Appendix 1

OD Strategy at SLaM

Louise Hall
What was this all about?

• We pulled together a group who were passionate about Organisational Development but who could also represent their CAG/business area/Service users in their comments and feedback.

• We recognise that this is not about creating a glossy brochure but identifying what OD means to us, what it consists of and developing a framework to then assess ourselves against in terms of strengths and gaps.

• The first part of this shows the outcome of our discussion and brainstorming and the second part shows what we recommend as a framework.

• The next stage would be to ensure that all key stakeholders are happy with our thinking, then assess where the gaps are and build any action into the People Plans corporately and locally.
Part Two of Our OD Strategy

WHAT WE ARE THINKING...
South London and Maudsley NHS Foundation Trust

How it feels to work here

Values and behaviours
Role modelling

Talent management

Staff survey

Organisational Strategy
Supporting structures and processes
Engagement
Leadership
Culture

SLaM Structure
Succession planning
Appraisals and PDPs
Business strategy
OD Strategy

CULTURE
OD Strategy - Culture

- What it means to work at SLaM
- What makes us proud to work here
- Sharing experience, stories and learning
- How we are treated (5 commitments)
- What makes us go the extra mile
- How we are valued; a focus on positives and learning rather than blame
- What opportunities we have to grow and develop
- Seeing, feeling, hearing the same wherever in our structure you sit
- The same innate and espoused values throughout SLaM
- First and consistent impressions in each and every site and interaction
- Patient centred...the reason we are all here
LEADERSHIP

OD Strategy
OD Strategy - Leadership Components

- Clear and shared values
- Clear and shared vision
- Clear and shared expectations
- Walking the walk
- Direction and business strategy delivery
- Confidence in the top team
- CAG tripartite leadership
- Manager capability and style
- Coaching culture
- Emotional intelligence
- Listening then acting on feedback
Suggested Leadership Development Approach

NOTE:
Barbara Grey to review what we have already
-To identify gaps and to pull together a consistent
-Programme that will be used

Learning to Inspire for senior managers or those who need to influence widely

Learning to Lead for middle and more established managers and team leaders

Learning to Manage for new managers

Three levels of development, with a Discovery Centre at the start of each to do assessment for development.
OD Strategy

ENGAGEMENT
OD Strategy – Engagement Components

- Staff survey and OHI
- Communications strategy across teams
- Listening to our people and acting on it
- Team data ie PEDIC
- Health and wellbeing
- Role modelling good practice
- Performance development and assessment, feedback including 360 degree and appraisals
- Management style and leadership
- Opportunity and development
- Staffside, service users and Council of Governors engagement
OD Strategy

SUPPORTING SYSTEMS AND PROCESSES
OD Strategy – Supporting Systems and Processes as enablers or inhibitors

- Career development
- Leadership development
- Recruitment by values
- Communications mechanisms
- Reward and recognition
- Performance management and enhancement
- Staff survey and checks and balances
- Quality processes
- Management Information
OD Strategy

ORGANISATIONAL STRATEGY
OD Strategy –
The Organisational Strategy

• A shared and owned business strategy for all to see
• Consistent and transparent decision making
• Mutual expectations across CAGs, Directorates, roles and functions
• Clear core ways of working aligned
• Embracing diversity
• Clear direction for the future
• Strong and trusted leadership to deliver success
• Future skills required identified and developed/procured
• Workforce plan identified
• Succession planning used
• Talent management used
OD Strategy

- Strategy – to determine the direction
- Structure – to determine the location of decision making
- Processes – to optimise information flow, systems and use of technology
- Rewards – reward systems to influence motivation of people to perform and address our goals, values and culture
- Policies – Human Resources policies to influence and define employee mind-sets and skills
**TRUST BOARD OF DIRECTORS – SUMMARY REPORT**

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

**Name of Report:** Review of Statutory and Mandatory Training

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

**Author:** Louise Hall

**Approved by:** (name of Exec Member) Dr Matthew Patrick

**Presented by:** Louise Hall

**Purpose of the report:** To provide the Trust Board of Directors with a review of the statutory mandatory training provided at SLaM, to confirm what steps are currently undertaken to ensure compliance and to propose a way forward

**Action required:** To note the report and to confirm the preferred option for development.

**Recommendations to the Board:** That the Board note the report and confirm their preferred option to be developed

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

**Summary of Financial and Legal Implications:**

**Equality & Diversity and Public & Patient Involvement Implications:**
Review of Statutory and Mandatory Training at SLaM

The Board of Directors requested that a review of the mandatory training that is provided at SLaM be undertaken, in order to identify if this training was genuinely mandatory as this is a key way that the Trust mitigates its clinical and quality risks from an Internal Audit perspective.

The second aspect of this request was to establish how we ensure that mandatory training was attended and non attendance followed up.

Finally it was requested that the overall training approach be considered in order to establish how else it might be done.

As a further consequence of this review, Corporate Induction could be revised but this is not addressed here as it will depend on the decision made as to the preferred option.

The purpose of this paper is to provide the Board with three options for the way forward in terms of the approach mandatory training and to ask for support for the chosen option.

Background

The training department currently provides the majority of the Mandatory training courses with the exception of ILS & Fire, although there are development plans to bring this internally by the end of 2014.

E & T have invested over the last 5 years to ensure that the courses use a variety of teaching methods including simulation, role play, videos (with hired professional actors etc), case studies – which include near misses and incidents, quizzes, group and individual exercises, PowerPoint, competency assessments and participant debates. They also offer a team training option for each of the face to face mandatory courses.

Some of the feedback for courses is exceptional ie BLS, PSTS team training and clinical risk training, although there is definite room for improvement in some others i.e. Infection control DVD.

The training compliance and monitoring processes were viewed as very rigorous and highly recommended by NHSLA as an example for other trusts to use and this assisted with achieving Level 3 status. We also receive positive feedback from CQC and Safeguarding Boards, who view the training as a ‘gold standard’.

There are however also issues with the location of the training centre being based at the Bethlem as this in itself acts as a disincentive for people attending training.
Mandatory Training – is it really mandatory?

We have three tiers of training;

**TIER 1:** Statutory and Mandatory training

**TIER 2:** Training Highly Recommended for Specific Groups of staff

**TIER 3:** Individual Professional Development

The only genuinely statutory training in our portfolio is Fire Training.

The scope of mandatory training is driven predominantly by statutory obligation, the NHS Litigation Authority minimum data set (MDS) for training (Appendix 1) and interpretation of Care Quality Commission standards. This in turn is reflected in the Monitor approval process. The NHS Litigation Authority (NHSLA) has set a target of 95% compliance for the MDS.

Some of our training is dictated by the NHSLA is to reduce our premiums and risk but it may be worth considering if the reduction justifies the additional time and resource cover to do this.\(^1\)

Whilst there are currently numerous courses in Tier 1, we prioritise the following five courses as *core mandatory training* which are the courses where compliance is reported at higher levels i.e. CQC/Safeguarding Boards/ CCGs/CEOPMR.

These five courses are:

- Fire Safety Awareness
- Infection Control
- Safeguarding Adults
- Safeguarding Children (Levels 1, 2 & 3)
- Promoting Safe & Therapeutic Services – PSTS Awareness, PSTS disengagement & PSTS Teamwork courses.

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\(^1\) The NHSLA levels result in discounts in premiums by 10%, 20% and 30% by level. However the Mandatory Training achievement is only one factor in the risk level assessment. It is also understood that NHSLA will remove these bandings and factors from March 2014 and will introduce a “Safety and Learning Service” instead.
How do we ensure that mandatory training is attended and non-attendance is followed up?

The first thing to do is to ensure that people only attend the required mandatory training for their role. There then needs to be a strong control on its attendance and repercussions if it is not. Making it as relevant and interesting for staff to be able to perform their role effectively and creating a “pull” will also help.

It should be noted that the requirement for all new staff to attend induction and to attend the majority of their mandatory training in the first week has also had a major impact on compliance levels, which were previously much lower but there are opportunities to consider an annual team-based mandatory update of a day for example, followed by a two or three yearly update for the other areas.²

The introduction of “Wired” will help with real time information being available and will make it easier for non-attendance to be followed up but it is still in the implementation phase and some work needs to be completed to make sure that staff are allocated to the correct areas in order to get accurate figures about attendance. This work is in progress.

The CQC and Monitor as well as other regulatory bodies are justifiably keen to ensure that we do prioritise our mandatory training for staff and we are doing the above to make sure this happens.

However, poor roster disciplines, high vacancy rates, high absence and poor general planning all combine to prevent staff being released or prioritising the training so these related issues will need to be addressed irrespective of which option we select as the way forward.

The NHS streamlining project will review the core mandatory training that we need to deliver and also ensure that staff are only expected to repeat training when it is due and not just when they change jobs. This will have some impact on frustration levels at being asked to repeat training as soon as someone moves between NHS organisations. We do currently map previous training based on the use of the pan London “passport” but the streamlining proposal extends this and will need tighter controls.

² The onboarding and induction review would need to ensure this advantage is not lost.
The E & T department also has robust measures in place to monitor compliance with the CAGs and this is done through:

- Monthly reporting and Quarterly compliance reports.
- Local E & T Committees
- Mandatory Training Log Committee (MTLC), which is the main forum for addressing problem areas and identifying an action plan to improve compliance
- Trust wide E & T Committee – MTLC reports directly to this
- CEOPMR – compliance under 50% has to be escalated to CEOPMR

If the CAG or directorate have not hit the target attendance, they receive up to three “warnings” and continued failure to ensure compliance may impact on the CPD budget being removed from the business area, based on the earned autonomy model.

**How do we make what training we do have interesting and attractive?**

The e-learning training modules that we have are provided for the large part by the National Skills Academy packages. These were established as the most cost effective, compliant and consistent way of delivering mandatory training to our staff.

In addition, we use professional trainers, subject matter experts and clinical staff to deliver face to face courses. Some courses interchange between face to face and e-learning for example Fire Training which is done annually, one year face to face, one year by e-learning.

The feedback that we receive for these courses is mixed but generally they are seen as too long, too generic and not always very interesting or relevant. We may want to avoid increasing the number of courses we have by not creating a separate course for each audience but then we have to accept that there will be some irrelevant content for some groups.

If we wish to stop using the NHS approved courses and to create our own suite of courses, we would need to consider the funding, evaluation and approval by key bodies as part of this decision as this could also potentially go against the Cores Skills Framework. This Framework will be used across London as part of the streamlining project.

There is an opportunity to make our training the best it could be, using electronic simulations, role plays with professional actors, interactive sessions which are done on line in the same way as some multi platform gaming is done such as Call of Duty, however by doing this we would be the first in the NHS to do so and it is potentially cost-prohibitive.

We are also aware that there are some gaps where we have the opportunity to use our in house e-learning team to develop a new package or to look outside and more creatively at what is available or able to be built, subject to the above.
Maudsley Learning would be keen to work with a third party to develop the material for any radical overall in the context of operating closely with SLaM. Although there is no output material to assess and compare with yet, we may want to consider giving them the opportunity to develop something that could then be used to be a commercial proposition elsewhere for them.

We also need to be aware that a number of the things that Maudsley Learning could manage for us are also provided in-house by our own teams and we need to be careful about increasing costs or duplicating services.

