)</td>
</tr>
<tr>
<td>Corp Income</td>
<td>(5)</td>
<td>(46)</td>
<td>188</td>
<td>(87)</td>
<td>77</td>
<td>127</td>
<td>3,981</td>
</tr>
<tr>
<td>Other reserves/provisions released</td>
<td>3,568</td>
<td>219</td>
<td>1,101</td>
<td>1,915</td>
<td>542</td>
<td>204</td>
<td>3,981</td>
</tr>
<tr>
<td>Use of Contingency</td>
<td>35</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>2,500</td>
</tr>
<tr>
<td>Total</td>
<td>1,660</td>
<td>(1,295)</td>
<td>(651)</td>
<td>1,129</td>
<td>(621)</td>
<td>(829)</td>
<td>(2,267)</td>
</tr>
</tbody>
</table>

## 3. CAG Issues

<table>
<thead>
<tr>
<th>CAG</th>
<th>Variance £000</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Psychosis      | (2,929)       | • Use of acute overspill beds increased by 1 in month 5 – the highest it has been since 2001. This is despite the opening of the Bethlem Triage Ward (costing £150k per month – unfunded) and additional investment in key community posts. In August, 41 beds were utilised of which 18 were in Lambeth and 13 in Croydon. The acute overspill overspend of £1.3m represents 46% of the total CAG ytd overspend. The overall £ position is expected to deteriorate in the short term as the risk share with Lambeth has already reached its cap. Discussions are taking place with the 4 local CCGs who have asked the Trust to provide options to deal with the activity pressure including the opening of 2 wards at Bridge House, the use of a rapid discharge support team and improving admission and discharge protocols and procedures.  
• A further £66k of Swk CCG QIPP has not been met this month (£328k ytd) with the disinvestment in both PICU and acute beds not being offset by reductions in expenditure and/or increases in income. Further discussions are taking place with the 4 CCGs to determine whether they will be... |
| Other reserves/provisions released | 3,568 | |
| Use of Contingency | 35 | |
| Total | 1,660 | |
invoiced for over activity given no beds have closed and beds remain fully occupied
• Complex placement activity has been split between NHSE commissioned and CCG commissioned. Both are currently overspending - £269k on NHSE and £416k on CCG (particularly Swk where further analysis of the position is being undertaken). In the meantime work continues to ensure effective gatekeeping, alternatives to placements are explored, placements are reviewed regularly and movement of patients to less costly step down is prioritised
• Ward nursing costs continued to fall in the month to £191k over ytd with PICU costs underspent in the month following a reduction in acuity and therefore observation costs
• Low occupancy and a continuing high income target based on opening additional beds on the Psychosis Unit has led to a further £98k shortfall in income this month (£342k ytd) excluding cross charged acute overspill. The Unit is now taking overspill patients and together with a more flexible ward environment, it is expected that occupancy levels will rise
• The drugs budget overspent by £47k in the month (£211k ytd) with the cost of paliperidone (costing £150 - £300 per patient per month) exceeding all other drugs and leading to the current overspending position. Cost reductions are expected within the next few months as the Trust moves to a third party delivery service and additional controls are placed on the use of paliperidone
• Only £712k of a potential £3.5m of QIPP has been fed into the month 5 position reflecting both the timing and uncertainty around some of the QIPP schemes
• The overspending position includes £2.89m of annual financial support as per the agreed Plan and a lower CIP target than other CAGs/Directorates proportionate to budget

<table>
<thead>
<tr>
<th>B&amp;D</th>
<th>(3,375)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>an increase of £578k in the month</td>
</tr>
</tbody>
</table>

- Loss of £3m transitional support, a reduction in the BDU income target and pay inflation have left an unfunded gap of £3m which is still to be addressed within the Plan (only partly addressed in 13/14 by the forensic transformation plan)
- Although transitional support has been provided to the NDS service, activity is below the revised plan (by £274k) whilst pay costs remain high and unchanged despite the closure of one of the two NDS units. In total the service is £454k overspent after 5 months. A staff restructure is expected to impact shortly and bring expenditure closer in line with revised income targets
- Overall £452k below target on C&V/CPC specialist income – mainly BDU and NDS service. This represents a deterioration in the position from last month, particularly for the BDU
- A number of CIP schemes (£0.8m) have been re-phased to deliver in the second half of the year which presents a greater risk should they not deliver given the limited time then available to implement corrective action
- Although NHSE provided additional income for Lambeth forensic placements, activity is not currently being contained within this revised block allocation. At month 5 placement budgets were £531k overspent (£113k over in the month).
- Ward nursing costs have remained at levels beyond the revised establishments - £53k month 1, £45k over month 2, £83k over month 3, £28k over in month 4 and £33k over in month 5 (ytd of £242k)
- NHSE have provided £1.8m of transitional finance to enable the bed price to remain fixed at 12/13 values but this will cease from 1/4/14
- Forensic activity in River House (despite a rise in external placements) had been below the 95% target set by NHSE. The agreement reached with NHSE includes tolerances and marginal rates which could have a further adverse impact if occupancy levels are not now maintained

The graph below shows the on-going deterioration in the Psychosis and B&D CAG positions over the last 12 months.
4. Key Cost Drivers

Performance against the main cost drivers is detailed below –

<table>
<thead>
<tr>
<th>Area</th>
<th>12/13 Mth 12 Variance £000</th>
<th>13/14 Mth 1 Variance £000</th>
<th>13/14 Mth 2 Variance £000</th>
<th>13/14 Mth 3 Variance £000</th>
<th>13/14 Mth 4 Variance £000</th>
<th>13/14 Mth 5 Variance £000</th>
<th>13/14 Total Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Nursing</td>
<td>(498)</td>
<td>(307)</td>
<td>(242)</td>
<td>(382)</td>
<td>(142)</td>
<td>(100)</td>
<td>(1,173)</td>
</tr>
<tr>
<td>Acute Overspill*</td>
<td>(432)</td>
<td>(316)</td>
<td>(43)</td>
<td>(211)</td>
<td>(492)</td>
<td>(272)</td>
<td>(1,334)</td>
</tr>
<tr>
<td>CPC/C&amp;V Income</td>
<td>(224)</td>
<td>(163)</td>
<td>(187)</td>
<td>(89)</td>
<td>(218)</td>
<td>(446)</td>
<td>(1,103)</td>
</tr>
</tbody>
</table>

*excluding cost of Bethlem Triage

- Acute/PICU Overspill

Overspill remains at record levels. Overall, 41 beds were used outside the Trust in August, an increase of 1 compared to the previous month resulting in a year to date net overspend of £1.3m. This position includes an offset for the Lambeth CCG risk share but as the activity cap has now been reached, no further funding is available and the shortfall is likely to accelerate without further agreement with the CCG about how such excess activity is to be handled. Similarly, the direct cost of the Croydon Triage Ward remains unfunded (£745k ytd) and this adverse variance is reflected in the overspending position of the Psychological Medicine CAG.

Discussions are taking place with the 4 local CCGs who have asked the Trust to provide them with options to deal with the activity pressure. These options will include the opening of 2 wards at Bridge House, extension of the Croydon Triage, the use of a rapid discharge support team and improving admission and discharge protocols and procedures.
- **Ward/Unit Nursing Costs (Table 2)**

At month 5 ward nursing costs were overspent by £100k (£1.17m ytd), a decrease in the rate of overspend from previous months. Expenditure exceeds budget by 4.5% with bank costs making up 25% of total pay costs (compared to 24% last year) and agency 1%. The top 10 wards highlighted in Table 3 make up 79% of the variance. Of particular note are the disproportionate number of MHOA wards/units which make up 5 of the top 10 and the NDS where one of the 2 units has closed but nursing costs have not fallen.

- **MSU/LSU Placements (NHSE Funded)**

The basis of the NHSE offer to SLaM was to only fund placements as at 1st April. Unless patients can be discharged/stepped down before their planned date, there is no funding available for new admissions. This position is reflected in the graph below which shows an on-going overspend following new admissions during the first 5 months (£691k ytd).
Cost per Case/Cost and Volume Income

The Trust has agreed Heads of Terms with NHS England regarding the price/volume and terms and conditions for a range of specialist services in 2013/14 (including low and medium secure beds). The reported position below is therefore based upon this agreement with transitional funding helping to keep prices largely at 12/13 levels. Some further adjustment is still to be made for tolerances/marginal rates of pay and CQUIN.

i) Cost per Case/Cost and Volume Income (lower activity in August)

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 5 £'000</th>
<th>Actual Invoiced At Month 5 £'000</th>
<th>Surplus/ Deficit(·) At Month 5 £'000</th>
<th>Surplus/ Deficit(·) Last Month £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>1,554</td>
<td>1,213</td>
<td>(342)</td>
<td>(243)</td>
</tr>
<tr>
<td>Behavioural &amp; Dev</td>
<td>4,165</td>
<td>3,713</td>
<td>(452)</td>
<td>(229)</td>
</tr>
<tr>
<td>Psychological Med</td>
<td>6,476</td>
<td>6,503</td>
<td>27</td>
<td>18</td>
</tr>
<tr>
<td>Mood and Anxiety</td>
<td>2,309</td>
<td>1,702</td>
<td>(606)</td>
<td>(515)</td>
</tr>
<tr>
<td>CAMHS</td>
<td>8,172</td>
<td>8,626</td>
<td>455</td>
<td>461</td>
</tr>
<tr>
<td>Addictions</td>
<td>1,206</td>
<td>1,022</td>
<td>(184)</td>
<td>(149)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23,882</td>
<td>22,780</td>
<td>(1,102)</td>
<td>(657)</td>
</tr>
</tbody>
</table>

The graph below illustrates the overall performance and performance by CAG.
Overall the Trust was £1.1m below target at the end of month 5, the position moved adversely by £445k in August. The majority of the underperformance has occurred in the following areas (similar to last year) –

- Psychosis Unit - low occupancy and a continuing high income target based on opening additional beds on the Psychosis Unit has led to a further £98k shortfall in income this month (£342k ytd) excluding cross charged acute overspill beds. The Unit is now taking overspill patients and with estate works now completed to enable greater gender flexibility on the ward, it is expected that occupancy levels will rise

- The closure of NDS 2 has meant that capacity is no longer sufficient to meet the income targets currently built into the BDP plan resulting in an income shortfall of £274k. The performance of the Behavioural Disorders Unit dropped back this month following improvements and is now showing a shortfall of £134k after 5 months

- The AED Unit – the Unit has closed impacting on the income variance as activity has ceased. The adverse income variance at month 5 is £586k. This will be offset to some extent following staff redeployment

- The Addictions Acute Assessment Unit - £19k deterioration in the month. Occupancy levels fell in August (to 53%) with income now showing a year to date shortfall of £147k despite £0.57m of Trust transitional support

4. Cost Improvement Programme (CIP) & CCG QIPP

a) Trust CIP (Table 4)

The Trust is reporting an overall adverse variance of £1.5m (26%) against its original plan of £15.8m at month 5. At month 5, 38% of the overall savings plan has been phased into the year to date position. In the case of B&D however, only 18% has been phased into the position reported here reflecting the backloaded nature of some of their schemes. A forecast position has been provided which shows that the % achieved is likely to remain fairly stable unless further schemes can be deployed.

The main areas of variance are highlighted and explained in Table 4. Currently these are linked to the estates rationalisation programme, through not delivering cost improvements following a reduction in MHOA continuing care beds and from a shortfall in the savings required through reductions in sickness, bank/agency costs and other HR driven strategies to offset the 2013/14 pay award.

b) CCG QIPP (disinvestment) - Table 5

There was an overall shortfall of £1.18m against the CCG QIPP target attributable to SLaM.

The main shortfalls are as per the report last month (see Table 5) –

- Some schemes have yet to be agreed with the CCGs but funding has already been removed from the block contract. To date this has only impacted by £83k due to the phasing of schemes. However from month 7, a number of significant schemes in Adult and MHOA services are due to come on stream for which plans are still being developed. These include a review of rehab services, a reduction in acute beds, a review of prescribing and the closure of continuing care beds. If these schemes slip or can’t deliver the scale of savings required then further discussions will be required with the CCGs to determine alternative measures and establish the risk share arrangement in place to compensate the Trust for the reduction in block income.
• The reduction in Southwark CCG purchased acute and PICU beds has not been fully offset by lower costs and/or an increase in income from other purchasers of beds (linked in part to the risk share agreements with other local CCGs). Notice has formally been given to all four boroughs of the exceptional demand figures and baseline information has been exchanged. A series of meetings has been set up on a “four borough” basis during September to agree actions and funding to resolve the issue in both the short-term and long-term.

• The retention of Granville Park (and associated costs) by MHOA, pending a review of estate by the CAG which should lead to savings later in the year. In addition staff were not re-deployed at the same time as the Unit closed leading to additional staffing costs whilst the HR process was completed.

5. Trust Summary Issues and Actions

The Trust’s financial position at the end of August continues to be a cause for concern with the retention of a financial risk rating of three at quarter two being an increasing challenge. The issues for the Board to consider remain as previously stated:

• Excessive demand and unfunded activity and the Board’s operational and financial response to these pressures,
• Delivery of the commissioner required cost improvement (CIP) and quality, innovation, productivity and prevention (QIPP) programmes,
• Achieving income targets (for specialist services).

These issues are picked up in separate papers to the Board.

If the activity pressures continue through September and resolution is not reached with the local CCGs the Trust Board will need to take difficult decisions in October to ensure that services offered and delivered are of a sufficiently high level of quality and affordable for the remainder of the financial year.

There may also be a need to consider taking significant corrective action in respect of contract delivery and staff and non-staff spending controls (over and above the delivery of the CIP and QIPP action plans already agreed).

An initial view of the September position (month 6), together with detailed updates on the contract activity, service transformation, CIP and QIPP and financial recovery plans will be made available in Part II of the Board Meeting.
# TRUST BOARD - SUMMARY REPORT

**Date of Board meeting:** 17th October 2013

**Name of Report:** Chief Executive’s report

**Heading:** - (Strategy, Quality, Performance & Activity, Governance, Information) Governance

**Author(s):** Paul Mitchell, Trust Board Secretary

**Approved by (name of Executive member):** Dr Matthew Patrick, Chief Executive

**Presented by:** Dr Matthew Patrick, Chief Executive

## Purpose of the report:
To inform the Board of significant issues arising from Trust Executive meetings, Performance Management meetings, an update on information governance issues, the local health economy and nationally in the NHS and Social Care.

## Action required:
To discuss items of concern and where necessary initiate additional assurance action.

## Recommendations to the Board:
To note the report.

## Relationship with the Assurance Framework (Risks, Controls, and Assurance):
The report highlights issues relating to the Assurance Framework arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.

## Summary of Financial and Legal Implications:
The report highlights any financial and legal Implications arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.

## Equality & Diversity and Public & Patient Involvement Implications:
The report highlights equality & diversity issues arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.
Chief Executive’s Report
October 2013

1. Introduction
I would like to start by saying how delighted I am to introduce my first report as Chief Executive of the South London and Maudsley NHS Foundation Trust having taken up my post on Monday, 14th October. It is an immense privilege to have the opportunity to lead such a remarkable organisation. I have already been made to feel most welcome by the staff that I have had the chance to meet.

As some of you will know, I worked as a Registrar at both the Maudsley and the Bethlem hospitals while I was training, some 25 years ago. Mental health services have undergone tremendous change and development over the intervening period and I think that we are again on the brink of a period of further change. I would hope that as we negotiate that change we can continue to focus on improve the quality of the lives of the people and populations we serve.

2. National issues
It is most timely that last week saw the publication of a report of crucial interest and importance to anyone associated with the provision of mental health services. Prof Dinesh Bhugra’s report “The future of mental health services” makes essential reading. The FOMHS Inquiry was set up by the Mental Health Foundation in 2012 to explore what mental health services might look like in 20-30 years’ time.

Its three main aims were:
1. to review the provision of mental health services in the UK in the light of current and future health and socio-economic developments
2. to promote debate on the proper aims and ambitions of mental health services
3. to consider how to make mental health services fit for purpose to deal with future challenges.

The Inquiry Panel was made up of senior representatives from a range of professions, alongside mental health service users and carers. It was chaired by Lord Carlile of Berriew and Professor Dinesh Bhugra.

The Panel took evidence from over 45 senior figures in mental health across the UK and received more than 1500 responses to its online Call for Evidence.

The report took into account key factors:

- Changing demographics
- Economic downturn
- Societal expectations, patient expectations
- Changes in knowledge base
- New diagnoses, increasing co-morbidity
- New media-apps, social media
- Fragmentation of services

The Inquiry identified six key themes that mental health services will need to address to become fit for purpose for the 21st century:
1. We need greater personalisation of services and the engagement of patients and their carers and families as equal partners in decisions about care and service provision. Patients at the heart with clear lines of communication.

