A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST WILL BE HELD ON TUESDAY 29TH JULY 2014 AT 3:00PM PILOWSKI ROOM, MAUDSLEY LEARNING CENTRE

AGENDA

1 APOLOGIES for absence: Dr Neil Brimblecombe
5 mins
2 Declarations of Interest

3 Minutes of the Board Meeting held on 24th June May 2014

4 MATTERS ARISING

PRESENTATION

5 To receive a presentation on the update on the AMH implementation Page 9 App A
20 mins

QUALITY

6 To receive an Apprentice Experience Story Page 22 App B
20 mins

PERFORMANCE AND ACTIVITY

7 To discuss the Finance Report – Month 3 Page 25 App C
8 To receive the Summary Performance Report July 2014 Page 42 App D
9 To receive the Workforce Workstream Overview Page 65 App E
10 To approve Place of Safety Report Page 80 App F
11 To receive an Update on Rehabilitation Alliance, Lambeth Page 88 App G
12 To approve the Estate Strategy – Douglas Bennett House Page 91 App H

GOVERNANCE

13 To receive a Report from the Chief Executive Page 93 App I

14 To receive an Update from the Council of Governors Page 99 App J

15 To receive an Update on Kings Health Partners Page 102 App K

16 To receive an Updated Risk Management and Assurance Strategy Page 103 App L

17 To receive the reports from the Board committees:
a) Audit Committee key issues, minutes, signed & sealed, Annual Report & revised draft Terms of Reference Page 134
b) Quality Committee key issues, minutes and Terms of Reference Page 167
c) Business Development and Investment minutes and draft Terms of Reference Page 184

INFORMATION

18 Director’s Reports Verbal
5 mins
19 Forward Planners Page 191 App N

20 Any other business

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

Date of Next Meeting: Tuesday 16th September – 1:00pm, Maudsley Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ. Please send apologies to Alison Baker 0203 228 4763
alison.baker@slam.nhs.uk

Please note that minutes from this meeting are a public document and will be published on the Internet and may be requested under the Freedom of Information Act (2000). Any attendee that would like their name omitted from the minutes should discuss this with the minute taker. Note that it may not always be possible to oblige as this is dependent on the persons role and the business being discussed.

web site: www.slam.nhs.uk
MINUTES OF THE SEVENTY SEVENTH MEETING OF THE BOARD OF DIRECTORS OF
THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 24TH JUNE 2014

PRESENT

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madeliene Long</td>
<td>Chair</td>
</tr>
<tr>
<td>Dr Martin Baggaley</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Dr Neil Brimblecombe</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Lesley Calladine</td>
<td>Non Executive Director</td>
</tr>
<tr>
<td>Dr Patricia Connell-Julien</td>
<td>Non Executive Director</td>
</tr>
<tr>
<td>Robert Coomber</td>
<td>Non Executive Director</td>
</tr>
<tr>
<td>Nick Dawe</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Alan Downey</td>
<td>Non Executive Director</td>
</tr>
<tr>
<td>Gus Heafield</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Dr Matthew Patrick</td>
<td>Chief Executive</td>
</tr>
</tbody>
</table>

IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Allen</td>
<td>Service Director, Addictions CAG</td>
</tr>
<tr>
<td>Alison Baker</td>
<td>PA to Chair &amp; Non Executive Directors</td>
</tr>
<tr>
<td>Kay Burton</td>
<td>Head of Mental Health Act Administration</td>
</tr>
<tr>
<td>Lucy Canning</td>
<td>Service Director, Psychosis CAG</td>
</tr>
<tr>
<td>Sarah Crack</td>
<td>Head of Communications</td>
</tr>
<tr>
<td>Steve Davidson</td>
<td>Service Director, MAP &amp; Psych Medicine CAGs</td>
</tr>
<tr>
<td>Eleanor Davies</td>
<td>Service Director, B&amp;DP CAG</td>
</tr>
<tr>
<td>Mark Ganderton</td>
<td>Council of Governors</td>
</tr>
<tr>
<td>Louise Hall</td>
<td>Director of Human Resources</td>
</tr>
<tr>
<td>Roy Jaggon</td>
<td>Head of Performance Management</td>
</tr>
<tr>
<td>Paul Mitchell</td>
<td>Trust Board Secretary</td>
</tr>
<tr>
<td>David Norman</td>
<td>Service Director, Older Adults and Dementia CAG</td>
</tr>
<tr>
<td>Rosie Peregrine-Jones</td>
<td>Assistant Director of Quality and Assurance</td>
</tr>
<tr>
<td>Zoë Reed</td>
<td>Director of Organisation and Community</td>
</tr>
<tr>
<td>Steven Thomas</td>
<td>Audit Committee Secretary (from Item 11 onwards)</td>
</tr>
<tr>
<td>Noel Urwin</td>
<td>Council of Governors</td>
</tr>
</tbody>
</table>

APOLOGIES

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Shitij Kapur</td>
<td>Non Executive Director</td>
</tr>
<tr>
<td>Prof Tom Craig</td>
<td>R&amp;D Director</td>
</tr>
<tr>
<td>Jo Fletcher</td>
<td>Service Director, CAMHS CAG</td>
</tr>
<tr>
<td>Angela Flood</td>
<td>Council of Governors</td>
</tr>
</tbody>
</table>

DECLARATIONS OF INTEREST

Routine declarations were made:

- Madeliene Long declared an interest as an Honorary Fellow of King’s College London.
- Dr Patricia Connell-Julien declared an interest as a former employee of King’s College London and as a Trustee of Southside Certitude Support.
**WELCOMES**

Madeliene Long welcomed the two new NEDs, Lesley Calladine and Alan Downey, to their first Board meeting.

**MINUTES**

The minutes of the meeting held on the 27th May 2014 were agreed as an accurate record of the meeting.

**BOD 74/14 MATTERS ARISING**

There were no matters arising from the previous minutes.

**BOD 75/14 SAFE STAFFING REPORT**

Dr Neil Brimblecombe explained that an earlier version of this report had been received by the Audit Committee who had made some amendments. Concerns regarding staffing levels and the skills of staff nationally were highlighted through a series of enquiries concerning the failings of care at Mid-Staffordshire Hospital. In October 2013 the Government published its response, which included a number of requirements for the future monitoring and measurement of staffing levels in all care settings.

The National Quality Board produced guidance so as to support organisations in making the right decisions and creating a supportive environment where staff were able to provide compassionate care. This currently only applied to inpatient care services.

Trust Boards were now clearly defined as having direct responsibility for agreeing and monitoring nursing staffing levels and ensuring that specific processes were in place that would demonstrate whether Trusts were meeting their planned staffing levels. An estimate of future staffing needs and current and future arrangements to maximise the effectiveness of ward staff had been carried out.

The need for increases in the number of nursing/support worker posts had been identified on several wards, with the most significant changes within mental health of Older Adults; Psychosis, primarily Lewisham and Southwark Wards and Triage wards at night.

Robert Coomber commented that the trust was not out of line with other similar providers. Dr Neil Brimblecombe and Elaine Rumble both confirmed that none of the wards mentioned had been unsafe regarding clinical staffing. Dr Patricia Connell-Julien commented that other staff groups impact on the quality of service provided.

The first monthly publication of planned and actual staff numbers had demonstrated a number of wards had experienced difficulty in ensuring the expected number of registered nurses arrived on shift. Plans were in place to deliver on these aspects of Safe Staffing guidance.

The report contained a table which laid out some of the key approaches adopted by the Trust, in line with national guidance, to promote and assure safe and efficient inpatient services.
Further actions would be to review the contribution of non-nursing clinical staff in inpatient settings within 6 months and provide monthly exception reports and planned actions to the Board where planned staffing rates on individual wards were significantly unmet. It had been agreed to report to the Board of Directors if the breach was more than 20%. The team would also be creating a centralised e-rostering support service and carry out further support worker development activities. The Board of Directors would also receive six monthly reviews of inpatient staffing. **Action: Dr Neil Brimblecombe.**

Dr Matthew Patrick commended this major piece of work which provided a helpful starting position to what would be an ongoing area of activity.

**The Board of Directors noted the national guidance and supported the changes in inpatient staffing recommended by the Safe Staffing review.**

**BOD 76/14 CLINICAL AUDIT ANNUAL REPORT 2013/14**

Dr Neil Brimblecombe explained that this report informed the Board of Directors of the corporate clinical audit work that had been undertaken in 2013/14 and highlighted priorities for 2014/15. Key achievements for the corporate audit programme and related activity over the past year had included, the delivery of the prioritised annual audit plan, where 33 projects had been completed by end of March 2014 and 5 projects were underway and carried over to the 2014/15 programme. 60% of projects in 2013/14 were monitoring NHS England or LSLC CQUINs or quality contract standards, which was an increase compared to the previous year. These projects had successfully contributed to the overall outcome of 100% compliance on QCUIN targets in 2013/14.

In terms of impact of the trustwide audit programme some improvements implemented following audits included, a new Mental Health Act practice note and the offer of guidance to staff on the rights of informal patients. Following the DNAR and the self–harm NICE audits, a patient information leaflet on cardiopulmonary resuscitation (CPR) had been produced and self-harm and crisis leaflets for each Borough had been produced.

Quarterly training workshops had been provided throughout 2013/14 and had been advertised on the Trust intranet Education & Training site, a total of 37 staff attended the sessions with an average feedback score of 3.5/4 (Good/Very Good).

In response to the Francis report and subsequent changes proposed for health care regulation, some key priorities for the CAET in 2014/15 include a Being Open audit and the annual review of SI and Complaints recommendations to aid prioritisation of policy, audit and QI resources.

**The Board of Directors noted the objectives/priorities for inclusion in 2014/15 program.**

**BOD 77/14 FINANCE REPORT – MONTH 2**

Gus Heafield reported budgets were being finalised but the Trust was behind plan at month 2. The Trust was reporting a £0.1m net surplus, which was £0.5m adverse variance from current plan, with £2.4m EBITDA, which was £0.4m adverse variance from current plan. There remained on-going issues that needed
to be addresses which were causing the current position to be off plan but Mr Heafield reported that he expected the Trust to be on plan at the end of Q1. These included ward nursing costs which were £286k off plan. Additional funding had been set aside to increase nursing establishments in certain areas following a Director of Nursing led review, however this funding did not fully cover the current rate of overspend and implied that the overspend was not solely a funding issue.

£2.25m of CIPs were not identified in the Plan and were impacting on the month 2 position by £0.4m. Additional Trustwide CIPs of £1.7m which were identified still had detailed plans to be developed. The Trust retained secondary commissioning responsibility for many non-forensic placements in Lambeth, Southwark and Lewisham. At month 2 these placements were £0.4m over, although interim transitional support had improved the financial positions in the Psychosis and B&D CAGs, they remained significantly overspent.

Progress had been significant for bed management, now there was a need to clarify the trajectory for the rest of the year and timings over internal capacity. This would be coming back to the Board next month.

Gus Heafield explained that the CIPs programme office would soon be operational and he would be ensuring that it tied in with performance management arrangements. Neil Brimblecombe reported that CIPs with significant clinical implications would be tested through Monitor’s quality impact assessment process.

**The Board of Directors noted the report.**

**BOD 78/14 SUMMARY PERFORMANCE REPORT MAY 2014**

Nick Dawe explained that this reported the Trust’s performance against the Operational Plan 2014/16 targets, and identified any major areas of learning and success.

The Trust’s position remained amber, however there had been significant improvements in performance as well as in the robustness and reporting information. We continued to make progress with programs as described in the Trust Operational Plan, in particular the AMH programme continued to deliver, as did the programmes for forensic services and CAMHS.

The operational perspective was considered red, this was due to total activity, capacity and overspill fall within planned and expected levels. There was one major national performance measure which was being failed. HTT gatekeeping continued to be below target, despite a programme of mitigation it was clear that this would not be met for the Q1 Monitor return.

Four Section 136 suites were reporting no availability, this was normally due to their being insufficient staffing available on the host ward. Immediate action to improve staffing levels had been actioned and plans to increase the number of individual rooms and consider consolidation of location was underway, and aimed for September 2014.

**The Board of Directors noted the report.**
BOD 79/14 REPORT FROM THE CHIEF EXECUTIVE
Dr Matthew Patrick reported that the London Health Commission’s work continued with a report due in the Autumn, he was representing Mental Health on the Committee. Emerging priorities included public health, younger people and mental health.

Meetings with the four Local Authorities were currently taking place, this was valuable work particularly in relation to social care going forward.

The Board of Directors noted the report.

BOD 80/14 REPORT FROM THE COUNCIL OF GOVERNORS
Mark Ganderton reported that the recent meeting of the Council of Governors, a presentation on the Trust strategy had been made Dr Matthew Patrick, Gus Heafield and Nick Dawe.

The Quality Group had recently met where the final draft of the Quality Account was discussed, with a statement produced following the meeting for inclusion in the Quality Account.

The bids group had also met recently, and the 2014 programme “Smile for Health” had now received 230 expressions of interest. The deadline for submission of bids was 4th July.

A meeting was being arranged to discuss possible revisions to the FT Constitution.

The Board of Directors noted the report.

BOD 81/14 KINGS HEALTH PARTNERS UPDATE
Madeliene Long explained that the CAGs had produced “Outcome” books (copies were available at the meeting). The books had also been available at the recent KHP Conference. Dr Matthew Patrick reported that they would be revised next year.

Madeliene Long reported that Simon Stevens, Chief Executive of NHS England, had spoken at the recent KHP Conference.

Madeliene Long confirmed that a KHP joint Governors meeting was being arranged. There was a KHP four way Board meeting taking place on 22nd July 2014.

The Board of Directors noted the verbal report.

BOD 82/14 MENTAL HEALTH ACT MANAGEMENT ANNUAL REPORT 2013/14
Dr Patricia Connell-Julien explained that this report informed the Board of Directors of Mental Health Act developments, activity and areas of concern for the year 2013/14, and thanked Kay Burton and her team for their hard work throughout the year.

Kay Burton explained that the Supervised Confinement working group had continued through the year focusing on review of the policy and reviewing the environment of the supervised confinement rooms. PAN London AHM training
continued with a small project group set up to complete the training package. The project had progressed with each participating organisation taking responsibility for designing a specific module.

During the year 2013-14 the Trust had used the Act on 3,847 occasions, this was a reduction of 1.5% on 2012/13. The highest use of the MHA was seen in the Psychosis CAG, followed by Psychological Medicine CAG, with Section 2 continuing to be the most used section and accounted for 78% of the total use, with section 3 accounting for 15%.

Kay Burton explained that questionnaires had been sent out regarding paper only hearings and the feedback would be collated. A meeting would be arranged for some time in August where representatives from the Council of Governors would be invited as well as the original working party. **Action: Kay Burton/Dr Patricia Connell-Julien.**

**The Board of Directors noted the report.**

**BOD 83/14 KEY POINTS FROM QUALITY SUB COMMITTEE AND TOR**

Dr Neil Brimblecombe introduced this report which summarised the key points of discussion at the preparatory meeting of the Quality Sub Committee, and contained the Terms of Reference for the Committee which had been updated.

Madeliene Long emphasised the importance of an effective Quality Committee in terms of the overall governance of the organisation. Lesley Calladine, Non-Executive Director would be Chairing the committee, and it had been agreed to include more senior clinical representation. Lesley Calladine confirmed that she would be meeting with Dr Neil Brimblecombe to take forward the work of the committee.

**The Board of Directors noted the report, and agreed the Terms of Reference for the Quality Committee.**

**BOD 84/14 DIRECTOR’S REPORTS**

- **Madeliene Long** – reported that she had recently attended a ward round, which had been an interesting experience, it highlighted the pressures and difficulties faced, however it also showed the commitment and professionalism of the staff.

  Madeliene Long, along with Dr Matthew Patrick, had attended the NHS Annual Conference held in Liverpool.

  Madeliene Long reported that she would be speaking at the FTN Governance Conference the following week.

**BOD 85/14 FORWARD PLANNERS**

The Forward planner was noted.