We should also review our trainers and approaches used to review who we use, how they deliver training and how effective they are at delivering the learning outcomes. One of the most effective ways of delivering training is to attendees who have a vested interest in being competent in the subject and when real life examples and scenarios are used. Stories, near miss examples, when things really went wrong and subsequent delegate debates about these are very powerful.

We may wish to consider how much we do this and how well as although we have a quality assurance process that has been previously used, this could be re-launched to focus on peer review, quality and impact as this approach has not been used for two years now.

It should also be noted that we also have the SUITE Team (Service Users Involvement on Training and education); this consists of about 30 Service users who facilitate and co-deliver on courses. The SU’s also playing a role in the design and evaluation of courses to ensure that we try to capture the SU perspective. We also have 2 Service user Apprentices in a training role which have just started and will run for one year.
Options

There are a number of different interpretations of the following combinations but I have focused on the three that I believe it is worth comparing.

**Option 1** is that we keep the Mandatory Training levels as they are, using the same providers and ways of delivering the material but focus heavily on compliance, including the use of disciplinary action when attendance does not occur.

**Option 2** is that we define our Training Needs to establish what we actually need to ensure compliance and risk is managed.

We then reduce the mandatory training in line with the Core Skills Framework minimum standards rather than the “gold standard” we currently require and allow the Directorates to agree what is appropriate for their areas beyond this. Every role would have an individual training plan, both mandatory, role specific and for continuous professional development (CPD) that would ensure the right training is delivered to individuals rather than by default. This could be achieved via an electronic “passport” that would then be used for inter-role movement across London and potentially nationally.

We reduce the training time required and categorise this as annual or three yearly.

We then only use e-learning for when we are providing information on a process or system but not for when the subject matter is really fundamental to the health and well being of our staff and service users. In all other cases we use a “blended” approach to fit the training method to the subject matter.

We focus on the content and delivery of our face to face training and make sure this is the best it can be and the time that is required to deliver is reviewed so a default time is not applied but some sessions may be manageable in 30/45/60/120 minute sessions for example. Technology could be used for some reminder delivery and ongoing assessment.

GSTT have offered to deliver some training jointly on a trial basis and even to operate a combined Education and Training delivery function. Whilst this may be something worth considering in the long term, it needs to be factored in that the Acute requirements are not consistently in line with the Mental Health requirements for content and depth of some training areas.

Finally, we ensure compliance via a combination of methods including ongoing evaluation methods, more e-learning and a greater focus on team learning, which we already offer to some extent. There would be repercussions in terms of fitness to practice if these assessments or training modules are not successfully achieved. It is hoped that fewer mandatory courses, delivered in a more targeted and interesting way would also help staff want to attend.
**Option 3** is that we radically overhaul all of our training content to be a mixture of highly interactive and simulation training, with a mix of on-line and face to face or team training. This would be combined with a combination of continuous assessment, via hand held devices or delivered via smart phones.

**Pros and cons of each option:**

<table>
<thead>
<tr>
<th>Option</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Greater compliance</td>
<td>Greater compliance levels&lt;br&gt;Least disruption to current processes, systems, controls, teams, content</td>
<td>Current approach not working well&lt;br&gt;Compliance levels a symptom of other issues&lt;br&gt;“Stick” approach not always the most effective</td>
</tr>
<tr>
<td>2 – Tailored, managed, more interesting, blended</td>
<td>Aligns with the approach used by KHP/GSTT&lt;br&gt;More appropriate and mapped personalised training, linked to roles&lt;br&gt;Training is more interesting and welcomed rather than resented&lt;br&gt;Behaviours changed more effectively&lt;br&gt;Sharing of ideas, best practice and experiences across delegates&lt;br&gt;Duration of courses is reviewed and reduced&lt;br&gt;Regularity of delivery is potentially reviewed and reduced&lt;br&gt;Supported by regulators and in line with CSF plans</td>
<td>Impact to existing teams, course content, processes&lt;br&gt;Impact to Wired, which is not fully implemented but this would need a change in structure (Note GSTT are using Wired for their model and it is working well)&lt;br&gt;Need to increase training delivery resources (clinical)&lt;br&gt;Time to undertake this change and transition period of potential confusion</td>
</tr>
</tbody>
</table>
| 3 – Radical overhaul | Leading edge, best practice approach to training | Significant and possibly prohibitive cost to develop at this stage  
Requirement on IT infrastructure  
Requirement for technology by staff or available in wards or centres  
May not suit everyone  
May result in a hybrid of traditional training and interactive  
More untested results so regulators not as clear on outcomes  
Time to develop |
Recommendation

It is suggested that the Board consider the second option as the one which will increase compliance, reduce overall training days lost and provide a more tailored and interesting training programme for staff. However we could additionally focus more on team training and the use of some more modern technology for assessments.

Key training should be face to face wherever possible but the content of these sessions should be focused, appropriate and relevant to the role. Any reduction in training attended will be in creating personalised training plans and the use of focused annual and three yearly team updates rather than increasing e-learning across the board. E-learning should be used for information giving modules.

We should do a full training evaluation in order to establish what is currently working well and where we receive poorer feedback. We do receive some extremely positive feedback on some courses so we should assess what makes them great and replicate this.

Our policies will need to change in some areas where training is currently dictated to be “mandatory”. Some courses may subsequently move from Tier 1 to Tier 2.

Although using the Core Skills Framework will increase the Trust’s Core training to include Equality & Diversity training, there is scope to review the other courses that do not fall within the CSF to move some courses into Tier 2 category.

Working with CAGs to identify target groups is key to this process and I would suggest that we identify the following categories for mandatory training:

- Core Mandatory Courses – defined by CSF – for all staff groups – no exceptions to rules (i.e. medical staff)
- Role Specific Mandatory Training
- CAG specific Mandatory training

Induction

It is then recommended that the Corporate induction\(^3\) be revised to be a 1.5-2 day introduction to SLaM, followed by a tailored and shortened programme for new joiners to ensure they are fit to operate safely in their roles as is done in other Foundation Trusts who require similar focus to us on PSTS. This would be a shorter induction for non-clinical staff and 2 days for clinical staff.

The induction would then be run more regularly, which would avoid the significant numbers attending and frustration of only allowing staff to join at one time of the month.

\(^3\) The current programme is shown in Appendix 2.
Appendix 1 - Training Needs Analysis (TNA) Minimum Data Set

Standard 1
• Health Record-Keeping Training (criterion 1.8)

Standard 2
• Investigation of Incidents, Complaints & Claims Training (criterion 2.5)

Standard 3
• Risk Awareness Training for Senior Management (3.6)
• Moving & Handling Training (criterion 3.7)
• Harassment & Bullying Training (criterion 3.8)

Standard 4
• Violence & Aggression Training (criterion 4.2)
• Slips, Trips & Falls Training (Staff & Others) (criterion 4.3)
• Slips, Trips & Falls Training (Patients) (criterion 4.4)
• Hand Hygiene Training (criterion 4.6)
• Inoculation Incident Training (criterion 4.7)

Standard 5 – n/a

Standard 6 – Organisations providing MH & LD services
• Clinical Supervision Training (criterion 6.1)
• Clinical Risk Assessment Training (criterion 6.3)
• Observation of Patients Training (criterion 6.5)
• Dual Diagnosis (Mental Health & Substance Misuse) Training (criterion 6.6)
• Rapid Tranquilisation Training (criterion 6.7)
• Medicines Management Training (criterion 6.9)

The following courses would move from Tier 1 to Tier 2 if we adopt the CSF guidance:
- Observation and engagement of patients
- Medicines Management
- Clinical Supervision
- Dual Diagnosis (although there is a CQUIN target for this of 80% compliance from target group)
- Practical Guide to Structured Investigations
- Health Record Keeping
- Rapid tranquilisation
Appendix 2 - Corporate Induction Programme - 5-day programme: days 1, 2 & 3 for all staff, day 4 & 5 for all clinical staff

Day 1: All Staff

<table>
<thead>
<tr>
<th>Time</th>
<th>Subject</th>
<th>Venue</th>
<th>Facilitator</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00 – 09.15</td>
<td>Registration</td>
<td>Lecture Hall</td>
<td>Demelza Petty</td>
<td>All</td>
</tr>
<tr>
<td>09.15 – 10.00</td>
<td>Welcome to Trust</td>
<td>Lecture Hall</td>
<td>Gus Heafield</td>
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<tr>
<td>10.00 – 10.30</td>
<td>HR Business Partners</td>
<td>Lecture Hall</td>
<td>HR Business Partners</td>
<td>All</td>
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<tr>
<td>10.30 – 10.45</td>
<td>Tea Break</td>
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</tr>
<tr>
<td>10.45 – 12.15</td>
<td>Group 2: Combating Stigma &amp; Promoting Social Inclusion</td>
<td>Room 1</td>
<td>Suite Team</td>
<td>Group 2</td>
</tr>
<tr>
<td></td>
<td>Group 1: Human Resources/Sign in including Infection Control DVD</td>
<td>Lecture Hall</td>
<td>HR</td>
<td>Group 1</td>
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<tr>
<td>12.15 – 13.15</td>
<td>Lunch</td>
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<tr>
<td>13.15 – 14.45</td>
<td>Group 2: Human Resources/Sign in including Infection Control DVD</td>
<td>Lecture Hall</td>
<td>HR</td>
<td>Group 2</td>
</tr>
<tr>
<td></td>
<td>Group 1: Combating Stigma &amp; Promoting Social Inclusion</td>
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<td>Suite Team</td>
<td>Group 1</td>
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<tr>
<td>14.45 – 15.00</td>
<td>Tea Break</td>
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<tr>
<td>15.00 – 16.30</td>
<td>PSTS Awareness (all staff)</td>
<td>Lecture Hall</td>
<td>PSTS Team</td>
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## Day 2: All Staff

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<tr>
<td>09.00 – 12.15</td>
<td>Group 1: Safeguarding Children Level 1 &amp; 2</td>
<td>Lecture Hall</td>
<td>Safeguarding Team</td>
<td>Group 1</td>
</tr>
<tr>
<td></td>
<td>Includes tea break at 10.30 – 10.45</td>
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<tr>
<td>10.30 – 10.45</td>
<td><strong>Tea Break</strong></td>
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<td></td>
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<tr>
<td>09.00 – 10.30</td>
<td>Group 2: Moving &amp; Handling Awareness</td>
<td>Room 1</td>
<td>Mark Wattley</td>
<td>Group 2</td>
</tr>
<tr>
<td>10.45 – 12.15</td>
<td>Group 2: Data Protection</td>
<td>Room 1</td>
<td>Ben Tunmore</td>
<td>Group 2</td>
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<tr>
<td>12.15 – 12.45</td>
<td><strong>Market Stalls</strong></td>
<td>Room 3</td>
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Day 3 All Staff