2. We need increased integration, driven by committed local leaders, between different parts of mental health services; between physical and mental health care; and between health and social care. This will need a new approach to training health and social care staff, and a change in culture and attitudes.

3. We need services that are designed to address an individual’s mental health, and mental health needs, across the life span from infancy to old age. Transitions to be made easier from adolescence to adult to older age.

4. We need shared training across disciplines from the start of people’s careers and in continuing professional development, moving psychiatry into community and primary care settings, and flexibility for staff to develop and move careers across disciplines.

5. Better funded research, into both clinical and social interventions to support people with mental health problems, alongside a commitment to ensure equality of access to the benefits of new technologies.

6. We need mental health to be treated as a core public health issue, so that it will be as normal for everyone to look after their mental health similar to and as part of their physical health and a public health workforce that sees mental health as one of its core responsibilities.

3. Trust and IoP issues

**Director of Nursing**

Final interviews for the Director of Nursing post will be taking place on Tuesday, 8th October.

This will be the last Board meeting attended by Dr Jane Sayer, currently Acting Director of Nursing and Education, who is leaving the Trust at the end of October to take up the post of Director of Nursing, Quality and Patient Safety at Norfolk and Suffolk NHS Foundation Trust. We give Jane our very best wishes for the future and thank her for her huge contribution to the Trust over many years.

Many people will be saddened by the news that Sharon Dennis passed away last week. Sharon worked at SLaM some years ago and her most recent post was Interim Director of Nursing and Quality at Northamptonshire Healthcare NHS Foundation Trust. She championed high standards of patient care, mental health nursing and nurses, women’s rights, equality and diversity as well as developing and supporting nurses in their careers.

She was also an active member of the Royal College of Nursing (RCN) as regional co-director and board secretary for the south east England section. The Windrush Nurses and Beyond Foundation had recently named its mental health nursing award after her.

**Channel 4 Broadcast**

SLaM is soon due to feature in a new landmark Channel 4 series. ‘Bedlam’ is a four-part observational documentary series that takes an in-depth and unprecedented look at mental health in Britain today, with exclusive access to a wide range of services, patients and staff at SLaM.

Key to the series, filmed over a year, is giving a voice to those who suffer with mental illness, from people with psychosis or bipolar disorder to those with severe anxiety. Each of the four films tackle a different aspect of mental health. One film features the Anxiety Disorders Residential Unit at Bethlem Royal Hospital, another features Lambeth Triage, the third focuses on the Speedwell support and recovery team and the final film features Aubrey Lewis 2, the older adult ward at Maudsley Hospital.
The title was decided upon both by SLaM and Channel 4. It’s based on the fact that SLaM can trace its roots back to 1247 when the Priory of St Mary of Bethlehem was established in the City of London. The priory, which became a refuge for the sick and infirm, was known as ‘Bedlam’ and was the earliest form of what is now Bethlem Royal Hospital.

The series has been made by The Garden Productions and the first film is expected to be broadcast on 31 October 2013, though this has not yet been officially confirmed by Channel 4.

4. Chief Executive Performance Management Review

Discussion at the September CE PMR meetings focused on linking the issues of:

- Managing the current significant additional activity pressures on many services, (this issue being progressed by clinically led and operationally supported meetings with lead commissioners).
- Using resources efficiently and effectively and staying within budget, (this issue being followed up by a structured review of existing action plans, and progress on CIP and QIPP schemes, including the qualitative dimension of these programmes).
- Addressing these operational and financial challenges whilst continuing to address issues around quality and patient perception and in particular hit key Monitor and Trust service quality and service improvement targets.

Other issues discussed included compliance with mandatory training requirements, estate responsiveness, statutory works and preparation for the October Board meeting.

5. Information Governance

Following the publication of the national Information Governance Review led by Dame Fiona Caldicott last April, the Secretary of State for Health considered the recommendations of this review and published the Government’s response on 12 September 2013. In the response, the Secretary of State agrees with the recommendations of the national IG Review and emphasises the importance of striking an appropriate balance between the protection of service users’ personal confidential information, and the effective use and sharing of such information to improve care.

The Government’s response to the IG Review puts special emphasis on the value of clinical data for research and the potential for research and development to lead to improvements in health and social care. In this section, the role of information governance is outlined in enabling effective, lawful, confidential and secure use of the wealth of clinical data held by NHS organisations. Like in the IG Review, the Secretary of State cites the work in South London and Maudsley NHS Foundation Trust as good practice and successful solutions which enables access to patient information while ensuring confidentiality is protected.

Health and Social Care Information Centre published their guide to confidentiality to time with the response from the Secretary of State. The document helpfully outlines guiding principles for health and social care staff to treat confidential patient information with respect.

Both documents have been reviewed in detail by the Information Governance Team to ensure that the Trust continues to follow the principles outlined and that the Trust IG policies and practice across clinical, research and corporate services are compliant with the latest guidance.

Dr Matthew Patrick
Chief Executive
October 2013

U / Board / Chief Executive report Oct 13
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 17th October 2013

Name of Report: Report from the Council of Governors

Heading: - (Strategy, Quality, Performance & Activity, Governance, Information)

Author: Paul Mitchell, Trust Secretary

Approved by: (name of Exec Member) Gus Heapfield, Acting Chief Executive

Presented by: Paul Mitchell, Trust Secretary

Purpose of the report:
To update the Board on the current areas of Council of Governors’ activity.

Action required:
To note.

Recommendations to the Board:
To note.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The Council of Governors is an integral component of the Trust’s Constitution as a Foundation Trust.

Summary of Financial and Legal Implications:
Budgetary provision has been made to support the activities of the Council of Governors.

Equality & Diversity and Public & Patient Involvement Implications:
The Council of Governors has a responsibility to ensure that the Trust’s membership is representative of the local populations in terms of diversity and that all members, including those from the patient & public constituencies, are fully involved.
1. Changes and elections to the Council of Governors

Following approval of the changes to the FT Constitution, further elections are being held to fill the remaining vacancies on the Council of Governors.

Angela Flood has been elected unopposed as a carer representative.

Alistair Edwards and Tina Lincoln have been elected unopposed as service user representatives.

Elections will take place to fill the one public constituency vacancy, there are four candidates. The results will be published on Wednesday, 13th November 2013.

The four CCGs covering Lambeth, Southwark, Lewisham and Croydon have been approached to nominate a representative to join the Council of Governors. The Croydon CCG Chief Officer, Paula Swann, has confirmed that she will be putting herself forward. Croydon Borough Council has also been contacted asking for a replacement nominee.

2. Membership and Communications Group

A workshop on membership development is scheduled to take place on Wednesday, 9th October 2013. A verbal report will be made at the meeting.

3. Members meetings on the development of the annual plan

As previously advised these will be held at:

Southwark: Monday 18th November, 5.00 to 7.00pm, at Maudsley Learning Centre, 82-96 Grove Lane, SE5 8SN.

Lewisham: Tuesday 19th November, 2.00 to 4.00pm, at Lewisham Carers’ Centre, Forest Hill, SE23 2LB

Lambeth: Monday 25th November, 2.00 to 4.00pm, at Lambeth ACCORD, 336 Brixton Road, SW9 7AA.

Croydon: Thursday 28th November, 5.00 to 7.00pm, at CVA Resource Centre, West Croydon, CR0 2TB.
4. Key dates

14th November – Joint GSTT, KCH and SLaM Governors induction

26th November – Further SLaM induction plus joint meeting between the Council of Governors and Board of Directors

16th December – Joint GSTT, KCH and SLaM Governors meeting (starting at 6.00 pm)

Paul Mitchell
Trust Secretary
October 2013
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 17th October 2013

Name of Report: KHP Board Update (verbal)

Heading: - (Strategy, Quality, Performance & Activity, Governance, Information) Governance

Author: 

Approved by: (name of Exec Member)

Presented by: Madeliene Long

Purpose of the report:
To inform the Board of Directors on the progress made on the development of SLaM/IoP Mental Health Clinical Academic Groups and the wider developments across King’s Health Partners

Action required:
The Board of Directors is asked to note the verbal report.

Recommendations to the Board:
The verbal report is for information.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
One of the purposes of the King’s Health Partners Executive is to ensure that the impact of the development of King’s Health Partners is positive with regard to each constituent organisation’s risks and controls

Summary of Financial and Legal Implications:
The current report does not contain any legal implications. As the work develops, any significant legal or financial implications will be brought to the Board of Directors for consideration. There are resource requirements to ensure that the Trust contributes to delivery within the King’s Health Partners Strategic Framework 2010-2014

Equality & Diversity and Public & Patient Involvement Implications:
A key purpose of King’s Health Partners is to improve the health and wellbeing of local people. In developing their strategies, the CAGs are specifically required to state how they will address the health inequalities reflected in the “heat map”. This of necessity requires that service users and their carers are actively involved in their own care and the developments within services. It also requires that no service user receives less favourable services or outcomes as a result of their ethnicity, gender, disability, sexuality, faith or age.
Date of Board meeting: 17th October 2013
Name of Report: Assurance Framework Report
Heading: Governance
Author: Jenny Goody, Governance Manager
Approved by: Nick Dawe
Presented by: Nick Dawe

Purpose of the report:
To present the principal risks that have been identified by the Trust’s operational management that are thought to most threaten the achievement of the Trust’s objectives in 2013/14. To understand the actions and progress with the actions designed to mitigate and control the principal risks.

Action required:
The Board of Directors is asked to review the attached report to ensure that all principal risks are identified, to confirm that actions to mitigate these risks are comprehensive and appropriate and that acceptable progress is being made towards completing these actions.

Recommendations to the Service Quality Improvement Sub Committee:
Accept the attached Assurance Framework Report, subject to any changes agreed by the Board of Directors. Note the significant and growing risks to patient quality and financial stability arising from the fact that in the four boroughs and Croydon in particular, actual demand and activity is significantly exceeding commissioned and funded levels.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
This paper forms the basis of the on-going process that ensures risk identification; mitigation and management comply with the requirements of the Assurance Framework.

Summary of Financial and Legal Implications:
The Assurance Framework underpins the statutory requirement to produce an Annual Governance Statement, which confirms that the Trust is appropriately and effectively governed and managed.

Equality & Diversity and Public & Patient Involvement Implications:
The Assurance Framework enables the Board to assess and manage the organisation’s principal risks and ensure that the Trust’s strategic aims are achieved.
Board Assurance Framework 2013/14

Introduction

The identification and management of risk forms a key part of the governance of the Trust. By the very nature of the services that the Trust provides and the reputation, scale and complexity of the Trust, the number of risks facing the Trust is large, with several of the risks being significant. It is not only important that the Trust identifies these significant risks, it is critical that the Trust has a realistic risk appetite that supports innovation, change and the capacity and capability to manage and mitigate risks.

Progress

All CAGs and Directorates have been asked to submit detailed progress updates on the risks applicable to them, citing local sources of assurance where appropriate. Responses have been received from the B&DP, CAMHS, MHOAD and Psychosis CAGs and the Capital Planning, HR, ICT and Nursing Directorates.

These responses have been aggregated into the summary report at Attachment 1, with key highlights described below.

Key changes: AF5 (Activity and capacity): with the certainty that activity volumes will now run well in excess of contracted and funded levels with a spending pressure of up to £13m, the score of this risk has moved from 12 to 20. This is a major area of concern that impacts on quality, safety and the ability to deliver objectives such as a balanced financial out-turn and an improved estate.

Key successes: AF1 (Quality issues): Recent work on complaint workshops has had positive feedback; carer engagement is being picked up by CAGs and Directorates. AF3 (Safety): The QuESTT tool has been piloted in the Psychosis CAG to identify deteriorating teams at an early stage and a graded response plan is being developed. AF6 (AMH transformation): HR workstream mobilised, ToR and planning commenced. AF8 (Organisational and operational position): Recruitment to key roles is in the advanced stages. AF9 (Estates responsiveness): A dedicated Project Manager is overseeing expenditure and developing phased cash flows and programmes of work to ratify expenditure. Property status reports are being developed on all units, outlining overall assessment and value/risk to the Trust. Occupational Management role created to increase productivity of Trust planning and efficiency of main Project Managers.

AF10 (Decision support): Work is currently underway to produce an Integrated Governance Report; first draft expected in November 2013.

The CAMHS CAG has reported that progress against all actions applicable to them is rated BLUE (completed & working, with identified benefits realised) or GREEN (progressing to plan and delivering to expectations).

The B&DP, MHOAD and Psychosis CAGs have provided comprehensive updates on actions applicable to them, which are all rated AMBER(slight delay in progress) or GREEN.
## Board Assurance Framework 2013/14

**Objective:** The service user is the centre of all we do

<table>
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<tr>
<th>Ref.</th>
<th>Risk Area</th>
<th>Risk Description</th>
<th>Consequences (Reason for Inclusion)</th>
<th>Risk Rating</th>
<th>Trust Lead(s)</th>
<th>Key Actions</th>
<th>Progress</th>
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</thead>
</table>
| 1.   | Offer people the quality of service they require / deserve | Insufficient attention is given to quality issues in strategic and operational decision making and practice.  
*Source of Assurance:*  
- Patient survey  
- Staff surveys  
- Supervision audits  
- Negligence complaints and claims  
- CQC and other regulatory actions outstanding | **Service Users:** Service users fail to thrive and improve; failure to embed a caring and compassionate culture.  
**Service:** Service users choose to go elsewhere.  
**Business:** Failure to comply with regulatory requirements and/or evidence Monitor's Compliance Framework. | 5 | Trust Board and Executive collectively, co-ordinated by Medical and Nursing Directors | Ensure the Trust’s Quality Plan for 2013/14 contains specific quality targets and baselines.  
Disseminate the Quality Strategy throughout the Trust.  
Ensure mechanisms for patient, carer and staff satisfaction are regular and robust and respond appropriately.  
Ensure that quality implication statements appear on all decision papers at CAG, Executive and Board level. |  |
| 2.   | Safety of patients, staff and public | Heightened levels of violent and aggressive behaviour.  
*Source of Assurance:*  
- Serious Incidents  
- Injuries reported to HSE under RIDDOR regulations  
- Claims | **Service Users:** Injury; unsatisfactory in-patient experience.  
**Service:** Injury to staff; poor staff morale; sickness absence.  
**Business:** Backfill costs; damage to Trust property and premises; litigation. | 4 | CAG Service Directors, co-ordinated by Medical and Nursing Directors | Implement Violence Reduction Strategy throughout the Trust.  
Develop Care Delivery System as a clinical toolkit to reduce violence.  
Address the problem of an aging/less fit workforce and their capability to use and train in PSTS techniques.  
Implement improved alarm system. |  |
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<tbody>
<tr>
<td>3</td>
<td>Safety of patients, staff and public</td>
<td>Unexpectedly high levels of Serious Incidents and Complaints.</td>
<td><strong>Service Users:</strong> High level of patient mortality.</td>
<td>4</td>
<td>CAG Service Directors, co-ordinated by Medical and Nursing Directors</td>
<td>Develop agreed benchmarks and a mechanism to raise awareness, identify issues and respond appropriately.</td>
<td></td>
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<td></td>
<td></td>
<td>Source of Assurance:</td>
<td><strong>Service:</strong> Lack of awareness of key performance indicators and inability to respond appropriately.</td>
<td>3</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Business:</strong> Litigation.</td>
<td>12</td>
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- **Service Users:** High level of patient mortality.
- **Service:** Lack of awareness of key performance indicators and inability to respond appropriately.
- **Business:** Litigation.
Objective: Provide effective and efficient services that meet the needs of our service users