**BOD 86/14 ANY OTHER BUSINESS**

No other business was considered.
BOD 87/14 MOTION TO EXCLUDE THE PRESS AND PUBLIC

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

The date of the next meeting will be: **Tuesday 29th July 2014 – 3:00pm Maudsley Board room, Maudsley Hospital, Denmark Hill, London, SE5 8AZ**

Chair
Date of Board meeting: 29/7/14

Name of Report: AMH Presentation

Heading: - Presentation

Author: Fran Bristow

Approved by: Martin Baggaley & Nick Dawe
(name of Exec Member)

Presented by: Fran Bristow, Lucy Canning, Steve Davidson

Purpose of the report:
Up-date on AMH implementation

Action required:
For information

Recommendations to the Board:

Relationship with the Assurance Framework (Risks, Controls and Assurance)
and level of assurance provided by the report - none, low, moderate, high:

Summary of Financial and Legal Implications:

Equality & Diversity and Public & Patient Involvement Implications:

Service Quality Implications:
Adult Mental Health Programme
Trust Board presentation

Fran Bristow, AMH Programme Director
Lucy Canning Service Director, Psychosis CAG
Steve Davidson, Service Director, MAP & PMed CAGs

July 29th 2014
The AMH Model – 3 main elements

1. Improved entry point to service and liaison interface with primary care.

2. Reducing Relapse rates and hospital bed usage through applying lessons from the EI model & from evidence about effective interventions in community teams

3. Transferring patients who no longer require secondary care to community/primary care settings

• Currently in place in Lambeth & Lewisham
The AMH Model – assumptions

• Is based on the proposition that reducing relapse, together with more effective demand management “at the front” and greater capacity in HTTs and community teams for crisis support reduces demand for beds so that we can make financial savings in time

• Recognises the crucial importance of community teams (including EI teams too) in the whole system of care

• Requires a considerable change in culture and that teams operate “leanly”

• Involves significant investment

• Aims for an overall reduction of 28% OBDs
Early intervention teams
• Emphasis on engagement and therapeutic optimism
• Smaller caseloads with enhanced skills
• Greater delivery of specific interventions

Home treatment
• Reduces rates and duration of admission
• Preferred by clients to hospital care

Relapse prevention
• Focus on prevention and early detection of relapse reduces crises and admissions
• Specialised out-patient mood disorder clinic

(Craig et al, 2004; Petersen et al, 2005; Garety et al, 2006)
(Burns et al, 1993; Murphy et al, 2012)
(Kessing LV, Hansen HV, Hvenegaard A et al, 2013)
### Governance

Programme Board – chaired by Medical Director

<table>
<thead>
<tr>
<th>5 workstreams:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings &amp; IT</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Clinical/Operational model</td>
<td>Clinical Directors</td>
</tr>
<tr>
<td>HR &amp; OD</td>
<td>Director of SLaM Partners + HR lead</td>
</tr>
<tr>
<td>Monitoring &amp; Evaluation</td>
<td>Clinical Director Psychosis CAG</td>
</tr>
<tr>
<td>Communications</td>
<td>Director Organisation &amp; Community</td>
</tr>
</tbody>
</table>
Implementation Phases

• Phase 1 set up (6 months) - complete
  – Engagement, development & consultation

• Phase 2 transition (4 months)
  – Moves, recruitment & training

• Phase 3 implementation (12 months)
  – Enhanced interventions, stabilisation, reduction in relapses, reduction in use of beds…… reduction in beds from end of this 12 months
Where we are at

• Lambeth & Lewisham
  Set up phase complete
  Transition phase May 14- Sept 14
  Implementation phase Sept 14-Sept 15

• Southwark and Croydon
  Due to commence phase 1 from April 15, but negotiations with commissioners mean we may start early
# Key Milestones

<table>
<thead>
<tr>
<th>Key milestone</th>
<th>status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move to new bases</td>
<td>complete</td>
</tr>
<tr>
<td>Move of service users between teams</td>
<td>To complete 1\textsuperscript{st} September 2014</td>
</tr>
<tr>
<td>Recruitment</td>
<td>Psychosis open day 25\textsuperscript{th} June</td>
</tr>
<tr>
<td></td>
<td>MAP recruitment – Lewisham complete</td>
</tr>
<tr>
<td></td>
<td>Lambeth interviews being held</td>
</tr>
<tr>
<td>Psychosis team based training</td>
<td>To complete Sept 2014</td>
</tr>
<tr>
<td>Leadership programme</td>
<td>To complete December 2014</td>
</tr>
<tr>
<td>Operational interfaces meetings – 2 weekly</td>
<td>To complete September 2014</td>
</tr>
<tr>
<td>to work through practical implementation</td>
<td></td>
</tr>
<tr>
<td>across interfaces</td>
<td></td>
</tr>
<tr>
<td>Team building &amp; Induction for new staff</td>
<td>To commence September 2014</td>
</tr>
</tbody>
</table>
Southwark

- Finalisation of the business case with the CCG – monthly meetings in place
- Service User and Carer engagement events in progress over July
- Aim to be ready for Scrutiny committee with the CCG & LA by September

Croydon

- In process of finalising business case
- Not sufficient funds for full AMH model, but agreeing which aspects of the model can be taken forward with funds available
Monitoring and Evaluation

- Baseline data being collected
- To commence monthly reporting from August 2014 in Lambeth & Lewisham
- Dashboard to be further developed to give reports at individual care co-ordinator, team, CAG and top level on monthly basis
- Fidelity to the model dashboard available to the Board from September
Current Risks

- Risk register review monthly at Programme Board
- 18 risks highlighted – only 2 red risks:
  - Failure to implement model due to inability to effect scale of change in terms of culture and working practice
  - Failure to implement to timescales due to slippage on milestones
- Mediation of risks
  - Training programmes, team building and leadership development programmes
  - CAG Executive team to team discussions & Q&A sessions
  - Currently on time – but keeping this as red until teams up and running in September
On-going actions

- Interfaces between pathways – fortnightly meetings
- Patient moves to new teams in Lambeth and Lewisham (running from 1st May to 1st September)
- Recruitment
- Staff training and development
- Team building
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 29 July 2014

Name of Report: Apprenticeship Scheme Overview

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

Author: John Sapani

Approved by: Louise Hall
(name of Exec Member)

Presented by: John Sapani

Purpose of the report:
To inform the Trust Board of Directors about the Apprenticeship scheme. To give the background information to support the presentation by one of the Apprentices.

Action required:
To note the report and support the scheme going forward.

Recommendations to the Board:
That the Board note the report and support the plan of action.

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

Summary of Financial and Legal Implications:

Equality & Diversity and Public & Patient Involvement Implications:
Apprenticeship Summary

Overview of the apprenticeship scheme

The main aim of this scheme is to support people with a lived experience of mental distress (i.e. who may or may not have been in touch with services) through their ‘recovery journey’ by developing a return to work programme or apprenticeships scheme. This is based on literature which highlights the fact that people with mental ill health are most disadvantaged in terms of employment. The literature also highlights the difficulty younger people (between the ages of 16-24) face regarding employment, so we also wish to support this population of young people who have experienced mental health distress and are likely to face a higher degree of barriers/challenges than anyone else. The recruitment process in phase 1 also highlighted the needs of those who have cared for someone who has experienced mental distress, so this opportunity was opened to them in phase 2 of the project.

A key part of the scheme is the contribution the apprentices make to services within the Trust, as part of their development. So this is a unique and innovative opportunity for services and wards within a variety of Clinical Academic Groups (CAGs) to be part of contributing to improving the quality of care and service delivery by supporting and using the lived expertise of those who have experienced mental health problems and carers.

The opportunity for both phases was made possible through funding competitively obtained from The Local Education and Training Board for South London (LETB).

Phase 1

Phase 1 of the project began in early 2013 and involved recruiting 5 people who have suffered mental distress into either an apprenticeship education administrator or trainers post within our education and training department. These apprentices will undergo workforce training and educational development for one year, in order to ultimately build their confidence and equip them with the necessary transferable skills to pursue employment of their choice, further educational development, on the job learning and contributing to the South London and Maudsley Trust (SLaM) Recovery College. These apprentices have currently been in post for 6 months.

During recruitment in phase 1 we got a high response from an interesting group of carers who wanted to apply for these opportunities, as they were also struggling to gain a route to employment, having experienced long absences from work due to caring responsibilities. Therefore, recognising the valuable experience and knowledge carers of those who lived with mental ill health can bring, we decided to extend the opportunity to them for phase 2 of the project.

Phase 2

Phase 2 of the project involved recruiting people with lived experience of mental distress as well as carers into an apprenticeship/return to work scheme to train them to be clinical
support workers. 4 people started on the 14th of July 2014. They have been attached to 4 carefully selected wards within our Trust (Addictions Acute Assessment Unit, National Autistic Unit, Chelsham and Hayworth wards) and as part of them learning on the job will undertake a Level 3 University of Competence in principles of Healthcare Practice course at London South Bank.

We will recruit apprentices from all ages, backgrounds, genders for one year. To also open this opportunity to people without them having to lose their benefits, I created two main routes of full time and part time working hours. These are as follows:

<table>
<thead>
<tr>
<th>Route 1</th>
<th>Route 2a</th>
<th>Route 2b</th>
</tr>
</thead>
<tbody>
<tr>
<td>They will spend a substantial proportion of their time as an apprentice actually doing the job they are developing a competence in. This will normally be for a minimum of 30 hours per week, but may be more. They will be paid for both the hours they spend working and studying in college.</td>
<td>Return to work experience If a person is in receipt of ESA (Employment Support Allowance) They will work 16 hours a week, but for no more than for 52 weeks. The rate of pay for this route will be £48.50 per week.</td>
<td>Return to work experience If a person is in receipt of Income support will work 16 hours a week, but can be longer that 52 weeks. Placement will be for 18 months. Rate of pay will be £20 per week.</td>
</tr>
<tr>
<td>Placement will be for 12 month</td>
<td>Placement will be for 12 months</td>
<td>Placement will be for 18 months</td>
</tr>
<tr>
<td>£5044 at £97 per week</td>
<td>£2522 at £48.50 per week</td>
<td>£1040 at £20 per week</td>
</tr>
<tr>
<td>Paid course fees</td>
<td>Paid course fees</td>
<td>Paid course fees</td>
</tr>
</tbody>
</table>

Those taking the full time route will spend 4 days within the prospective service learning and developing to required competencies to carry out the job. This will be supplemented through attending College one day a week. Those taking the part time routes will spend one day a week learning on the job and attending College one day a week.

All College fees and payments for work within the prospective service will be funded by the apprenticeship scheme.

To support the apprentices through this journey, each apprentice has been assigned to a professional staff from their prospective profession to act as mentor throughout the whole year.

A service evaluation will be completed with the apprentices after each year of the scheme to identify what work and what could be improved upon. This will also include narrative accounts of the apprentices’ experiences and outcomes achieved around their employment, education and personal Recovery. In addition, outcomes achieved for the service as a whole. Following this year there will be a 3 month follow up of apprentices to see where they are at after the scheme.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 29th July 2014

Name of Report: Finance Report

Heading: Performance & Activity

Author: Tim Greenwood, Mark Nelson
Finance Directorate, BRH

Approved by: Gus Heafield
(name of Exec Member)

Presented by: Gus Heafield

Purpose of the report:
The Finance Report provides an update on the financial position of the Trust as at 30th June 2014 (month 3). It also includes summary information from the draft Q1 in Year Monitoring Return which must be submitted to Monitor by the 31st July 2014 in line with the Compliance Framework. The Template enables Monitor to focus on actual performance in the most recent quarter and year to date and to verify that the Trust is achieving its plan, that it is meeting its healthcare targets/indicators and that its risk profile continues to justify its current risk ratings. In the event that Monitor identifies material issues through its in-year monitoring, it will communicate its conclusions to the Trust and indicate whether there is a need for any specific follow-up action.

Action required:
To note the contents of the Report/Monitoring Return and the financial pressures and for the members of the Board of Directors to satisfy themselves that actions are appropriate to address them.

Recommendations to the Board:
That the Trust Board of Directors approves the report on the financial position for June 2014.

That the Trust Board approves the Q1 in Year Financial Reporting Return and signature of the Finance Declaration that it will continue to maintain a continuity of service risk rating of at least 3 over the next 12 months

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The report is a key component of the assurance framework in terms of the effective and efficient management of resources.
Summary of Financial and Legal Implications:
The Trust must make the best possible use of public money and meet regulatory requirements and deliver to plan. As a Foundation Trust, the Trust’s financial performance is assessed by Monitor against the relevant quarter of the annual plan and against the overall plan. Monitor will adjust the annual risk rating if in-year monitoring shows significant adverse variance to plan which could increase the frequency and intensity of future monitoring. In cases where in-year monitoring reveals a significant breach of the Authorisation, the Trust may be subject to intervention and enforcement actions.

Equality & Diversity and Public & Patient Involvement Implications:
The report identifies activity and financial pressures that if not resolved may have implications on the Trust’s ability to deliver its equality, diversity and patient involvement commitments as set out in the Annual Plan

Service Quality Implications:
The report identifies activity and financial pressures that if not resolved may have implications on the Trust's ability to deliver its quality commitments as set out in the Annual Plan
**SLaM - Financial Overview as at 30th June 2014 (Q1 / Month 3)**

### Income and Expenditure

- **Continuity of Service Risk Rating (from 4)**
  - 0.02m net deficit (0.02m favourable variance from plan ytd)
  - €3.0m EBITDA (0.0m favourable variance from plan ytd)

Although the Trust has made progress on a range of issues, there remain outstanding risks and cost pressures that need to be resolved. In particular the Trust needs to make progress in the following areas:

- Finalisation of contracts with CCGs & NHS E including agreed QIPP and community investment plans
- Agrement of placements funding with 9kw CCG which is running at unsustainable levels
- Delivery of identified schemes for the £2.25m of CIPs unidentified in the Plan, together with the £1.7m of Trustwide CIPs which are phased to deliver towards the end of the year
- Ensure COUIN target of 100% is met as funding is fully committed
- Conclude work on safer staffing levels and budget adjustments including additional investment requirements from the Trust over £2.2m more than invested by CCGs through the tariff deflator
- Psychois off target by £1.3m ytd with overspends on placements, drugs, community staffing and unmet CIPs helping to drive the position. Recovery plan to be implemented
- Review of capital planning budgets and expenditure to agree approach to capitalisation of internal investment plans
- Agreement of placements funding with Swk CCG which is running at unsustainable levels
- Monitor upper risk indicator >115% of which cash in non-GBS bank deposit
- Monitor upper risk indicator <85% of which cash in non-GBS bank deposit
- Ensure CQUIN target of 100% is met as funding is fully committed
- Conclude work on safer staffing levels and budget adjustments including additional investment requirements from the Trust over £2.2m more than invested by CCGs through the tariff deflator

### Financial Position

- **Cumulative Net YTD Surplus (deficit)**
  - £0m
  - £1.8m
  - -0.1%
  - £0.02m net deficit (£0.2m favourable variance from plan ytd)

- **Cumulative EBITDA YTD**
  - €3.3m
  - €3.3m
  - 0.1%
  - €3.29m
  - €3.29m
  - 0.1%

### Key Financial Drivers

- Ward Nursing - €0.8m overspent
- Performance v CIP - €0.3m - 11% < target
- Complex/Non Secure Placements - €0.58m overspent
- Drugs - €0.2m overspent
- Cost per Case/Cost & Volume - €0.06m ytd > target
- Acute Overspill - €0.1m overspent excluding impact of risk share

### Comments:

Net deficit of £0.02m was £0.2m favourable variance from plan at the end of June. This included an operational deficit of £1.2m caused by overspends particularly in Psychosis, B&D and Estates. The operational deficit is being offset by the Trust contingency reserve at month 3 but these reserves will not be sufficient to negate the current run rate over the remainder of the year.
South London and Maudsley NHS Foundation Trust

Finance Report 2014/15 – June 2014 (month 3)

The Finance Report is split into 3 sections –

A) Headlines, Issues & Actions
B) Risks
C) Finance Analysis
D) Q1 Monitor Submission

Section A – Headlines, Issues & Actions

1. Headlines

Year to date
- £0.02m net deficit (£0.2m favourable variance from plan) – see Table 1
- £3.3m EBITDA (£0.1m favourable variance from plan) – see Table 1
- The Operational Plan performance was a Continuity of Service Rating of 4 with a liquidity rating of 4 based on liquidity of 31 days operating expenditure and a debt service ratio of 3 based on our planned EBITDA for Q1 of £3.2m.

Forecast
We are forecasting that the Trust will hit its financial targets within the Operational Plan for 14/15 (CoSRR of 4 and EBITDA £16m and net surplus of £1m) however there are some significant challenges to be delivered over the remaining 9 months of the year. The Operational plan targets for EBITDA rise from of £3.2m at Q1 to £3.5m in Q2, £4.2m in Q3 and £5m in Q4. This is in line with the CIPs profile. The challenges and risks are set out in the sections below.

2. Trust Summary Issues and Actions

Although the Trust has made progress on a range of issues, there remain outstanding risks and cost pressures that need to be resolved. In particular the Trust needs to make progress in the following areas:
- Finalisation of contracts with local CCGs. Contract sign off is imminent with Lambeth and Lewisham CCGs. Outstanding issues however remain with Southwark CCG re QIPP and NHS England placement transfer values and with
Croydon CCG re investment in inpatient/community services. Meetings are scheduled between the parties to seek resolution.