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<td>Lecture Hall</td>
<td>Demelza Petty</td>
<td>All</td>
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<td>09.15 – 10.15</td>
<td>Health &amp; Safety Awareness</td>
<td>Lecture Hall</td>
<td>Anne Varham</td>
<td>All</td>
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<td>Diversity &amp; Equality</td>
<td>Lecture Hall</td>
<td>Esther Craddock</td>
<td>All</td>
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<tr>
<td>11.00 – 12.30</td>
<td>Group 1: Safeguarding Adults</td>
<td>Lecture Hall</td>
<td>Esther Craddock</td>
<td>Group 1</td>
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<td>11.00 – 12.30</td>
<td>Group 2: Fire Training</td>
<td>Room 1</td>
<td>Mark Bond</td>
<td>Group 2</td>
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<td>12:30 – 13:30</td>
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<td>Room 1</td>
<td>Mark Bond</td>
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<tr>
<td>15.15 – 16.00</td>
<td>Service User Perspective</td>
<td>Lecture Hall</td>
<td>Suite Team</td>
<td>All</td>
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<td>16.00 – 16.45</td>
<td>Complaints and Service Improvement</td>
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<td>Complaints Team</td>
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</tbody>
</table>
Day 4: All clinical staff (Allied Health Professions / Qualified Nurses / Health Care Assistants / Support Workers)

<table>
<thead>
<tr>
<th>Time</th>
<th>Subject</th>
<th>Room/Facilitator</th>
<th>Time</th>
<th>Subject</th>
<th>Room/Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.15 – 11.00</td>
<td>PSTS Disengagement Skills</td>
<td>PSTS Team Lecture Hall</td>
<td>09.15 – 11.00</td>
<td>Clinical Risk Workshop</td>
<td>David Gray Room 1</td>
</tr>
<tr>
<td>11.00 – 11.15</td>
<td>Tea Break</td>
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<td>11.00 – 11.15</td>
<td>Tea Break</td>
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<tr>
<td>11.15 – 12.30</td>
<td>PSTS Disengagement Skills</td>
<td></td>
<td>11.15 – 12.30</td>
<td>Clinical Risk Workshop</td>
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<tr>
<td>13.30 – 15.00</td>
<td>PSTS Disengagement Skills</td>
<td></td>
<td>13.30 – 15.00</td>
<td>Clinical Risk Workshop</td>
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<td>15.00 – 15.15</td>
<td>Tea Break</td>
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<td>15.00 – 15.15</td>
<td>Tea Break</td>
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</tr>
<tr>
<td>15.15 – 16.30</td>
<td>PSTS Disengagement Skills</td>
<td></td>
<td>15.15 – 16.30</td>
<td>Clinical Risk Workshop</td>
<td></td>
</tr>
</tbody>
</table>
Day 5: All clinical staff (Allied Health Professions / Qualified Nurses / Health Care Assistants / Support Workers)

### Medical staff / Qualified Nurses & AHPs

<table>
<thead>
<tr>
<th>Time</th>
<th>Subject</th>
<th>Room/Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.15 – 12.15</td>
<td>Group 1: Basic Life Support</td>
<td>Lecture Hall</td>
</tr>
</tbody>
</table>
| 09.15 – 10.45 | Group 2: Promoting Recovery Orientated Practice | Mark Dalgarno & Suite Team  
                          Room 1                                    |
| 10.45 – 11.00 | Tea Break                                   |                                       |
| 11.00 – 12.15 | Group 2: Mental Health Act                 | Bob Lepper 
                          Room 1                                    |
| 12.15 – 13.15 | Lunch                                       |                                       |
| 13.15 – 16.15 | Group 2: Basic Life Support                 | Lecture Hall                          |
| 13.15 – 14.45 | Group 1: Promoting Recovery Orientated Practice | Mark Dalgarno & Suite Team  
                          Room 1                                    |
| 14.45 – 15.00 | Tea Break                                   |                                       |
| 15.00 – 16.15 | Group 1: Mental Health Act                 | Bob Lepper 
                          Room 1                                    |

Week 2: Inpatient Nursing staff complete 5-day PSTS Awareness course (Bethlem Community Centre)
TRUST BOARD - SUMMARY REPORT

Date of Board meeting: 17th December 2013

Name of Report: Chief Executive’s report

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

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

December 2013

1. Introduction

I am writing this report towards the end of my second month in the Trust, happily now counting in months not weeks! I was pleased to hold the first of my "Meet the Chief Executive" session with Madeliene at the Maudsley hospital last week. It was well attended and we had a lively discussion. I intend to have similar sessions at the other main sites early in 2014. I have also made a number of service visits over the past weeks and will be continuing these, with the Chair where possible, to enable us to see at first hand a wide range of the services we provide.

2. National issues

Pressure on services
With the winter period approaching there is concern that the NHS will be placed under severe pressure over the coming months. Whilst this will be felt most intensely in the acute hospitals there is a growing pressure on mental health services. Staff at SLaM are well aware of this as the use of private sector facilities is reaching unprecedented levels but this is not unique to SLaM as mental health services across the country are being equally stretched.

Francis report
The government has made its final response to the Francis report and has confirmed that it will implement the vast majority of the recommendations. One of the overwhelming messages of the report is that the ‘culture’ within Trusts needs to change. Too often the system makes it easier to comply with poor care, rather than challenging it.

All Trusts and FTs are expected to carefully consider the Francis report and its recommendations and produce a response which is right for the organisation. A response which is agreed by the Trust Board is expected both by our regulators and commissioners.

The SLaM Francis Working Group has been tasked to develop an organisational response to the Francis Report, and draft a proposal. It is acknowledged that SLaM is in a period of transition and the plan may need to be adapted. Nevertheless progress can be made in developing a coherent approach to the provision and development of quality patient centred care, within available financial resources.

London Health Commission
The Mayor of London, Boris Johnson, recently announced that Lord Darzi will chair the London Health Commission, an independent inquiry set up to review health and healthcare in the capital. Lord Darzi will oversee a plan that will not just look at healthcare provision but also examine what impacts the health and wellbeing of Londoners. The Commission will undertake an ambitious programme of work over the next year before reporting back to the Mayor with a set of recommendations in the autumn 2014.
Lord Darzi will be supported by an experienced team from across London and beyond to sit on the wider Commission and chair expert groups to look at the four main themes of the review. The themes are; improving the quality and integration of care; enabling high quality and integrated care delivery; healthy lives and reducing health inequalities; and health economy, research and education. I have been invited to join and will represent both mental health and mental health providers.

The first role of the Commission will be to conduct an evidence-based investigation into healthcare provision and resources for Londoners. The Call for Evidence is now underway and will close in the New Year.

2. Trust issues

Channel 4 Broadcast
The Bedlam series has come to an end. We have been overwhelmed by the support, feedback and comments from patients, staff and members of the public.

The series has been a phenomenal success and some of that has been evident through the conversations which have been sparked on social media sites. When agreeing to take part in this series we wanted to improve understanding of mental illness, increase awareness and help to destigmatise. From the reaction so far we have gone some way to achieving that.

#Bedlam has trended on Twitter during each episode which means it was one of the most talked about subjects at that time. During the second episode, Crisis, it potentially reached a staggering 21million people on Twitter. We have certainly never seen so many meaningful and insightful discussions on mental health between a wide range of people.

Bedlam took two years to make and was the product of careful planning and negotiation with staff, stakeholders and patients.

Director of Nursing
We welcome Dr Neil Brimblecombe who has been appointed Director of Nursing at South London and Maudsley NHS Foundation Trust.

Dr Brimblecombe will be joining SLaM in mid December from South Staffordshire and Shropshire Healthcare NHS Foundation Trust where he has been Director of Nursing and Chief Operating Officer for the last three years. He will bring with him a wealth of operational experience from within the NHS and from professional leadership roles at the Department of Health and the National Institute for Mental Health in England.

Monitor Q2 ratings
We have heard from Monitor that their analysis of Q2 is now complete. Based on this work, the Trust’s current ratings are:

- Financial risk rating - 3
- Shadow continuity of services risk rating - 3
- Governance risk rating - GREEN

Care Quality Commission visits
Visits were made to River House, Snowsfield, Jim Burley Unit and John Dickson ward. These were covering compliance and environmental issues. Overall the visits were positive and the Trust has commented on the draft reports.
Closure of neurodevelopmental inpatient unit
The decision has been made to close the neurodevelopment inpatient unit at Bethlem Royal Hospital by 20 December 2013.

The 15 bed unit provides treatment for adults with mild to moderate learning disability as well as forensic and / or challenging behaviour. It is managed by the Behavioural and Developmental Psychiatry CAG.

Having made various changes to the service over the last two years to try and secure its future, the CAG executive team has concluded that it is not possible to continue providing a financially viable, high quality, safe and therapeutic service.

Members of the CAG Executive have met with staff and trade union representatives on the unit to inform them of the closure decision. Following this meeting, the senior management team contacted relatives, GPs and commissioners to discuss the process for arranging alternative placements for each of the 14 patients. Patients themselves will be informed by their care coordinator/named nurse and via the ward community meeting.

Institute of Psychiatry awarded £5m for schizophrenia research
The Institute of Psychiatry (IoP) at King’s College London has been awarded £5m from the Medical Research Council (MRC) to set up a research consortium to advance personalised medicine for schizophrenia.

Led by Professor Shitij Kapur, Dean and Head of School of the IoP at King’s, the project will use neuroimaging and genetic studies to develop objective markers capable of predicting which people will respond to which medications, and ultimately aim to address the current method of prescribing antipsychotic medications.

A large number of patients spend too long on ineffective drugs which impact greatly on their mental health, well-being and quality of life whilst the costs of ineffective treatment is a huge financial burden to the NHS, consuming 25-50% of the total national mental health budget.

4. Chief Executive Performance Management Review

Introduction
A full range of indictors are reviewed with each CAG / directorate, however only those of requiring further discussion are scheduled for CEO PMR Part 2.

Patient Safety
CQC visits
A draft report regarding visits to JBU and John Dickson wards has been received and the Trust will respond as regards factual accuracy. Environment had been the only concern out of six areas reviewed and N Dawe is leading the action planning to address the environmental issues raised.

PAV
Practice assurance visits are under way within the Trust.

Safeguarding training
Achievement against the safeguarding children target of 85% varies across the Trust and ranges between 68% and 97%. It was noted that poor availability of safeguarding training is hindering performance in this area. In the main Safeguarding Adults achievement is
generally good and two CAGs have exceeded the 85% target with 89%. However, at its lowest, achievement is at 72%.

**SUI report**
The meeting noted a report from the SUI office, which raised concerns about the timeliness of investigations. The report outlined by CAG the average time it was taking to complete investigations, the number of breaches so far and some narrative on extensions that have been granted.

**Clinical Effectiveness**

**CQUIN**
The Trust CQUIN lead gave an update on achievement against upcoming Q3 targets such that CAGs can make a final push to the end of December.

**Physical Health CQUINs**
Not all CAGs are achieving consistently against the targets and there are some wild variances in achievement by ward.

**Recovery and Support Plans CQUIN**
The target is not yet agreed, but is likely to be around 50%; current performance hovers around 27% across the Trust.

**EIEO Integrated Discharge Recovery Planning CQUIN**
The current audit shows that 37% of discharges (that have documentation) meet the quality areas.

**NHSE CQUIN (Secure, CAMHS, Eating Disorder and Perinatal Inpatients)**
CAGs were updated regarding Q2 achievement, where the focus is on physical health. On the whole, Q2 targets were achieved.

**Patient Experience CQUIN**
CAGs were reminded that wards should provide evidence and updates regularly to the Trust PPI Lead to ensure that work is underway to achieve the Q4 milestones.

**HR Themed review**
Another themed review took place this month with particular and detailed focus on bank and agency, absenteeism and return to work, use of e-roster, recruitment, turnover and appraisals. HR business partners provided analysis and meetings reviewed this alongside CAGs.