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<tbody>
<tr>
<td>4</td>
<td>Forward Plan</td>
<td>Failure to deliver the Forward Plan (CIPs and QIPPs).</td>
<td>Service: Inability to deliver the service that is fit for purpose. Business: The Trust is not operationally viable.</td>
<td>4 3 12</td>
<td>Executive and CAG Service Directors</td>
<td>Improve ‘SMART’ monitoring of CIP and QIPP delivery. Manage performance of CIP and QIPP delivery, holding managers to account at Board meetings.</td>
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<tr>
<td>5</td>
<td>Activity</td>
<td>Demand for services exceeds capacity and contracted levels.</td>
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<td></td>
<td></td>
<td>Source of Assurance:  Board Report on Finance</td>
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<tbody>
<tr>
<td>6.</td>
<td>AMH transformation</td>
<td>Insufficient capacity &amp; capability to deliver the AMH transformation programme (due to its scale and experimental nature).</td>
<td>Service Users: Don’t receive a modern and applicable service. Service: Loss of market share, through commissioners or service users choosing to go elsewhere. Business: Unaffordable business model that does not meet demand; failure to comply with regulatory requirements.</td>
<td>4 3 12</td>
<td>AMH CAG Service Directors</td>
<td>Produce SMART Business Case. Key metric: Business Case approved by Board. Identify and train implementation project team. Monitor progress against plan and report to Board.</td>
<td>HR - G</td>
</tr>
<tr>
<td>7.</td>
<td>Forensics transformation</td>
<td>Insufficient capacity &amp; capability to deliver the Forensics transformation programme (due to its scale and experimental nature).</td>
<td>Service Users: Don’t receive a modern and applicable service. Service: Loss of market share; through commissioners choosing to go elsewhere. Business: Unaffordable business model that does not meet demand; failure to comply with regulatory requirements.</td>
<td>4 3 12</td>
<td>B&amp;DP CAG Service Directors</td>
<td>Produce SMART Business Case. Key metric: Business Case approved by Board. Identify and train implementation project team. Monitor progress against plan and report to Board.</td>
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**Objective:** Retain the position of a leading MH Trust, with proven clinical and business success

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<tbody>
<tr>
<td>8.</td>
<td>Organisational and Operational Position</td>
<td>High levels of vacant, acting and interim posts, coupled with high levels of organisational change, including the advent of the Kings Health Partnership.</td>
<td>Service: Insufficient management capacity / capability to deliver or support the delivery of clinical services; prolonged uncertainty and inability to act. Business: Failure to comply with regulatory requirements and/or evidence Monitor's Compliance Framework.</td>
<td>3 4 12</td>
<td>Chief Executive</td>
<td>Identify and manage gaps proactively. Identify and develop leadership skills. Recruit to key Director and other senior posts.</td>
<td>HR - G</td>
</tr>
<tr>
<td>9.</td>
<td>Estates responsive and proactive service</td>
<td>The estate is not functionally suitable for key services. (Condition of premises stock and backlog maintenance need)</td>
<td>Business: Rapid repairs; inability to deliver approved projects; failure to comply with regulatory requirements.</td>
<td>3 4 12</td>
<td>Finance and HR Directors (pro temps)</td>
<td>Initiate rapid response arrangement and create buffer stock of key estate components and decant facilities. Improve operational, programme and project management arrangements. Ensure proactive approach to statutory testing and remedial works programme. <em>Key metric: Delivery of procurement process and % completion of works programme.</em></td>
<td></td>
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| 10.  | Decision support| Lack of timely and accurate performance information (clinical, contractual, bed, etc.). | **Service:** Inability to make correct operational and strategic decisions.  
**Business:** Under recovery of income (including PbR), fines, contract sanctions and inability to implement zero based budgeting. | 4 3 12      | Medical, Strategy and Finance Directors, supported by Director of ICT Strategy | Identify information requirements, establish data supply (source and timetable) and monitor performance. |          |
|      |                 | **Source of Assurance:**  
• Balanced scorecard reported to Board                                             |                                                                                                      |             |                                                                               |                                                                                                |          |
| 11.  | Business Retention| Failure to retain and develop our business (retain/expand market share, expand into new markets and respond to commissioner needs, policy and intentions). | **Service:** The need for further efficiencies that are increasingly difficult to achieve.  
**Business:** Loss of market position/influence, loss of income of brand equity. | 3 4 12      | Medical, Strategy and Finance Directors                                      | Ensure that SLaM’s models of care are seen to be innovative and credible.  
Identify prospective customers, review their requirements and provide appropriate response. |          |
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</table>
| 12.  | New NHS    | Failure to develop robust relationships with CCGs, SCGs and Local Authorities, in light of commissioning changes and the introduction of Payment by Results.                                                                 | Service Users: New commissioning plans may not be perceived as patient focussed.  
Service: Service users choose to go elsewhere.  
Business: Delays / changes in commissioning intent; reduced income. | I: 4  
L: 3  
R: 12 | Strategy Director and CAG Service Directors | Refresh marketing strategy and commit to a market share defence / expansion plan.  
Improve relationships with key GPs, commissioners and boroughs through targeted contact, information provision and support.  
Review 4Ps (product, placement, price and promotion) approach to service offering to community, GPs and commissioners. |

**Progress Key:**

- **BLUE:** Completed & working; identified benefits realised;
- **GREEN:** Progressing to plan; delivering to expectations;
- **AMBER:** Slight delay in progress; uncertainty that identified benefits will be realised;
- **RED:** Amber status for more than one reporting period, i.e. late and not delivering as expected;
- **PURPLE:** Failure in timing and/or results; reconsider if this action is appropriate.

Where progress ratings are Blue, Green or Amber, the predominant rating is reported. If any Action is reported as being Red or Purple for any CAG or Directorate, this is the rating reported to the Board, with full supporting details.
## Purpose of the report:

To present to the Board the revised and updated Risk Management and Assurance Strategy.

The strategy has been reviewed to increase the clarity and simplicity of the governance arrangements, ensure a better correlation between the Trust’s objectives and priorities and risk and governance issues and improve reporting and action tracking and delivery arrangements.

### Action required:

To consider and approve the strategy, with any further amendments and recommendations that may be considered necessary.

### Recommendations to the Board:

To approve the revised and updated Risk Management and Assurance.

### Relationship with the Assurance Framework (Risks, Controls and Assurance):

The strategy is a key component of the overall assurance framework.

### Summary of Financial and Legal Implications:

There are no direct financial implications of the strategy. The strategy complies with best practice requirements and forms part of the governance expectation that is visited by statute and direction on NHS Foundation Trusts.

### Equality & Diversity and Public & Patient Involvement Implications:

Consideration has been given to equality diversity and public and patient involvement implications. There are no specific issues that need to be addressed as a result of agreeing the updated strategy.
Risk Management and Assurance Strategy

Ratified by the Board of Directors
Date: 22 October 2013

Issue date November 2013
Version 7.0
Review Date October 2014
Document Author Jenny Goody
Interim Governance Manager
Document Lead Nick Dawe,
Interim Director of Finance and Corporate Governance
Document Risk Owner Nick Dawe
Number of Pages 45
Target Audience All Staff
Equalities Compliant Yes (Assessed by policy author, Sep-13)
HRA Compliant Yes (Assessed by Claims and Litigation Manager, Sep-13)

Key Related Documents:
Incident Policy (v2.1, Sep-11)
Health & Safety Risk Assessment Policy (v3.0, Dec-11)
Clinical Risk Assessment and Management of Harm Framework (v6.1, Oct-11)
1.0 INTRODUCTION

1.1 Statement of Intent

The South London and Maudsley NHS Foundation Trust (the Trust) aims to provide the mental health and substance misuse services people need, to nationally consistent standards of quality and safety, in a way that makes the best use of financial resources. This includes the Trust’s ability to do so irrespective of the various crises and disruptions it may be presented with.

Plans are in place to ensure on-going compliance with all legislative requirements, existing national standards and targets, and any national standards and targets that come into force. The Trust strives to minimise risk through the use of a rigorous process for the identification, quantification and mitigation of all risk.

The Trust has in place a governance model with membership of non-Executive Directors on each of the Board Committees. The Trust’s continued integration of clinical and all non-clinical risk is in line with Department of Health guidance and Monitor’s Code of Governance. The Risk Management and Assurance Strategy supports the Trust’s Quality Strategy, within which five quality priorities have been identified for 2011/14: access to services, patient safety, patient experience, clinical effectiveness and building capacity & capability for quality improvement.

The Trust is committed to assuring itself that it has effectively discharged its responsibilities for the performance of the Trust through effective arrangements for monitoring and continually improving the quality of healthcare provided to its service users, ensuring that best practice arrangements are in place for risk management and the assurance framework to support the Annual Governance Statement. The Trust is also committed to assuring itself that the necessary planning, performance management and risk management arrangements are in place to deliver its Annual Plan.

1.2 Background

Risk Management is the proactive identification, classification and management of issues that may affect the Trust’s delivery of its objectives. The Trust is fully committed to its goal of reducing to an acceptable level the risks to all aspects of its operations through the optimal use of available resources. It aims to manage and minimise the impact of such events, whether clinical, non-clinical, financial or corporate, on service users, carers, staff, contractors and the public.

The Trust recognises that risk management is an integrated part of the management process, enabling managers to focus on the achievement of key objectives, and it will continue to work towards risk management being an integral part of the culture of the organisation. This includes disseminating the message that all staff have a responsibility to identify and minimise unacceptable risks and providing staff with the tools to assist them in undertaking this responsibility.

The Trust endeavours to create an open, just and fair culture that encourages all staff and contractors to report risks, hazards, near misses and incidents. In addition, service users and carers are encouraged to report concerns or any risk related issues to healthcare professionals, the Trust’s Patient Advice and Liaison Service or the Complaints Department so that lessons are learned and disseminated across the organisation.

1.3 Board of Directors’ Statement on Responsible Risk Taking

The Board accepts that staff, service users and carers will all make decisions which may not have predictable or definitely successful outcomes. Taking these often difficult decisions is a part of everyday practice. The Board fully supports staff in taking these decisions provided they are made responsibly by qualified staff and by reference to the principles of good professional practice. Responsible management of
risk is achieved by sensible adherence to safe practice for staff and service users through the continuous process of development and dissemination of good policy and protocols. The two key processes supporting responsible risk management include adherence to the Trust Framework for the Assessment of Clinical Risk and Management of Harm and the proactive use of the electronic Patient Journey System (ePJS - the Trust’s integrated clinical information system) with particular reference and careful completion of risk screens, assessments and risk events where clinically indicated.

Examples of ensuring responsible risk management include:

- Making use of the Care Program Approach (CPA) policy; crisis and contingency planning can help in arriving at a high risk decision and ensuring good communication
- Difficult decisions being discussed fully with key members of the team
- Testing decisions with colleagues
- Seeking advice from professional bodies
- Seeking advice from Trust lawyers
- Clear entries in the healthcare record (ePJS) outlining how the decision was made and the alternatives considered
- Good note-keeping enabling the justification of decisions.

1.4 Definitions

**Clinical Academic Group (CAG):** Clinical Academic Groups (CAGs) are relatively new structures which bring together clinical services and academic activities within a series of single managerial units. Their creation underpins King’s Health Partners – the Academic Health Sciences Centre (AHSC) that has been established with King’s College London, Guy’s and St Thomas’ and King’s College Hospitals NHS Foundation Trusts.

**Directorate:** For the purposes of this strategy, ‘directorate’ is used to define the corporate and infrastructure directorates within the Trust: ICT, Estates & Facilities, Capital Planning, HR, Strategy & Business Development, Nursing, Clinical Management and Finance.

**Risk Management:** Risk management encompasses the culture, processes and structures directed towards the effective management of potential opportunities and adverse effects, comprising the systematic process of risk identification, analysis, evaluation and mitigation of potential and actual risks to service users, staff, Trust property, reputation or the general public.

**Risk:** A risk is the possibility that something will happen that will have an impact on the Trust’s aims and objectives. It is measured in terms of **impact** (severity of the effect if the risk occurs) and **likelihood** (probability or frequency of the risk occurring).

**Risk Rating:** All risks are rated by assessing their **impact** and **likelihood**, both on a scale of 1 to 5. There are three stages of risk ratings that need to be considered:

- **Initial** risk rating, which is the level of risk before any controls have been applied;
- **Current** risk rating, which reflects the controls that are currently in place to mitigate the risk;
- **Target** risk rating, which is the realistically acceptable level of risk remaining when all identified controls are in place and active.

**Risk Category:** All risks held within CAG or Directorate Risk and Assurance Registers are assigned a category: Injury, Statutory Compliance, Service Continuity, Finance and Reputation.
Principal risk: Principal risks refer to activities, events or situations that have the potential to cause serious harm to the organisation. Harm is defined in terms of physical injury, operational delays, non-achievement of objectives or performance targets, financial impact, loss of reputation or adverse media attention. The Trust’s Risk Analysis Tool at Appendix B defines the Trust’s understanding of ‘significant’, ‘severe’ and ‘catastrophic’ outcomes, which together define ‘principal’ risks.

Risk appetite: By the very nature of the services that it provides and its reputation, scale and complexity, the number of significant risks facing the Trust is large. It is not only important that the Trust identifies these, it is critical that the Trust has a realistic risk appetite that supports innovation, change and the capacity and capability to manage and mitigate risks. The Trust’s risk appetite is currently set at 12, which means that Trust-wide strategic risks rated 12 and above are regularly reviewed by the Board of Directors and progress towards mitigating them is monitored jointly by the Audit Committee and the Service Quality Improvement Committee.

Controls: Controls are the policies, procedures and practices that are in place to reduce the likelihood of a risk occurring or to mitigate it if it does occur.

Assurances: Assurances provide evidence about how well the controls are working.

Assurance Framework: The Trust’s Assurance Framework comprises the principal strategic risks that threaten the Trust and is aligned to the three principal objectives of the Trust:

- The service user is the centre of all we do
- Provide effective and efficient services that meet the needs of our service users
- Retain the position of a leading MH Trust, with proven clinical and business success

The following information held within the Assurance Framework is reported regularly to the Board of Directors and its sub committees: risk area, description (including primary sources of independent assurance), the consequences should the risk be realised, its current rating, Executive lead(s), the key actions planned to further reduce or eliminate it and progress to date. Progress is reported by one of five colours, namely:

- **BLUE**: Completed & working; identified benefits realised;
- **GREEN**: Progressing to plan; delivering to expectations;
- **AMBER**: Slight delay in progress; uncertainty that identified benefits will be realised;
- **RED**: Amber status for more than one reporting period, i.e. late and not delivering as expected;
- **PURPLE**: Failure in timing and/or results; reconsider if this action is appropriate.

Data relating to existing controls, assurances (from all possible sources) and planned actions is maintained at CAG/Directorate level, but this is reported to the Board and/or its sub committees on an exception basis only. If any Action is reported as being Red or Purple, full supporting details are reported to the Board and/or its sub committees.

The Assurance Framework is currently reported in the format of the template at Appendix C; it is held on a Word document and is available for review via the Intranet.

Corporate Risk Log: The Trust’s Corporate Risk Log comprises the principal operational risks that threaten the achievement of local or Trust objectives. For each risk within the Corporate Risk Log there is a full description, the controls in place to minimise the impact or likelihood of the risk and any actions planned to further reduce or eliminate it. The identification of sources of assurance is becoming an increasingly significant aspect of risk management, and details include where assurance can be
gained that the risk is adequately controlled and what the assurance is (for example, an Internal Audit Report giving Significant Assurance).

The Corporate Risk Log is currently reported in the format of the template at Appendix D; it is held on an Excel spreadsheet and is available for review via the Intranet.

**Risk Classification:** The risks within the Corporate Risk Log fall into two classes, namely:

- **Principal** active operational Trust-wide risks and local catastrophic risks, which are not yet fully under control and are expected to be present on CAG and/or directorate Risk & Assurance Registers as well as the Corporate Risk Log, with actions planned to further mitigate them;
- **Principal** inherent operational Trust-wide risks, which are currently under control and for which the Board (or an appropriate Board sub-committee) expects robust assurances. An important function of risk management is to provide assurance that the principal risks facing the Trust are being controlled effectively; this refers especially the inherent risks that would have a significant impact on the Trust if realised. The Corporate Risk Log therefore contains inherent risks gathered from a variety of sources, such as Never Events, CQC Registration and the Infection Control and Safeguarding Children assurance frameworks.

**Risk & Assurance Registers:** Risk & Assurance Registers are held at CAG / directorate level and contain all risks identified for that particular service, irrespective of risk rating. Various sources and methods are used to identify these risks, such as Serious Incidents (SIs), other incident reporting, Complaints, Health & Safety risk assessments, service planning, objective setting, brainstorming, and feedback from staff and service users. CAG and directorate Risk & Assurance Registers also include any active Trust-wide risks within the Corporate Risk Log that relate to their service. For example, Business Continuity Management is a principal Trust-wide risk - it features in the Corporate Risk Log and is also present on the Risk & Assurance Register of every CAG and directorate. Likewise, Violence & Aggression is featured in the Corporate Risk Log and is present on the Risk & Assurance Register of every CAG.

Risk & Assurance Registers are currently reported in the format of the template at Appendix E; as a minimum, risks have the following information documented: source and description of the risk, controls and assurances currently in place, initial, current and target risk rating, any actions planned to further mitigate the risk and the date of the next planned review of the risk. All CAG and directorate Risk & Assurance Registers are held on the Datix Risk Management system, accessed on the Intranet via Datixweb; key individuals with responsibility for risk management, including the Board of Directors, can review all Risk & Assurance Registers via Datixweb.