- The bed trajectory and AMH programme metrics for the year have been finalised. The trajectories in the CCG contracts anticipate a step change in our contracted capacity at the start of Q3. **Detailed plans to reduce our internal capacity in line with the bed trajectories are being developed.**

- In Croydon the levels and impact of the investment have been agreed in principle with the CCG for 14/15 with the focus shifting to the impact in 15/16 and beyond. **The Updated Business Case for Croydon investment has been submitted to the CCG and a decision is expected once it has gone through the CCG Governance and sign-off processes in September/October. There are no indications that this is a significant risk to sign-off of the proposals and the Trust is maintaining its current investment in Croydon beds and HTTs whilst awaiting a decision.**

- The Board will be aware that the risks on placements have been significantly reduced from 2013/14 as a result of transferring the budgets and liabilities on Forensic placements back to NHS England. The systems and processes have been improved to ensure smarter control of the budgets and better dialogue between the Trust and commissioners. The remaining placements budgets held by the Trust in Southwark and Lewisham continue to run at unsustainable levels (£0.6m overspent at Q1). The Trust has been in discussion with both CCGs to agree a way forward. **A performance model has been completed to demonstrate growth and cost pressures and a meeting is to be scheduled with Southwark CCG/LA later in July to reach agreement on risk share arrangements. A one in - one out process for planned non-emergency placements has been agreed with Lewisham CCG as an interim mitigating measure pending further discussions and a workshop arranged to discuss plans to address growth in demand. There is an expectation that the actions proposed could recover the position over the course of the remainder of the year.**

- Detailed work has been taking place with the CAGs to agree the safer staffing rotas for inpatient and community units. This has resulted in a higher level of investment than originally planned and is £2.2 more than the additional funding provided by CCGs through a reduced tariff deflator. The Trust identified additional investment as part of the operational plan to reflect actual performance in the services in 13/14. The investment requirement has been compounded by changes in the staffing requirements of MHOA continuing care homes following their transformation from homes for life to more intensive move on facilities. **The expectation is that once agreed and signed off that the wards and CAGs will manage within their total revised resource. Final meetings are due to take place at the end of the month with Executive sign off and agreement to invest will be part of the finalisation of the month 4 results.**

- The Psychosis CAG overspent by £0.5m (£1.3m ytd) in month 3 with overspends on placements (£0.2m), drugs (£0.1m), medical/community staffing (£0.1m) and unmet CIPs (£0.1m) helping to drive the position. The CAG is
  - Reviewing its use of paliperidone with a view to implementing alternatives and further measures
  - Implementing a plan to reduce drugs wastage that is expected to impact from August
- Exploring how junior doctor rotas can be made more efficient and to mitigate the impact of sickness and short notice absences on out of hours cover.

- The BDP CAG, despite being in receipt of transitional support to offset the loss of NHSE income, overspent by £0.07m (£0.5m ytd). The CAG has trading gaps on Offender Health, ADHD, Behavioural Genetics, NAU, Croydon LD and Placements. The BDP CAG has been working over the course of the last month on their assessment of the sustainability and viability of these services in terms of the contribution to the tripartite mission alongside the finances. We had intended that the CAG would present this to the Board however there has been insufficient time for agreement with the Executive before the presentation to the Board. There are some measures which the CAG are recommending which we propose we should proceed with prior to the next Board meeting in order to mitigate the pressure on costs. I can update the Board at the meeting on 29 July.

- The MHOA CAG overspent by £0.06m (£0.2m ytd) in month 3. The position is primarily driven by nurse staffing issues in the specialist care units and wards and will be largely dealt with following internal investment under the safer staffing review. We expect the budgets to be finalised as part of the month 4 reporting.

- We are working with the budget holders on the pressures within the infrastructure budgets and expect to have made substantial progress with these issues to report back to the next meeting. These actions will be to ensure budgets reflect the current requirements and costs; recharges of the internal capital planning team costs to the capital expenditure projects are appropriate; and action plans are being implemented to address any overperformance or financial issues. This will be reported back to the Board at its next meeting.

- Although capital expenditure moved closer to Plan in month 3, the Q1 position was still below Plan by 27%. As a result the Trust must submit a capital expenditure reforecast to Monitor for the remainder of the year (see Section D 3 for more detail).

Section B – Risks to the Plan

The income and expenditure account includes a number of assumptions/risks which were described last month and unless indicated otherwise have not been amended -

- There remains a gap in the CIP plans required to deliver a balanced financial plan; £2.25m of CIPs were not identified in the Plan and for prudence have been factored into the financial position in quarter 1. Additional offsetting CIP schemes have been identified and will feed into the position after Q1. An update on the whole CIP programme will be presented to the Board at the meeting in September.

- The contract with NHS E has not been signed although provisional agreement has been reached. The basis for the agreement was a one-off non-recurrent contribution of £750k from the Trust towards the gap in 14/15 which was matched by NHS England. As a result the forensic services commissioned by NHSE are operating at a cost in excess of our committed income. The details of the signed contract and implications and options for 15/16 will be presented to a future Board meeting in order to address the viability and sustainability issues for Forensic services.
o There remains a gap in the Lambeth, Southwark and Lewisham CCG QIPP plans; although agreement in principle has largely been reached with Lambeth and Lewisham, some QIPPs totalling £0.9m require detailed plans from Psychosis and MHOA to confirm their viability. The gap in Southwark of c£1.6m remains, some of which as a potential source of funding for the proposed investment in AMH. The gap includes the proposed reduction in Local Authority placements funding, and is subject to further discussion with the CCG/LA.

o The Plan assumed that £2.2m of funding previously removed by Southwark CCG to cover off a transfer of specialist funding to NHS E would be re-instated. Although £1.4m has been agreed with Southwark CCG as recurrent and therefore not in dispute in 13/14 or in future, the remaining gap is still to be resolved; a meeting took place with the Southwark Chief Finance Officer on 17th July to help clarify the position and agree a way forward. As a result a joint CCG/SLaM meeting with NHS E is being arranged to seek further resolution of the remaining balance.

o The Plan assumed £5.2m of funding from Croydon CCG to deal with the bed pressures in the borough, and agreement has been reached in principle but yet to be confirmed by the CCG once it has gone through its formal governance and approval processes. We do not think that there is a significant risk that the decision of the CCG will be materially different however their processes won’t conclude until September/October.

The Plan assumed that the Trust would achieve 100% CQUIN. This funding is fully committed and so any non-achievement will result in an adverse variance: CQUIN schemes have been agreed and Q1 requirements submitted to the CCGs for sign off. Currently there are no indications that target will not be met.

The Plan assumed Lewisham CCG support for the AMH model, but the CCG have stated their intent to put no further funding into this beyond the £300k invested in 2013/14; agreement has been reached for 14/15 but leaves a shortfall of £0.6m and a risk to the Plan that will increase in 15/16 without agreement to increase funding and/or transfer funding from resulting bed reductions.

Gus Heafield
Chief Financial Officer
July 2014
## Section C – Finance Analysis

### 1) Financial Summary

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Current Month Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
<th>Year To Date Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Psychosis</td>
<td>99,516,100</td>
<td>8,831,000</td>
<td>512,700</td>
<td>26,791,800</td>
<td>1,269,100</td>
</tr>
<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>0</td>
<td>69,800</td>
<td>69,800</td>
<td>474,300</td>
<td>474,300</td>
</tr>
<tr>
<td>03. Mood, Anxiety, Personality</td>
<td>668,900</td>
<td>70,000</td>
<td>30,700</td>
<td>217,900</td>
<td>59,200</td>
</tr>
<tr>
<td>04. Psychological Medicine</td>
<td>(184,900)</td>
<td>(160,400)</td>
<td>(145,000)</td>
<td>(211,300)</td>
<td>(165,100)</td>
</tr>
<tr>
<td>05. Child &amp; Adolescent Service</td>
<td>2,364,500</td>
<td>218,300</td>
<td>7,600</td>
<td>504,700</td>
<td>(91,600)</td>
</tr>
<tr>
<td>06. MHOA And Dementia</td>
<td>652,600</td>
<td>117,700</td>
<td>63,300</td>
<td>385,300</td>
<td>222,100</td>
</tr>
<tr>
<td>07. Addictions</td>
<td>0</td>
<td>(48,800)</td>
<td>(48,800)</td>
<td>(41,700)</td>
<td>(41,700)</td>
</tr>
<tr>
<td>08. Clinical Support Services</td>
<td>1,830,900</td>
<td>149,600</td>
<td>(3,000)</td>
<td>499,000</td>
<td>41,300</td>
</tr>
<tr>
<td>09. Infrastructure Directorates</td>
<td>49,016,500</td>
<td>4,357,100</td>
<td>493,100</td>
<td>12,678,500</td>
<td>236,000</td>
</tr>
<tr>
<td>10. Corporate Income</td>
<td>(99,050,600)</td>
<td>(8,098,600)</td>
<td>211,700</td>
<td>(25,011,200)</td>
<td>236,000</td>
</tr>
</tbody>
</table>

**Operational Deficit**

<table>
<thead>
<tr>
<th></th>
<th>Full Year Live Budgets (£)</th>
<th>Current Month Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
<th>Year To Date Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Corporate Other</td>
<td>(81,407,000)</td>
<td>(6,338,300)</td>
<td>194,700</td>
<td>(19,579,800)</td>
<td>197,800</td>
</tr>
<tr>
<td>12. Contingency - planned</td>
<td>2,405,000</td>
<td>0</td>
<td>(200,417)</td>
<td>0</td>
<td>(601,250)</td>
</tr>
<tr>
<td>13. Contingency - committed</td>
<td>4,637,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14. Other reserves/provisions released</td>
<td>3,532,100</td>
<td>0</td>
<td>(1,683,483)</td>
<td>0</td>
<td>(2,532,350)</td>
</tr>
</tbody>
</table>

**Corporate Other**

<table>
<thead>
<tr>
<th></th>
<th>Full Year Live Budgets (£)</th>
<th>Current Month Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
<th>Year To Date Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(70,832,900)</td>
<td>(6,338,300)</td>
<td>(1,689,200)</td>
<td>(19,579,800)</td>
<td>(2,935,800)</td>
</tr>
</tbody>
</table>

**EBITDA**

|                      | (16,018,900)              | (832,600)                | (497,100)                     | (3,292,500)            | (77,700)                     |

**15. Post EBITDA Items**

|                      | 15,085,000                | 938,000                  | (215,000)                     | 3,316,400              | (137,600)                    |

**Trust Financial Position**

|                      | (933,900)                 | 105,400                  | (712,100)                     | 23,900                 | (215,300)                    |

### Area

<table>
<thead>
<tr>
<th>Area</th>
<th>2013/14 Total Variance</th>
<th>2014/15 Total Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>CAGs</strong></td>
<td>(1,082)</td>
<td>(1,212)</td>
</tr>
<tr>
<td>Infrastructure Directorates</td>
<td>(459)</td>
<td>(301)</td>
</tr>
<tr>
<td>Corp Income</td>
<td>(97)</td>
<td>(16)</td>
</tr>
<tr>
<td>Other reserves/provisions released or Unidentified CIPs</td>
<td>(113)</td>
<td>(201)</td>
</tr>
<tr>
<td>Use of Contingency prior to finalising budget allocations</td>
<td>500</td>
<td>1,585</td>
</tr>
<tr>
<td><strong>Total EBITDA</strong></td>
<td>(1,251)</td>
<td>(146)</td>
</tr>
</tbody>
</table>

32 of 191
2. Key Cost Drivers

Note – for B&D £3.5m of transitional funding has been provided in 14/15, overspending forensic placements transferred to NHS E from 1/4/14 and NDS closed in Q4 13/14

<table>
<thead>
<tr>
<th>Area</th>
<th>13/14 Mth 10 Variance £000</th>
<th>13/14 Mth 11 Variance £000</th>
<th>13/14 Mth 12 Variance £000</th>
<th>2014/15 Mth 1 Variance £000</th>
<th>2014/15 Mth 2 Variance £000</th>
<th>2014/15 Mth 3 Variance £000</th>
<th>2014/15 Total Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Nursing</td>
<td>(79)</td>
<td>(167)</td>
<td>(276)</td>
<td>(130)</td>
<td>(286)</td>
<td>(142)</td>
<td>(558)</td>
</tr>
<tr>
<td>Acute Overspill</td>
<td>(274)</td>
<td>(140)</td>
<td>(193)</td>
<td>0</td>
<td>0</td>
<td>(129)</td>
<td>(129)</td>
</tr>
<tr>
<td>Unmet CIPs*</td>
<td>(139)</td>
<td>(242)</td>
<td>(106)</td>
<td>(70)</td>
<td>(282)</td>
<td>54</td>
<td>(298)</td>
</tr>
<tr>
<td>Psychosis Drugs</td>
<td></td>
<td></td>
<td></td>
<td>(39)</td>
<td>(87)</td>
<td>(89)</td>
<td>(215)</td>
</tr>
<tr>
<td>CPC/C&amp;V Income</td>
<td>(191)</td>
<td>(549)</td>
<td>(462)</td>
<td>(62)</td>
<td>16</td>
<td>110</td>
<td>64</td>
</tr>
<tr>
<td>Placements</td>
<td>(48)</td>
<td>(72)</td>
<td>(109)</td>
<td>(213)</td>
<td>(145)</td>
<td>(230)</td>
<td>(588)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>(731)</strong></td>
<td><strong>(1,170)</strong></td>
<td><strong>(1,146)</strong></td>
<td><strong>(514)</strong></td>
<td><strong>(784)</strong></td>
<td><strong>(426)</strong></td>
<td><strong>(1,724)</strong></td>
</tr>
</tbody>
</table>

* excludes the acute overspill CIP as this is reflected explicitly in the row above

Performance against the main cost drivers is detailed below –

- **Acute/PICU Overspill**

Overall, 11 beds were used outside the Trust in June, a decrease of 12 compared to the previous month. This puts the Trust slightly ahead of Plan after 3 months following additional measures taken to address the overspill issue. Two downward step changes have been built into the Plan to reflect the opening of 6 additional beds on Bethlem Triage and the impact of AMH investment from October. Although obds are below plan there is a £0.1m adverse variance due to a shortfall in funding of the Plan.
Note – excludes impact of any risk share agreements. From month 7, the updated plan requires a step change reduction in internal beds to bring it in line with the contracted CCG bed day trajectory

- **Ward/Unit Nursing Costs (Table 2)**

At month 3 ward nursing costs were overspent by £558k, an increase of £142k in the month, spread across a number of wards but particularly impacting CAMHS, Psychological Medicine and MHOA. A significant element of the current reported overspend relates to budget allocations pending and agreement has been reached on the detailed budgets within Psychosis and MHOA CAGs and the budget allocations for the CAGs will be finalised to feed into the Month 4 positions.

- **Complex Placements**

Forensic placements transferred to NHS E at the start of the year having overspent by £2.3m in 2013/14. The Trust remains the secondary commissioner for other placements in Lambeth, Southwark and Lewisham. In month 3 these placements overspent by £230k (£558k year to date). The majority of the overspend (68%) relates to Southwark where the Council is intending to reduce its funding contribution significantly. Discussions continue with the CCG/Council to establish an appropriate level of funding. Small risk shares are in place in Lambeth and Southwark but are not sufficient to mitigate a forecast overspend of £2.4m (excluding any reductions in local authority funding).
- **Cost per Case/Cost and Volume**

The position has moved slightly ahead of Plan (0.3%) and represents a large improvement from 2013/14 following the closure of the AED and NDS units. The main areas of concern continue to be the ADHD service and the Addictions Assessment Unit (AAU) where activity remains below target. The adverse position of the AAU is in spite of the Trust providing both transitional support of £470k and payment of £320k to access 2 beds as part of the acute overspill plan.

---

### Variable Income (Cumulative) Variance From Plan (By CAG)

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 3 £'000</th>
<th>Actual Invoiced At Month 3 £'000</th>
<th>Surplus/ Deficit(-) At Month 3 £'000</th>
<th>Surplus/ Deficit(-) Last Month £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>952</td>
<td>981</td>
<td>29</td>
<td>24</td>
</tr>
<tr>
<td>Behavioural &amp; Dev</td>
<td>4,820</td>
<td>4,757</td>
<td>(63)</td>
<td>(20)</td>
</tr>
<tr>
<td>Psychological Med</td>
<td>4,214</td>
<td>4,286</td>
<td>71</td>
<td>(17)</td>
</tr>
<tr>
<td>Mood and Anxiety</td>
<td>2,584</td>
<td>2,584</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>CAMHS</td>
<td>5,415</td>
<td>5,461</td>
<td>45</td>
<td>(2)</td>
</tr>
<tr>
<td>Addictions</td>
<td>459</td>
<td>441</td>
<td>(18)</td>
<td>(40)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>18,445</strong></td>
<td><strong>18,510</strong></td>
<td><strong>64</strong></td>
<td><strong>(46)</strong></td>
</tr>
</tbody>
</table>
4. **Cost Improvement Programme (CIP) & CCG QIPP**

   **a) Trust CIP (Table 4)**

   The Trust is reporting an overall adverse variance of £298k (11%) against its original Q1 Monitor plan of £2.8m. This is an improvement from month 2. The main areas of current variance have been highlighted in previous reports. This includes both a delay in closing Gresham PICU and requirement to utilise the savings to fund external placements, continuing pay overspends in MAP A&T teams which were planned to be addressed by month 1 and expected pay savings in B&D not yet materialising. These adverse variances have been partly offset by savings that have been delivered ahead of plan in MHOA. Further CIPs schemes are being developed and the full pictures of the CIP programme will be presented to the Board at the next meeting.

   Specific schemes are being identified and planned to meet those CIPs which were unidentified and those which were Trustwide projects at the time of the Operational Plan was being finalised. These are expected to begin delivering in the second half of the year but we continue to flag these as a risk for delivery in the financial forecasts.

   **b) CCG QIPP (disinvestment) - Table 5**

   There was an estimated shortfall of £396k against the CCG QIPP target attributable to SLaM. However most of this shortfall is not included within the month 3 position as the detailed plans to meet the QIPP targets have yet to be agreed. In total £2.5m of CCG QIPP savings have yet to be agreed/identified (out of a total QIPP target of £5.9m) although removed from the block contracts. The Trust will not sign up to savings plans that cannot be delivered and alternative approaches will be sought if the current proposals are not feasible.