**Appraisals**
CAGs continue to work towards achieving 100% appraisals with performance varying from 73% to 80%. Work is also ongoing to capture ratings information and understanding of performance within appraisals.

**Patient Experience**

**Complaints**
There continues to be good progress regarding outstanding complaints and CAGs have plans in place to address any backlogs. The use of dedicated staff in one CAG is bearing fruit, as is the revision of processes.

**Quality Schedule indicators**
Overall the Trust has achieved 87% against a target of 90% regarding completion of PEDIC surveys. In reality most CAGs have achieved above 90%, but one CAG is reducing overall performance with a score below 30%. CAGs were also reminded that just as important is
that teams identify themes for improvement from survey results, and that they can demonstrate progress made towards making (patient-recognised) improvements.

**Quality Account indicators**

Only one CAG had achieved 90% or more regarding the “Do you feel safe?” question posed in inpatient surveys. For the others, performance ranged between 75% and 89%. Wards must now develop action plans in response to their scores and resubmit PEDIC data in Q4.

Overall the Trust has achieved a score of 75% against a target of 60% regarding the question “Have you been offered a crisis plan for emergency mental health situations?”

**Access**

*Delayed discharge*

Delayed discharge levels were at 5.04%.

**Early interventions**

The Trust continues to over perform against this target.

**HTT**

Current performance stands at 95.35%.

**Education and Training**

Mandatory training levels and action plans to achieve core target levels were reviewed. The Nursing directorate’s new five-day training programme for inpatient staff aimed at reducing violence on wards has begun.

**Finance**

Meetings reviewed the Trust M7 position and progress against CIP and QIPP plans.

5. **Information Governance**

It has been a remarkable year for information governance. I list below the key developments in the Trust and nationally.

The national Information Governance Review led by Dame Fiona Caldicott was completed and the final report with recommendations to the Secretary of State for Health was published in April. The overarching aim of the review was to outline key principles of handling health and social care information in order to strike an appropriate balance between the protection of service users’ personal confidential information, and the use and sharing of such information to improve care.

The Trust was invited to contribute to the review. A number of developments in the Trust, including CRIS as an effective tool for pseudonymisation of clinical information for research, ‘consent for contact’ (C4C) model implemented to improve recruitment to research trials and ‘myhealthlocker’, which provides service users’ online access to their own mental health information were discussed with the review panel. These developments were recognised as innovative applications of information governance principles to enhance service users’ information rights and enable effective, secure and lawful utilisation of clinical information for research. The published report cites these examples of good practice in the Trust.

In September, the Government’s response to the national Caldicott IG Review retained the emphasis on the value of clinical data for research and service improvements in health and social care. The role of information governance was outlined in enabling effective, lawful, confidential and secure use of the wealth of clinical data held by NHS organisations. The
Both national reports were reviewed by the Information Governance Team to update the Trust action plan to ensure continued compliance with good practice standards.

The Trust Information Governance Team has been actively involved in national and regional stakeholder groups in 2013. The team contributed to national consultations that were aimed to develop IG standards to support health and social care services in a challenging period of transition. The Information Governance Community led by London Connect has been working with health and social care organisations across London over the last year to drive improvement and choice of information transparency to share the benefits of online health records and secure information sharing. The Trust has taken a leading role in the group, which published a public guide on information sharing and governance featuring successful case studies of innovative information sharing developments taking place across London, including SLaM's CRIS. The Trust Head of Information Governance and the Caldicott Guardian is continuing to collaborate with the community on consent models to support integrated care pathways, providing clear information to patients about their personal data in health records and how this information is used to improve the treatment and care options available to them.

The National Information Governance Board (NIGB) undertook a number of stakeholder events and roadshows over the last few months of their operation early in 2013 to support smooth transition of the national IG work to the new health and social care landscape. The Trust was invited to contribute to key discussions in stakeholder groups around information sharing and presented recent achievements in the Trust at NIGB roadshows. The Trust continues to contribute to the discussions around consent, confidentiality and secondary uses of clinical information as part of a number of London-wide groups as well as national bodies such as the Confidentiality Advisory Group of the Health Research Authority.

The King’s Health Partners Caldicott Group, which was set up in 2009 led by the Trust has continued to review service developments and research programmes that straddle partner organisations to review implementation plans to ensure their compliance with national information standards. The KHP Caldicott Group published the second version of the King’s Health Partners Information Sharing Policy. The policy is the first shared policy in the AHSC and provides guidelines to ensure that sensitive clinical, education and employment records are shared between constituent partners of KHP and its external partner agencies for the purposes of delivering and improving patient care, teaching, research, audit and protecting the public in a lawful, secure and confidential manner.

Following the publication of the Health and Social Care Information Centre guide to confidentiality, which is the new confidentiality code of practice, the Trust policies on confidentiality and information sharing were reviewed and updated in line with the principles outlined in the national code of practice.

The Trust completed the annual self-assessment of compliance with national information governance requirements and submitted the NHS Information Governance Toolkit for 2012-13 (version 10) in March. The Trust overall score represented 91% compliance with the requirements of the Toolkit by demonstrating Level 3 (highest) compliance with 74% of the standards and Level 2 (satisfactory) compliance with the remainder. The assessment was independently audited with an overall opinion of ‘substantial assurance’. Following the submission of the assessment, an action plan was agreed for the following year. The Trust submitted a mid-year progress update to the Health and Social Care Information Centre in
October to demonstrate the outcome of the work completed as outlined the action plan for 2013-14.

Further details of key developments to maintain the Trust’s compliance with national IG standards, common law duty of confidentiality, Data Protection and Freedom of Information Acts were summarised in the Caldicott and FoI Annual Reports, which were presented to the Trust Executive and the Board.

The key priorities for the Information Governance Team in 2014 will include improvement of capability and expertise for research information governance that aligns with the DH Information Strategy, review of the Trust information governance framework to maximise utilisation of clinical information for holistic healthcare research, including those from medical specialties outside mental health, empowerment of service user and carer experience by improving access to personal health information, and striking the balance between duty of confidentiality and duty to share information for direct provision of care by effective and controlled flows of clinical information within healthcare settings to facilitate seamless care.

Dr Matthew Patrick  
Chief Executive  
December 2013
Date of Board meeting: 17th December 2013

Name of Report: Report from the Council of Governors

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

Author: Paul Mitchell, Trust Secretary

Approved by: Dr Matthew Patrick, Chief Executive

(name of Exec Member) Noel Urwin, Lead Governor, Council of Governors

Presented by: Noel Urwin, Lead Governor, Council of Governors

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. Reports from the Working Groups

1.1 Membership and communications

Plain English
As previously reported, SLaM FT is now subscribing to Plain English.

The initial training day has taken place and was very useful. The course included internet etiquette.

A working group is being established to measure the success of the programme.

Council of Governors elections
Elections for the remaining vacancies (1 carer and 4 service users) have taken place. Alistair Edwards, Tina Lincoln (service users) and Angela Flood (carer) have been elected.

Internal and external induction sessions have been arranged for all the new governors elected in 2013.

Membership discount scheme
The roll out of the service in the Croydon area has not been satisfactory; this is being taken up with the contractor.

1.2 Annual plan development

The Annual Plan and Strategy Group met on 14th October.

The group received a brief update on the annual plan and Monitor’s requirements, then discussed and agreed how the membership engagement events should run and the mechanisms to advertise the events in advance.

Membership engagement events:
During the last two weeks in November the Council of Governors have hosted membership engagement events in the four boroughs. Each event followed the same format, commencing with a welcome from one of the Governors, followed by a brief scene-setting presentation from Zoe Reed. Participants were then asked to consider the question:

What would you like us to prioritise over the next 1-3 years – bearing in mind that we will see a real-time reduction in funding and increased demand for our services?

Each group were then asked to choose their two top priorities and briefly describe them to the room. Having heard all the priorities groups then picked one that they
wanted to do more detailed work on. Some tables chose to work on topics that other groups had suggested, rather than one of their own priorities.

Following the second session a representative from each table presented their ideas to the room and after hearing from all the groups the participants voted for their ‘top’ priority. The following table captures the priorities that were worked on, and the results from each event.

<table>
<thead>
<tr>
<th>Southwark – 18th November</th>
<th>Lewisham – 19th November</th>
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</thead>
<tbody>
<tr>
<td>1. Better care on discharge</td>
<td>*Improved awareness [working with media, GPs, carers groups]</td>
</tr>
<tr>
<td>2. Recovery and choice</td>
<td>*More engagement with Commissioners</td>
</tr>
<tr>
<td>3. Bed crises</td>
<td>*Better use of resources on the Bethlem site</td>
</tr>
<tr>
<td>4. Improved crises services</td>
<td>*results of the voting to be confirmed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lambeth – 25th November</th>
<th>Croydon – 28th November</th>
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</thead>
<tbody>
<tr>
<td>1. Current services to be evaluated and the good ones developed further</td>
<td>1. Greater integration of services between staff at all levels</td>
</tr>
<tr>
<td>2. Training for GPs</td>
<td>2. Training for carers</td>
</tr>
<tr>
<td>3. *Offering more counselling services to in-patients</td>
<td>3. Empowering staff</td>
</tr>
<tr>
<td>*tied for third place</td>
<td></td>
</tr>
</tbody>
</table>

The material generated by participants will be written up and the Council of Governors Planning group will then meet to review the content and the learning from the events. A brief report summarising the events will be produced and distributed to all the attendees.

1.3 Quality
The Quality Group met on Tuesday, 5th November 2013.

The group reviewed the actions from the previous meeting and then focused on the planning and quality aspects of the four membership engagement events arranged to be held later in November.

1.4 Bids Steering Group
The Bids Steering group met on Thursday 5th December.

An event will be held on Thursday 9th January 2014 for all bidders to ‘Keep on Smiling’, to gather feedback and to learn from the experiences of this round of bidding.

The next Council of Governors’ Bids Scheme will start in April 2014 and will be called ‘Smile for Health’.
2. Joint meeting between the Council of Governors and the Board of Directors

2.1 Background
A joint meeting between the Council of Governors and the Board of Directors took place on Tuesday, 26th November 2013.

The format was similar to previous years where attendees reviewed achievements and areas where there was scope for improvement.

2.2 Review of 2013
Areas highlighted as successes included the Bedlam film production in conjunction with Channel 4, the establishment of the Recovery College, increased innovation brought about by the financial challenges, improved communications to Governors and staff and the positive outcome of recent CQC visits.

Further work was required in the area of co-production, developing a greater readiness to accept the challenge of change and meeting the increasing expectations of the public, commissioners and regulators.

It was noted that recent legislation had increased the powers of Governors, particularly in their duty to hold the Non Executive Directors to account for the performance of the Board. It was agreed that this was an area that required greater attention and that it should be the subject of a joint seminar in the Spring of 2014.