**Risk Lead:** Each risk within the Assurance Framework is assigned Executive Director(s) who are ultimately accountable for the strategic risks on which they lead. Each risk within the Corporate Risk Log is assigned a Trust-wide lead who provides progress updates on a regular basis. CAG and directorate Risk & Assurance Registers identify local leads for each risk.

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1 Rated 12 or above, as defined by the Trust’s Risk Analysis Tool at Appendix B
2.0 STRATEGY OBJECTIVES AND SCOPE

2.1 Objectives
The objective of the Trust’s Risk Management and Assurance Strategy is to promote a consistent and integrated approach to risk management across all parts of the organisation, embracing clinical, non-clinical and corporate risks. This underpins and is directly linked to the first of the Trust’s key priorities which is to provide high quality, safe and innovative clinical care and treatment that meets the expectations of services users and their carers and the requirements of commissioners and regulators.

The Trust aims to take all reasonable steps in the management of risk with the overall objective of providing a safe environment for service users, carers, staff, visitors and the general public. The culture of the Trust will continue to be one of innovation and learning to ensure its continued success and good reputation.

2.2 Scope
The Trust’s Risk Management and Assurance Strategy describes the arrangements for the Trust’s Assurance Framework and Corporate Risk Log and supports compliance with the Trust’s Terms of Authorisation and the requirements of Monitor’s Compliance Framework. It also supports compliance with the NHS Litigation Authority (NHSLA) Risk Management Standards for Mental Health & Learning Disability Trusts and Registration with the Care Quality Commission (CQC).

This document applies to all employees of the Trust and contractors or other third parties working within the Trust. Managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their approach to quality, corporate and clinical governance. This will contribute to the maintenance of an effective and robust Assurance Framework and the signing of the Trust’s annual Governance Statement.
3.0 LEAD COMMITTEES AND GROUPS WITH RESPONSIBILITY FOR RISK MANAGEMENT

The Trust is committed to continued integration between clinical and non-clinical strands of governance through a unified assurance framework for risk management, an integrated support structure and the use of a consistent methodology for risk assessments. The Trust’s governance framework, outlined in Figure 1 at Appendix A, ensures a co-ordinated approach to governance and risk management. The framework is reviewed at intervals to ensure that the approach remains effective and fit for purpose. Figure 2 at Appendix A shows the relationships between the lead subsidiary committees and groups with responsibility for risk management.

This section describes how the responsibilities of different Trust committees for risk management and assurance activities are executed. More detail is provided in the Terms of Reference for each committee, which are available on the Intranet. The Terms of Reference for the Audit Committee and Service Quality Improvement Committee (the Board sub-committees with overarching responsibility for risk), the Trust Executives and the Quality Governance and Risk Management Committees are provided at Appendix G.

3.1 Board of Directors

The Board of Directors is accountable for the effectiveness of internal controls (clinical, non-clinical, corporate and financial); it is required to produce an annual Governance Statement, which gives assurance that reasonable controls are in place to manage the Trust’s affairs efficiently and effectively.

Every three months, the Board of Directors considers the principal strategic risks within the Assurance Framework that are rated equal to or above the Trust’s risk appetite of 12. The Board of Directors has delegated the monitoring of the principal operational risks within the Corporate Risk Log to its sub committees, the Audit Committee and Service Quality Improvement Committee, who report serious risk issues on an exception basis.

The Board of Directors reports back to the CAG Directors via the Chief Executive’s update to the Trust Executive meetings.

3.2 Audit Committee

The Audit Committee, which is chaired by a Non-Executive Director, functions as the Trust’s assurance committee by reviewing its risk management systems and ensuring that the Assurance Framework and Corporate Risk Log are built and managed robustly. The Audit Committee reviews the Board’s Assurance Framework at every meeting and is responsible for regularly monitoring the management of the operational financial risks within the Corporate Risk Log. The Audit Committee also monitors Internal and External Audit work plans, which includes using the Assurance Framework to determine the annual Internal Audit Plan and reviewing the Internal Audit Review of Governance and Risk Management arrangements. Internal Audit reports provide an assessment of the adequacy of risk controls and identifies any gaps in assurances; audit recommendations and management responses are monitored by the Audit Committee. The Audit Committee provides a briefing note, flagging key issues, to the Board of Directors the month after their meeting; urgent issues are raised verbally by the Audit Committee Chair at the Board meeting following directly after their meeting.

3.3 Service Quality Improvement Committee

The Service Quality Improvement Committee, also chaired by a Non-Executive Director, provides assurance to the Board of Directors on the delivery of the Quality Strategy; it examines where there have been failures in service quality and monitors
progress against actions planned to address them. It has responsibility for monitoring the effectiveness of the risk management systems that underpin the Quality Strategy and monitors the non-financial risks contained within the Assurance Framework and the management of the Service Quality risks contained within the Corporate Risk Log. The Service Quality Improvement Committee meets bi-monthly and reviews Patient Stories, Serious Incidents and Complaints at every/alternate meeting(s). The committee is informed by three sub-committees: the Quality Governance Committee, the Risk Management Committee and the Quality Programme Delivery and Assurance Group; it also reviews a summary of quality issues arising from claims, inquests, Never Events, patient experience, Information Governance, CQC inspections, compliance with the Mental Health Act and external inquiries gathered from specialist individuals within the Trust and compiled by the Assistant Director of Governance.

The Service Quality Improvement Committee provides a briefing note, flagging key issues, to the Board of Directors and Audit Committee after each of its meetings and feeds relevant issues back to its own sub-committees. Urgent issues are raised verbally by the Service Quality Improvement Committee Chair at the Board meeting following directly after their meeting.

### 3.4 Trust Executive

The Trust Executive comprises Executive, CAG, Service and Clinical Directors and ensures continuous and measured improvement in the quality of care and service delivery across the Trust by sharing knowledge and experience of quality improvement and discussing areas of interface between services. The Trust Executive has overarching executive responsibility for risk management within the Trust; it undertakes detailed scrutiny of specific strategic or operational Trust-wide risks, identifying any areas of concern to be reported to the CAGs as appropriate. It also identifies and assesses new Trust-wide risks for inclusion in the Assurance Framework or Corporate Risk Log.

The membership of the Trust Executive ensures a widespread and consistent understanding of the risk and assurance processes across the Trust, providing an integrated and effective management tool. It encourages the early and accurate identification of Trust-wide risks and the agreement of a reasoned, proportionate response commensurate with the need to encourage innovation.

The Trust Executive receives escalation reports from the Quality Governance and Risk Management committees; each member reports back to their local CAG/directorate meetings as appropriate.

### 3.5 Quality Governance Committee

The Quality Governance Committee (QGC) provides assurance to the Service Quality Improvement Committee that there are robust systems in place to ensure that the essential standards of quality and safety are being met by Trust services, that action is planned and taken on substandard performance and that the Trust is planning and driving for continuous quality improvement. The Quality Governance Committee is chaired jointly by the Director of Nursing and the Medical Director and has a number of key groups and committees reporting to it on a regular basis; these include:

- CAG Clinical Governance and Clinical Audit & Effectiveness committees
- AIMS Group
- ECT Committee
- Essence of Care Group
- Infection Control Committee
- Patient Information Group
- Medical Devices Committee
• Medicines Management Committee
• Nutrition Group
• Physical Healthcare Committee
• Prevention and Management of Violence and Aggression Committee

The Quality Governance Committee meets quarterly and reviews the active operational clinical risks within the Corporate Risk Log and considers Trust-wide clinical risks escalated by CAGs or directorates, determining whether they need to be placed on the Corporate Risk Log and other CAG / directorate Risk & Assurance Registers. The committee escalates Trust-wide clinical issues to the Trust Executive and the Service Quality Improvement Committee as required.

3.6 Risk Management Committee
The role of the Risk Management Committee is to provide assurance that there are robust systems for risk management across all services managed by the Trust. The Risk Management Committee is chaired by the Director of Finance and Corporate Governance and has a number of key groups and committees reporting to it on a regular basis; these include:
• CAG Risk Management committees
• Caldicott Committee
• Education & Training Committee
• Emergency Preparedness Group
• Freedom of Information Committee
• Health, Safety & Fire Committee
• ICT Security Committee
• Safeguarding Adults Committee
• Safeguarding Children Committee

The Risk Management Committee meets quarterly and reviews the active operational risks within the Corporate Risk Log and considers Trust-wide risks escalated by CAGs or directorates, determining whether they need to be placed on the Corporate Risk Log and other CAG / directorate Risk & Assurance Registers.

The committee considers consistency and quality issues arising from the monitoring and comparison of CAG / directorate Risk & Assurance Registers and escalates Trust-wide issues to the Trust Executive and the Service Quality Improvement Committee as required.

3.7 Quality Programme Delivery and Assurance Group
The Quality Programme Delivery and Assurance Group is responsible for delivering the quality targets and priorities expressed within the Trust Quality Strategy and annual Quality Account. It is chaired by the Medical Director and has a number of key groups reporting to it on a regular basis; these include:
• Patient Experience Group
• PSTS Committee
• Trust Outcomes Group
• Quality Improvement Co-ordinating Group

The Quality Programme Delivery and Assurance Group meets bi-monthly and is accountable to the Trust Executive and the Service Quality Improvement Committee.
3.8 Other Groups

HQ Directors Meeting

The HQ Directors meet weekly for informal discussions relating to the principal issues facing the Trust.

The HQ Directors agree the content of the Assurance Framework report (summary highlights and risks) that is presented to the Board of Directors on a quarterly basis.

CAG / Directorate Risk Management Meetings

Each CAG and directorate is required to have a local risk management forum where their Risk & Assurance Register is reviewed and new risks are identified and assessed. Risks with a red\(^2\) current risk rating or red\(^3\) delivery status are reviewed monthly; all other risks are reviewed on a quarterly basis.

A representative from each CAG is required to attend the quarterly meetings of the Risk Management Committee, where risks that have an impact across the whole organisation are reviewed and added to the Corporate Risk Log as appropriate.

A representative from each directorate is required to attend meetings of the Risk Management Committee every six months.

CAG Clinical Governance Meetings

Each CAG is required to have a local clinical governance forum to consider reports and bulletins that have an impact on governance and patient safety and review any newly ratified clinical policies, identifying methods of providing clinical staff with the key messages contained within them. CAG Clinical Governance meetings also review the clinical risks within their local Risk & Assurance Register.

A representative from each CAG is required to attend the quarterly meetings of the Quality Governance Committee, where clinical risks that have an impact across the whole organisation are reviewed and added to the Corporate Risk Log as appropriate.

Chief Executive’s Performance Management Review

The Chief Executive’s Performance Management Review meetings are the main forum for monitoring and managing performance across the Trust and are a key source of assurance to the Board, as cited in the Corporate Risk Log. CAG and directorate Risk & Assurance Registers are reviewed at monthly or quarterly Chief Executive’s Performance Management Review meetings, where local and Trust-wide risk management issues are identified.

\(^2\) As defined by the Trust’s Risk Analysis Tool at Appendix B
\(^3\) As defined in the Risk & Assurance Register template at Appendix E
4.0 **RISK MANAGEMENT ROLES AND RESPONSIBILITIES**

This section describes the responsibilities of Trust staff for various elements of the Trust risk management and assurance arrangements. The Terms of Reference of all Trust meetings include their membership and are available on the Intranet.

4.1 **Directors**

**Chief Executive:** As accountable officer, the Chief Executive has overall responsibility for ensuring that the Trust’s governance and risk management systems are adequate to cover all of its activities. This includes ensuring that the Trust meets relevant statutory requirements and that it complies with best practice as described by the Department of Health and Monitor. The Chief Executive is required to sign the annual Governance Statement on behalf of the Board of Directors to provide stakeholders with the assurance that the Trust has met its governance responsibilities.

**Non Executive Directors:** Board Committees are chaired by Non Executive Directors, who are accountable to the Board of Directors through the Chairman. They play an essential role in ensuring that the Trust’s governance and risk arrangements are robust and effective. There is cross membership of Non Executive Directors between the Board sub-committees to provide co-ordination and ensure that informed decisions are made based upon the organisation’s entire risk profile.

**Executive, Non-Voting and CAG Directors:** All Directors of the Trust are accountable to the Chief Executive and have responsibility for the management of risk within their individual CAG or directorate; this includes the timely and systematic maintenance of Risk & Assurance Registers, ensuring that they are regularly reviewed in CAG / directorate meetings. They are also responsible for contributing to the construction and on-going review of the Assurance Framework and the implementation of resulting action plans. CAG Directors are asked to present specific risk assessments to the Audit Committee or Service Quality Improvement Committees as required so that accounting officers can fully understand the risk and the actions being taken to manage them.

**Director of Finance and Corporate Governance:** has specific responsibility for managing the development and implementation of the Trust’s Integrated Governance framework as well as for non-clinical risk management arrangements. This includes the on-going development and maintenance of the Assurance Framework, Claims Management and Health & Safety.

**Director of Strategy & Business Development:** has specific responsibility for Performance Management (which includes the review of Risk & Assurance Registers), external relationships with Overview & Scrutiny Committees and Local Involvement Networks, and the quarterly and annual declarations to Monitor.

**Director of Nursing and Medical Director:** have joint responsibility for clinical risk management, which includes clinical governance, medical devices, safeguarding children, safeguarding vulnerable adults, the Mental Health Act, serious incidents (SIs) and complaints. The Medical Director is the nominated Trust Director for Infection Protection and Control (DIPC).

**Director of Human Resources and Organisational Development:** has specific responsibility for the continuing suitability of the Trust’s staff.

**Director of Estates, Facilities and Capital Planning:** has overall responsibility for the continuing fitness of the Trust’s buildings, plant and non-medical devices used by Trust staff, and has particular responsibilities for security, waste management, fire safety and environmental management.
4.2 Deputy / Assistant Directors

Deputy Director of Information, Communications and Technology (ICT): is the designated Senior Information Risk Owner (SIRO), with responsibility to manage information risk on behalf of the Chief Executive and the Board.

Deputy Director Clinical Governance and Patient Safety: is responsible for coordinating the process of monitoring compliance with the Care Quality Commission Essential Standards through nominated lead directors; leads on the patient safety and clinical governance agenda, including the development of information relating to clinical quality.

Assistant Director Patient Safety: is responsible for the on-going development, implementation, and evaluation of adverse incident reporting systems, which accord with the requirements of the National Patient Safety Authority (NPSA); manages the processes for reporting, investigating, managing and learning from incidents.

Assistant Director of Governance: ensures that there is a strategy, process and the tools in place to enable the Trust to consolidate risk management and governance within an efficient and systematic framework that is embedded within the organisation. This includes developing and maintaining the Assurance Framework to ensure that the Board of Directors and its sub committees are provided with accurate and intelligent information on which to base their decisions. The Assistant Director of Governance provides a focal point for the consolidation and aggregation of CAG and directorate risks into Trust-wide risks, which form the basis of the Corporate Risk Log. The Assistant Director of Governance also manages the processes for monitoring and comparing CAG and directorate Risk & Assurance Registers to ensure consistency and quality.

[post currently vacant, being covered by Interim Governance Manager]

4.3 Managers

Health and Safety Risk Manager: advises the Trust on Health and Safety, including statutory compliance requirements; responsible for ensuring that there are systems in place to ensure that safety alerts are disseminated, implemented and monitored.

Senior Managers: responsible for implementing risk management within their areas as outlined in this document and for engaging their staff with this process. They are responsible for ensuring that their staff receive the necessary level of risk management awareness training, ensuring that they are competent to identify, assess and manage risk within their working environment. They are also responsible for implementing and monitoring action plans and risk management control measures within their designated area(s) of responsibility, ensuring that they are appropriate and adequate.

Business Managers: act as the conduit for identifying, capturing and assessing risks; they maintain an overview of active CAG risks, taking account of progress in completing actions planned to reduce their likelihood or potential impact. Business Managers ensure that risk management is incorporated into the operational and business planning processes, ensuring that risk recording and assessments are undertaken in accordance with Trust policy.
4.4 All Staff

Risk management responsibilities and authorities form part of all job descriptions and management objectives. All staff employed within the Trust, including contracted staff and staff employed by social services but working with health care staff are expected to:

- Report risks, hazards, incidents, accidents and near misses using the recognised channels\(^4\) (refer to the Trust's Incident Policy available on the Intranet).
- Attend training as identified by their manager or as stated in the Trust mandatory training plan. This includes update and refresher training as required by Trust policy or statutory legislation.
- Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of others that may be affected by the Trust’s business.
- Comply with all Trust policy, procedure and protocol to protect the health, safety and welfare of anyone affected by the Trust’s business (refer to the Trust’s Health & Safety Policy available on the Intranet).
- Be aware of this Trust Risk Management and Assurance Strategy (available on the Intranet) and comply with it.
- Neither intentionally, nor recklessly, interfere with nor misuse any equipment provided for the protection of safety and health. Report any damage to such equipment and take all reasonable measures to ensure that equipment is functioning correctly.
- Be aware of emergency procedures, such as resuscitation, evacuation and fire precaution pertaining to their particular locations.