5. **Local CCG Contract Positions**

   Contracts with our 4 local CCGs have yet to be signed although 2 are now imminent. The main outstanding financial issues are largely to do with QIPP (and whether the plans to remove funding are reasonable or not) and investment in the AMH model –

   - **Lambeth** – c£0.6m of QIPP schemes do not have detailed plans in place and are therefore still subject to agreement.
   - **Southwark** – c£1.1m of QIPP schemes remain to be agreed. In addition the Local Authority is intending to reduce their contribution to the placements budget which is overspent at Q1 as described earlier. Agreement has been reached with the CCG over part of the 13/14 transfer of funding to NHS E for specialist services. The Trust and CCG are pursuing further discussions with NHSE to resolve the remaining element of approximately £800k
   - **Lewisham** - £1m of QIPP schemes have been agreed in principle but detailed plans are required to confirm their viability. There remains a gap in funding of the AMH model of £0.65m which was not built into the Trust Plan.
   - **Croydon** – although an in principle agreement has been reached over the details and requirements of the investment of £5.2m in 14/15 we are awaiting formal agreement and sign-off by the CCG.
6. Capital Expenditure

Monitor has retained a risk indicator for capital expenditure – the risk indicator being triggered by capital expenditure being +/- 15% against Plan.

Capital expenditure at month 3 is £2.4m against current planned expenditure of £3.4m. This represents a 27% variance from plan and will therefore require a resubmission of the year 1 (2014/15) capital plan within the Q1 Monitor return – this will be covered in detail elsewhere on the agenda as is provisional subject to agreement by the Board in relation to the Estates Strategy Implementation.

The main variances from plan in 14/15 are -

- £750k slippage on ward refurbishment programme but due to accelerate in Q3/Q4 as a result of the Douglas Bennett House proposals being presented to the Board separately
- £577k slippage on the EDU move to Maudsley AL2

Ward Refurbishment programme – The original intention was an allowance of £500k for six wards across the Trust, however just prior to the start of the FY it was decided that a better intention would be to complete a building as a whole, so the team are currently reviewing Douglas Bennett House to refurbish this in the second half of this financial year.

EDU – McKenzie ward is undergoing a period of essential refurbishments whilst it is decanted which has extended the programme – as a result the service are remaining in AL2 slightly longer than planned. However, the works programme has been reviewed by the capital team and they expect to deliver the project by Christmas as planned, but with a shorter site programme.

Section D – Draft Q1 Monitor Submission

The Financial and Governance Combined Return must be submitted to Monitor by the 31st July 2014 in line with the Compliance Framework. The in-year reporting return enables Monitor to focus on actual performance in the most recent quarter and year to date and to verify that the Trust is achieving its plan, that it is meeting its healthcare targets/indicators and that its risk profile continues to justify its current risk ratings. In the event that Monitor identifies material issues through its in-year monitoring, it will communicate its conclusions to the Trust and indicate whether there is a need for any specific follow-up action.

1. Draft Q1 In-Year Reporting Return

The in-year return is reporting a Q1 breakeven position and £3.3m of EBITDA. This is consistent with Sections A and C of the Board Report.

2. Forecast Continuity of Service Risk Rating

The CoSRR comprises two financial metrics that are averaged to calculate the overall rating:

1. Liquidity – number of days of operating costs held in cash or cash-equivalents
2. Capital servicing capacity – the degree to which income covers financial obligations i.e. debt service cover
The liquidity of the Trust is strong and is expected to remain at a rating of 4 over the next 12 months whilst we maintain our focus on delivery of the 2 year plan and resolution of emerging issues within the operational services.

The Trust has delivered the Q1 EBITDA target and although as indicated earlier the financial position will be under pressure in the remainder of the year with outstanding risks to address we expect to hit our financial targets.

It is on this basis I can confirm and recommend that the Board confirms - that the Trust will continue to maintain a continuity of service risk rating of at least 3 over the next 12 months

3. Capital Expenditure Declaration

As described above the Trust will need to make a reforecast of its capital position in its Q1 return to Monitor. The return is being considered separately on the Board agenda on 29 July 2014.

Gus Heafield
Tim Greenwood
Mark Nelson
July 2014
## South London & Maudsley NHS Foundation Trust

### Q1 Income & Expenditure Statement

#### Operating

##### NHS Clinical Revenue

<table>
<thead>
<tr>
<th>Description</th>
<th>£m (r/w)</th>
<th>Year ending 31-Mar-14</th>
<th>Year ending 31-Mar-14</th>
<th>Quarter ending 30-Jun-14</th>
<th>Quarter ending 30-Jun-14</th>
<th>Year to date ending 30-Jun-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Mandatory Non-protected revenue</td>
<td>307.158</td>
<td>£ 56.262</td>
<td>£ 56.156</td>
<td>-0.106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>72.949</td>
<td>-1.52</td>
<td>-1.52</td>
<td>-1.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from non-patient services to other bodies</td>
<td>72.949</td>
<td>-1.52</td>
<td>-1.52</td>
<td>-1.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>308.160</td>
<td>0.25</td>
<td>0.25</td>
<td>0.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Revenue, Total</td>
<td>53.827</td>
<td>0.188</td>
<td>0.188</td>
<td>0.188</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>306.707</td>
<td>0.27</td>
<td>0.27</td>
<td>0.27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Expenses within EBITDA, Total</td>
<td>-52.880</td>
<td>-0.50</td>
<td>-0.50</td>
<td>-0.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and Amortisation</td>
<td>-2.152</td>
<td>-0.09</td>
<td>-0.09</td>
<td>-0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Expenses excluded from EBITDA, Total</td>
<td>-54.032</td>
<td>-0.624</td>
<td>-0.624</td>
<td>-0.624</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Operating</td>
<td>-2.387</td>
<td>-0.025</td>
<td>-0.025</td>
<td>-0.025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Operating income</td>
<td>-2.387</td>
<td>-0.025</td>
<td>-0.025</td>
<td>-0.025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance income</td>
<td>-2.387</td>
<td>-0.025</td>
<td>-0.025</td>
<td>-0.025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Operating expenses</td>
<td>-2.387</td>
<td>-0.025</td>
<td>-0.025</td>
<td>-0.025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance Costs</td>
<td>-2.387</td>
<td>-0.025</td>
<td>-0.025</td>
<td>-0.025</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Plan for Variance for 39 of 191
<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Sense</th>
<th>Year ending 31-Mar-14</th>
<th>Year ending 31-Mar-14</th>
<th>Quarter ending 30-Jun-14</th>
<th>Quarter ending 30-Jun-14</th>
<th>Year to date ending 30-Jun-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest Expense on Bridging loans</td>
<td>£m</td>
<td>(-ve)</td>
<td>-0.001</td>
<td>0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
</tr>
<tr>
<td>Interest Expense on Non-commercial borrowings</td>
<td>£m</td>
<td>(-ve)</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
</tr>
<tr>
<td>Interest Expense on Commercial borrowings</td>
<td>£m</td>
<td>(-ve)</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
</tr>
<tr>
<td>Interest Expense on Finance leases (Non-PFI)</td>
<td>£m</td>
<td>(-ve)</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
</tr>
<tr>
<td>Interest Expense on PFI leases &amp; liabilities</td>
<td>£m</td>
<td>(-ve)</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
</tr>
<tr>
<td>Interest Expense, Total</td>
<td>£m</td>
<td>(-ve)</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
<td>-0.001</td>
</tr>
<tr>
<td>PDC dividend expense</td>
<td>£m</td>
<td>(-ve)</td>
<td>-7.008</td>
<td>-0.158</td>
<td>-7.166</td>
<td>-1.872</td>
<td>-1.872</td>
</tr>
<tr>
<td>Finance Costs [for non-financial activities], Total</td>
<td>£m</td>
<td>(-ve)</td>
<td>-7.008</td>
<td>-0.158</td>
<td>-7.166</td>
<td>-1.872</td>
<td>-1.872</td>
</tr>
<tr>
<td>Other Finance Costs</td>
<td>£m</td>
<td>(-ve)</td>
<td>-0.082</td>
<td>0.005</td>
<td>-0.077</td>
<td>-0.077</td>
<td>-0.077</td>
</tr>
<tr>
<td>Non-Operating expenses</td>
<td>£m</td>
<td>(-ve)</td>
<td>-7.09</td>
<td>-0.153</td>
<td>-7.243</td>
<td>-1.872</td>
<td>-1.872</td>
</tr>
<tr>
<td>Non-Operating expenses [including contingencies]</td>
<td>£m</td>
<td>(-ve)</td>
<td>-7.09</td>
<td>-0.153</td>
<td>-7.243</td>
<td>-1.872</td>
<td>-1.872</td>
</tr>
<tr>
<td>Non-Operating expenses, Total</td>
<td>£m</td>
<td>(-ve)</td>
<td>-7.09</td>
<td>-0.153</td>
<td>-7.243</td>
<td>-1.872</td>
<td>-1.872</td>
</tr>
<tr>
<td>Surplus/(Deficit) before Tax</td>
<td>£m</td>
<td></td>
<td>-6.971</td>
<td>-2.506</td>
<td>-7.268</td>
<td>-0.015</td>
<td>0.22</td>
</tr>
<tr>
<td>Memorandum lines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>£m</td>
<td></td>
<td>363.802</td>
<td>366.052</td>
<td>85.97</td>
<td>87.887</td>
<td>1.917</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>£m</td>
<td></td>
<td>370.773</td>
<td>373.977</td>
<td>-86.706</td>
<td>-87.903</td>
<td>-1.697</td>
</tr>
<tr>
<td>Total Operating Revenue for EBITDA</td>
<td>£m</td>
<td></td>
<td>365.542</td>
<td>362.616</td>
<td>85.052</td>
<td>87.445</td>
<td>2.399</td>
</tr>
<tr>
<td>Total Operating Expenses for EBITDA</td>
<td>£m</td>
<td></td>
<td>352.951</td>
<td>357.631</td>
<td>-81.829</td>
<td>-84.144</td>
<td>-2.315</td>
</tr>
<tr>
<td>EBITDA</td>
<td>£m</td>
<td></td>
<td>-8.05</td>
<td>5.923</td>
<td>3.223</td>
<td>3.301</td>
<td>0.078</td>
</tr>
<tr>
<td>EBITDA Margin Metric (YTD)</td>
<td>%</td>
<td></td>
<td>2.246</td>
<td>1.554</td>
<td>3.79%</td>
<td>3.776</td>
<td>3.216</td>
</tr>
<tr>
<td>Operating surplus/(deficit)</td>
<td>£m</td>
<td></td>
<td>-1.521</td>
<td>-4.256</td>
<td>-1.597</td>
<td>-1.872</td>
<td>-0.125</td>
</tr>
<tr>
<td>Surplus/(Deficit) After Tax</td>
<td>£m</td>
<td></td>
<td>-6.971</td>
<td>-2.506</td>
<td>-7.268</td>
<td>-0.015</td>
<td>0.22</td>
</tr>
<tr>
<td>Return after Financing</td>
<td>£m</td>
<td></td>
<td>-6.971</td>
<td>-2.506</td>
<td>-7.268</td>
<td>-0.015</td>
<td>0.22</td>
</tr>
<tr>
<td>Surplus/(Deficit) before impairments and transfers</td>
<td>£m</td>
<td></td>
<td>-6.971</td>
<td>-2.506</td>
<td>-7.268</td>
<td>-0.015</td>
<td>0.22</td>
</tr>
<tr>
<td>Cost Improvement Programmes</td>
<td>£m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue Generation Programmes</td>
<td>£m</td>
<td>/-ve</td>
<td>1.589</td>
<td>-0.003</td>
<td>1.564</td>
<td>1.696</td>
<td>1.699</td>
</tr>
<tr>
<td>Pay Expense savings CIP recurrent</td>
<td>£m</td>
<td>/-ve</td>
<td>7.472</td>
<td>0.05</td>
<td>7.522</td>
<td>0.778</td>
<td>-0.653</td>
</tr>
<tr>
<td>Pay Expense savings CIP non recurrent</td>
<td>£m</td>
<td>/-ve</td>
<td>7.472</td>
<td>0.05</td>
<td>7.522</td>
<td>0.778</td>
<td>-0.653</td>
</tr>
<tr>
<td>Drugs expense savings CIP recurrent</td>
<td>£m</td>
<td>/-ve</td>
<td>0.334</td>
<td>0.069</td>
<td>0.403</td>
<td>-0.069</td>
<td>-0.069</td>
</tr>
<tr>
<td>Drugs expense savings CIP non recurrent</td>
<td>£m</td>
<td>/-ve</td>
<td>0.334</td>
<td>0.069</td>
<td>0.403</td>
<td>-0.069</td>
<td>-0.069</td>
</tr>
<tr>
<td>Misc. Other Operating Expenses CIP recurrent</td>
<td>£m</td>
<td>/-ve</td>
<td>3.117</td>
<td>0.087</td>
<td>3.124</td>
<td>0.219</td>
<td>0.138</td>
</tr>
<tr>
<td>Misc. Other Operating Expenses CIP non recurrent</td>
<td>£m</td>
<td>/-ve</td>
<td>3.117</td>
<td>0.087</td>
<td>3.124</td>
<td>0.219</td>
<td>0.138</td>
</tr>
<tr>
<td>Cost Improvement Programmes, Total</td>
<td>£m</td>
<td></td>
<td>12.992</td>
<td>0.124</td>
<td>12.872</td>
<td>2.773</td>
<td>2.482</td>
</tr>
<tr>
<td>CIP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>£m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>£m</td>
<td></td>
<td>363.802</td>
<td>366.052</td>
<td>85.97</td>
<td>87.887</td>
<td>1.917</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>£m</td>
<td></td>
<td>370.773</td>
<td>373.977</td>
<td>-86.706</td>
<td>-87.903</td>
<td>-1.697</td>
</tr>
<tr>
<td>Total Operating Revenue for EBITDA</td>
<td>£m</td>
<td></td>
<td>365.542</td>
<td>362.616</td>
<td>85.052</td>
<td>87.445</td>
<td>2.399</td>
</tr>
<tr>
<td>Total Operating Expenses for EBITDA</td>
<td>£m</td>
<td></td>
<td>352.951</td>
<td>357.631</td>
<td>-81.829</td>
<td>-84.144</td>
<td>-2.315</td>
</tr>
<tr>
<td>EBITDA</td>
<td>£m</td>
<td></td>
<td>-8.05</td>
<td>5.923</td>
<td>3.223</td>
<td>3.301</td>
<td>0.078</td>
</tr>
<tr>
<td>EBITDA Margin Metric (YTD)</td>
<td>%</td>
<td></td>
<td>2.246</td>
<td>1.554</td>
<td>3.79%</td>
<td>3.776</td>
<td>3.216</td>
</tr>
<tr>
<td>Operating surplus/(deficit)</td>
<td>£m</td>
<td></td>
<td>-1.521</td>
<td>-4.256</td>
<td>-1.597</td>
<td>-1.872</td>
<td>-0.125</td>
</tr>
<tr>
<td>Surplus/(Deficit) After Tax</td>
<td>£m</td>
<td></td>
<td>-6.971</td>
<td>-2.506</td>
<td>-7.268</td>
<td>-0.015</td>
<td>0.22</td>
</tr>
<tr>
<td>Return after Financing</td>
<td>£m</td>
<td></td>
<td>-6.971</td>
<td>-2.506</td>
<td>-7.268</td>
<td>-0.015</td>
<td>0.22</td>
</tr>
<tr>
<td>Surplus/(Deficit) before impairments and transfers</td>
<td>£m</td>
<td></td>
<td>-6.971</td>
<td>-2.506</td>
<td>-7.268</td>
<td>-0.015</td>
<td>0.22</td>
</tr>
<tr>
<td>Key to Scoring</td>
<td>Revenue Available for Capital Service</td>
<td>Capital Service</td>
<td>Capital Service Cover</td>
<td>Capital Service Cover metric</td>
<td>Capital Service Cover rating</td>
<td>Liquidity</td>
<td>Operating Expenses within EBITDA, Total</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------</td>
<td>----------------</td>
<td>-----------------------</td>
<td>----------------------------</td>
<td>-----------------------------</td>
<td>-----------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1.872</td>
<td>1.78x</td>
<td>3</td>
<td>2.5 1.75 1.25 &lt;1.25</td>
<td>29.091</td>
<td>-84.555</td>
</tr>
</tbody>
</table>

**Continuity of Service Risk Ratings At Q1**

**Reported YTD to 30-Jun-14**

**£m**

1) **Capital Service Cover**

- PDC dividend expense
- Interest Expense on Overdrafts and Working Capital Facilities
- Interest Expense on Bridging loans
- Interest Expense on Non-commercial borrowings
- Interest Expense on Commercial borrowings
- Interest Expense on Finance leases (non-PFI)
- Interest Expense on PFI leases & liabilities
- Other Finance Costs
- Non-Operating PFI costs (eg contingent rent)
- Public Dividend Capital repaid
- Repayment of bridging loans
- Repayment of non-commercial loans
- Repayment of commercial loans
- Capital element of finance lease rental payments - On-balance sheet PFI
- Capital element of finance lease rental payments - other

**Key to Scoring**

- Revenue Available for Capital Service: 3.327
- Capital Service: -1.872
- Capital Service Cover: 1.78x
- Capital Service Cover metric: 3
- Capital Service Cover rating: 2.5 1.75 1.25 <1.25

2) **Liquidity**

- Working capital balance (for use in CoS rating calculation)
- Operating Expenses within EBITDA, Total
- Liquidity metric (days)
- Liquidity rating

**Continuity of Service Risk Rating**: 4
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 29th July 2014

Name of Report: Summary Performance Report, July 2014

Heading: Performance

Author: Roy Jaggon, Head of Performance Management

Approved by: Nick Dawe, Chief Operating Officer

Presented by: Nick Dawe, Chief Operating Officer

Purpose of the report:

To report the Trusts’ performance against the Operational Plan 2014/15 targets, identify any major areas of learning and success, identify and analyse underperformance and provide action plans to address such underperformance, taking due account of benchmarking information as appropriate.