2.3 Key current issues facing the organisation – presentation from Matthew Patrick
- H&SCA disruption to previous organisational relationships
- NHS unaffordability in the longer term with ongoing flat funding
- Internal environment, particularly the pressure on beds
- Context of delivery of social models of health
- KHP accreditation
- SLaM strategy
- Improvement of basic care to local citizens - IT, quality systems, compassion
- More commercial focus, developing bidding capacity

2.4 Challenges – feedback from groups
- Accommodating forced change
- Commissioning changes
- Increasing responsiveness
- Commissioning models
- Bed Management
- Relationships between Governors /Board
- Partnerships decisions – KHP
- Quality information
- Relationships with stakeholders
- Transformational change takes time
- Developing a culture of co-production
- Staff performance
2.5 Opportunities – feedback from groups

- Shared rapid learning
- Receptiveness to new ideas
- Use KHP for SLaM to increase influence
- Co-production
- Preventions strategies - developing the recovery model
- Use skills or Governors
- NED/Governors engagement
- AMH changes
- Develop talent with SLaM
- Make services more commercially viable

2.6 Priority areas for the Council of Governors in 2014

- New role of governors – arrange meeting for Spring 2014 (PM – March 2014)
- Provide additional information for Governors (PM – January 2014)
- Closer Work between Governors and NEDs. Develop programme for NED attendance at CoG working groups (PM – March 2014)
- COG papers to be taken as read to free time for discussion (ML – March 2014)
- Increase Governors knowledge of quality information (Quality group – June 2014)
- Check how others organisations (FTN) are taking forward issues (PM – March 2014)
- Closer IOP/SLaM integration with CAGs (MP – ongoing)

3. Nominations Committee

The report from the Nominations Committee will ask the Council of Governors:

3.1 To note the progress on the recruitment of up to two Non Executive Directors on the SLaM Board of Directors for a period of up to three years.
3.2 To agree an extension of the term of Harriet Hall as a Non Executive Director on the SLaM Board of Directors for a period of up to two months to ensure a handover with a newly appointed NED.
3.3 To agree the recommendation from the Nominations Committee for the re-appointment of Prof Shitij Kapur as a Non Executive Director on the SLaM Board of Directors for a period of up to three years.
3.4 To receive an update on the appraisal of the Chair.

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

**Date of Board meeting:** 17th December 2013  
**Name of Report:** KHP Board Verbal Update  
**Heading:** - (Strategy, Quality, Performance & Activity, Governance, Information)  
**Author:** (name of Exec Member)  
**Approved by:** (name of Exec Member)  
**Presented by:** Professor Sir Robert Lechler  

### 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 approve 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.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 17th December 2013

Name of Report: BDP CAG proposal for name change

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

Author: Natalie Bowditch

Approved by: (name of Exec Member) Dr Matthew Patrick

Presented by: Eleanor Davies & Jean O’Hara

Purpose of the report:
To propose a change of name for the current Behavioural Disorders Unit.

Action required:
To review the report and ask the Board for approval to change the name of the service.

Recommendations to the Board:
To change the name of the Behavioural Disorders Unit to the ‘National Autism Unit’.

To group the current adult autism and ADHD services under the name ‘National Autism and ADHD Service for Adult’s (NAASA).

Relationship with the Assurance Framework (Risks, Controls and Assurance):
This service is part of Service Line 2 within the BDP CAG and is monitored via the Senior Management Team meeting and CAG Executive meeting.

Summary of Financial and Legal Implications:
By including ‘autism’ in the name of the service, it is expected that referrers, families and carers will become more aware that SLaM provide an inpatient service for autism and that referrals to this cost per case service will increase thus ensuring increase in cost per case income for the service.

Equality & Diversity and Public & Patient Involvement Implications:
The report positively supports equality and is inclusive of patient and carer opinion.
BDP CAG proposal for name change

1. Introduction

The Behavioural Disorders Unit is an inpatient service which provides assessment and treatment for adult males with high functioning autism spectrum disorder (ASD) and:

- Severe functional impairment due to mental illness
- Behaviour that challenges others.

There has been an increase in feedback from staff attending conferences, learning events and meetings suggesting that the Behavioural Disorders Unit could benefit from changing the name of the service. Initial feedback suggested that a change of service name would:

a) provide referrers and commissioners with a clearer understanding of who the service can treat.

b) reduce stigma for patients, families and carers who use the service, by removing the term ‘behavioural disorders’.

c) increase awareness that South London and Maudsley provide a specialist inpatient service for adults with high functioning autism.

2. Legislation

The *Autism Act 2009* committed the Government to publishing an adult autism strategy to transform services for adults with autism. The autism strategy was published in March 2010 and set out a number of key actions and recommendations for central Government as well as the NHS and local authorities. Five key areas include:

- increasing awareness and understanding of autism
- developing a clear and consistent pathway for diagnosis
- improving access to services and support people need to live independently within the community
- employment
- enabling local partners to develop relevant services to meet identified needs and priorities.

The Government is currently reviewing the implementation of the autism strategy. Autism is a current priority for local commissioners and it is essential
they are aware of the adult autism services provided by SLaM. Having ‘autism’ incorporated in the service name would promote awareness.

3. Survey

An online survey was conducted over a two week period to ask referrers, commissioners, BDP staff (clinical and non clinical) and relevant charities if they thought a change of service name would be beneficial.

Respondents were asked to rank 8 proposed name choices in order of preference. The proposed name choices included:

- National Adult Autism Spectrum Service
- The Maudsley Centre for ASD
- National Autism and ADHD Service for adults (NAASA)
- National Autism Unit (NAU) at the Maudsley
- The Maudsley ASD service
- Autism Inpatient Service
- Autism Assessment and Treatment Service
- Behavioural Disorders Unit (no change)

In addition, respondents were asked why they selected their preferred choice and were invited to propose further suggestions which could improve the service name.

4. Results

There were 70 respondents to the survey. Over half of the respondents (62%) were clinicians.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62%</td>
<td>Clinician</td>
</tr>
<tr>
<td>27%</td>
<td>Commissioner</td>
</tr>
<tr>
<td>9%</td>
<td>Charity organisation</td>
</tr>
<tr>
<td>1%</td>
<td>Non clinical staff</td>
</tr>
<tr>
<td>1%</td>
<td>Other</td>
</tr>
</tbody>
</table>
Graph 2 outlines the preferred name from all respondents.

<table>
<thead>
<tr>
<th>Preferred Service Name - Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Autism and ADHD Service for adults (NAASA)</td>
</tr>
<tr>
<td>National Autism Unit (NAU) at the Maudsley</td>
</tr>
<tr>
<td>National Adult Autism Spectrum Service</td>
</tr>
<tr>
<td>Autism Assessment and Treatment Service</td>
</tr>
<tr>
<td>The Maudsley Centre for ASD</td>
</tr>
<tr>
<td>Behavioural Disorders Unit</td>
</tr>
<tr>
<td>The Maudsley ASD Service</td>
</tr>
<tr>
<td>Autism Inpatient Service</td>
</tr>
</tbody>
</table>

From the survey, 91% of respondents felt the Behavioural Disorders Unit could benefit from changing the service name.

5. Reasons for preferred choice and comments.

Respondents were asked why they selected their preferred choice and were invited to propose further suggestions which could improve the service name. The main themes from comments received include; the service name should:

- describe who the service is for, though the title should not be too long. (59%)
- be short and concise,
- include ‘National’ to represent it being a national service,
- not include ‘behavioural disorders’ to reduce patients being labelled and reduce the stigma. A change of name would give a more positive feel.
- not include jargon or acronyms.
Using ‘Maudsley’ in the title had a mixed response. Some respondents felt it linked quality and trust with the service, others felt it was misleading as the service is at the Bethlem Royal Hospital and not the Maudsley.

6. Service Users, families and carers

Carers and service users were asked to comment on the consideration of changing the service name. Comments included:

- Behavioural Disorders Unit (BDU) is not a helpful name. I don’t like the sound of it; it implies bad behaviour.
- When I see the BDU name when visiting, I think it is very unfortunate.
- Doesn’t mention complex needs. Autism may imply lower functioning autism across the spectrum rather than the higher functioning patients that the ward sees.
- The name should change. National Autism Unit is very good, as you see patients all over the country and implies national service. It may imply a link with National Autistic Society.
- Yes good idea as all the patients are on the autism spectrum.

7. Recommendation

It is recommend that the Behavioural Disorders Unit rename the service to the ‘National Autism Unit’.

National Autism Unit communicates that the service is for people with autism and is available nationally. The name remains short, concise and free from jargon.

To present a clearer pathway for adult ASD and ADHD services provided by SLaM, I recommend that current services are grouped under the ‘National Autism and ADHD Service for Adults’ (NAASA) as illustrated below.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 17th December 2013

Name of Report: Caldicott Guardian Annual Report to the Trust Board

Heading: Governance

Author: Dr Dele Olajide

Approved by: (name of Exec Member) Dr Martin Baggaley

Presented by: Dr Dele Olajide

Purpose of the report:

To update the Board on the work of the Caldicott Guardian, the Caldicott Committee and the Information Governance Team for the past year.

Action required:

For the Board to note content.

Recommendations to the Board:

As above.

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

Data Protection, use of clinical information and involvement of patients & carers in the process links to Standards for Better Health, Care Quality Commission Regulations, Trust Risk Register and the Assurance Framework.

Summary of Financial and Legal Implications:

There are clear legal implications for the sound management of clinical information within the Trust.

Equality & Diversity and Public & Patient Involvement Implications:

Protection of clinical information on behalf of patients. Providing access to clinical information through appropriate processes covered by statute.
CALDICOTT GUARDIAN ANNUAL REPORT

2012
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1- Introduction to the Caldicott Guardian Annual Report

The role of the Caldicott Guardian has evolved since it was first established in 1997 following the recommendations of the Caldicott Report. It may yet change again when Caldicott Mark 2 is published next year. Currently, it sits within the Information Governance Framework, Information Governance Toolkit (IGT), and the legal Frameworks around common law duty of confidentiality, Data Protection Act (1998), Human Rights Act (1998), and Freedom of Information Act (2000).

The key roles of the Caldicott Guardian include:

- Production of procedures, guidelines and protocols around Patient Confidentiality
- Key responsibilities in respect of staff awareness and training of their responsibilities around patient confidentiality
- Acting as Champion of the relationships between the patients and their information
- Close scrutiny of and where necessary, input into, information sharing protocols with other agencies
- Undertake a strategic role in the development and maintenance of the integrity of the electronic patient records.

Finally, the Caldicott Guardian as “an Information Guardian should have direct access to the Board and should take the lead for Information Governance and the Board should receive periodic reports on Information governance issues.” (Sir David Nicholson 2007).

I would like to draw the attention of the Board to the following highlights in the Report:

- As in previous years, the Trust’s SAR compliance rate of 97% is above the national average and higher than any of the mental health trusts in London (Table 1)
- The Trust scored 91% on the IG Toolkit and rated Satisfactory in the overall grade and again, our performance is among the best nationally (Table 2).
- Reported information breaches continues to be low and of such degree as to not impact on the Trust’s reputation and integrity. Our contact with the Information Commissioners Office (ICO), following an information breach, has been one of openness resulting in commendation from the ICO’s case handlers on each occasion. Given the large staff population, operating from multiple sites and the sheer volume of data sharing with partner organizations, the Trust is vulnerable to data breaches and must strive to retain its very high standard of data security and information governance.
Future Challenges:

Consent:
The Trust should encourage the democratization of patient consent as part of its drive to increasing patient empowerment and autonomy. The consent for consent (C4C) protocol is the first and necessary step in this direction and in the new-year we plan to engage in both local and national debates on how to make patient consent a collaborative effort between patients and clinicians.