\(^4\) Via Datixweb, the Trust’s online Incident Reporting system
5.0 RISK MANAGEMENT AND ASSURANCE PROCESSES

The Trust has a number of mechanisms in place to systematically identify, assess, mitigate and monitor its risks which, when taken together, provide the Board with assurance that the risks facing the Trust are being appropriately managed.

The mechanisms outlined below operate within a common framework to ensure that the approach to risk management is on-going, systematic and consistent.

5.1 Process for the Management of Risk

There are four stages in the Trust’s formal risk management process:

Risk Identification: Risks can be identified proactively in advance of the risk occurring or reactively once a related incident or near miss has occurred. Proactive risk assessment involves the on-going or periodic review of risk in a given locality, service or operation; although this normally refers to the on-going programme of Health & Safety risk assessments, it can refer to any form of proactive risk assessment. The Trust uses a number of specific risk assessment tools for different situations, such as Health & Safety risk assessment tools, clinical risk assessment tools, both generic and specific, the Capital Programme risk assessment tool and infection control audit tools. Individual risk assessments are also carried out for both staff and service users (including safeguarding issues). The tools are all used in accordance with their relevant policies, which are listed in Appendix F.

Risks identified by community teams, outpatient clinics, on wards or within directorate teams are reported to ward managers or team leaders (or equivalent), who escalate them to Business or Service Managers. They are then discussed at local Risk Management or Clinical Governance meetings and added to CAG / directorate Risk & Assurance Registers as appropriate. Potentially catastrophic risks are brought to the urgent attention of the CAG or directorate executive team as soon as they are identified.

Risks are identified in a number of other ways, including: business planning, service development or project initiatives as well as the review of incidents, claims and complaints. All staff should be aware of the Trust’s priorities, on which the Assurance Framework is based, and should consider these when identifying risks at a local CAG / directorate level.

The Board of Directors Trust Executive identifies and assesses new strategic risks as part of the annual planning cycle.

Risk Analysis and Prioritisation: Risk rating allows each risk to be prioritised relative to other risks; it uses the likelihood of the risk occurring and the impact if it does occur to produce a risk rating between 1 (1x1) and 25 (5x5). The initial risk rating reflects the position if no controls were in place; the current risk rating takes the assured effectiveness of current controls into account; the target risk rating reflects the realistic level at which the risk is deemed to be acceptable and no further action is required to mitigate it.

The Risk Analysis Tool at Appendix B is used to grade all risks, whether within the Assurance Framework, the Corporate Risk Log or within CAG / directorate Risk & Assurance Registers. It is the responsibility of the person or forum that first identifies a risk to describe and score it and consistent use of the Trust’s Risk Analysis Tool ensures a systematic approach to risk grading.

A newly identified operational risk is approved by the relevant CAG or directorate risk management forum before it is placed on their Risk & Assurance Register; in the event of a serious risk being identified, the relevant Director can approve the risk outside of these meetings. If the risk is rated 12 or above and is deemed to have Trust-wide implications, the Risk Management Committee, Quality Governance Committee or Service Quality Improvement Committee will consider whether it should be added to the Corporate Risk Log.
Newly identified strategic risks are approved by the Service Quality Improvement Committee, the Audit Committee, the Trust Executive or the Board of Directors.

**Risk Treatment:** This can include avoiding the risk by not undertaking activity that could lead to the risk occurring or transferring the risk to an external party, but risk treatment will normally involve developing an action plan to reduce the risk to an acceptable level by ensuring that adequate control measures are in place and are operating effectively.

**Risk Monitoring and Review:** Systematic and structured reporting, escalation and monitoring of risk assessments and action plans are required, consistent with the overall status of the risk.

Risks are currently reported in the format of the template at Appendix E; this includes a nominated local Risk Lead, who is the person accountable for the mitigation of the risk within his or her CAG / directorate.

Additional information relating to each operational risk is held within Datix, the Trust’s Risk Management system; this can be reported in different formats to different forums as required.

Each CAG and directorate has a nominated officer with responsibility for maintaining their Risk & Assurance Register; all CAG / directorate Risk & Assurance Registers are held on the Datix Risk Management system, maintained on the Intranet via Datixweb. Full instructions on the use of Datixweb for maintaining and/or viewing Risk & Assurance Registers can be found on the Intranet.

CAGs and directorates are required to monitor any Red risks within their Risk & Assurance Registers on a monthly basis and review all risks quarterly. When it is felt that a risk has been fully mitigated (its current risk rating being brought down to its target risk rating by the application of controls), it can be archived by closing it on the Datix system. Closed risks are reviewed annually to confirm that they no longer exist or are still under control and do not pose a threat to the organisation.

The Corporate Risk Log is maintained by the Assistant Director of Governance on an Excel spreadsheet. It is reviewed at the quarterly meetings of the Risk Management Committee, Quality Governance Committee, Service Quality Improvement Committee and Audit Committee.

The Assurance Framework is also maintained by the Assistant Director of Governance on a Word document. It is reviewed at the quarterly meetings of the Service Quality Improvement Committee and Audit Committee and every six months by the Board of Directors.

### 5.2 Escalation of Local Risks

When a CAG or directorate identifies a potentially Trust-wide operational risk that is rated 12 or above, it is raised at a monthly meeting of the Trust Executive or, if more appropriate, at a quarterly meeting of the Quality Governance Committee or Risk Management Committee. A potential Trust-wide active risk is discussed by one of these committees before the decision is made to add it to the Corporate Risk Log and also to all relevant CAG / directorate Risk & Assurance Registers.

A risk that is identified by a CAG or directorate that is specific to them but outside their control also needs to be placed on the Risk & Assurance Register of the CAG / directorate that can control or mitigate it. Such risks are discussed at the Risk Management Committee but are only added to the Corporate Risk Log if they are deemed to be ‘catastrophic’.

The Quality Governance Committee and Risk Management Committee regularly review the active Trust-wide risks within the Assurance Framework, which enables

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5 As defined by the Trust’s Risk Analysis Tool at Appendix B
the committees to track the status of active operational risks that have an impact across the whole organisation.

5.3 Board Assurance
The Board of Directors requires assurance that the principal strategic, inherent and active operational risks that face the Trust are being controlled effectively. The Assurance Framework is a high level management record of the principal strategic risks that could affect the delivery of the Trust’s objectives and provides a pragmatic method for their effective management, providing a structure of evidence to support the Annual Governance Statement. The principal risks held within the Assurance Framework, with a summary highlight report, is presented to the Board of Directors and its sub committees on a quarterly basis.

The Board of Directors has delegated the detailed review of the principal clinical and non-clinical operational risks within the Corporate Risk Log, both active and inherent, to the Service Quality Improvement Committee and Audit Committee respectively. These committees review a report of their subset of the Corporate Risk Log on a quarterly basis, which is prefaced by a summary of the major changes and concerns relating to these risks. Executive Leads are held to account at each of these committees for the robustness of the assurances relating to the inherent risks, and the progress towards completing the actions planned to mitigate the active risks, assigned to them.

5.4 Performance Management
The Chief Executive’s Performance Review meetings are the main forum for monitoring and managing performance across the Trust. They are a key source of assurance to the Trust Executive and the Board, as cited in the Corporate Risk Log. Performance Review meetings are part of the Trust’s validation and authorisation process to which all external returns are subject. All standards and targets, National Service Framework (NSF) assessments, service mapping and local delivery plans are reviewed through Performance Review. In addition, themed reviews enable key topics to be reviewed across the organisation. Standing items include finance, activity, complaints, HR dashboard and Risk & Assurance Registers. Representatives from ICT, Estates & Facilities and all CAGs attend Performance Review meetings monthly and representatives from HR, Strategy & Business Development, Nursing, Clinical Management and Finance attend quarterly.

5.5 Monitor’s Compliance Framework
The Trust is required to make quarterly and annual self certification declarations to Monitor, detailing compliance with its Terms of Authorisation. This process is led by the Strategy & Business Development directorate, which also oversees the submission of the Annual Plan to Monitor.

All are signed off by the Board of Directors.
5.6 NHSLA Risk Management Standards
The NHS Litigation Authority (NHSLA) has produced Risk Management Standards for different categories of NHS organisations, including Mental Health & Learning Disability Trusts. These standards cover organisational, clinical and non-clinical risks. The NHSLA assesses NHS organisations against three distinct levels:
Level 1: whether effective risk management systems and processes have been documented (Policy).
Level 2: whether the systems and processes described at Level 1 have been implemented (Practice).
Level 3: whether the organisation is monitoring compliance with these systems and processes and acting on the findings to improve performance (Performance).
Each level contains five standards comprising ten criteria that are equally weighted. Compliance with each level entitles the Trust to increasingly significant reductions in its contributions to the NHSLA’s risk pooling schemes. It also enables the Trust to demonstrate to its stakeholders and to the wider public that it is embedding risk management ‘best practice’ throughout the Trust.

[Please note that the NHSLA are currently reviewing the way in which they will assess NHS organisations in the future]

5.7 Care Quality Commission Registration
The Care Quality Commission (CQC) standards consist of 28 outcomes supported by detailed criteria. The Trust needs to achieve compliance with the core standards and must provide evidence to support this in its annual declaration to the CQC. The achievement of the compliance of the essential standards of quality and safety provides a source of significant assurance to the Board on systems of internal control.

6 RISK MANAGEMENT AWARENESS TRAINING

6.1 Board of Directors
The Board of Directors receives risk management awareness training in accordance with the Training Needs Analysis section of the Education and Training Policy (v8, May-11). Attendance is monitored by the Deputy Director of Education & Training and the Assistant Director of Governance follows up any non-attendance by arranging individual training sessions.

6.2 Senior Managers
A risk management awareness seminar has been developed to enable Senior Managers to understand the key aspects of risk management, the effective escalation of risks and their risk management role within the Trust.
Risk Management Awareness Training for Senior Managers has been designated as mandatory (Tier 1), and is monitored by the processes outlined in the Training Needs Analysis section of the Education and Training Policy (v8, May-11).

6.2 Other Staff
The provision of appropriate risk management awareness training is important to ensure that all staff possess sufficient awareness of risk management and are competent to identify, assess and manage risk within their working environment. All Trust staff receive basic training in Health & Safety, Incident Reporting and Risk Management as part of the Trust’s Induction Programme.

6 Grade 8a and above, excluding Board members
7 MONITORING COMPLIANCE

The arrangements for monitoring compliance with this Strategy are outlined below:

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<th>Measurable policy objective</th>
<th>Method</th>
<th>Frequency</th>
<th>Responsibility</th>
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<td>Process for assessing how risk is managed locally</td>
<td>Audit of local risk management processes</td>
<td>Annual</td>
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<td>Audit Committee</td>
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<td>Reporting arrangements into high level committees</td>
<td>Audit of agendas, minutes and annual reports</td>
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<td>Reporting arrangements to the Board</td>
<td>Audit of Board reports &amp; minutes</td>
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<td>Process for ensuring that all board members and senior managers receive relevant risk management awareness training</td>
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<td>Audit of senior manager attendance</td>
<td>Annual</td>
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<td>Process for following-up non-attendance (in relation to risk management awareness training)</td>
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<td>Process for assessing how all risks are assessed</td>
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<td>Audit of CAG / directorate Risk &amp; Assurance Registers – process &amp; content</td>
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<td>Audit of monitoring Active Operational risks within the Assurance Framework</td>
<td>Annual</td>
<td>Assistant Director of Governance</td>
<td>Audit Committee</td>
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8 REVIEW AND VERSION CONTROL
This Strategy has been developed in light of currently available information, guidance and legislation, which may be subject to change. It is reviewed annually by the Service Quality Improvement and Audit Committees and any recommendations for change are submitted to the Board of Directors for formal ratification.

Version Control:

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<td>Damien Gibson</td>
<td>Final</td>
<td>Initial version</td>
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<td>22/01/2008</td>
<td>Jenny Goody</td>
<td>Final</td>
<td>Updated to comply with current practice and NHSLA requirements</td>
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<td>Jenny Goody</td>
<td>Interim</td>
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<td>Jenny Goody</td>
<td>Draft</td>
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## DISSEMINATION PLAN

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<th>Risk Management and Assurance Strategy</th>
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<td>22/10/2013</td>
</tr>
<tr>
<td>Dissemination lead:</td>
<td>Trust Secretary, <a href="mailto:Paul.Mitchell@slam.nhs.uk">Paul.Mitchell@slam.nhs.uk</a></td>
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<td>If yes, in what format and where?</td>
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<td>To be disseminated to:</td>
<td>All Directors, Senior Managers, Business Managers and Team Leaders</td>
</tr>
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<td>How will it be disseminated, who will do it and when?</td>
<td>A group email will be sent by Paul Mitchell, alerting teams to download the Strategy for local use, once it has been formally ratified by the Board of Directors</td>
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<td>Paper or Electronic?</td>
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APPENDIX A

Figure 1: Governance Framework

Figure 2: Risk Management Committees

* Teams, Wards and Corporate departments report in to local Risk Management, Clinical Governance and Clinical Audit & Effectiveness committees as required
## RISK ANALYSIS TOOL

### PART 1: RISK IMPACT GRADING

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<thead>
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<th>GRADES</th>
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<td>SEVERE</td>
</tr>
<tr>
<td>3</td>
<td>SIGNIFICANT</td>
</tr>
<tr>
<td>2</td>
<td>MODERATE</td>
</tr>
<tr>
<td>1</td>
<td>LOW</td>
</tr>
</tbody>
</table>

(For use by Senior Managers and Directors)
PART 2: RISK RATING

<table>
<thead>
<tr>
<th>Impact</th>
<th>Likelihood</th>
<th>1 Remote</th>
<th>2 Unlikely</th>
<th>3 Possible</th>
<th>4 Likely</th>
<th>5 Certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Low</td>
<td>Remote</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2 Moderate</td>
<td>Unlikely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>3 Significant</td>
<td>Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>4 Severe</td>
<td>Likely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>5 Catastrophic</td>
<td>Certain</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

To rate a risk:
1. Grade the impact of the worse case scenario [Part 1].
2. Multiply this impact [1-5] by the likelihood [1-5], to get the rating.