Action required:

To review the progress being made with delivering the Operational Plan 2014/15, consider the robustness, timing and success of actions to address issues and to quantify areas where a more detailed report will be required for the next Board.

Recommendations to the Board:

To approve the report noting that this is the third report reflecting the new performance framework and observations around layout and level of detail would again be welcome.

Relationship with the Assurance Framework

The Performance Framework is a operational control with an assurance level of moderate.

Summary of financial and legal implications:

Specified where relevant in the report.

Equality and diversity and public and patient involvement implications:

None.

Service Quality Implications:

None.
Summary Performance Report, July 2014

Introduction

This is the third report reflecting the new performance framework and brings together a Trust wide view of performance from operational team to whole trust level, using a performance pyramid and balanced scorecard approach. This month we have enhanced the report further by including the Trust Quality Dashboard and the Safer Staffing Report in detail. The Trust Board summary level performance pyramid is included as Appendix 1. Red, Amber, Green performance flags together with direction of travel indicators are used to assist in the interpretation of performance as is benchmarking information if relevant.

OVERALL PERSPECTIVE

Compared to last month the Trust position remains Amber. However within this assessment there have been significant improvements in performance as well as improvements in the robustness and completeness of performance information.

QUALITY PERSPECTIVE

The Quality agenda is being progressed by the Quality subcommittee of the Board which met earlier this month to lead this work. The Quality Dashboard in included for the first time in the report as Appendix II. This is a developing dashboard, which incorporates both indictors against Trust quality priorities published within the Trust’s quality strategy, and a number of other key quality indicators. The dashboard will be refined as the Quality Sub Committee develops the core indicator set, the presentation of indicators in the report and an improved understanding of the impact for patients and actions where required. Value thresholds and RAG rating where not given will be developed.

The Safe Staffing national requirements were discussed at the Board last month and this month sees the first exception report included here as Appendix III. Nine wards across four CAGs had reported breaches all due to vacancies of qualified nurses. This is being addressed through Trust wide recruitment drives.

PROGRAM PERSPECTIVE

The Trust continues to make progress with programs as described in the Trust Operational Plan. This includes clarity around deliverables and milestones. In particular the AMH program continues to deliver to milestones, although the finalisation of the model and integration of pathways is slightly behind schedule. The patient transfers across teams are in amber zone with some issues identified during transfers in Lewisham. Meetings have been planned with services users and carers to understand the experience of service users during the transformation process.
The Forensic program is also progressing well focussing on a complete review of services including skill mix and staff numbers with the aim of narrowing the contractual funding gap with NHSE and keeping within budget. Some progress has been made with NHSE and the details are being finalised.

The CAMHS ‘Turn-a-round’ project which reviews all teams in terms of quality, activity, skill-mix and staff numbers, continues to make progress.

OPERATIONAL PERSPECTIVE

The overall position is considered red because although total activity falls within planned and expected levels the Trust has failed the HTT gatekeeping national target for quarter one, pressure on place of safety suites remains high and overspill activity levels are above target.

- HTT gatekeeping performance continues to be below target at 83.2% year to date (target 95%). A number of actions have been put in place as follows:
  a. A request for a bed will only be accepted from a HTT worker
  b. Development of an operational report in PJS that enables daily reporting and review
  c. Changes to PJS to ensure evidence that an assessment has taken place is recorded in the correct place and in the right format

The latest information suggests that following the undertaking of all actions identified above that a performance of 100% will be recorded for August and September and the Quarter 2 performance target will be met.

- Activity over performance for inpatients continues to be around 1% and within the tolerance assumed in the annual plan (finance and capacity) of variations between plus/minus 5%.

- Overspill (non-planned placement) activity is at the 23rd July 10 placements for acute (target 8) and11 placements for PICU (target 6).

- Complaints resolution: this was reported as a specific issue for Psychosis CAG last month. Good progress in eliminating complaints waiting 6 months for a response has occurred with now only two outstanding). Complaints waiting between 1-3 months will be eliminated by the end of August.

- Place of Safety, please see separate Board report.

RESOURCE PERSPECTIVE

Estates: progress on the statutory estates compliance programme is to plan. In terms of delivering the Estates Strategy and Capital Programme there are only two projects with significant but purposeful delays. These delayed projects are: Eating Disorders ward r-provision delayed purposefully to reduce decant pressures and keep maximum bed capacity available; Ward Refurbishment Programme at the Maudsley as switch is made from
redecoraction to major refurbishment option for Douglas Bennett House (see separate Board paper).

IT and Workforce Strategic Programmes following their approval now require further work to confirm milestones and targets.

Finance is subject of a separate Board report.

**CAG PERSPECTIVE (Operational Performance Management Meetings Level 1 and 2)**

The key RAG rated issues from the July Operational performance management meetings is attached at Appendix IV. In addition to the issues already identified, increasing difficulties in recruiting band 5 and 6 nursing staff and absence of agencies to provide suitable cover is beginning to have significant impacts on capacity levels, transformation programmes and general progress. It is proposed to bring back to the Board a detailed action plan on this issue in September.

King’s Health partners (KHP) Heat Maps have been prepared by KHP from information previously provided through the Performance Council meetings. The heat maps, one per CAG, were shared and CAGs were asked to review and update as required. Once complete it is intended to share this information across KHP.

Staff appraisals under way with a significant number of appraisals completed. Dates have been booked for the remainder of appraisals for completion by the end of August 2014.

**FURTHER DETAIL**

The Performance Pyramid is enclosed as appendix I.

The figures and analysis supporting this report are available on request

Roy Jaggon
Head of Performance Management

22nd July 2014
Our quality priority this year is to work to increase the number of patients who feel safer when in our hospitals.

We will stop the transfer of acute patients to private sector hospital beds outside the Trust.

We will make it easier for patients to access help in a crisis. No one should experience being turned away when in a crisis.

We will improve the quality of the environments within our in-patient wards.

We will ensure that all patients receive an individual service at medication and mealtimes when in hospital.

We will improve the way we involve patients in their care planning and make sure patients understand their care plans.

We will continue to improve our screening of patients for cardio-vascular and metabolic disease.

We will help patients to quit smoking and move to no smoking across all Trust sites and in all clinical environments.

We will improve GP access to SLaM assessments, so that more patients are seen quicker for first assessment.

- **Waiting Times**
  - To increase the number of people who when asked say they feel safe in our services
  - To reduce the number of times that patients are physically restrained
  - Measure the number of patients transferred to acute overspill beds outside the Trust
  - Community patients to respond positively to the question, “Have you been offered a crisis plan for emergency mental health situations?”

- **Improvement in PLACE environmental audit scores**
  - No patient will queue for medication or meals when in hospital
  - All new CPA referrals to have completed S&R plan

- **Assessing, documenting and acting on six key cardio metabolic test results recorded for patients**
  - Increase the number of smokers offered intervention NRT or counselling
  - See more patients at home and in primary care settings for first contact
Operations

Assessment by Time, Quality, Resources

Contracts

Activity / Capacity Management

Sanctions

CQUIN

• OBD’s – Over-Performance

• Copy of Care Plan

• Physical Health: Improving Physical healthcare to reduce premature mortality in people with Severe Mental Illness

• 7 DFU

• Discharge

• Physical Health Checks

• PbR

• Recovery

• Delayed Discharges
Operations

Regulatory / Compliance / Legal

 RAF (SQIR – Report)

CQC Inspection

- Delayed Discharges – Monitor YTD
- CPA 12 Month Review
- HTT Gatekeeping
- 7 Day Follow-up
- Early Intervention
- LD Access
- Data Completeness - Identifiers
- Data Completeness - Outcomes

Assessment by Time, Quality, Resources
Operations

Assessment by Time, Quality, Resources

Productive

CIP / QIPP

CIPs PLANNED

- Addictions
- BDP
- CAMHS
- MAP
- MHOAD
- PSYMED
- PSYCHOSIS
- Trust-Wide
- All Others
Resources

Estates

Statutory Requirements

Availability and Quality of Environment

Capital Programmes

Maudsley Hospital Strategic Development & BRH Strategic Development

Lewisham Community Strategic Development & Southwark Community Strategic Development

Ward refurbishment and improvements & Backlogs and Statutory wards

IT renew and expand infrastructure & IT substituting for labour e.g. telemedicine solutions, remote diagnosis

Health & Safety

• Fire Safety
• Asbestos
• Legionella
• CAS (Central Alert System)
• Waste Management
• Anti-ligature (Audit and Implementation)

Addictions
• BDP
• CAMHS
• MAP
• MHOA
• PSYMED
• PSYCHOSIS
• MULTIPLE CAG’s
• CORPORATE
Resources

Finance

Income

Expenditure

EBIDTA

Sickness Rate

Vacancy Rate

Bank and Agency Rates

Staffing

Assessment by Time, Quality, Resources
<table>
<thead>
<tr>
<th>Indicator Area</th>
<th>Indicator</th>
<th>Source</th>
<th>Governance Driver</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q1</th>
<th>SPC Spark</th>
<th>YTD (avg)</th>
<th>RAG Thresholds</th>
<th>Trend</th>
<th>Special cause?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU Is Violence and aggression - staff victims</td>
<td></td>
<td>DATIX</td>
<td>Trust Quality Strategy</td>
<td>57</td>
<td>48</td>
<td>54</td>
<td>70</td>
<td></td>
<td>57.3</td>
<td></td>
<td>SPC Trend</td>
<td>➔</td>
<td>N</td>
</tr>
<tr>
<td>SU Is Violence and aggression - patient victims</td>
<td></td>
<td>DATIX</td>
<td>Trust Quality Strategy, Safety Thermometer</td>
<td>20</td>
<td>40</td>
<td>34</td>
<td>56</td>
<td></td>
<td>37.5</td>
<td></td>
<td>SPC Trend</td>
<td>➔</td>
<td>Y</td>
</tr>
<tr>
<td>Violent RIDDORs</td>
<td></td>
<td>DATIX</td>
<td>HSE, Trust Quality Strategy</td>
<td>18</td>
<td>27</td>
<td>14</td>
<td>13</td>
<td></td>
<td>18.0</td>
<td></td>
<td>SPC Trend</td>
<td>➔</td>
<td>Y</td>
</tr>
<tr>
<td>Do you feel safe? [on the ward] target &gt;=90 %</td>
<td></td>
<td>PEDIC</td>
<td>Trust Quality Strategy</td>
<td>78.8%</td>
<td>83.4%</td>
<td>85.4%</td>
<td>77.9%</td>
<td></td>
<td>81.4%</td>
<td></td>
<td>75-90%</td>
<td>➔</td>
<td>Y</td>
</tr>
<tr>
<td>Increase the number of patients who feel safe on the ward</td>
<td></td>
<td>QIST</td>
<td>Trust Quality Priorities</td>
<td>4</td>
<td>8</td>
<td>11</td>
<td>11</td>
<td></td>
<td>-</td>
<td>-</td>
<td>Take Up</td>
<td>➔</td>
<td>-</td>
</tr>
<tr>
<td>Increase the quality of in-patient environments</td>
<td>Do you feel the ward is clean?</td>
<td>PEDIC</td>
<td>Trust Quality Priorities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>87.9%</td>
<td></td>
<td>87.9%</td>
<td></td>
<td>75-85%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Improve the quality of in-patient environments</td>
<td>Do you feel the furniture is comfortable?</td>
<td>PEDIC</td>
<td>Trust Quality Priorities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>84.7%</td>
<td></td>
<td>84.7%</td>
<td></td>
<td>75-85%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PLACE Visits ‘Condition, Appearance and Maintenance’</td>
<td></td>
<td>PLACE</td>
<td>Trust Quality Priorities</td>
<td>-</td>
<td>-</td>
<td>81.3%</td>
<td>-</td>
<td>-</td>
<td>81.3%</td>
<td></td>
<td>75-85%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Patients receiving an individualised service</td>
<td>Wards where patients are expected to queue for medication. Target = 0</td>
<td>Heads of Nursing</td>
<td>Trust Quality Priorities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>23.1%</td>
<td></td>
<td>23.1%</td>
<td></td>
<td>10-25%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Patients receiving an individualised service</td>
<td>Wards where patients are expected to queue for meals. Target = 0</td>
<td>Heads of Nursing</td>
<td>Trust Quality Priorities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>53.8%</td>
<td></td>
<td>53.8%</td>
<td></td>
<td>10-25%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Indicator Area</td>
<td>Indicator</td>
<td>Source</td>
<td>Governance Driver</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>SPC Spark</td>
<td>YTD</td>
<td>RAG Thresholds</td>
<td>Trend</td>
<td>Special cause?</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>--------------</td>
<td>-----</td>
<td>----------------</td>
<td>-------</td>
<td>----------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physical Health</td>
<td>No of eligible patients having six key metabolic c-v tests CQUIN</td>
<td>Clinical Audit Team</td>
<td>Trust Quality Priorities, CQUINs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70-90%</td>
<td>-</td>
<td>-</td>
<td>No data available until Audit in Quarter Three 2014/15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication with GP CQUIN</td>
<td>Clinical Audit Team</td>
<td>Trust Quality Priorities, CQUINs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>70-90%</td>
<td>-</td>
<td>-</td>
<td>No data available until Audit in Quarter Two 2014/15</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>No of patients with smoking status recorded</td>
<td>Clinical Audit Team</td>
<td>Trust Quality Priorities, CQUINs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>59.0%</td>
<td>59.0%</td>
<td>50-80%</td>
<td>-</td>
<td>Data from Quarterly smoking cessation audit. Change of methodology in Q1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No of smokers offered NRT or counselling to quit</td>
<td>Clinical Audit Team</td>
<td>Trust Quality Priorities, CQUINs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>56.0%</td>
<td>56.0%</td>
<td>25-50%</td>
<td>-</td>
<td>Data from quarterly audit - no of smokers with a PHS offered any type of intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acheivement against smoking cessation training target</td>
<td>Education and Training</td>
<td>Trust Quality Priorities, CQUINs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>61.5%</td>
<td>61.5%</td>
<td>40-50%</td>
<td>-</td>
<td>Level 1 - 1152/2333 (49.4%), Level 2 - 20/2333 (0.9%), Level 3 - 263/2333 (11.3%) inc comm</td>
<td></td>
</tr>
<tr>
<td>GP/SLaM assessments</td>
<td>% of new patient assessments conducted outside MAP A&amp;T Team Base</td>
<td>AMH Transformation Project?</td>
<td>Trust Quality Priorities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>No data. This data item is not included the AMH transformation project data set</td>
<td></td>
</tr>
<tr>
<td>Use of private beds</td>
<td>Number of patients in private beds per day</td>
<td>BedState Dashboard</td>
<td>Trust Quality Priorities</td>
<td>37</td>
<td>46</td>
<td>23</td>
<td>23</td>
<td>32</td>
<td>10-15</td>
<td>N</td>
<td>-</td>
<td>Trend clearly improving. 12 patients in private overspill at 30/06. Data split by PICU and AMH not available</td>
<td></td>
</tr>
<tr>
<td>Access to help in a crisis</td>
<td>Have you been offered a crisis plan for emergency mental health situations?</td>
<td>PEDIC</td>
<td>Trust Quality Priorities</td>
<td>76.9%</td>
<td>75.6%</td>
<td>79.4%</td>
<td>67.9%</td>
<td>74.9%</td>
<td>50-70%</td>
<td>N</td>
<td>Variation within control limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Can you access mental health services quickly and easily if you need to?</td>
<td>PEDIC</td>
<td>Trust Quality Priorities</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>82.4%</td>
<td>82.4%</td>
<td>50-70%</td>
<td>-</td>
<td>No data prior to April 2014</td>
<td></td>
</tr>
<tr>
<td>Recovery and support planning</td>
<td>No of Patients with completed R&amp;S plan</td>
<td>Insight</td>
<td>Trust Quality Priorities, CQUINs</td>
<td>19.8%</td>
<td>25.6%</td>
<td>41.3%</td>
<td>51.9%</td>
<td>34.7%</td>
<td>50-80%</td>
<td>Y</td>
<td>Clear positive trend.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No of R&amp;S plans meeting acceptable standards</td>
<td>Clinical Audit Team</td>
<td>Trust Quality Priorities, CQUINs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>49.2%</td>
<td>49.2%</td>
<td>50-75%</td>
<td>-</td>
<td>The average proportion of fully completed items of the R&amp;S plan</td>
<td></td>
</tr>
<tr>
<td>Indicator Area</td>
<td>Indicator</td>
<td>Source</td>
<td>Governance Driver</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>SPC Spark (avg)</td>
<td>YTD (avg)</td>
<td>RAG Thresholds</td>
<td>Trend</td>
<td>Special cause?</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------</td>
<td>-----------------</td>
<td>-------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----------------</td>
<td>-----------</td>
<td>----------------</td>
<td>-------</td>
<td>---------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Safety and Outcomes Data</td>
<td>7 Day Follow up</td>
<td>ePJS/Insight</td>
<td>Monitor Target</td>
<td>95.2%</td>
<td>96.7%</td>
<td>98.4%</td>
<td>95.7%</td>
<td>-</td>
<td>96.5%</td>
<td>85-95%</td>
<td>➣</td>
<td>Y</td>
<td>Q1 data is first two months only - April and May data</td>
</tr>
<tr>
<td></td>
<td>Delayed Discharges</td>
<td>ePJS/Insight</td>
<td>Monitor Target</td>
<td>3.0%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>-</td>
<td>2.9%</td>
<td>7.5-10%</td>
<td>➣</td>
<td>N</td>
<td>Within target. Variation within control limits</td>
</tr>
<tr>
<td></td>
<td>HTT Gatekeeping</td>
<td>ePJS/Insight</td>
<td>Monitor Target</td>
<td>95.0%</td>
<td>96.0%</td>
<td>96.0%</td>
<td>83.5%</td>
<td>-</td>
<td>92.6%</td>
<td>90-95%</td>
<td>➣</td>
<td>Y</td>
<td>Q1 data is first two months only - April and May data</td>
</tr>
<tr>
<td></td>
<td>Paired HoNOS score rate (CPA)</td>
<td>ePJS/Insight</td>
<td>Trust Outcomes Target</td>
<td>83.3%</td>
<td>81.0%</td>
<td>79.5%</td>
<td>77.4%</td>
<td>-</td>
<td>80.3%</td>
<td>60-70%</td>
<td>➣</td>
<td>Y</td>
<td>Remains above target, but clear downward trend</td>
</tr>
<tr>
<td></td>
<td>Inpatient annual Physical Health Screen. Sanctions to be applied by CCG under 95%</td>
<td>ePJS/Insight</td>
<td>National Priority</td>
<td>47.1%</td>
<td>46.5%</td>
<td>57.9%</td>
<td>63.7%</td>
<td>-</td>
<td>53.8%</td>
<td>90-95%</td>
<td>➤</td>
<td>Y</td>
<td>Sanctions to be applied by CCG under 95% completion</td>
</tr>
<tr>
<td></td>
<td>Copies of Care Plan given %</td>
<td>ePJS/Insight</td>
<td>CQC</td>
<td>-</td>
<td>-</td>
<td>94.0%</td>
<td>94.0%</td>
<td>-</td>
<td>94.0%</td>
<td>90-95%</td>
<td>➤</td>
<td>-</td>
<td>Only financial year data available</td>
</tr>
<tr>
<td></td>
<td>&lt;18 week wait time AMH services</td>
<td>ePJS/Insight</td>
<td>National Acute Services Target</td>
<td>92.7%</td>
<td>91.4%</td>
<td>91.9%</td>
<td>91.8%</td>
<td>-</td>
<td>91.9%</td>
<td>TBC</td>
<td>➤</td>
<td>N</td>
<td>Variation within control limits</td>
</tr>
</tbody>
</table>