Information sharing with partner organizations and other agencies: The accessibility of the electronic patient journey has not only improved patients care and the ease of undertaking clinical research through CRIS, but has seen increased demand for information sharing with the police, local authority, third sector health providers as well as commissioners. The existing information guidelines do not provide clarity for how to handle these new demands. We have had to deal with demands on a case by case basis. We take the view that information sharing should facilitate patient care and that confidentiality should not be a veil behind which information sharing with partner agencies is obstructed.

Patients’ breaches of their personal data through social media: This is a potential minefield as patients exercise their right to access their data and publish it on the internet. Professionals are rightly anxious about the risk of their personal confidentiality being compromised by finding information of consultations or family work ending up on YouTube. A revised clinical media policy will need to take these developments on board.
2- Trust Caldicott Committee

The Trust Caldicott Committee is chaired by the Caldicott Guardian and attended by representatives of all Clinical Academic Groups, professional groups, Mental Health Act Office, Complaints, Training and Education, ICT, Legal and R&D Departments as well as two service user representatives.

The Committee’s overall aim is to develop processes for raising awareness of patients’ confidentiality, Caldicott principles and the impact of secondary use services (SUS) of patients’ data across the whole organisation. Such a robust objective is considered necessary in order to support compliance with national standards set out in the Information Governance Toolkit, as well as to ensure that the Trust can achieve recognition as a national and international exemplar in this vital area of information governance.

The Caldicott Committee is actively engaged in the process of approving new and updated policies related to Information Governance, as well as resources to improve staff awareness on Caldicott principles, patient confidentiality and consent as well as serious untoward incidents (SUI). The committee continues to work collaboratively with our King’s Health Partners to ensure that robust information governance arrangement in established across the partnership.

The Committee organised a Caldicott Committee Away Day, which was held on 12th October 2012. The half day event focused on issues around Caldicott principles and patient confidentiality in Mental Health, the future challenges, risks, opportunities and strategic direction and development.

The key topics discussed on the day were:

- The need to be up to date with technology i.e. anticipating patient’s use of technology (social media, personal records disclosure and empowerment).
- Information sharing in relation to SUS i.e. research
- Dealing with challenges of information sharing with other organisations whilst working collaboratively i.e. anticipating the Caldicott 2 report
- Anticipating what will happen in the future i.e. challenges that will be faced and how this will affect the KHP merger.

The key outcomes from the day which have now been incorporated into the Caldicott forward plan for 2013/14:

- Pioneering projects in SLaM
- Use of Social Media
- Good practices in Information Governance
- Recognition of new developments i.e. Consent for Consent, Secure transfer tool and receptive to new technology.

3. Performance Figures

3.1 Subject access requests

Consistent with a large organisation such as SlaM, the volume of subject access requests (SAR) continues to increase year on year. In 2012, the Data Protection
Office received a total of 1632 subject access requests compared with 1527 in the previous year. The requests for SAR are from service users, carers / relatives and their legal representatives, the Police, CPS, other NHS healthcare providers, social services and other newly created agencies.

The Trust has a legal obligation to respond to requests for access to medical records or relevant clinical information within 40 days of receipt of a valid request. The subject access requests compliance rate is determined by the number of cases completed within this statutory time limit compared to the total number of access requests received.

A comparison of the number of subject access requests and compliance rates from 2011 and 2012 are shown in Table 1 below.

Table 1 – Comparison of the number of subject access requests and compliance in 2011 and 2012

<table>
<thead>
<tr>
<th>Subject Access Requests</th>
<th>Total No of Requests(2011)</th>
<th>Compliance Rate (%)</th>
<th>Total No of Requests(2012)</th>
<th>Compliance Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>101</td>
<td>97</td>
<td>127</td>
<td>91</td>
</tr>
<tr>
<td>February</td>
<td>129</td>
<td>95</td>
<td>150</td>
<td>91</td>
</tr>
<tr>
<td>March</td>
<td>117</td>
<td>94</td>
<td>150</td>
<td>94</td>
</tr>
<tr>
<td>April</td>
<td>138</td>
<td>96</td>
<td>123</td>
<td>99</td>
</tr>
<tr>
<td>May</td>
<td>142</td>
<td>96</td>
<td>143</td>
<td>97</td>
</tr>
<tr>
<td>June</td>
<td>147</td>
<td>96</td>
<td>120</td>
<td>99</td>
</tr>
<tr>
<td>July</td>
<td>142</td>
<td>94</td>
<td>130</td>
<td>98</td>
</tr>
<tr>
<td>August</td>
<td>161</td>
<td>96</td>
<td>162</td>
<td>100</td>
</tr>
<tr>
<td>September</td>
<td>95</td>
<td>96</td>
<td>139</td>
<td>100</td>
</tr>
<tr>
<td>October</td>
<td>113</td>
<td>98</td>
<td>163</td>
<td>98</td>
</tr>
<tr>
<td>November</td>
<td>136</td>
<td>98</td>
<td>132</td>
<td>97</td>
</tr>
<tr>
<td>December</td>
<td>106</td>
<td>94</td>
<td>93</td>
<td>95</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1527</td>
<td>96</td>
<td>1632</td>
<td>97</td>
</tr>
</tbody>
</table>
Presented in Figure 1 is a comparison between 2011 and 2012 subject access requests compliance rates.

**Figure 1: Comparison of subject access requests compliance rates (2011-2012)**

![Graph showing the comparison of subject access requests compliance rates between 2011 and 2012.](image)

**Table 2 - IG Toolkit Assessment Summary report**

<table>
<thead>
<tr>
<th>Overall</th>
<th>Assessment</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Not Relevant</th>
<th>Total Req'ts</th>
<th>Overall Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Version 10 (2012-2013)</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>33</td>
<td>1</td>
<td>45</td>
<td>91%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td></td>
<td>Version 9 (2011-2012)</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>32</td>
<td>1</td>
<td>45</td>
<td>90%</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

**Grade**

- **Not Satisfactory**: Not achieved Attainment Level 2 or above on all requirements (Version 8 or after)
- **Satisfactory**: Achieved Attainment Level 2 or above on all requirements (Version 8 or after)
3.3 Confidentiality and information incidents

All confidentiality and information incidents are recorded through the online incident reporting tool. The Trust reported a total of 120 confidentiality and information incidents between 1st January and 31st December 2012.

No incidents with severity scale of 3 or above were reported in 2012. 53 incidents were reported at severity of 1-2 and 67 incidents were recorded at severity of 0 as outlined in Table 3 below:

Table 3: Severity of confidentiality and information incidents in 2012

<table>
<thead>
<tr>
<th>Severity Scale</th>
<th>Description</th>
<th>Criteria</th>
<th>No of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No significant reflection on any individual or body.</td>
<td>Minor breach of confidentiality. Only a single individual affected.</td>
<td>67</td>
</tr>
<tr>
<td>1</td>
<td>Damage to an individual’s reputation.</td>
<td>Potentially serious breach. Less than 5 people affected or risk assessed as low (e.g. files were encrypted).</td>
<td>37</td>
</tr>
<tr>
<td>2</td>
<td>Damage to a team’s reputation.</td>
<td>Serious potential breach. Risk assessed high (e.g. unencrypted clinical records lost). Up to 20 people affected</td>
<td>16</td>
</tr>
<tr>
<td>3</td>
<td>Damage to a service’s reputation</td>
<td>Serious breach of confidentiality. Up to 100 people affected.</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Damage to an organisation’s reputation.</td>
<td>Serious breach with either particular sensitivity (e.g. sexual health details). Or up to 100 people affected.</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Damage to NHS reputation.</td>
<td>Serious breach with potential for ID theft or over 1000 people affected.</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>120</td>
</tr>
</tbody>
</table>

The severity of these incidents according to the NHS Connecting for Health classification for Information Governance incidents are summarised in Table 4:

Table 4: Summary of confidentiality and information incidents in 2012

<table>
<thead>
<tr>
<th>Category</th>
<th>Nature of incident</th>
<th>Number of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Loss of inadequately protected electronic equipment, devices</td>
<td>7</td>
</tr>
</tbody>
</table>
or paper documents from secured NHS premises

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises</td>
<td>10</td>
</tr>
<tr>
<td>III</td>
<td>Insecure disposal of inadequately protected electronic equipment, devices or paper documents</td>
<td>9</td>
</tr>
<tr>
<td>IV</td>
<td>Unauthorised disclosure</td>
<td>54</td>
</tr>
<tr>
<td>V</td>
<td>Other</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>120</td>
</tr>
</tbody>
</table>

Examples of confidentiality incidents reported include:

- Inappropriate use of mobile devices
- Unauthorised audiovisual recordings by service users/carers on hospital grounds/ward
- Inappropriate use of social media by service users/carers
- Unauthorised disclosure without service user consent
- Inappropriate disposal of confidential waste
- Inappropriate location for confidential conversation/document
- Unauthorised disclosure via email, postal service and fax.
- Loss of encrypted ICT equipment
- Cold calling by legal representatives

Key actions taken to mitigate incidents reported:

Unauthorised disclosures

The IG team continues to provide awareness resources to improve quality checks that staff must undertake prior to sending confidential documents via email, fax and post. A guidance document on the appropriate use to Outlook address book was issued to staff, to provide key guidance on selecting/checking recipients in the address book when sending emails.

The Information Governance team issued quarterly newsletters which feature a range of topics like sharing confidential information, secure information transfers and confidential waste disposal, as well as helpful hints and tips.

These resources are available on the Confidentiality pages at the following link http://sites.intranet.slam.nhs.uk/ICT/Services/TeamPortfolio/informationgovernance/confidentiality/default.aspx or on request via the Data Protection Office.

Inappropriate use of mobile devices

Use of mobile devices by service users and relatives must be in accordance with the Trust mobile phone usage policies. The use of mobile devices with audiovisual and recording functions should only occur with prior arrangement and permission of individuals involved.

Cold calling by legal representatives
There were reported incidents of legal firms ringing inpatient unit phones and soliciting their services to inpatients detained under the Mental Health Act. These incidents have been followed up with the legal firms asking them to avoid contacting inpatients services but contact the Trust via the Mental Health Act Office.

**Inappropriate disposal of confidential waste**

The Information Governance team reviewed the existing process for external collection of confidential waste by contractors and key weaknesses were identified in the process. The Information Governance team worked closely with the procurement team to review the contractual arrangements in line with current industry standards and good practice. A confidential waste procedure and additional awareness resources were developed and made available to all staff including contractors. Staff members were also reminded to refresh mandatory IG training including relevant information security modules.

**Inappropriate location for confidential conversation/documents:**

Staff awareness resources like screensavers and newsletter have been developed featuring guidance on choosing confidential spaces to discuss details of confidential clinical information where members of public or other patients cannot hear them. Public places, public transport, staff canteen are not appropriate to discuss clinical issues.

**3.4 Complaints**

There were 7 Information Governance complaints received by the Trust in 2012. The complaints were in relation to right of access to records under the Data Protection Act (1998) within the statutory timeframe, unsubstantiated claim of unauthorised disclosure of personal information and denied access to records of a deceased patient.

**4. Service achievements in 2012**

**4.1 Policy updates**

The following policies were reviewed in 2012

- **Information Sharing policy:**
  The Information Sharing policy was reviewed with minor updates.

- **Confidentiality policy:**
  In 2012 there were no significant changes in the legislation and national guidance so no changes were proposed for this policy. The policy is due an extensive review in 2013.