PART 3: RISK MANAGEMENT - ACTION AND TIMESCALES

<table>
<thead>
<tr>
<th>KEY</th>
<th>Risk Level</th>
<th>Action and Time scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED</td>
<td>CATASTROPHIC 20 – 25</td>
<td>Immediate action must be taken to manage the risk. Control measures should be put into place which will have the effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.</td>
</tr>
<tr>
<td>AMBER</td>
<td>SEVERE 16</td>
<td>Significant resources may have to be allocated to reduce the risk. Where the risk involves work in progress urgent action should be taken.</td>
</tr>
<tr>
<td>AMBER</td>
<td>SIGNIFICANT 12 – 15</td>
<td>Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and weighed against the impact of an event. Establish more precisely the likelihood of harm as a basis for determining the need for improved control measures.</td>
</tr>
<tr>
<td>AMBER</td>
<td>MODERATE 8 – 10</td>
<td>Efforts should be made to reduce the risk and the likelihood of harm to be established before implementing further controls. Existing controls should be monitored and adjusted. Consideration may be given to a more cost-effective solution or improvement that imposes no additional cost burden.</td>
</tr>
<tr>
<td>GREEN</td>
<td>LOW 1 – 6</td>
<td>Acceptable risk. No further action or additional controls are required. Risks at this level should be monitored, and reassessed at appropriate intervals.</td>
</tr>
</tbody>
</table>
ASSURANCE FRAMEWORK TEMPLATE

Objective:

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Area</th>
<th>Risk Description</th>
<th>Consequences (Reason for Inclusion)</th>
<th>Risk Rating</th>
<th>Trust Lead(s)</th>
<th>Key Actions</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

GUIDANCE FOR COMPLETING THE ASSURANCE FRAMEWORK TEMPLATE

1. **Ref:** Unique risk identifier
2. **Risk Area:** Generic area of risk
3. **Risk Description:** Specifies the cause of the risk and what the risk / issue is
4. **Source of Assurance:** Primary sources of independent assurance that evidence how well the controls are working
5. **Consequences:** The reason for including this risk, in terms of service users & carers and the Trust’s service and business
6. **Risk Rating:** The current risk rating - use the Risk Analysis Tool to score the risk for Impact (I) x Likelihood (L) = Rating (R)
7. **Trust Leads(s):** The Lead Director(s) responsible for mitigating this strategic risk
8. **Key Actions:** A summary of the action(s) identified to mitigate the risk
9. **Key metric:** A measurement of the progress towards completing each action
10. **Progress:** The overall status of the actions planned to mitigate the risk:
    - **BLUE:** Completed & working; identified benefits realised;
    - **GREEN:** Progressing to plan; delivering to expectations;
    - **AMBER:** Slight delay in progress; uncertainty that identified benefits will be realised;
    - **RED:** Amber status for more than one reporting period, i.e. late and not delivering as expected;
    - **PURPLE:** Failure in timing and/or results; reconsider if this action is appropriate.
## CORPORATE RISK LOG TEMPLATE

<table>
<thead>
<tr>
<th>Ref</th>
<th>AF xref</th>
<th>Trust Lead</th>
<th>Source</th>
<th>Title</th>
<th>Description</th>
<th>Existing Controls</th>
<th>Assurances</th>
<th>Current Grading</th>
<th>Target Grading</th>
<th>Gaps in Control / Assurance</th>
<th>Actions Planned to Address Gaps</th>
<th>Action Plan Update</th>
<th>Delivery Status</th>
<th>Direction of Travel</th>
</tr>
</thead>
</table>

### GUIDANCE FOR COMPLETING THE CORPORATE RISK LOG TEMPLATE

1. **Ref**: Unique risk identifier
2. **AF xref**: Cross reference to the related strategic risk within the Board’s Assurance Framework
3. **Trust Lead**: The lead specialist within the Trust
4. **Source**: Identifies the source of the risk (incident, claim, H&S assessment, CAG or directorate meeting, etc.)
5. **Title**: Brief description of the risk
6. **Description**: Specifies the cause of the risk, what the risk / issue is, and what the possible consequences could be
7. **Existing Controls**: What policies, procedures and practices are in place to reduce the likelihood of the risk occurring or mitigate the risk if it does occur
8. **Assurances**: Where evidence can be gained about how well the controls are working and what the evidence shows
9. **Current Risk Grading**: The current risk rating - use the Risk Analysis Tool to score the risk for Impact (I) x Likelihood (L) = Rating (R)
10. **Target Risk Grading**: The realistically acceptable level of risk remaining when all identified controls are in place and active
11. **Gaps in Control / Assurance**: Where you are failing to put effective controls in place or where you are failing to gain evidence about their effectiveness
12. **Actions Planned to Address Gaps**: A summary of the action(s) identified to mitigate the risk
13. **Action Plan Update**: A summary of the progress towards completing each action
14. **Delivery Status**: The overall status of the actions planned to mitigate the risk:
   - **GREEN**: On target to achieve Target Risk Grading by due date;
   - **AMBER**: Good progress is being made, may be some slippage towards achieving Target Risk Grading;
   - **RED**: Poor progress is being made on actions planned and Target Risk Grading is unlikely to be achieved
15. **Direction of Travel**: An indication of whether or not the risk is improving
APPENDIX E

RISK & ASSURANCE REGISTER TEMPLATE

<table>
<thead>
<tr>
<th>Ref</th>
<th>Source</th>
<th>Title</th>
<th>Description</th>
<th>Risk Lead</th>
<th>Existing Controls</th>
<th>Assurances</th>
<th>Current Grading</th>
<th>Target Grading</th>
<th>Actions</th>
<th>Delivery Status</th>
<th>Last Review Date</th>
</tr>
</thead>
</table>

GUIDANCE FOR COMPLETING THE RISK & ASSURANCE REGISTER TEMPLATE

1. **Ref:** Unique risk identifier
2. **Source:** Identifies the source of the risk (incident, claim, H&S assessment, etc.)
3. **Title:** Brief description of the risk
4. **Description:** Specifies the cause of the risk, what the risk / issue is, and what the possible consequences could be
5. **Risk Lead:** The person with responsibility for mitigating this risk locally
6. **Existing Controls:** What policies, procedures and practices are in place to reduce the likelihood of the risk occurring or mitigate the risk if it does occur
7. **Assurances:** Where evidence can be gained about how well the controls are working and what the evidence shows
8. **Current Risk Grading:** The current risk rating - use the Risk Analysis Tool to score the risk for Impact (I) x Likelihood (L) = Rating (R)
9. **Target Risk Grading:** the realistically acceptable level of risk remaining when all identified controls are in place and active
10. **Actions:** A summary of the action(s) identified to mitigate the risk, their due date and the progress towards completing them
11. **Delivery Status:** The overall status of the actions planned to mitigate the risk:
    - GREEN = On target to achieve Target Risk Grading by due date;
    - AMBER = Good progress is being made, may be some slippage towards achieving Target Risk Grading;
    - RED = Poor progress is being made on actions planned and Target Risk Grading is unlikely to be achieved
12. **Last Review Date:** The date this risk was last reviewed, which gives an indication of the currency of the information
APPENDIX F

Risk Identification Sources

Health & Safety risk assessments: the Trust’s Health & Safety Risk Assessment Policy (v3.0, Dec-11) outlines the roles of directors, managers and staff in protecting, where reasonably practicable, all people from risk whilst at work and provides detailed guidance on the management of Health & Safety risks.

Management and investigation of incidents: the Trust has the following policies in place relating to incidents:
- Incident policy (v2.1, Sep-11)
- Investigation of incidents, complaints and claims policy (v2.2, Jul-12)
- Learning and embedding lessons arising from incidents, complaints and claims (v3.1, Nov-11)
- Aggregation of incidents, complaints and claims (v3.1, Nov-11)
- Being open policy (v3.2, Nov-11)

These polices help to ensure that incidents are reported and acted upon within a just and fair culture where the emphasis is on learning lessons and making improvements rather than seeking to ascribe blame. The policies describe the arrangements for the reporting, management, investigation and learning from incidents, serious incidents (SIs), complaints and claims and the requirement to notify SIs to external stakeholders such as primary care commissioners, the strategic health authority and the National Patient Safety Agency (NPSA).

Safety Alerts: the Trust has a system for managing, implementing and monitoring safety alerts received through the Central Alerting System (CAS). This is described in detail in the Medical Devices Policy (v5, Jan -11) and instructions issued by the Trust CAS Liaison Officer to the CAG CAS representatives.

Management of Complaints: the Trust recognises the value of learning from both complaints and concerns and uses this information to drive improvements in quality, safety and patient experience. The Complaints Team lead on the management and investigation of complaints and work collaboratively with the Patient Advice and Liaison Service who deal with and seek to resolve concerns raised by service users, relatives and visitors. The process for dealing with complaints and concerns is outlined in the Complaints Policy (v3.2, Jul-12).

Claims and Inquests management: The Claims & Litigation team ensure the timely and effective response to any legal claim in accordance with the pre-action protocol for the resolution of clinical disputes, as set out in the Civil Procedure Rules 1998 (as amended). The team liaises with HM Coroner and clinicians in respect of the inquest process. Any concerns or recommendations (Rule 43) raised by the Coroner are communicated appropriately to ensure that remedial action is taken. Claims and inquests which are linked to an incident are investigated according to the Trust’s Incident Policy to ensure that appropriate action is taken to reduce the risk of recurrence and improve patient safety and experience. The process for the management of claims is set out in the Claims Handling Policy (v2.2, Oct-11).

Clinical Audit: there is extensive clinical audit activity within the Trust both at CAG and corporate (Trust-wide) level. The Trust-wide corporate audit program covers three broad areas to reflect the dimensions of quality highlighted in ‘High Care Quality for All’, namely patient safety, clinical effectiveness and patient focus. Findings from these audits are fed back to appropriate members of staff via newsletters and audit bulletins. Reports are presented to CAG clinical audit and/or Executive groups and to the Quality Governance Committee, where recommendations and action plans are monitored. These processes are described in the Trust’s Clinical Audit Policy (v2.1, Aug-11).

Implementation of Best Practice: the Trust has mechanisms in place to implement the latest guidance and recommendations from the National Institute for Health and
Clinical Excellence (NICE) and the relevant National Confidential Enquiries. These processes are described in the Implementation of NICE Guidance and National Confidential Enquiries in SLaM Policy (v3.1, Aug-11).

**Reviewing and learning from external reviews & recommendations:** the Trust has a systematic approach to ensure that it responds to external reviews and recommendations in a way that will achieve maximum benefit for the organisation, in terms of improved quality of service, improvements in patient care, reduced risk and effective use of staff resources. The process is outlined in the Responding to External Recommendations Specific to the Organisation Policy (v1.4, Jul-11).

**Infection Control assurance framework:** the Trust has an assurance framework which demonstrates that infection control is an integral part of Clinical and Corporate Governance. These activities include a review of statistics on the incidence of alert organisms (such as MRSA or clostridium difficile), outbreaks and Serious Incidents, with an outline of the actions taken to deal with occurrences of infections. An annual audit programme ensures that policies have been implemented; the findings of the audits are fed back to key staff and action plans to address any critical issues are followed up by the Infection Control Team. This process is outlined in the Infection Control Policy (v1, Jan-10).

**Safeguarding Children assurance framework:** the Trust has developed a Safeguarding Children assurance framework in response to the many and various reviews, recommendations and actions that have been published since 2009 and the increased scrutiny and challenges that are required. The Framework is structured around 5 main themes and guidance from the CQC, the Children Act 2004, the NHS London ‘Baby Peter’ Recommendations and the NPSA Rapid Response Report. The Framework pulls the information and evidence together in one place and CAG managers and safeguarding leads have access to the Framework via the Intranet.

**Whistle Blowing:** the Whistle Blowing Policy (v2, Sep-10) sets out the Trust’s guidelines for raising concerns about anything within the Trust involving danger (to patients, the public or colleagues), professional misconduct or financial malpractice. This enables concerns to be raised safely at an early stage and in the right way. The Trust welcomes genuine concerns and is committed to dealing responsibly, openly and professionally with them. The whistle blowing procedure protects the interests of patients, staff and the Trust and aids the delivery of a safe service.
**TRUST BOARD OF DIRECTORS – SUMMARY REPORT**

**Date of Board meeting:** 17 October 2013  
**Name of Report:** Key Points and Minutes from the Service Quality Improvement Sub Committee of the Board  
**Heading:** Governance  
**Authors:** Jenny Goody, Governance Manager  
**Approved by:** Nick Dawe, Interim Finance Director  
**Presented by:** Harriet Hall

**Purpose of the report:**
To present a brief summary of the key points discussed at the meeting of the Service Quality Improvement Sub Committee of the Board held on 17 September 2013 drawing the Board’s attention to key points for consideration.  
To present the draft minutes of the meeting of the Service Quality Improvement Sub Committee of the Board held on 17 September 2013.

**Action required:**
The Board of Directors is asked to note this report and decide on whether any further action or briefing is required in relation to the key issues raised.

**Recommendations to the Board:**
Issues for attention are highlighted within the report.

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**
The Service Quality Improvement Sub Committee provides assurance to the Board that the principal risks to service quality, recorded within the Assurance Framework, are being; correctly identified, correctly judged and classified and most importantly, are being actively and managed and mitigated by named staff.

**Summary of Financial and Legal Implications:**
The Audit Committee carries out an annual review of the Annual Governance Statement; the work of the Service Quality Improvement Sub Committee informs this review.

**Equality & Diversity and Public & Patient Involvement Implications:**
Equality & Diversity and Public & Patient Involvement are reviewed by the Service Quality Improvement Sub Committee.
Key points from the meeting of the Service Quality Improvement Sub Committee held on 17 September 2013

Quality Indicators Dashboard

The committee reviewed a third iteration of the quality indicators dashboard, which details the metrics relating to the quality indicators within the Trust Quality Strategy/Account. It was noted that work has begun to roll out the Care Delivery System (an approach that improves the interaction and communication between all members of the care team and the patient) and the plan is to recruit all inpatient wards to the programme before the year end. There is an issue with collecting continuous data relating to CPA patients with Recovery and Support plans, which will be followed up by the Performance Review process. The Family and Friends test is being piloted on some wards and, although it is not yet mandatory for Mental Health services, more services are being encouraged to include this question in local surveys.

The Board’s attention is drawn to the growing importance of the Family and Friends test in terms of reputation and ultimately commissioner and patient choice. Action has already been taken in areas of concern identified in the first survey. In addition the Board’s attention is drawn to the fact that as the test is based on a “customer perception” survey method that any response by the Trust to the issues raised will need equally to be patient perception orientated.

Quality Strategy Update

The committee reviewed the Trust’s progress towards achieving its Quality Strategy. Average waiting times have improved, with few specialist services have waiting times of more than 18 weeks; GP liaison has also improved with 100% compliance with the CQUIN target for 2012/13. There have been various peaks in the number of reported violent incidents and no underlying causal factor or factors have yet been determined. However with activity levels being in most services well above commissioned levels and wards operating at higher occupancy levels than planned, there are concerns that this will raise both the absolute number and the likelihood of incidents violent occurring. Fewer complaints are being reopened, and fewer complaints are being escalated to the PHSO.

The Board’s attention is drawn to the issue that although the Trust must do all it can within available resources to address waiting times, the waiting times for specialist services are mainly a product of the deliberate decision of the commissioner to contract for historic levels of activity. Waiting lists are a subject of discussion with the commissioner at the quarterly contract review meetings.

The Board’s attention is drawn to the issues round activity pressures on wards and occupancy levels being such that it may be impacting adversely on the number and frequency of incidents. The Trust is currently in discussion with commissioners around the service, quality and resource impacts arising from the unprecedented levels of demand on inpatient services.

Quality Governance Framework

The committee reviewed the completed results of a gap analysis between the Trust’s existing arrangements and those set out in Monitor’s Quality Governance Framework. There is no evidence as yet to support the initial responses, which will be gathered as the next step. Four actions were noted: to develop an integrated quality and risk report, to instigate a more consistent approach to quality impact assessments; to restructure the SQISC and to instigate systematic and consistent monitoring of CQC standards in all services.
The Board’s attention is drawn to the work being undertaken to improve further the intelligence based approach to quality governance and the further need to move from reactive to proactive measures to ensure the quality of services is protected and wherever possible, improved.

Corporate Risk Log Review – Operational Service Quality Risks

The committee reviewed the Trust-wide clinical risks within the Corporate Risk Log (CRL). A potential risk relating to support from the police was highlighted; this is currently a growing cause for concern and the increased risk is sufficiently high to warrant inclusion in the CRL. Further work is underway to analyse the Trust’s use of police time and identify areas where calls to the police could be managed differently. The poor uptake of PSTS training was also noted, as was the fact that the e-prescribing pilot has been unsuccessful.

The Board’s attention is drawn to the multi-agency conversations currently occurring with the Metropolitan Police to ensure no unilateral change in service and support occurs and a reasoned and agreed update of roles and responsibilities occurs.

The Board’s attention is also drawn to the fact that formal reviews and action plans have been requested in respect of PSTS training and the e-prescribing project because of significant committee concerns about these issues.

Risk Management and Assurance Strategy

The Trust’s updated Risk Management and Assurance Strategy, and associated changes to the committee’s Terms of Reference were approved.

The Board’s attention is drawn to the significant consultation and review that has led to the changes in the Strategy so that arrangements more fully represent the needs of the Trust.

BLI Process

A proposal was presented to the committee to change the Trust’s Board Level Investigation (BLI) process for serious incidents to more fully align the approach with national guidance.

It was considered that the suggested change in process needed to be approved by the Board to ensure that the proposed alignment, and in particular the changes in the timing and nature of Non Executive engagement in the process was appropriate.

Suicide and Homicide

The committee reviewed an update from the recent National Confidential Inquiry into suicide and homicide involving people with mental illness and a summary of the recent SLaM suicide audit. Suicide rates are generally rising, which is considered possibly to be related to the current economic climate. Although no suicides took place on inpatient units during the period of the audit, it identified a gap between carrying out a risk assessment and ensuring a plan is in place to manage the risk of suicide.
The Board’s attention is drawn to the fact that although suicide rates in the four boroughs are below the national and London average that the issue is of high concern. A meeting is scheduled for CAGs to review these recommendations and to ensure that preventative strategies can be agreed, incorporating better practice when dealing with the risk of suicide.

Clinical Audit Programme

The committee reviewed highlights from the Q2 Clinical Audit programme, which included audits of patient information and multiple transfers between ward and care locations. It was found that a number of services had out of date material, which has been raised with them. The audit of patient transfers concluded that few patients were moved more than once, and those that were usually moved to PICU and back; only one patient in the sample of 74 had been moved a significant number of times.