The SPC Sparkline shows data over time in comparison to median, 2 standard deviations and 3 standard deviations. Standard statistical rules are used to detect special causes (as opposed to natural variation). Where there is a special cause this should be the focus for any improvements. Where there is no special cause any improvements should be applied to the system as a whole.
## OPERATIONAL PERFORMANCE MEETINGS, PERIOD ENDING 19th July 2014 (App IV)

<table>
<thead>
<tr>
<th>CAG</th>
<th>Weakness / Threat</th>
<th>Concern</th>
<th>Strength / Opportunity</th>
<th>Other Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Requiring formal action plan from ()</td>
<td>Requiring ameliorating action from ()</td>
<td>Requiring action from ()</td>
<td>Requiring action from ()</td>
</tr>
</tbody>
</table>
| CAMHS | • Safer staffing, high level of vacancies and recruitment difficulties particularly in Kent (JF)  
• Action plans in place with some items still outstanding.  
• Bed management performance meeting established and meeting monthly | • NHSE contract lack of clarity re specialist OPs.                        | • NHSE tier 4 review due shortly, general and PICU potential development opportunities (JF and ND).  
• Together with other CAGs review age policies and boundaries (all SDs plus MB). |                                                                            |
|       | Addictions                                                                         |                                                                          |                                                                                         |                                                                            |
|       | • Pharmacy stock holding remains a risk issue (MA, ND, MB). Outstanding item, meeting date to be arranged. | • AAU activity has increased in month but is still low overall even with admissions from Triage wards. An audit to check the quality of assessments and screening will done to see if more patients fit the criteria for AAU (MB). | • Tenders for Lewisham and Wandsworth are imminent and will require additional capacity and support from Corporate Services (ND) |                                                                            |
|       |                                                                                   |                                                                          |                                                                                         | • Clarity on smoke free initiative funding required (GH).                   |
**OPERATIONAL PERFORMANCE MEETINGS, PERIOD ENDING 19th July 2014 (App IV)**

<table>
<thead>
<tr>
<th>Psychosis</th>
<th>AMH View</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Good progress in eliminating complaints waiting 6m for a response (3 outstanding).</td>
<td>• All milestones on time but integration of pathways and patient transfers across teams are in amber zone.</td>
</tr>
<tr>
<td>• 50 complaints waiting between 1-3 months to be eliminated by the end of August.</td>
<td>• Issues with recruiting Band Six and above staff.</td>
</tr>
<tr>
<td>• Infection control audits – continued lack of response from some wards. Immediate action taken to ensure engagement and compliance.</td>
<td>• Good feedback on mandatory five-day training.</td>
</tr>
<tr>
<td>• Safer staffing, reduction in the number breaches compared to last month.</td>
<td>• Meetings with Southwark on transition from initial AMH model to full transition.</td>
</tr>
<tr>
<td>• Recruitment is an issue, quality of candidates is poor. (LC, HR).</td>
<td>• Southwark triage proposals to be agreed</td>
</tr>
<tr>
<td>• Funding gap in placements; YTD spend of £800K, projected £2million for the year. Undertake an audit in Southwark and Lewisham to assure CCGs (LC, ND, Contracts).</td>
<td></td>
</tr>
<tr>
<td>• Clear guidance on the reduction in bed numbers over the next two years to be translated into trajectories (ND).</td>
<td></td>
</tr>
<tr>
<td>• Review copies of care plan usage and terminology to increase effectiveness and meet targets (RJ).</td>
<td></td>
</tr>
<tr>
<td>• Junior doctors cost pressure.</td>
<td></td>
</tr>
<tr>
<td>• Annual leave cover planning to take into account, risk, throughput and operational requirements (LC, MB, HR).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## OPERATIONAL PERFORMANCE MEETINGS, PERIOD ENDING 19th July 2014 (App IV)

<table>
<thead>
<tr>
<th>MAP and PMED</th>
<th>• HTT gatekeeping target missed in Quarter 1 due to compliance, data quality and systems issues. All admissions to go through four dedicated HTT staff (SD).</th>
<th>• Impact of not being able to access PICU beds quickly results in increased acuity on the ward, implications to be confirmed (SD).</th>
<th>• Ladywell entrance and associated issues need to clarify plans (ND).</th>
</tr>
</thead>
</table>
| MHOAD        | • Safe staffing confirmation of investment. Noted risk that this specific investment being incorporated into future commissioners savings plans (GH, DN).  
• Memory services waiting list is an issue with imaging centre one of the bottlenecks; costing discussions with PSYMED to do neuroimaging (DN).  
• Recruitment of Band 6 and above is an issue (DN, HR) |                                                                                                                                                                                                 |                                                                                                                                                                                                 |
**OPERATIONAL PERFORMANCE MEETINGS, PERIOD ENDING 19th July 2014 (App IV)**

| BDP | Safer Staffing levels issues with specialist services where it is possible to flex staff as occupancy rates vary, (ED, NB).  
Issues with recruiting to Band 7 and above positions (ED, HR).  
£600K deficit in LD Community teams; reconfiguration of services is under discussion (ED). | Meeting with NHSE on Forensic services. Trust committed to spend £500K with an investment in three additional beds but there is no QIPP.  
Support is needed to market the specialist services. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>Safer staffing: 4 CAGs with breaches (CAMHS, MHOAD, PM and Psychosis). This primarily due to vacancies in qualified staff. Actions being taken.</td>
<td>Appraisals under way with high percentage completed. Dates booked for the remainder. Completion by the end of August 2014.</td>
</tr>
</tbody>
</table>
Date of Board meeting: 29 July 2014
Name of Report: Workforce Workstream Overview
Heading: - (Strategy, Quality, Performance and Activity, Governance, Information) Performance and Activity
Author: Louise Hall
Approved by: Matthew Patrick (name of Exec Member)
Presented by: Louise Hall

Purpose of the report:
To inform the Trust Board of Directors of how the Workforce Transformation phased plan will be managed and delivered.

Action required:
To note the report and support the plan of action.

Recommendations to the Board:
That the Board note the report and support the plan of action.

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

Summary of Financial and Legal Implications:

Equality & Diversity and Public & Patient Involvement Implications:
South London and Maudsley Foundation Trust Workforce Workstream 2014-2016

1 CONTEXT

With current levels of demand, SLaM is facing unprecedented financial pressure until we feel the benefits of our developing clinical, commercial and business strategies kick in. Workforce costs are 70% of our overall expenditure and sustaining the current costs is an increasing financial challenge. It is vitally important therefore that we implement a strategic workforce plan that helps prepare for and control both workforce costs and capability whilst supporting effective and efficient delivery of our strategic objectives.

In line with our two year operational plan our short term our challenge is to maintain the Trust’s financial viability by reducing workforce costs by £20M by the end of 2016, while maintaining the quality of care we already provide to service users and the community at large.

Set against this we need to be able to strategically predict, manage and respond to ever-changing healthcare requirements in line with our five year strategic plan to create a more agile, responsive, multi skilled and flexible workforce with relevant skill levels, in line with the wider economic and organisational climate.

We are therefore proposing a three phase approach:

**Phase 1:** short term tactical activities to reduce costs as soon as possible, without impacting our ability to transform our workforce going forward.

**Phase 2:** medium term activities to realign our organisation to reflect the known and forecast service changes.

**Phase 3:** medium term strategic activities to align our organisation with our developing commercial strategy.

Developing and delivering a workforce fit for the future is unlike any other project; it is an extremely large and complex undertaking that has huge consequences for individuals and for the Trust if we don’t get it right. It is important to recognise now, that what we do and how we do it will have a significant impact on staff, their families and on our service users. The expectation is to also do this with minimal impact on staff employment.

The purpose of this document is to outline the short term activities that will support the delivery of a workforce plan that will in turn enable a £20M reduction in workforce costs over the next two years through maximising efficiencies and minimising redundancies. A number of these initiatives have started in previous years but have not been completed or delivered the expected changes. This time around however, we have to deliver and each member of the Senior Management team is tasked with and accountable for their areas of workforce related change delivery.
In addition, the workstream will be managed as a programme of works and in line with project management principles.

This is not designed to be a full Workforce Strategy Plan, which would encompass activities such as development and engagement; however these factors have been included in our overall HR Plan.

2 Approach

The financial pressures on the Trust indicate that we need to take immediate action to reduce costs through a series of tactical actions. We have already consulted widely through workshops with the SMT, the Executive, the JSC, HR and CAG Service Directors among others on the measures we can take to reduce costs in the short term (See Appendix 1).

Through this consultation a number of suggested focus areas have arisen which have been analysed, prioritised and agreed as areas of focus.

1. CAGs and Operations: structure, duplication, overhead, budget accountability – led by Nick Dawe
2. Medical: review of job plans, benchmarking and value analysis – led by Martin Baggaley
3. Nursing: effective E-Rostering and Safer Staffing – led by Neil Brimblecombe and Michael Kelly
4. IT/Finance: review the use of contractors, agencies and ad hoc – led by Gus Heafield with HR support for the specific areas co-ordinated by Louise Hall
5. HR: focus more strongly on performance and sickness absence – led by Louise Hall
6. HR: increase the challenge on backfilling vacant roles, remove any roles that have been open for longer than 6 months - led by Louise Hall
7. HR: implement a focused performance and potential plan for our Band 7 and 8 managers to give them the capability to manage people, change and budgets more effectively – led by Louise Hall
8. Infrastructure; review the workforce compilation in the light of cost, effectiveness and readiness for the future and options reviewed for each - each SMT Infrastructure lead to focus on their areas
9. Estates: consider closing the services or estates that are not appropriately funded, increase funding or look at commercial opportunities to compensate for the lack of funding – lead by Nick Dawe
10. Internal communications and messaging; communicate the message that we all have a role to play to manage cost and to prepare for the future – led by Sarah Crack/Comms to lead in conjunction with messaging from CE and SMT

While all of the areas outlined above have significant implications for the workforce, they are primarily actions which are the responsibility of the identified senior managers. In each case the relevant workstream will capture any potential people impacts to feed into the HR Workforce work stream to quantify the impact on the workforce, ensure legal compliance and to ensure that suitable HR resource is available to support the initiative.

Specifically HR will be accountable for the following workstreams:
2.1 **Focus more strongly on absence**  
Absence costs us £5.3 million annually in terms of staff cost. This does not include paying for backfills, reduced productivity and manager time to manage absence.

Absence levels have reduced by 0.5% over the six months from July 2013 to January 2014. We should aim to reduce this by at least a further 0.5% in the next six months generating savings of £0.4 - 0.5 million by:

- Identifying areas of significant absence
- Analysing the causes
- Reviewing the HR policy, remove HR from every stage of the process to speed things up
- Focusing on sickness absence, including rigorous and consistent application of the policies, return to work interviews, manager referrals to Occupational Health and fast implementation of workplace adjustments.
- Providing our first line managers with the knowledge, skills and confidence to address absence issues where they exist

2.2 **Focus on performance enhancement and recognition**  
We need to encourage our workforce individually and collectively to perform by focusing on those things that contribute most to the Trust’s overall strategic plan. Each member of staff must be committed to delivering high quality healthcare, compassionately and safely.

It is commonly recognised that not every staff member performs to the levels or behaviours expected of their role or grade. Employees who do not consistently display the highest standards of performance, engagement and behaviour will be fully supported by their manager and the Trust to improve their performance through an agreed development plan. If notwithstanding this support, an employee’s performance or behaviour does not improve, it will result in escalation to the Trust’s Disciplinary Policy or Performance Issues (Capability) Policy as appropriate.

Managers will require training, development and be motivated to deliver increased levels of performance from their teams.

In terms of recognition, we will use the AfC increment link to performance to ensure our more senior managers are recognised for their delivery and contribution. We will also look at financial and non-financial ways of recognising staff for their contribution, ideas and exceptional performance.

2.3 **Recruitment, bank, agency and open positions**  
Historically when restructures have taken place, a reduction in permanent heads has been filled by bank and agency staff. This action disguises the true cost of running the function. There has also been a reluctance to fill open roles to act as a buffer in case future cuts need to be made.

Once the structure and new ways of working have been agreed, we will be able to focus on open vacancies, close those that have been open for more than 6 months and operate with an agreed % contingency on open roles in line with the core – periphery model outlined earlier. We can then look to fill any roles outside this agreed % with permanent workers.
Where we know that there are going to be significant service changes, we should look to use contingency workers to give us flexibility, but ensuring at all times we have safe staffing levels and we can be assured of delivering high quality compassionate care.

Bank and agency use will be limited to an agreed flexible/contingency level. Where a job has been cut, it will not be backfilled by temporary resources. We need to understand and clearly communicate to managers at all levels of the organisation the relative costs/benefits of using establishment, bank and agency workers to backfill roles.

We will also need to analyse regretted attrition in order to minimize this and ensure we retain our best people, which in turn will reduce the need for use of bank and agency.

Greater levels of control and governance will be required for backfilling closed posts and new roles will only be agreed with high levels of scrutiny. An IT and Finance infrastructure will need to be built in order to manage this process in a timely and effective manner (including the use of e-Roster V10).

We also need to ensure that the candidate pool is at the right level by working with NHSP and our agencies to provide a quality and ample resource pool. The Safer Staffing reviews have led to an increased need for nurses and we will consider how we recruit to these levels but also by recruiting and attracting the best candidates.

2.4 REVIEW THE USE OF CONTRACTORS AND AGENCIES IN NON-CLINICAL AREAS

We need to have a clear view of all contingency workers (Contract and Agency) engaged by the Trust, contract terms, period of engagement, the business case for their continued employment and alternatives for backfilling with lower cost resources. Contracts are often extended beyond their initial planned duration without review and reauthorization: we need to put a process in place to address this.

We have already identified contractors and agency staff and commenced a review of all agency or self-employed staff who have been employed for a period of over one year.

Going forward we will implement a process that will require a business case and senior level sign off for all contract workers.