**4.2 Improving awareness**

The Caldicott Committee reviewed available information resources for service users and staff in relation to the way sensitive personal information is handled to maintain confidentiality whilst enabling access to records. Additional resources were identified to improve awareness of staff responsibilities.

The information resources that were made available to service users and staff as outlined in the Information Governance Communications Plan 2012 - 13 include the following:
- Guidance on Confidentiality- Your Responsibilities: Staff Information Leaflet
- Use of Personal Information- Your Rights: Service User Information leaflet
- Confidentiality Matters: Confidentiality poster for staff and service users
- Information Governance articles in SLaM News (Quarterly magazine for service users, carers, staff, members and public)
- Quarterly information governance newsletters were published in 2012. They featured key staff guidance on secure handling and sharing data, information governance training and staff awareness resources.

4.2 1 Confidentiality and sharing information with carers and families

Several carers forum indicated the requirement for clear guidance on sharing information with carers. The Information Governance team developed a one page guidance, which provides advice and direction to staff on how to share information with carers and families without breaching the patient’s confidentiality.

The guidance document has been developed to produce a leaflet on sharing information with carers. It outlines advice and guidance to staff on how to share information with carers and families without breaching the patient’s confidentiality. The leaflet is also available at the following link

http://sites.intranet.slam.nhs.uk/ICT/Services/TeamPortfolio/informationgovernance/confidentiality/For%20Trust%20Staff/Guidance%20on%20Confidentiality/Carers_families_Leaflet%20130515.pdf

4.2 2 IG in Transition poster

There has been an increase in the number of incidents due to service transitions. It is of paramount importance that clinical services conduct thorough checks when moving in and out of premises to ensure that personal data is not left behind. The guidance document that entitled “Do not leave your reputation behind” highlights the steps to take when planning to move site was developed. The document aims to provide guidance to services that are moving to emphasise the importance of maintaining information security through service transition.

The document is available on the Confidentiality page at the following link

http://sites.intranet.slam.nhs.uk/ICT/Services/TeamPortfolio/informationgovernance/confidentiality/StaffWPP/IG%20in%20Transition%20SLaM%20120905.pdf

4.3 Information Governance Training Programme.

The Trust continues in its pursuit to increase awareness of Information Governance. The training is offered through facilitated sessions for new employees and existing staff through e-learning. The Trust is required to attain 95% of staff trained and is on target to achieve to meet this requirement. Information Governance training is periodically reviewed to ensure that it is both effective and up to date.

The annual review of the IG training conducted in 2012 indicated that the sessions are well received and attended. Information Governance awareness has increased and more staff are aware of their responsibilities and training needs in relation to data protection, confidentiality and records management.

4.4 Information Governance Assurance Programme
4.4.1 Records Keeping Standards/Record Management Audits (Health Records Audit)
An ongoing programme of clinical quality review of health records is held on the Trust’s electronic Patient Journey System (ePJS) to:

- undertake a qualitative and quantitative review of health records kept on the Trust’s ePJS system against the standards published in the Clinical Records Policy;
- provide assurance of record keeping standards for the completion of all health records held by the Trust on ePJS;
- monitor compliance with the records management standards outlined in the Trust’s Clinical Records Policy;
- ensure that health records on ePJS are of a quality and integrity that supports and enhances the best clinical treatment and care for the Trust’s patients.

The audit results show that electronic patient records are consistent in its structure, content, and layout as well displayed in a chronological order. The date and time of the entries were completed; completion of discharge summary has now reduced to within 7 days of discharge compared to 32 days as at the last review.

Overall the audit results shows the Trust is compliant with maintaining accurate record keeping and secure disposal of patient’s health records on Electronic Patient Journey system.

4.4.2 Missing persons audit

This audit reviewed the process of how missing persons from the Trust wards are reported over a period and how the generated alerts are managed. The objective was to ensure that the process was effective and efficient in locating missing persons as well as measuring outcomes. The outcome of the audit highlighted the need to improve incident reporting quality by including more information on immediate actions, including external agencies where the missing person was notified.

4.4.3 Register of information assets review

This is a regular review of the Trust registers to ensure all information assets are recorded effectively, regularly monitored for accuracy and all the associated risks are documented.

The audit reviewed all existing 284 assets, identified information assets that were still active. Those that were no longer in use were amended and updated. In addition, new information assets were identified and added to the register.

4.4.4 ePJS Access Controls

The review of access to ePJS is a requirement of the NHS Information Governance Toolkit (Standards 305). This standard requires organisations to control access to information systems and ensure the system functionality is configured to support user access controls and by further ensuring that formal procedures are in place to control the allocation of access rights to local information systems and services.
The audit results showed no evidence of inappropriate/unauthorised access by staff to the patient’s records sampled, evidencing that staff are implementing the training received around data protection, confidentiality, and the observance of legitimate relationships when accessing patient records.

**4.4.5 Electronic documents audits - audit of local scanning procedure**

The audit was designed to provide assurance that records held on ePJS and Clinical Document Repository (CDR) are of adequate quality and that effective procedures exist to guide staff through the process of scanning documents to create electronic records in accordance with the Trust Clinical Records Policy and digitisation procedure.

The review identified a sophisticated and detailed audit trail built into CDR and that the documented procedures for scanning bureaus were adequate.

Recommendations from the review included updating the scanning procedure to include details of the disposal of redundant paperwork once electronic copies had been uploaded to avoid duplication and comply with the Data Protection Act.

**4.4.6 Pseudonymisation audit**

The aim of the review was to demonstrate that the Trust complies with NHS policy and the legal requirement that patient level data should not contain identifiers when they are used for purposes other than the direct care of patients, including flows of information between providers and commissioners.

The review identified compliance with the Trust procedure for pseudonymisation and that it was adequately communicated to staff, with the pseudonymisation process (i.e. de-identification and use of safe file transfer facilities) sufficient to comply with Department of Health guidance.

**4.4.7 Review of Data Protection Subject Access Requests and Service User Satisfaction audit**

The objective of the review was to gauge service user satisfaction about the way their information is handled, to see if they feel their confidentiality is respected and whether they were satisfied with the guidance provided about how their personal information is used. The review included an internal review of the quality of the Information Governance Team Subject Access Request database.

Nearly three quarters of service users who completed the questionnaire had not seen or were not aware of the leaflet “Use of Personal Information – Your Rights”. A third knew they could request a copy of their clinical record and of all surveyed, around three quarters would approach their clinician if they had any queries about their record. Only 16% had concerns over the sharing of their personal confidential information.

The review of the Data Protection Office Subject Access Database found that it was functioning well and the Subject Access Request compliance rate was 96%, with the
majority of requests being from solicitors, patients, the police and health professionals.

The main recommendations were that wards and teams should raise service user awareness of their rights of access to health records and regularly offer them copies of the information leaflet which outlines how the Trust handles their personal information and health records.

4.4.8 Registration Authority Review

The aim of this audit was to provide assurance that the Registration Authority operational processes complied with the requirements of the Information Governance Toolkit, and that the Trust was taking appropriate action to proactively manage those processes, working towards compliance with Level 3 for each of the requirements 9-303 and 9-304.

The audit provided assurance that the use and administration of access to common systems under Registration Authority is carried out in accordance with policy and best practice, ensuring the security of sensitive information and accountability for transactions.

The audit concluded that the majority of Information Governance Toolkit requirement criteria were being complied with, and there were plans to further improve compliance.

4.5 My Healthlocker

South London and Maudsley NHS Foundation Trust (SLaM) and the Institute of Psychiatry implemented an electronic personal health records (ePHR) system for service users. The objective of this innovation was to improve the use of outcome measurement across SLaM services, explore the development of a connected health model (between SLaM and primary care) as well as promote research for the development and use of personal health records.

The ePHR system will interface with SLaM’s electronic Patient Journey System (ePJS), the Case Register Interactive Search (CRIS) system and GP systems through a connected health model approach. The programme was piloted with the CAMHS and Psychosis Clinical Academic Groups (CAGs) in SLaM and GP practices in Lambeth.

4.6 Secure Transfer tool

The Secure transfer tool was implemented to ensure that transfers and flows of personal confidential information from the Trust are made securely. The tool was identified as an example of good practice, and provides assurance that users are able to securely transfer files between Trust departments, other NHS organisations and external agencies and negates the need for emailing information or storing and transferring information on memory sticks.

More information on the Secure Transfer tool is available at the following link http://sites.intranet.slam.nhs.uk/ICT/help/selfservice/Shared%20Documents/Secure%20File%20Transfer.aspx
5 Planning for 2013

The Information Governance Action Plan for next year covers the following key priority areas:

- Developing innovative ways to further improve staff awareness of information governance,
- Review training needs of different staff groups in different service areas,
- Develop capability and expertise for research information governance that aligns with the DH Information Strategy
- Develop a unified approach to IG reviews for KHP-wide developments
- Enable service users’ better access to better quality information
- Monitor and improve service user experience
- Improve and maintain compliance with changing requirements
- Further embedding good information governance practice

6 Further Information

If you would like further information about the work outlined in this annual report and relevant issues, please contact:

The Caldicott Guardian
c/o Information Governance Office
CR2
Maudsley Hospital
Denmark Hill
London SE5 8AZ

e-mail: Dataprotectionoffice@slam.nhs.uk
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 17th December 2013

Name of report: Freedom of Information (FoI) Committee Annual Report

Heading: Governance

Author: Head of Information Governance

Approved by: Trust Secretary

Presented by: Director of Finance

Purpose of the report:
To provide an update to the Trust Board on the Trust FoI activity, the work of the FoI Committee, Trust FoI compliance, performance and quality management.

Action required:
To discuss areas of concerns and suggest additional assurance actions where required.

Recommendations to the Board:
To note the report

Relationship with the Assurance Framework (Risks, Controls, and Assurance):
- Trust and CAG Risk and Assurance Frameworks
- Care Quality Commission Regulations (Section 5, Outcome 21, Regulation 20 – Records)

Summary of Financial and Legal Implications:
Trust compliance with the Freedom of Information Act (2000)

Equality & Diversity and Public & Patient Involvement Implications:
Not applicable to this report
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1- Executive Summary

South London and Maudsley NHS Foundation Trust (the Trust) has been working to comply with the requirements of the Freedom of Information Act (2000) (the Act) and to meet Corporate Information Assurance requirements that are set in the NHS Information Governance Toolkit.

The Trust demonstrated high levels of compliance with the requirements of the Act in 2012-13 by responding to 98% of the requests within the statutory timeframe of 20 working days.

The number of requests received by the Trust per year has increased by 13% compared to the previous year. The requests for information have been driven by the need for transparency in the way the Trust conducts its business with majority of the requests coming from members of the public, media and researchers.

Ongoing training on the implications of the Act on NHS organisations and responsibilities of staff is conducted as part of the Information Governance Training Programme. The key objective of the training is to ensure that the Trust’s Freedom of Information (FoI) Policy is implemented, staff awareness of the access to corporate information covered by this legislation is further improved and the timescale for replying to requests for information under the Act is complied with.

The Trust achieved 100% compliance with the Corporate Records Assurance standards in version 10 of the Information Governance (IG) Toolkit in 2012-13. A significant part of the evidence that supports the Trust’s compliance is the product of the IG Assurance Programme, which includes reviews undertaken independently alongside internal audits undertaken by the Information Governance Team.