The Board’s attention is drawn to the fact that the triage model of operation by its very nature will lead to admission and assessment on one ward and transfer if required to another ward. Multiple transfers for issues of bed availability were the major concern as was the placement of patients in distant placements due to capacity constraints. Both issues are urgently being attended to.
DRAFT

MINUTES OF THE
SERVICE QUALITY IMPROVEMENT
SUB-COMMITTEE OF THE TRUST BOARD OF DIRECTORS

HELD ON: 17th SEPTEMBER 2013 at 13:00

AT: Boardroom, Maudsley Hospital

Present:
Harriet Hall (Chair) Non-Executive Director (HH)
Patricia Connell-Julien Non-Executive Director (PCJ)
Gus Heafield Acting Chief Executive (GH)
Martin Baggaley Medical Director (MB)
Jane Sayer Acting Director of Nursing & Education (JS)
Nick Dawe Director of Finance & Corporate Governance (ND)
Cliff Bean Deputy Director Patient Safety & Assurance (CB)

In Attendance:
Roy Jaggon Head of Performance Management (RJ)
Rosie Peregrine-Jones Clinical Audit & Effectiveness Manager (RPJ)
Andy Cantrell Clinical Audit Project Officer (AC)
Maggie Cork KPMG (MC)
Lizzie Tuckey KPMG (LT)
Kelly Reid Internal Audit (Parkhill) (KR)
Nicola Meeks Internal Audit (Parkhill) (NM)
Olivia Howarth (minutes) Business Manager – CE’s Office (OH)

Apologies:
Zoë Reed Director Strategy & Business Development (ZR)
Jenny Goody (Secretary) Governance Manager (JG)
<table>
<thead>
<tr>
<th>Item</th>
<th>Business Item</th>
<th>Action by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Apologies</strong></td>
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<tr>
<td></td>
<td>As received above.</td>
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<tr>
<td>2.</td>
<td><strong>Declarations of interest / notifications of any other business</strong></td>
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<tr>
<td></td>
<td>No declarations of interest or notification of any other business were received.</td>
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<tr>
<td>3.</td>
<td><strong>Minutes of SQISC Meeting on 23rd July 2013</strong></td>
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<td></td>
<td>The minutes were agreed as an accurate record.</td>
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<tr>
<td>4.</td>
<td><strong>Action Point Tracker: Outstanding Actions &amp; Closures</strong></td>
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<tr>
<td></td>
<td>The actions shaded green have been addressed since the last meeting and it was agreed that these could be closed.</td>
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<td></td>
<td>An update was given on the following outstanding actions:</td>
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<tr>
<td></td>
<td><strong>Action 39:</strong> Quality Account - CB noted that the communications plan is already in train, focusing on encouraging teams to concentrate on the quality priorities for this year; this will be notified through staff communication channels.</td>
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<tr>
<td></td>
<td><strong>CLOSED</strong></td>
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<td></td>
<td><strong>Action 68:</strong> CQC consultation - JS updated the committee on the two recent CQC compliance visits to River House and Woodland House; the Trust is now fully compliant on all outcomes at both locations. The CQC are still showing a concern on the website which is incorrect and the CQC has been made aware of this.</td>
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<td></td>
<td><strong>CLOSED</strong></td>
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<td><strong>Action 70:</strong> Estates and Facilities – HH asked that E&amp;F matters that have an impact on quality are fully recorded; clarification is needed as to whether they should be incorporated into the dashboard. JS suggested that this could be incorporated into the Quality Governance Report.</td>
<td></td>
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<tr>
<td>5.</td>
<td><strong>FOR DISCUSSION</strong></td>
<td></td>
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<tr>
<td>6.</td>
<td><strong>Quality Indicators Dashboard</strong></td>
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<td></td>
<td>AC presented the third iteration of the quality dashboard, which is still being developed and was brought to the committee to provide feedback.</td>
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<tr>
<td></td>
<td>The committee was asked to note that this is not a complete data set for Q2, as the end of the quarter has not yet been reached. It was noted that the data quality pie chart indicators in the side column are not all green.</td>
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<tr>
<td></td>
<td>The following points were noted:</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>1. Care delivery system – the project team has begun work, planning to recruit 50 inpatient wards to the programme before the year end.</td>
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</tr>
<tr>
<td></td>
<td>2. CPA patients with Recovery and Support plans - there is an issue with obtaining continuous data, which will be picked up as part of the performance management review.</td>
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</tr>
<tr>
<td></td>
<td><strong>Action:</strong> Follow up the issue of continuous data relating to CPA patients with Recovery and Support plans at CEOPMR.</td>
<td></td>
<td>GH / RJ  Nov-13</td>
</tr>
<tr>
<td></td>
<td>3. Team annual review – the majority of in-patient wards have had a review within the past two years; the outcomes team are committing more resources to this.</td>
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<td></td>
<td>4. Family and friends test – this is being piloted on some wards, although it is not yet mandatory for Mental Health services. As this is a target for next year it was queried whether it could be rolled out to all services now; Ray Johansen-Chapman is encouraging more services to include this question in local surveys.</td>
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</tbody>
</table>
## 6. Quality Strategy Update

CB provided an update on the Trust’s Quality Strategy, explaining that it is important to make a distinction between the quality targets set out in the 2011-14 Quality Strategy and those published in the Quality Account, which are different this year. The Strategy is nearing the end of its term and will be replaced by a fresh strategy next year, although some targets are likely to remain.

The following points were noted:

1. **Access to services** – the average waiting time has improved; few specialist services have waiting times of more than 18 weeks. GP liaison has also improved and the CQUIN target for 2012/13 was met 100%.

2. **Patient safety** – the number of reported incidents of violence was discussed, various peaks have been noted, especially recently in forensics. CB noted that it can be difficult to understand the factors which cause fluctuation in data, although activity pressures clearly play a key role.

   The violence reduction strategy has a number of elements which the CAGs are implementing. The care delivery system includes a number of different interventions, zoning being the key one that the majority of inpatient services have taken up. This evidences that the strategy has had positive pay off in services where elements of it had been implemented.

   GH questioned how patient safety data ties in with the successful interventions being rolled out and requested this data analysis for the next meeting.

**Action:** Analyse the relationship between successful interventions and patient safety data and present to the next meeting of the SQISC.

CB  Nov-13

3. **Patient experience** – the latest national survey results are being published imminently. Fewer complaints are being reopened, and fewer complaints are being escalated to the PHSO.

4. **Building capacity and capability for quality improvement** – the central quality improvement support service QuIST, continues to develop its service and offering to CAGs.

## 7. Quality Governance Framework

JS presented the results of an in-depth gap analysis of the Trust’s compliance with Monitor’s Quality Governance Framework. There is no evidence as yet to support the initial responses, which will be gathered as the next step.

Four actions were noted:

1. An integrated the quality and risk report will be developed to replace the fragmented reports that currently go to the Board. The report will be Trust-wide with the option to drill down to individual CAGs and departments. The resources needed to produce this report were questioned, as not all data streams are fully automated; JS undertook to gauge the resource implications for the Board to approve and will also take this to the Executive team.

2. Instigate a more consistent approach to quality impact assessments (particularly for cost improvement schemes), with concurrent early warning indicators, working through what escalation triggers are, together with definitions of what is escalated to Board level.

3. Restructure the SQISC and meet bi-monthly; this requires Board
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<th>Business Item</th>
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<td>4.</td>
<td>Instigate systematic and consistent monitoring of CQC standards in all services.</td>
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8. **Corporate Risk Log Report**

The Trust-wide clinical risks within the Corporate Risk Log (CRL), with updates from Trust leads highlighted in blue text, were reviewed. The new format was welcomed, and the committee discussed the updates and whether there was sufficient progress being made to be assured that the risks were being mitigated sufficiently.

CB noted a potential risk relating to support from the police, which was discussed at a meeting held the day before. The system is currently in a state of flux and the increased risk is sufficiently high to warrant inclusion in the CRL. GH stated that a protocol with five borough MPS Commanders has been signed and that he recently met with Steve Davidson and the MPS, where assurances were given; this issue has been escalated and immediate actions are in place. Further work is underway to analyse the Trust’s use of police time and identify areas where calls to the police could be managed differently.

HH questioned the poor uptake of PSTS training and asked that where training is being relied upon to mitigate risks, this problem should be addressed. This issue has also been raised at the Audit Committee, who have asked the HR Director to present to them at their next meeting; it was agreed the SQISC would not duplicate the task but await the outcome of the Audit Committee discussions.

HH noted that the e-prescribing pilot has been unsuccessful, and asked what alternatives had been explored. MB stated that he will raise this with Pharmacy.

**Action:** Discuss the issues relating to e-prescribing with Pharmacy and report back to the next meeting.  

**FOR DECISION**


Thanks were noted to JG for updating the Trust's Risk Management and Assurance (RMA) Strategy; the following principal changes were noted:

1. The Trust has reverted to maintaining a high level Assurance Framework comprising a dozen or so strategic risks, underpinned by a Corporate Risk Log comprising the principal active and inherent operational risks that could threaten the achievement of the Trust’s objectives.
2. The Trust Executive will discuss specific strategic or operational risks from the Assurance Framework or Corporate Risk Log respectively as and when the need arises.
3. Primary sources of independent assurance will be incorporated into the reformatted Assurance Framework.
4. The relevant data relating to existing controls, assurances and planned actions will be collected at CAG/Directorate level, but not necessarily reported to the Board or its sub committees.
5. CAG Directors will be asked to present their risk assessments to relevant committee(s) so that accounting officers can fully understand their risks and actions being taken to manage them.

After due consideration, the updated RMA Strategy was agreed. It will now be presented to the October meeting of the Board of Directors for formal ratification.
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<th>Item</th>
<th>Business Item</th>
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<tbody>
<tr>
<td>10.</td>
<td>SQISC Terms of Reference</td>
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<td></td>
<td>The committee’s Terms of Reference have been updated to reflect the changes to the Trust’s Risk Management and Assurance Strategy. After due consideration, the updated Terms of Reference were agreed.</td>
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<td>FOR INFORMATION</td>
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<tr>
<td>11.</td>
<td>BLI Process</td>
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<td></td>
<td>CB presented an overview of the Trust’s Board Level Investigation (BLI) process for serious incidents, which has not changed since the inception of the Trust. It is out of step with National guidance; there is now considerably more external scrutiny of our serious incidents and the current two-tier systems is confusing. The proposal is to have a system whereby a strategy meeting is held after a serious incident has occurred to plan the investigation. At the conclusion of the investigation, there will be an inclusive closure meeting. A Board member will chair the planning and closure meetings, which will dovetail with the internal investigation.</td>
<td>CB</td>
<td>Jan-14</td>
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<td>It was felt that this should be discussed at the Board, and CB undertook to expand the specific expectations for NEDs in a Board paper.</td>
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<td></td>
<td>Action: Present a proposal to update the Trust’s BLI process to a future meeting of the Board of Directors.</td>
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<td>12.</td>
<td>Suicide and Homicide</td>
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<td>RPJ presented an update from the recent National Confidentiality Inquiry into suicide and homicide involving people with mental illness and a summary of the recent SLaM suicide audit. The key point to note is that suicide rates are generally rising, which is considered to be related to the current economic climate. In the SLaM audit, 74 cases of suicide over a 3 year period from March 2009 – 2012 were reviewed. There were no deaths on inpatient units during this time - they occurred when the patient was on leave. In a number of cases, suicidal ideation was identified as a risk. The audit highlighted the high completion rate of risk assessments, but identified a gap between carrying out the risk assessment and ensuring a robust plan is in place to manage the risk. Other areas to consider are looking at plans related to risks identified, such as providing better information to families and carers. Currently the MAPD and Psychosis CAGs are discussing crisis interventions, as 40% of the suicides were caused by temporary factors in a person’s life; if those patients had had support at the crucial time, outcomes may have been different. A meeting is scheduled for CAGs to review these recommendations and it is hoped that preventative strategies can be agreed, incorporating better practice when dealing with the risk of suicide.</td>
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<td>The committee reviewed a brief report of quality issues identified by the Trust leads for Inquests, Patient Experience, Information Governance and the CQC. HH requested a detailed feedback report on the CQC Assessment and Admission visit that took place in July 2013.</td>
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<td>Action: Present detailed feedback on the July CQC Assessment and Admission visit to the next meeting.</td>
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<td>The report was noted by the committee.</td>
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14. **Clinical Audit Programme**  
RPJ presented the highlights from the Q2 Clinical Audit programme:  

**Patient Information Audit:** 36 wards were visited to assess what patient information was accessible, in relation to CQC standards. A number of services had out of date material, which has been raised with them. CB confirmed that patient information leaflets will be included in this year’s practice assurance visits.  

**Multiple Transfer Audit:** An audit of patient transfers over a three month period was conducted after one patient reported being moved 12 times in one in-patient spell. Results concluded that few patients were moved more than once, and those that were usually moved to PICU and back. Only one patient in the sample of 74 had been moved five times.  

MB added that the Bed Management Committee will be setting up a bed management coordination office and recording multiple transfers.  
The report was noted by the committee.

15. **Sub-committee Escalation Reports**  
The **Risk Management Committee** submitted a précis of their meeting held on 7 July 2013; the committee were pleased to note the progress being made on Estates statutory compliance issues.  
The **Quality Governance Committee** has not met since the last meeting of the SQISC.  
The **Quality Programme Delivery & Assurance Group** submitted a précis of their meeting held on 3 September 2013, which was noted by the committee.

**ADMINISTRATION**

16. **Feedback to Board of Directors & Audit Committee**  
It was agreed that there are a few key points that require wider discussion, and HH will raise these at the October meeting of the Board of Directors.  
It was agreed that the Audit Committee should be made aware of the Education & Training compliance issue and the results of the Governance Framework gap analysis.  
The Board of Directors and Audit Committee will also receive a highlight report comprising a précis of the meeting minutes for information.

17. **Feedback to RMC and QGC**  
It was agreed that there were no urgent issues that need to be fed back to the Risk Management or Quality Governance committees at this time; they will be provided with a highlight report comprising a précis of the meeting minutes for information.

18. **Forward Planner**  
The Forward Planner for 2013 was noted by the committee, although it was agreed this would alter as changes to the committee take effect.

19. **Any Other Business**  
No other items were raised.

20. **Dates of future 2013 meetings**  
6 November, 9:00 – 11:00
TRUST BOARD OF DIRECTORS (‘THE BOARD’) – SUMMARY REPORT

Date of Board meeting: Thursday 17th October 2013

Audit Committee:

Name of Report: (a) draft minutes of meeting held 10.Sep.2013

Heading: Governance

Author: Steven Thomas (Audit Committee Secretary)

Approved by: Robert Coomber (Audit Committee Chair and Non Executive Director – ‘NED’)

Presented by: Robert Coomber (Audit Committee Chair and NED)

Purpose of the reports:

Audit Committee draft minutes. To inform the Board about proceedings at the Audit Committee meeting held on 10.Sep.2013


Action required:

Review the documentation presented.

Recommendations to the Board:

Note the documentation presented.

Relationship with the Assurance Framework (Risks, Controls and Assurance):

The Audit Committee’s role includes consideration of the Assurance Framework.

Summary of Financial and Legal Implications:

No specific significant implications identified.

Equality & Diversity and Public & Patient Involvement Implications:

No specific significant implications identified.

KEY ISSUES SUMMARY (references are to the Audit Committee minutes attached)

(The Audit Committee Chair may wish to expand or amend the following at the Board meeting)

At its 10.Sep.2013 meeting, the Audit Committee concluded that no matters required escalation for the attention of the Board (14.1 refers). However the Audit Committee considers that the Board should be made aware of the Audit Committee’s concerns about the following issues (references are to the Audit Committee minutes):

- **E-rostering (10.1.1(d))**: internal audit reports that the benefits of e-rostering may not have been realised, as SLaM has not conducted a post-implementation review.
- **Cost Improvement Programme – CIP (10.1.2)**: the Audit Committee noted several issues indicating a possible need for CIP planning processes and commissioning negotiations to start earlier in the year.
- **Key committees (10.1.5)**: the Audit Committee Chair will informally recommend to the Board that officer attendances at meetings of key committees be reviewed, aiming to ‘streamline’ attendances.
- **Mandatory training (10.1.7)**: the Audit Committee Chair will formally recommend that the Board takes steps to: (a) encourage, and enforce, full attendance at mandatory training (this includes disciplinary action where appropriate); and (b) re-assess the categorisation of training as ‘mandatory’.
NOTES
The AC Chair decides on the appropriate order in which to take agenda items at AC meetings, and this is not necessarily the order shown below. The minutes focus on recording the information and assurances provided in the meeting, in response to questions from AC members and otherwise, rather than on the questions themselves.