2.5 IMPLEMENTATION OF E-ROSTERING V10

The Trust uses e-Roster v9.5 which has a number of limitations. Currently the system can only be used to roster and report on Trust employee’s and does not include a facility to implement Safer Staffing levels. With a significant proportion of the care provided by NHSP and to a lesser extent agency staff, the Trust is unable to effectively roster or provide accurate management reporting on rostering levels or effectiveness. With the implementation of e-Roster V10 we will be able to implement E-Rostering of NHSP bank staff together with the setting of and reporting on Safer Staffing levels. This should enable the Trust to make much more efficient use of rosters. We will also for the first time roster Doctors using e-Roster.

Once implemented, we will look to analyse e-Roster to understand better how we can best use utilise our workforce to deliver 24/7 coverage more efficiently and cost effectively. We already know there are some areas where we use E-Rostering well and other areas where it has not been fully adopted.
Common problems are repeated annually with limited learning in some areas i.e. planning for Summer and Christmas leave and rotas.

We are also reviewing the rules in terms of the number of variations and local arrangements on e-Roster which may in some cases result in inefficient rostering and therefore generating additional staff costs.

E-Rostering is not being utilised as effectively as it could at a CAG level and as a result, further training has been provided within the CAGs and E-Rostering “champions” have been nominated in the CAGs.

The improvements in this area are key, not only to have effective resourcing but also to have useful management information that can help inform the way to run the CAGs. A 1% increase in E-Rostering efficiency can result in £2m of savings, for example.

2.6 “MANAGING EFFECTIVELY”: A FOCUSED PERFORMANCE AND POTENTIAL PLAN FOR OUR BAND 6, 7 AND 8 MANAGERS

Nearly all first level and second level managers in clinical areas have developed and promoted through professional excellence, often will little managerial development. Employees therefore experience differing qualities of management and a lack of consistency in the way it has been applied. There is significant amount of data from the employee survey and other sources that tells us that employees are not being managed as effectively or efficiently as they should.

If we are to deliver our two year operational and five year strategic plan there is an expectation that managers would be required to manage people and budgets in a more focused and consistent way, it is therefore recognised that there is a need to provide our people managers with the skills and knowledge to enable them to do this effectively.

It is critical to the delivery of our long term plan that line managers at all levels of the organisation display, support and live the expected managerial behaviours. How well our managers inspire their people to perform and grow will be a critical success factor in determining our personal and collective futures.

We will need to carry out a training needs analysis, build a full business case and design the programme, however initial indications are that we would look to develop this key group of staff in the following areas;

<table>
<thead>
<tr>
<th>Managing:</th>
<th>Work</th>
<th>Self</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance/recognition</td>
<td>Commercial</td>
<td>Role of the Manager</td>
</tr>
<tr>
<td>Development</td>
<td>Budgets</td>
<td>Planning, Organising</td>
</tr>
<tr>
<td>Coaching</td>
<td>Rostering</td>
<td>Directing, Evaluating</td>
</tr>
<tr>
<td>Appraisal</td>
<td>Effective meetings</td>
<td>Delegating</td>
</tr>
<tr>
<td>Absence</td>
<td>Team management</td>
<td>Managing high</td>
</tr>
<tr>
<td>Disciplinary</td>
<td>Keeping quality high in</td>
<td>performers and</td>
</tr>
<tr>
<td>Staff Engagement</td>
<td>changing times</td>
<td>careers</td>
</tr>
<tr>
<td>Change Management</td>
<td>Patient experience and</td>
<td>safety</td>
</tr>
</tbody>
</table>

70 of 191
2.7 PEOPLE SYSTEMS
We are evaluating the use of an integrated people system, to align with ESR but which will support an integrated Trust objective cascade process, assessment of objective delivery, ability to link Personal Development Plans to CPD and career progression and also to identify our top performers.

2.8 ORGANISATIONAL DESIGN WORK
In order to make a major shift in the way we work, the HR team will need to support the operational activity to review, evaluate and change the ward and operational team make up. This will need initial benchmarking and best practice work that the team can advise on how best to implement and use going forward. This activity will involve all areas of the business thinking of what they will do, how this can be replicated and the impact of any changes on other parts of the business and our partners.

2.9 MANAGING THE CHANGE
We also recognise that this period of transformational change will potentially mean changes to jobs and a perceived or real potential threat to job security. While continuing to run the existing system, we need to invest additional funding in staff and support leaders, managers and employees to manage the change and transform the future as detailed above.

In delivering plans we must constantly consider how we:

- Maintain staff engagement
- Involve and consult with staff
- Develop retention strategies for key staff during the change period
- Educate and motivate employees at all levels on the importance of understanding data, systems, processes and people and acting on their responsibilities
- Communicate openly with staff on our progress
- Implement change in a timely manner
- Maintain an unwavering commitment to providing high quality and compassionate healthcare

The list of actions and activities outlined are not intended to be exhaustive; we already know there are many more we need to do. We are also aware that things will change along the way, requiring us to constantly review our activities to meet challenges and opportunities as they appear.
3 NEXT STEPS

We will set up a multidisciplinary project team, led by Louise Hall, to start working on the detailed planning, analysis, modelling, options and recommendations for both the strategic and tactical transformation of the workforce. Critical to the quality of these activities is a close relationship with the teams developing the Estates and IT strategies - both of which have significant impact on workforce planning.

To ensure successful delivery, we will utilize well established project management and change management methodology – (our project methodology will be based on Prince2 process and principles and Workforce Planning on the NHS England Six Step approach). We will also use the AIM Change Management methodology to support its delivery, as research carried out by McKinsey in 2002 indicated that there is a strong correlation (0.7) between the percentage value captured and quality of change management).

A full and detailed project plan is being created including, TORs, Risks & Issues, stakeholder management plans, identified work packages, resource plans and a full business case. It is important to recognise that apart from the workstream lead, project team members will consist of Trust staff who work in busy operational roles. Additionally, other projects such as Estates and IT will be competing for some of the same resources and it will therefore be important that where possible we carefully coordinate and sequence our work packages to avoid conflict with other commitments and initiatives.

Detailed project milestones and plans will be agreed for each work package and the project as a whole. Once the work packages have been assigned they will be carefully monitored against milestones and quality plans to ensure that they stay on track. Risks, Assumptions, Issues and Dependencies logs will be completed and regularly reviewed. Any deviation from the plans or unexpected events will be reported to the Project Board and corrective actions will be taken. Before each stage is begun, change management and communication plans will be completed, regularly updated and executed.

To a degree we have already made strong progress on this stage of the project. Workforce transformation has featured strongly in both the Monitor two year operational and the five year strategic plan. Much work has been done on early engagement of stakeholders, exploration of options and a draft workforce paper has been produced and discussed at the SM. We are in essence committed to delivering the project; we do however have to formally agree our approach and create a detailed project plans. We have provisionally identified the project team and completed a high level cost / return analysis (Appendix 3). We have as outlined already initiated some of the obvious work packages such as absence and contractor/agency reviews.
4 Appendix 1: Prioritised List of Short Term Cost Reduction Measures Based on Stakeholder Feedback — All Areas

4.1 Structure and Management

- Operate AMH CAGs as one cost centre to maximise benefits of working together.
- Duplications in CAGs and infrastructure
- Rationalise CAGS
- Restructure management levels. Excess management overheads. Delayering to reduce overlap and speed up decision making
- Review consultant medical – not performing to their reward. Review all high graded posts consultants and Band 9
- Understanding SLaM cross charging – is there a return on investment
- Introduce effective service line reporting / management

4.2 Roles / Productivity / Costs

- Benchmark key roles against other MH Trust’s to understand where productivity gains should be focused
- Redefine the band 7 role to be more effective and a do-able job.
- Review administration support required we may be up rather than down if we are using staff at the right level of their banding.
- Review contracted workforce to deliver more consistent 24/7 coverage
- SWOT teams to focus on failing wards areas. Tackle underperformance and remove non-productive areas
- Workforce mix change – offer voluntary redundancy to eligible groups, recruit apprentices, peer support workers, use of charities etc.
- Up skill and retrain staff to be able to fulfil more than one role and be able to be used flexibly across the Trust.
- Increased utilisation of band 4 clinical roles – currently underutilised and the increased use of advanced clinical non-medical roles e.g. Assistant Practitioners, Nurse Prescribers
- Review Clinical consultant requirements in line with cost effective leadership. Benchmark senior medical people against other relevant MH groups and look to reduce if over staffed.
- Contractor reviews and look at agency use in non-clinical areas
- Focus on sickness and performance

4.3 Infrastructure

- Close estates i.e. hospitals
- Outsource support services such as elements of HR, finance, Estates or ITT to reduce costs, but more importantly increase quality and service levels.
4.4 **STRATEGIC**

- We need to decide on who we are, focus on our uniqueness and look to move out of non-strategic areas
- Focus on core business, what’s sustainable, what’s unique, complex, high added value, form partnerships. Carry out a core business exercise for the Trust
- Form partnerships and integrate service delivery with the third sector

5 **KEY STAKEHOLDERS AND MESSAGES**

As outlined earlier, we have already consulted wildly and we know that as a result of reports in the media stakeholders are conscious of the cost pressures on the NHS. Staff are therefore aware that change is in the air: however it’s critical we take a lead on communications.

**What we want to communicate**

<table>
<thead>
<tr>
<th>Audience</th>
<th>Know</th>
<th>Feel</th>
<th>Do</th>
</tr>
</thead>
</table>
| Employees | • Workforce costs are 70% of our overall expenditure and sustaining the current costs is an increasing financial challenge  
• In 2013/14 we posted the largest deficit in our history  
• Our current model of delivery is unsustainable and we therefore need to significantly re-engineer the way we deliver mental health services. Hospitals are, and will become more specialized, with many services have to move out into primary care and the community.  
• Mental Health care itself will also develop and change in that treatment will increasingly focus on efforts to anticipate and prevent issues occurring as well as dealing with consequent problems and avoiding relapse.  
• The commercial landscape has also significantly changed and will continue to change with greater competition from within the NHS and the private sector.  
• Critical to our success will be the development of an agile, responsive, flexible and engaged workforce, able to quickly adapt to meet ever changing needs. We will need to work differently, in | • It’s a difficult task, but necessary one  
• We are taking a well-considered planned approach to cost reduction  
• Concerned but not threatened  
• That we’re listening and consulting  
• Involved  
• We think of them as individuals and not just a number  
• Not afraid to ask questions or “stick their head above the parapet”  
• They are treated in a fair way  
• They are not being “targeted”  
• They understand why we have to do what we are doing  
• There have been many scare stories in the past that has resulted in no change, this time there definitely will be  
• Engaged with their work and the Trust despite the difficult | • Don’t panic  
• Keep contributing  
• Continue to provide high quality compassionate care and Put the patient at the centre of all they do.  
• Live SLaM’s values and commitments  
• Support the process we are going through  
• Raise concerns safely when they have to. |
different places in different ways, with different people.
• These trends will continue to develop in years to come, requiring everyone in the Trust to work towards greater integration of our services internally and partnerships externally.
• Our future is exciting, but it will also often feel challenging.
• It is vitally important therefore that we implement a strategic workforce plan that helps prepare for and control both workforce costs and capability whilst supporting effective and efficient delivery of our strategic objectives.
• In the absence of our fully developed commercial and business strategy, our short term challenge is to maintain the Trust’s financial viability; reducing workforce costs by £20M (not necessarily workforce numbers) by the end of 2016, while maintaining the quality of care we already provide to service users and the community at large.
• Our long term plans to create a more agile, responsive and flexible workforce with relevant skill levels.
• It’s not going to be easy. It is an extremely large and complex undertaking that has huge consequences for individuals and for the Trust if we don’t get it right.
• The scope of the project.
• Timescales.
• The consequences if we don’t succeed.
• We are looking to understand how we can most effectively reduce costs through looking at all aspects of workforce costs, direct, indirect, productivities, efficiencies, senior managers, middle, junior, clinical, staff, infrastructure staff.
• We are looking to be fair in all circumstances.
• Part of a well-defined, highly performing team.
• Supported by their manager when needed.
• It’s not all downside there may be some opportunities and that they can progress their career and skills within the Trust where possible.

Part of a well-defined, highly performing team.
that we do
- We want to involve, consult and communicate with staff as much as possible
- We will do what we can to avoid redundancies, but we can’t guarantee it
- What we will expect from them and what they can expect from the Trust
- We want to support those staff that may be adversely impacted

<table>
<thead>
<tr>
<th>Managers</th>
<th>In addition to the above:</th>
<th>In addition to the above:</th>
<th>In addition to the above:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Support staff during the change, don’t be afraid to talk to staff even if you don’t know the answer</td>
<td>• Responsible for their staff</td>
<td>• Support both the Trust and their staff during what may be a challenging time</td>
</tr>
<tr>
<td></td>
<td>• Seek clarification from senior managers if they need it, but don’t expect senior managers to have all the answers</td>
<td>• Well supported by their managers and the Trust</td>
<td>• Don’t be afraid to have regular conversations</td>
</tr>
<tr>
<td></td>
<td>• Their roles and responsibilities is as managers and leaders and not just as great clinicians</td>
<td>• Informed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• How we will work together and in partnership</td>
<td>• Prepared and that they have the resources and skills to do what is expected of them</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Engaged with their work, their team and the Trust</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unions</th>
<th>In addition to the above:</th>
<th>In addition to the above:</th>
<th>In addition to the above:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What the Trust’s aims are and the competitive, commissioning and financial pressures it faces</td>
<td>• Involved</td>
<td>• Speak to their membership</td>
</tr>
<tr>
<td></td>
<td>• That the Trust is committed to involving and consulting them genuinely in the decisions that affect their members</td>
<td>• Taken seriously</td>
<td>• Engage appropriately with the Trust in a ‘problem-solving’ way.</td>
</tr>
<tr>
<td></td>
<td>• How we will work together and in partnership</td>
<td>• They have influence and we welcome their ideas that the Trust is behaving honestly throughout difficult times</td>
<td>• Take balanced view across the Trust</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Senior Management</th>
<th>In addition to the above:</th>
<th>In addition to the above:</th>
<th>In addition to the above:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What is expected of them in their role</td>
<td>• Responsible!</td>
<td>• They mustn’t be afraid to make difficult decisions</td>
</tr>
<tr>
<td></td>
<td>• All information / options which will allow them to make any informed decisions required from them</td>
<td>• They should do the right thing</td>
<td>• They own the delivery of the overall project</td>
</tr>
<tr>
<td></td>
<td>• They should not be political or paroquial, we’re all in this together</td>
<td>• Well supported by their line manager, even at their own senior level.</td>
<td>• They should work as a team</td>
</tr>
<tr>
<td></td>
<td>• How to engage, lead and inspire their teams</td>
<td></td>
<td>• They need to support their managers and staff through the process</td>
</tr>
<tr>
<td></td>
<td>• The are expected to demonstrate visible leadership</td>
<td></td>
<td>• They should</td>
</tr>
</tbody>
</table>
communicate whatever they can, when they can in line with the overall project comms plan
- What is expected of them to deliver high quality patient centred care with shrinking resources, engagingly, so that their services retain their engagement.
- They should be visible in the workplace

<table>
<thead>
<tr>
<th>Role</th>
<th>Expectations</th>
</tr>
</thead>
</table>
| CAG Management                | • What is expected of them.  
• How to engage, lead and inspire their services under pressure  
• That they belong to a clearly defined, well organised and cohesive team, clear of its expectations  
• Act in an exemplary, unified way; the pressures they face must not be played out visibly to the CAG’s staff or users. |
| Service users and Carers      | • TBC  
• TBC  
• TBC |
## 5.1 Potential High Level Savings from Workforce Cost Reduction Programme

Costs below are based on best estimates; work is underway to refine the potential cost savings. Figures in **bold** are HR accountabilities.