2- Purpose of the Freedom of Information (FoI) Annual Report

The purpose of the Trust Freedom of Information Annual Report is to reflect on the impact of the Act, effectiveness of internal procedures in place to ensure compliance as well as outlining learning and action points. The report provides an overview of the work undertaken by the Information Governance Team and overseen by the FoI Committee in 2012-13.

3- Key Objectives of the FoI Committee

The overall objective of the FoI Committee is to ensure that an effective corporate records management is implemented in line with the Trust Information Governance Strategy. The Committee works to improve the awareness of the Freedom of Information Act (2000) and its relevant procedures throughout the Trust by implementing ways of embedding an openness culture to improve corporate transparency and to review Trust FoI performance, compliance with national legal requirements and Trust guidelines.
4- The Trust FoI Performance

The number of the requests received in this 12-month period shows a consistent and continuing upward trend. A total of 220 information requests were received under the Freedom of Information Act between 1 April 2012 and 31 March 2013. The Trust responded to 98% of requests within the statutory timeframe of 20 working days. The remainder (2%) were marginally delayed due to internal review of the responses for completeness and accuracy. The requestors were notified of the delay and the date they could expect the response.

An overview of the Trust’s annual performance is provided in Table 1.

<table>
<thead>
<tr>
<th>FOI Requests</th>
<th>Total No of requests</th>
<th>Compliant requests</th>
<th>Non-Compliant requests</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>49</td>
<td>49</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Q2</td>
<td>57</td>
<td>57</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Q3</td>
<td>57</td>
<td>56</td>
<td>1</td>
<td>98%</td>
</tr>
<tr>
<td>Q4</td>
<td>57</td>
<td>53</td>
<td>4</td>
<td>93%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>220</td>
<td>215</td>
<td>5</td>
<td>98%</td>
</tr>
</tbody>
</table>

4.1 Internal reviews and complaints

If a requester is unhappy with the response to their request, they can request an internal review. There were 4 requests for internal reviews of responses received. Two of these were upheld and the other two were not.

Three complaints were made to the Information Commissioner’s Office in relation to FoI responses provided by the Trust in 2012-13, of which 2 were partially upheld, and 1 was not upheld.

Where internal reviews or complaints were partially upheld or upheld, these related to requests where the decision not to release the information was considered to be covered by an exemption, which was subsequently overturned. In the cases that were not upheld, the decision by the Trust not to release the information as it was exempt from disclosure under the Act was maintained.

4.2 Category of requestors

The requests for information came from members of the public (including local residents, service users and carers), national and local media, academics, public bodies such as other NHS organisations, local authorities, charities, Members of the Parliament and their staff (such as Parliamentary researchers), legal professionals and private companies (including consultancy firms and employment agencies).

Table 2 below shows the number of requests by category of requestor.
### Table 2 - Category of requestors

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of requests</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Academic</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Media (Local and National)</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td>MPs/ Councillors/Political Researchers</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>NHS</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Public bodies</td>
<td>56</td>
<td>25</td>
</tr>
<tr>
<td>Public (individuals)</td>
<td>81</td>
<td>37</td>
</tr>
<tr>
<td>Voluntary/ Campaigning groups</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>220</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

#### Fig 1 – Category of requestors

4.3 Types of information requested

The majority of the information requests were related to financial issues, workforce and information technology (76%). The remainder (24%) were related to clinical services, mostly focused around service provision, pharmacy and patient safety issues.

The subject matter of FoI requests varied but the following were common themes in 2012-13:

- Trust annual expenditure,
- Trust policies,
- Spending on agency staff and consultancy,
- Maintenance contracts
- Staff suspensions and long term absence,
- Patient safety and serious incidents,
- Electronic health records, IT systems and equipment,
- Confidentiality breaches,
- Contracts and commissioned services,
- Children and adolescents referred and treated by the Trust,
- Prescribing,
- Deceased patients,
- Private healthcare insurance
- Organisational structures,
- Mental Health Act,
- Service provision i.e. waiting times, referrals process

**Fig - 2 Types of information requests**

4.4 Comparison of Performance with Previous Years

In this 12-month period, there was an increase in the number of requests received compared to last year (13%). The overall annual compliance rate fell by 1%. This was due to requests delayed for accuracy and completeness checks. A snapshot of the last five years’ performance is presented in Table 3.

<table>
<thead>
<tr>
<th>Table 3- FoI compliance rate comparison (April 2008 to March 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FOI Requests</strong></td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>2012-2013</td>
</tr>
<tr>
<td>2011-2012</td>
</tr>
<tr>
<td>2010-2011</td>
</tr>
<tr>
<td>2009-2010</td>
</tr>
<tr>
<td>2008-2009</td>
</tr>
</tbody>
</table>
5- Refusals and exemptions

Disclosure of some of the information requested under the Act may be refused for one of the following reasons:

- The information falls under one or more of the exemptions under the Act,
- The cost of processing the request would exceed the appropriate limit set by Ministry of Justice, which is £450 for NHS organisations,
- The request is considered as being repeated or vexatious.

The applicable exemptions to all or part of the information requested in 2012-13 is presented in Table 4. Of the 220 requests received, exemptions were applied to 8 of these requests. Out of the remaining 212, 10 were refused as the information requested was not covered by the Act or not held by the Trust.

### Table 4- Exemptions applied to FoI requests in 2012-2013

<table>
<thead>
<tr>
<th>Exemption</th>
<th>Description</th>
<th>No of times used</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 21</td>
<td>Information accessible to applicant by other means</td>
<td>3</td>
<td>Already published as part of the Trust Publication Scheme on the Trust website.</td>
</tr>
<tr>
<td>Section 40</td>
<td>Personal information</td>
<td>5</td>
<td>Personal data within the meaning of the Data Protection Act (1998)</td>
</tr>
</tbody>
</table>

If the cost of processing a request exceeds the appropriate limit set by the Ministry of Justice which is £450 for NHS organisations, the Trust can turn the request down after giving the requestor an option to modify the scope of their request. There were no requests that were turned down for this reason in 2012-13.

There were no requests that were considered as repeated or vexatious in this period.

6- Publication Scheme

The Trust is required to proactively publish and maintain a Publication Scheme under Section 19 of the Freedom of Information Act. The Publication Scheme sets out key documents published by the Trust under the classifications outlined by the Information Commissioner’s Office (ICO).

The Trust’s Publication Scheme provides useful information to the public in relation to the structure of the Trust, services provided, strategic priorities, spending and key policies. These are available on the Trust’s website at the following link: [http://www.slam.nhs.uk/about-us/freedom-of-information](http://www.slam.nhs.uk/about-us/freedom-of-information)

In October 2012 an annual review of the Publication Scheme was undertaken by the Information Governance Team to ensure up-to-date information was available to support organisational transparency and in accordance with the Publication Scheme Review guidance.
7- Monitoring Implementation

The FoI Committee meets quarterly to provide corporate information assurance to the Trust Executive and the Board against the requirements of the Freedom of Information Act (2000) and the NHS Information Governance Toolkit.

The Committee aims to improve the awareness of the Freedom of Information Act (2000) and its relevant procedures throughout the Trust and to implement ways of embedding an openness culture to improve corporate transparency. The Freedom of Information Committee has overseen the delivery of the following in 2012-2013:

- Quarterly review of the Trust FoI performance
- Review of the Trust’s Corporate Records Policy (June 2012)
- The Trust FoI Annual Report 2011-12 (October 2012)
- Review of the Trust Publication Scheme (December 2012)
- Review of Information Assets (January 2013)
- Review of the assurance required for NHS corporate records management standards (Information Governance Toolkit v10) (January 2013)
- Review of the FoI Committee Terms of Reference (February 2013)
- Corporate Records Independent Review (March 2013)
- Monitoring follow-up actions and improvements arising from reviews undertaken throughout the year (quarterly)

8 Corporate Records Management Assurance

8.1 Review of Information Assets

It is a national requirement that NHS organisations maintain a register of all information assets. An information asset is a definable piece of information stored in any manner that is recognised as ‘valuable’ to an organisation. An example in the Trust is the electronic staff records, ESR, which holds vital information regarding staff and payroll.

In order to maintain the asset register in accordance with corporate records management, good practice standards, the NHS Connecting for Health Information Governance Toolkit, the register of information assets (RIA) was audited in January 2013.

The overall objective of this review was to provide assurance that the register is fit for purpose and the process to record its key information assets and register of information assets is monitored.

8.2 Corporate Records Independent Review

The Trust is required to review how departments are managing corporate records in accordance with the requirements of the IG Toolkit, NHS Code of Practice and other relevant guidance and legislation.

The Corporate Records review was conducted independently by Internal Audit. The review conducted showed that the Trust provides adequate assurance that risks material to the achievement of the organisation’s objectives for the system are managed and controlled.

The report made recommendations on areas where the Trust’s assurance ratings were adequate namely records identification and compliance. An action plan was agreed to review the areas highlighted in the recommendations.

- Rolling plan for corporate records will be drawn and presented to the FoI Committee.
- Compliance spot checks to be extended to cover corporate areas like Finance and Complaints.
- Resources to improve awareness of Trust Corporate Records Policy to be identified and further resources to be developed.

The following reviews will be conducted in 2013/14
- Review of the Information Asset register
- Review of staff awareness of corporate records management
- Compliance spot checks of corporate records areas.

9- Compliance with Corporate Information Standards on the Information Governance Toolkit

All Trusts are required to maintain the confidentiality and security of the personal and corporate information it holds. The Information Governance Toolkit checks compliance of NHS organisations with key corporate records requirements. Table 5 provides key categories of these standards and the Trust score for each standard for 2012/13 submission.

<table>
<thead>
<tr>
<th>No</th>
<th>Standard</th>
<th>2012-13</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-601</td>
<td>Documented and implemented procedures are in place for the effective management of corporate records.</td>
<td>Level 3</td>
<td>Yes</td>
</tr>
<tr>
<td>10-603</td>
<td>Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000.</td>
<td>Level 3</td>
<td>Yes</td>
</tr>
<tr>
<td>10-604</td>
<td>As part of the information lifecycle management strategy, an audit of corporate records has been undertaken.</td>
<td>Level 3</td>
<td>Yes</td>
</tr>
</tbody>
</table>

10- Forward Plan

The Freedom of Information Committee will oversee the delivery of the following in 2013-2014:

- Review of the Trust’s FoI performance (quarterly)
- Review of the Trust Corporate Records Management Policy
- Independent review of corporate records management (review of recommendations)
- Review of staff awareness (update)
- Review of the Trust Publication Scheme
- Corporate Records Management Action Planning (IG Toolkit v11 standards)
- Review of Information Assets Register (update)
- Review of the assurances required for NHS corporate records management standards (Information Governance Toolkit v11)
11- Further Information

Trust Freedom of Information intranet site provides useful resources and policies for staff on the FoI Act (2000)
http://sites.intranet.slam.nhs.uk/ICT/Services/TeamPortfolio/informationgovernance/foi/default.aspx

Trust FOI Disclosure Log is a library of all Freedom of Information requests received by the Trust and responses provided since 2007.
http://sites.intranet.slam.nhs.uk/ICT/Services/TeamPortfolio/informationgovernance/foi/foldatabase/default.aspx

Trust Publication Scheme acts as a charter commitment to the kind of information the Trust routinely publishes.