1. UNMINUTED SESSION
1.1 No unminuted session was held. No requests for such a session had been received. The AC noted this.

2. INTRODUCTION AND APOLOGIES FOR ABSENCE
2.1 RC opened the meeting. RC explained that, as foreseen for this particular meeting, there was a smaller volume of business requiring discussion than usual. No apologies for absence had been received. After due discussion the AC noted this agenda item.

3. DECLARATIONS OF INTEREST
3.1 RC asked all present to declare any relevant interests. Routine declarations were made. PCJ declared an interest as a former employee of King’s College London and as Trustee of Southside Certitude Support. SK declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. SK advises and consults with pharmaceutical companies periodically. After due discussion the AC noted these declarations.

4. MINUTES OF PREVIOUS AC MEETING(S)
4.1 The AC considered the final draft minutes of the AC meeting held on Tuesday 25th June 2013. ST drew the AC’s attention to the paper from JG noting a correction to the report minuted at 12.4.2(c). ST advised
that the minutes accurately reflected what had been reported at the meeting, but the report itself required correction as set out in the paper. After due discussion the AC approved the minutes.

5. ACTION POINTS (‘APs’) FROM PREVIOUS AC MEETINGS

5.1 The AC considered the AP list. After due discussion the AC noted the AP list. Post meeting note: with the AC Chair’s agreement ST has updated the AP list to reflect information received during the AC meeting and subsequently.

6. MATTERS ARISING (IF ANY)

6.1 No other matters arising were reported. The AC noted this.

7. KEY POINTS FROM RECENT SQISC MEETING(S)

7.1 JG presented this report based on the most recent meeting of the Service Quality Improvement Sub Committee (‘SQISC’). JG reported that there were no key issues to be flagged for the AC’s attention. After due discussion the AC noted the report.

8. REPORTS FROM AND DISCUSSIONS WITH SLaM MANAGEMENT (OTHER THAN FINANCE)

8.1 There were no such reports or discussions. The AC noted this.

9. EXTERNAL AUDIT

9.1 Progress report

9.1.1 MH and AF advised that the external audit plan would be presented at the December 2013 AC meeting, and would take account of the issues identified in the 2012/13 audit. MH and AF confirmed that, since the previous AC meeting, Monitor had issued no material which MH and AF considered should be brought to the AC’s attention. After due discussion the AC noted the agenda item.

10. INTERNAL AUDIT (INCLUDING ICT AUDIT AND CLINICAL AUDIT IF RELEVANT)

10.1 Progress report

10.1.1 KL and NM presented this agenda item, and in particular:

(a) KL advised as follows. Internal audit has amended the general form and content of the Progress Report, aiming to improve its quality. Section 4 of the report notes seven Key Performance Indicators (‘KPIs’). The suite of KPIs, which reflects advice received from ND, could be changed if the AC wishes. NM will produce an updated report on the status of audit agreed actions. This will be based on hard copy records, as the electronic records are not currently operative. The AC approved the new style of the Progress Report and the KPI suite;

(b) NM summarised internal audit activity over the past months (report section 2) noting that 28% of the internal audit plan had been delivered (in terms of days input);

(c) NM advised how internal audit review reports would outline any implications of the Francis Report, and how internal audit plans took account of commissioning risk;

(d) KL and NM reported that the benefits of e-rostering may not have been realised, as SLaM has not conducted a post-implementation review. ND advised that although e-rostering is controlled by Human Resources the keys to successful implementation are: (i) appropriate dialogue with the nursing function; and (ii) a change in mindset from that in force when the original rostering system was in place, based around staff preferences;

(e) NM flagged three key issues and risks (report section 3), discussed as noted below; and

(f) after due discussion the AC noted the agenda item.

CIP and QIPP programmes

10.1.2 The meeting discussed the cost improvement programme (‘CIP’) and the quality, innovation, productivity and prevention (‘QIPP’) programme, and:

(a) KL and NM advised that the current CIP 27% underperformance was largely due to the difficulty of accurate planning given the major changes faced by SLaM and other Foundation Trusts (‘FTs’). KL advised that other FTs were experiencing issues similar to SLaM;

(b) SK noted that the ‘spend to save’ initiative would not be an explanation of CIP overspend because the spend would have been budgeted for;

(c) ND advised that two key specific reasons for apparent CIP underperformance are: (i) accurate planning is difficult. Commissioning agreements with key commissioners (such as Lambeth) are taking longer to finalise, because commissioners are intentionally holding off doing so, and because SLaM is
challenging commissioners’ proposals far more than in previous years; and (ii) cost inflation is being managed on a global basis, which is probably excessively prudent. ND considered that after adjustment for such factors, there is very little actual CIP underperformance. ND reported pharmacy savings as one specific example of CIP underperformance;

(d) ND advised that SLaM faces unique constraints in meeting CIP targets compared with other FTs. SLaM’s reliance on block contracts that focus on managing activity mean that SLaM needs to focus on achieving CIP targets whilst balancing QIPP performance, whereas Acute FTs can focus on CIP performance. Smaller mental health FTs (unlike SLaM) can declare themselves ‘full’ if CIP targets are under pressure, and put the responsibility back to commissioners to deal with the patients turned away;

(e) RC noted that there seemed little improvement in CIP management since 2012/13, and that for 2014/15 onwards the difficulties in CIP planning will be even greater than for 2013/14. RC was concerned that SLaM’s risk rating might be adversely affected; and

(f) KL and NM advised that internal audit’s previous work on CIP performance had focused on assessing SLaM’s controls and processes.

10.1.3 Action/(timescale). Internal audit will amend their workplan so that future work on CIP performance will critically review outcomes and will include benchmarking, rather than focusing on controls and processes (Dec.13).

Committee meetings and attendance

10.1.4 NM advised that internal audit had identified an issue of poor attendance at committee meetings, with many instances of apologies for absence and attendance of alternates with inappropriate knowledge. RC considered that SLaM had an excessive number of committees. ND’s view was that changes in the senior management team caused some difficulties with attendances but nothing major, and a more significant issue is attendance by officers not required for meetings to achieve their purposes.

10.1.5 Action/(timescale). RC will informally recommend that the Board reviews its key committees, and the officers whose attendance is required to ensure the meetings of these key committees are fully effective. The purpose of the Board’s review is to maximise the attendances of these officers at these meetings and hence maximise the efficiency and effectiveness of these key committees (Oct.13).

Attendance at mandatory training

10.1.6 NM advised that internal audit had identified an issue of insufficient levels of attendance at mandatory training, and:

(a) NM advised that this could cause problems, including increased levels of claims;

(b) SK noted that a large amount of training was categorised as mandatory and suggested that SLaM could reassess the appropriate categorisation of training as ‘mandatory’; and

(c) ND flagged the significant amount of training conducted by e-learning methods, which reduced the training burden by flexibly enabling trainees to study at times most convenient to them.

10.1.7 Action/(timescale). RC will formally recommend that the Board takes steps to: (a) encourage, and enforce, full attendance at mandatory training (this includes disciplinary action where appropriate); and (b) re-assess the categorisation of training as ‘mandatory’ (Oct.13).

11. LOCAL COUNTER FRAUD SPECIALIST (‘LCFS’)  

11.1 Intelligence briefing/benchmarking report

11.1.1 DK presented this report, and:

(a) DK advised that reported fraud as a proportion of 2011/12 budgeted spend was 3% for the NHS overall, but less than 1% for SLaM. DK considered that this indicated that fraud at SLaM was relatively well controlled, as the alternative explanation (that SLaM is relatively poor at detecting/reporting actual fraud) was unlikely given the level of counter fraud work performed;

(b) DK reported that the numbers of referrals and investigations at SLaM were somewhat higher than the average for Parkhill’s client base of Mental Health Trusts. RC noted that the implications of this were unclear as SLaM itself (in terms of scale of activities, staff numbers and so on) is far larger than average;

(c) ND advised that Mental Health Trusts face lower risks of major fraud than Acute Trusts; and

(d) after due discussion the AC noted the agenda item.
11.2 Progress report September 2013

11.2.1 DK presented the report, and in particular:

(a) DK reported on counter fraud training, noting that the counter fraud ‘stall’ at SLaM staff induction sessions is generally well received and attended, and noting that LCFS continues to work with SLaM to develop an e-learning package (sections 3.6 to 3.8);

(b) DK confirmed that there were no major new issues to report;

(c) RC noted that there was an apparently large number of old cases that remained open (section 5.4). DK advised that once cases were with the Police or the Crown Prosecution Service they could take a long time to finalise. RC noted several cases with Human Resources where disciplinary action was still awaited after several months (cases 5763, 5784, 5802 and 5803 opened in May/June 2013); and

(d) after due discussion the AC noted the agenda item.

11.2.2 Action/(timescale). RC will discuss with Human Resources the reasons for apparent delays in closing counter fraud cases passed to them for resolution (Oct.13).

12. RISK MANAGEMENT AND FINANCE

12.1 Report from Director of Finance on items 12.2 onwards

12.1.1 ND reported as appropriate within agenda items 12.2 to 12.5 below. ND also reported that whilst the dispensation to exclude charitable funds from consolidation ended on 31 March 2013, it still remained unclear whether consolidation was now required. After due discussion the AC noted this.

12.2 Briefing note: response to issues raised in external audit reports

12.2.1 ND reported that he had issued a briefing note on this subject to the Board, confirming that SLIAM was now complying with Monitor’s requirements on calculating performance indicators, or had appropriate approval from Monitor for any alternative calculation methods adopted. ND advised that a review performed by Grant Thornton had confirmed the foregoing, and that the rules for calculating performance indicators were not clear-cut but involved some interpretation. After due discussion the AC noted the agenda item.

12.3 Risk Management and Assurance Strategy (‘RMAS’): review updated document

12.3.1 JG presented this report, and in particular:

(a) JG flagged the key changes to the RMAS noted on AC agenda pages 63 to 65;

(b) in particular JG reported that: ‘the Trust will revert to maintaining a high level Assurance Framework comprising a dozen or so strategic risks, underpinned by a Corporate Risk Log comprising the principal active and inherent operational risks that could threaten the achievement of the Trust’s objectives. The Assurance Framework will be reported to the Board and its sub committees in a simple, summary format, with full details reported in only exceptional circumstances’;

(c) JG advised that the SQISC would review clinical entries on the assurance framework, and the AC would review any other entries;

(d) ND explained the reason for including a further colour-code (purple) to report the level of progress in addressing risks identified (RMAS page 5 of 45);

(e) SK queried why, in the table set out on RMAS page 22 of 45, the Education and Training Committee appeared as a risk management committee rather than a committee considering delivery (the table is headed ‘Risk Management Committees’). JG explained that the heading of the table was misleading: the table did not seek to show reporting lines between committees, but sought to clarify which committees (such as the Education and Training Committee) provided input to the risk reports reviewed by other committees and by the Board; and

(f) after due discussion the AC noted the agenda item, agreed the changes proposed to the RMAS and noted that the table set out on RMAS page 22 of 45 should be clarified.

12.4 Corporate Risk Log report (and ND’s verbal report re Assurance Framework)

12.4.1 ND presented the Corporate Risk Log, and:

(a) ND explained that overperformance was the root cause of the key high (red) risks flagged by the Corporate Risk Log in many areas. ND reported that overperformance had been identified during planning as a major issue for the NHS in London generally, and SLIAM had allowed a contingency of 5% which seemed adequate at the time. ND reported that the current actual level of overperformance for SLIAM and the NHS in London was some 15%, and that this had been flagged to the Board in May
2013 as soon as it was apparent that it was not a one off anomaly. ND reported that the Board’s response in May 2013 had been to review quality of care and examine alternative approaches;

(b) JG reported that the intended response to major risks being reflected in the Corporate Risk Log was for the relevant risk owners to attend and explain to the relevant group (Board, Executive or committee) the action being taken to address those risks. JG reported that this could be difficult depending on the timing of risk inception and the relevant meetings. ND reported that a key factor affecting the nature and depth of the Executive’s review of an issue was the number of areas for which that issue was a root cause of high (red) risks; and

(c) after due discussion the AC noted the Corporate Risk Log report and the Assurance Framework report.

12.4.2 Action/(timescale). ND and JG will explain to the AC how the Board and the Executive respond to key risks flagged to the Board and the Executive through the risk management system, and how lasting changes in behaviour are promoted (Dec.13).

12.4.3 Action/(timescale). RC and ST will discuss how to ensure that the relevant risk owners attend the AC meeting to explain the up to date position on corrective actions responding to major risks, including those risks arising shortly before an AC meeting (Oct.13).

12.5 Signed and sealed documents, SFI breaches and STAs

12.5.1 ND presented the ‘signed and sealed’ report, the ‘single quote/tender action submissions (‘STA’)’ report, and the ‘breaches of Standing Financial Instructions (‘SFIs’)’ report. RC noted that several relatively minor SFI breaches were reported. ND reported that this was not unexpected, because over the past couple of months a higher number of tender waivers had been approved in order to allow key projects to proceed. ND also considered that there was some benefit in reporting small SFI breaches, because this might reveal trends indicating more serious issues. After due discussion the AC noted the agenda item and approved the proposal that the signed and sealed report be appended to the draft minutes of the AC meeting when these are taken to the Board of Directors for information.

13. AC-RELATED MATTERS

13.1 AC workplan for the year ahead

13.1.1 ST presented the workplan. After due discussion the AC approved the workplan, subject to any updating required to reflect points raised in the meeting.

14. CPD NEEDS, ESCALATION OF MATTERS TO THE BOARD AND ANY OTHER BUSINESS

14.1 After due discussion the AC concluded that all agenda items and supporting agenda papers had received due consideration, that no significant training (Continued Professional Development – ‘CPD’) needs had been identified for AC members, and that (except where otherwise noted in these minutes) no matters required escalation for the attention of the Board. There being no further AC business, RC closed the meeting.

15. DATE OF NEXT MEETING

15.1 The next quarterly meeting will be held on Tuesday 17th December 2013 from 10:45 to 12:45 in the Boardroom, Maudsley Hospital.

ACTION POINT (‘AP’) LIST

Refer overpage
### ACTION POINT (‘AP’) LIST

Excluded from the AP list below are actions previously agreed by the AC as completed and actions agreed by the AC Chair as completed.

<table>
<thead>
<tr>
<th>Date arising</th>
<th>AC action point</th>
<th>Action lead</th>
<th>Date to complete</th>
<th>Notes/evidence that completed (or ref to relevant agenda item)</th>
<th>AC Chair sign off</th>
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<tr>
<td>10.09.13</td>
<td>10.1.3 Internal audit will amend their workplan so that future work on CIP performance will critically review outcomes and will include benchmarking, rather than focusing on controls and processes</td>
<td>KL, NM</td>
<td>Dec.13</td>
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<td>10.09.13</td>
<td>10.1.5 RC will informally recommend that the Board reviews its key committees, and the officers whose attendance is required to ensure the meetings of these key committees are fully effective. The purpose of the Board’s review is to maximise the attendances of these officers at these meetings and hence maximise the efficiency and effectiveness of these key committees</td>
<td>RC</td>
<td>Oct.13</td>
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<td>10.09.13</td>
<td>10.1.7 RC will formally recommend that the Board takes steps to: (a) encourage, and enforce, full attendance at mandatory training (this includes disciplinary action where appropriate); and (b) re-assess the categorisation of training as ‘mandatory’</td>
<td>RC</td>
<td>Oct.13</td>
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<td>10.09.13</td>
<td>11.2.2 RC will discuss with Human Resources the reasons for apparent delays in closing counter fraud cases passed to them for resolution</td>
<td>RC</td>
<td>Oct.13</td>
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<td>10.09.13</td>
<td>12.4.2 ND and JG will explain to the AC how the Board and the Executive respond to key risks flagged to the Board and the Executive through the risk management system, and how lasting changes in behaviour are promoted</td>
<td>ND, JG</td>
<td>Dec.13</td>
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<td>10.09.13</td>
<td>12.4.3 RC and ST will discuss how to ensure that the relevant risk owners attend the AC meeting to explain the up to date position on corrective actions responding to major risks, including those risks arising shortly before an AC meeting</td>
<td>RC, ST</td>
<td>Oct.13</td>
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**Note.** The table seeks to help AC members monitor and control key actions arising at AC meetings, and so does not necessarily list all points of detail such as drafting points. Attendees are expected also to make their own notes of action points affecting their areas of responsibility.
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<th>Number</th>
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<td>Lease in respect of car parking at the rear of 151-152 Blackfriars Road, London SE1 (1 copy)</td>
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