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14/15</td>
<td>15/16</td>
</tr>
<tr>
<td><strong>Absence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence</td>
<td><strong>£0.5</strong></td>
<td><strong>£0.5</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.21</strong></td>
<td><strong>£0.21</strong></td>
</tr>
<tr>
<td>Sickness on wards - £55m staff cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.49</strong></td>
<td><strong>£0.49</strong></td>
</tr>
<tr>
<td>Sickness on Other Clinical Services - £130m</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.42</strong></td>
<td><strong>£0.42</strong></td>
</tr>
<tr>
<td>Sickness on Other CAG pay costs - £20m</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.12</strong></td>
<td><strong>£0.12</strong></td>
</tr>
<tr>
<td>Sickness on Corp/central/support functions - £35m</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.03</strong></td>
<td><strong>£0.03</strong></td>
</tr>
<tr>
<td><strong>Focus on performance and recognition</strong></td>
<td><strong>£0.0</strong></td>
<td><strong>£1.1</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£1.10</strong></td>
<td><strong>£1.10</strong></td>
</tr>
<tr>
<td>Assume £220m pay (exclude medics and Senior Mgrs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Use of E-Rostering and other MI tools</strong></td>
<td><strong>£0.3</strong></td>
<td><strong>£0.3</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.3</strong></td>
<td><strong>£0.3</strong></td>
</tr>
<tr>
<td>Figure just to highlight its potential impact, but could be greater as staff costs in clinical areas £183m</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delayering and reduction in management overheads</strong></td>
<td><strong>£0.6</strong></td>
<td><strong>£1.2</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.6</strong></td>
<td><strong>£1.7</strong></td>
</tr>
<tr>
<td>Consultants and Clinical staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Identify productivity gains</strong></td>
<td><strong>£0.0</strong></td>
<td><strong>£0.7</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.0</strong></td>
<td><strong>£0.0</strong></td>
</tr>
<tr>
<td>Review of Critical roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Appropriate grading and acting at top increment</strong></td>
<td><strong>£0.0</strong></td>
<td><strong>£0.8</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.0</strong></td>
<td><strong>£0.5</strong></td>
</tr>
<tr>
<td>Outsourcing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benchmarking productivity</strong></td>
<td><strong>£0.0</strong></td>
<td><strong>£0.0</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recruitment, bank agency and open positions</strong></td>
<td><strong>£0.3</strong></td>
<td><strong>£0.8</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.25</strong></td>
<td><strong>£0.75</strong></td>
</tr>
<tr>
<td>Targeted reductions in agency staff usage, replacement either with bank or agency, together with targeted reduction in regretted attrition of key staff, tied in with tighter performance mgmt on staffing budgets</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Use of contingency workers in non-clinical areas</strong></td>
<td><strong>£0.4</strong></td>
<td><strong>£0.4</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>£0.4</strong></td>
<td><strong>£0.4</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td><strong>£2.6</strong></td>
<td><strong>£7.9</strong></td>
</tr>
</tbody>
</table>

78 of 191
## 5.2 Project Costs

<table>
<thead>
<tr>
<th>Workstream lead (1.0 wte)</th>
<th>%WTE</th>
<th>Days</th>
<th>Day costs</th>
<th>Total Cost</th>
<th>Cost Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workstream lead (1.0 wte)</td>
<td>1</td>
<td>132</td>
<td>650</td>
<td>85800</td>
<td>External</td>
</tr>
<tr>
<td>VAT</td>
<td></td>
<td></td>
<td></td>
<td>17160</td>
<td></td>
</tr>
<tr>
<td>MI lead</td>
<td>0.2</td>
<td>220</td>
<td>202</td>
<td>8888</td>
<td>Internal</td>
</tr>
<tr>
<td>Finance support / representation (variable, but estimated at 0.1 - 0.2 wte)</td>
<td>0.2</td>
<td>220</td>
<td>346</td>
<td>15224</td>
<td>Internal</td>
</tr>
<tr>
<td>Nursing support / representation (variable, but estimated at 1.0 wte)</td>
<td>0.1</td>
<td>220</td>
<td>346</td>
<td>7612</td>
<td>Internal</td>
</tr>
<tr>
<td>Medical support / representation (variable, but estimated at 0.1 wte)</td>
<td>0.1</td>
<td>220</td>
<td>479</td>
<td>10538</td>
<td>Internal</td>
</tr>
<tr>
<td>Psychology support / representation (variable, but estimated at 0.1 wte)</td>
<td>0.1</td>
<td>220</td>
<td>479</td>
<td>10538</td>
<td>Internal</td>
</tr>
<tr>
<td>4 X HRBO support (variable, but estimated at 0.2 wte)</td>
<td>0.8</td>
<td>220</td>
<td>292</td>
<td>51392</td>
<td>Internal</td>
</tr>
<tr>
<td>OT support / representation (variable, but estimated at 0.1 wte)</td>
<td>0.1</td>
<td>220</td>
<td>479</td>
<td>10538</td>
<td>Internal</td>
</tr>
<tr>
<td>Commercial support / representation (variable, but estimated at 0.1 wte)</td>
<td>0.1</td>
<td>220</td>
<td>409</td>
<td>8998</td>
<td>Internal</td>
</tr>
<tr>
<td>Operations support / representation (variable, but estimated at 0.1 wte)</td>
<td>0.1</td>
<td>220</td>
<td>409</td>
<td>8998</td>
<td>Internal</td>
</tr>
<tr>
<td>Comms support (variable, but estimated at 0.1 wte)</td>
<td>0.1</td>
<td>220</td>
<td>202</td>
<td>4444</td>
<td>Internal</td>
</tr>
<tr>
<td>Staffside</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service users</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>240130</strong></td>
<td></td>
</tr>
<tr>
<td><strong>External</strong></td>
<td></td>
<td></td>
<td></td>
<td>102960</td>
<td></td>
</tr>
<tr>
<td><strong>Internal</strong></td>
<td></td>
<td></td>
<td></td>
<td>137170</td>
<td></td>
</tr>
</tbody>
</table>
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 29th July 2014

Name of Report: Place of Safety

Heading: Performance and Activity

Author: Lou Hellard Deputy Director Clinical Services and Caroline Sweeney, Clinical Service Lead PICU

Approved by: Nick Dawe, Chief Operating Officer

Presented by: Nick Dawe, Chief Operating Officer

Purpose of the report:

To alert the Board to the occasional unavailability of a place of safety service due to a variety of demand, staffing and patient damage reasons and to indicate how the issue will be addressed in both the short and medium term to protect the quality of service and the reputation of the Trust.

The Trust currently operates one place of safety suite at each of the four hospital sites. Staff cover for the suites is provided by a host ward on each site, the PICU wards at Lambeth, Maudsley and Ladywell and the Triage ward at the Bethlem.

Work has been in train to expand physical capacity for several months with an additional suite becoming available at Bethlem in September. Some staffing issues have also been addressed since April.

Action required:

The Board is asked to:

- Note the critical impact that the absence of place of safety capacity has on the quality of service and the reputation of the Trust.
- To appreciate the outlier position of the Trust in terms of frequency of use of places of safety this is subject to further review.
- To note and support the immediate measures being taken to improve the availability of the place of safety suites.
- To note that further and more strategic options to improve place of safety provision will be brought back for the Board to consider in September.
Recommendations to the Board:

To approve the report and the actions being taken to improve place of safety availability.

Relationship with the Assurance Framework

This is a report concerned with service quality and service access.

Summary of financial and legal implications:

A general duty applies to public bodies to provide places of safety when needed; CCG contractual requirements also require the provision of places and safety. Additional staffing costs for the immediate measures have been covered in the recent “Safe Staffing” review. The need for further investment and possible benefit from such investment will be considered in the September Board paper.

Equality and diversity and public and patient involvement implications:

The lack of provision of places of safety has significant equality, diversity and public implications due to the nature of the population that we serve.

Service Quality Implications:

These are significant as lack of availability of this service can have significant ramifications for individual patients.
Place of Safety Suites – Improving Availability

1. Introduction:

During the weekend commencing 5pm July 11th – 9 am July 14th, 2014, there were four instances of the use of police custody cells due to unavailability of Place of Safety suites (PoS) within the Croydon, Lambeth, Lewisham and Southwark area.

During this time, one suite was out of action due to client damage, and two other suites were each closed for two shifts respectively due to lack of available staff and one suite for one shift due to lack of available staff.

From the Trust perspective the non-availability of a POS suite is considered to be a “never event” because it is unacceptable both for patient experience and Trust reputation.

Therefore, a quick analysis of the number of instances of suite unavailability and the causes over the weekend period, along with some short and medium solutions has been put together within this briefing paper.

It also worth noting that SLaM had the highest incidence of the use of 136 suites across London (see appendix 1) in 2013/14. This issue needs further examination as the reasons for the differences need to be understood, e.g. scale of catchment area, population demographic, local police and clinical practice, other “magnet” factors.

2. Analysis of PoS issues during the weekend of 5pm July 11th – 9am Monday 14th July 2014

2.1 Demand on PoS

There were 9 referrals to place of safety during the above time frame- 5 of which were accommodated immediately. Table 1 below shows the activity and outcomes over the preceding 11 weeks. The demand although high was not dissimilar to previous weekends.

(Table 1)

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Referrals</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>02.05 - 05.05</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>09.05 - 12.05</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>16.05 - 19.05</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>23.05 - 26.05</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>30.05 - 02.06</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>06.06 - 09.06</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>13.06 - 16.06</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>20.06 - 23.06</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

Page 1 of 6
2.2 Use of police custody suites due to lack of PoS availability

There were a total of four episodes of Police returning patients to custody over the weekend of Friday 11th July to Monday 14th July 2014. The details of these were as follows:

- Friday July 11th: 2 after 5pm
  - Patient referred from Lambeth police, PoS made available 90 minutes after initial referral
  - Patient referred from Lewisham police, PoS made available 7hrs after initial referral
- Monday July 14th: 2 in the morning:
  - Patient referred from Lambeth Police, PoS made available 6.5hrs post initial referral.
  - Patient referred from Lambeth Police, PoS provided 3.5hrs after initial referral although Police could not immediately transfer due to resources.

Table 2 below shows the reasons why the referrals could not be accepted where they were not immediately accommodated in PoS.

(Table 2)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Referring Police</th>
<th>LAM</th>
<th>SWARK</th>
<th>LEW</th>
<th>CROY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.07</td>
<td>20:13</td>
<td>LAM</td>
<td>OCC</td>
<td>OCC</td>
<td>OCC</td>
<td>CLO - ENVIRO OCC</td>
</tr>
<tr>
<td>11.07</td>
<td>22:25</td>
<td>LEW</td>
<td>OCC</td>
<td>OCC</td>
<td>CL -</td>
<td>OCC</td>
</tr>
<tr>
<td>14.07</td>
<td>01:40</td>
<td>LAM</td>
<td>OCC</td>
<td>CLO - STAF</td>
<td>CL - ENVIRO</td>
<td>CLO - STAF</td>
</tr>
<tr>
<td>14.07</td>
<td>08:00</td>
<td>LAM</td>
<td>CLO - STAF</td>
<td>CLO - STAF</td>
<td>CL - ENVIRO</td>
<td>OCC</td>
</tr>
</tbody>
</table>

Key:
OCC = occupied
CLO = closed due to absence of available staff to cover suite
CL = closed due to damage by patient that cannot be immediately remedied

2.3 PoS availability during the weekend

- Lambeth PoS: open all weekend until Monday morning with closure then due to staffing
- Lewisham PoS: closed all weekend due to client damage- reopened on Monday morning
• Southwark PoS: open all weekend other than the Sunday PM shift
• Croydon PoS: closed Monday night shift, but otherwise open

3. Reasons for lack of PoS availability

3.1 Reasons for closure

There were a number of reasons that caused the PoS suites within the Trust to become unavailable over the weekend in question. These included:

• Damage to one PoS:
  - The Lewisham suite was closed for the whole weekend due to client damage over the weekend. This meant that the Trust available PoS capacity was down by 25%.

• Staffing issues:
  - Southwark closed on Sunday PM shift due to acuity levels and lack of NHSP availability (one patient requiring supervised confinement creating an increased staffing requirement which could not be provided by NHSP)
  - Croydon closed Monday night due to staffing levels. In this instance the Triage ward staffing for that shift was comprised only of NHSP staff and therefore a place of safety coordinator could not be made available.
  - Lambeth closed Monday morning due to staffing. NHSP shift not filled although this was resolved at 11am

3.2 Actions in place prior to the weekend of July 11th/12th:

• All PICU wards have increased their core staffing to help support Pos. PoS also draws on acute wards to supply the rest of the PoS team required. However these shifts are supported largely through NHSP at present until recruitment is complete.

• As NHSP struggle to cover shifts on a Monday, substantive staff are proactively rostered on (in PICUs and acute wards)

• All acute and PICU vacancies are being advertised and a recruitment trajectory developed, which now includes the additional staff to implement the new skill-mix
4. Issues raised and possible solutions

4.1 Issues

The issues over the weekend in question have identified the following main challenges in terms of keeping PoS open which go beyond the initial actions already in place:

- Given the demand on SLaM PoS, having a suite closed due to client damage immediately tips the system.
- While additional staffing has been funded, at present until recruitment is complete, the wards need to rely on NHSP to fill the shifts. NHSP are finding it problematic to cover shifts, which when combined with acuity on the wards requiring (including seclusion and observations) is further exacerbated, leading to problems with providing enough staffing to keep the suites open.
- NHSP rely predominantly on SLaM staff to supply for shifts requested, therefore while SLaM has a number of vacancies and/or NHSP have not broadened their pool of staff, the problem is likely to continue.
- Vacancies are actively being recruited to but recent and historical recruitment of Band 5s and Band 6s has identified serious problems with attracting good quality candidates, leading to large numbers of interviews but few successful candidates.

4.2 Agreed short and medium term solutions

A meeting was called on July 16th, led by the Chief Operating Officer, to review this briefing. At this meeting the following short and medium term measures were agreed:

In the short term:

- Planning for the weekend to ensure that suite staffing is covered from substantive staff, effective from the weekend commencing Friday 5pm 18th July.
- Review of available staffing for PoS (confirming staffing for the next 24 hours) has been included in the daily demand/capacity bed teleconference from July 16th with a further review at 3pm daily if required to review staffing for the night and following morning.
- Review of the 136 protocol to increase available capacity, so that suites can be made available as soon as possible. This will be approved at the Trust Bed Management meeting on Wednesday 23rd July.
- Development of a cross CAG escalation process by July 23rd whereby in extremis, staff will be supplied from other CAGs to keep PoS open (including exploring through discussion whether this should include both ward based services and Home Treatment Teams). This will also include a reiteration of the Duty Senior Nurse mandate to flex staff across the site for which they are responsible.
• Recruitment trajectories are monitored via performance meetings for all wards, and clarity is given by HR that recruitment can continue alongside the need to place redeployees

• Reiteration of the protocol for maintenance and clearing staff to respond to PoS as required will be completed.

• Further discussion to be had to consider the proposal that for an interim period it may be worth the Trust considering a “first to fill” list in terms of requests for staff from NHSP to support PoS remaining open.

In the medium term:

• As recruitment of quality staff is a “wicked problem” across Band 5s and Band 6s, it is requested that a taskforce including the Director of Nursing, the Director of HR, the Deputy Directors of Nursing across the CAGs, Head of Crisis Pathway and the Deputy Director of Inpatients be set up to develop a new recruitment strategy which can be implemented from August 2014 onwards.

• Works are planned to increase the number of beds within the Southwark and Croydon PoS suites to 2 each, giving a total of 6 beds by December 2014. This will allow for spare capacity in times of client damage or in extremis subject to safe staffing levels.

• A PoS strategy meeting is being set up to develop a more robust strategy for PoS provision across the Trust in the future, including number of suites required, location, consideration of a single Trustwide resource, management and pathway.

It is intended that a further report to the Board is brought back in September that addresses these medium-term issues.
Appendix 1

Total admissions to London Mental Health Trust Places of Safety April 2013 – March 2014 (Camden and Islington data N/K).

(Graph taken from Street Triage Report by Caroline Sweeney- CSL PICU and POS 8.7.14)
Date of Board meeting: 29th July 2014

Name of Report: Rehabilitation Alliance, Lambeth

Heading: Performance and Activity

Author: Nick Dawe, Chief Operating Officer

Approved by: Nick Dawe, Chief Operating Officer

Presented by: Nick Dawe, Chief Operating Officer

Purpose of the report:

This report is designed to update the Board to the progress being made with an alliance approach to the provision of rehabilitation services in Lambeth.

In addition this report is seeking formal delegated authority to proceed with the formation and operation of a rehabilitation alliance subject to an evaluation of operational and financial risk, noting that decisions will need to be made at short notice in late September to early October.

The Trust has been actively engaged with Lambeth CCG, Lambeth GPs and the voluntary sector in Lambeth for several years as part of the “living Well initiative and through individual projects such as the Hub (integrated care provision).

A further specific project being taken forward in Lambeth is to redesign mental health rehabilitation (health and social) services and use an alliance approach and form of contract to deliver the change and support services subsequently.

The basic service and economic thinking that underlies the commissioner’s approach to the transformation is that existing hospital and health and social placement based services are considered too “fixed” and too “expensive” and that better value would be obtained by having a greater variety of alternative service offerings that would step down most patients to a position where they would be less reliant on state provided and/or funded services.

With the new alliance offer as envisaged it would allow commissioners to disinvest in rehabilitation services whilst meeting the demand for services and maintaining if not improving outcomes.

In respect of the rehabilitation services currently provided by the Trust in Lambeth their scale is as follows:

- 33 of the 35 beds on McKenzie and Tony Hillis Wards
- Direct cost budgets in the order of £4.6m
- Direct staffing of 76 whole time equivalents

The proposed partners in the alliance, both of which the Trust has worked alongside of in the past are Certitude and Thamesreach. Primary Care, the CCG itself and Lambeth social Services will also be key players alongside other voluntary bodies.

The operational and financial implications for the Trust are yet to be worked through in detail, however the scenarios which are more likely include:

- Some reduction in inpatient activity and therefore capacity within the rehabilitation pathway (both private and SLaM based) through work with partners around the provision of alternative solutions with a flexible offer.
- The above along with the possibility of developing more community based services including outreach into other providers or other SLaM teams

There are risks around contribution to overheads, however by virtue of the partnership arrangements the Trust should however lose most of the volume risk in terms of demand exceeding supply and equally most of the expectation of funding the cost and standing the risk of service transformation.

However, how the final model will be shaped is the subject of further discussion, investigation and negotiation with partners over the next couple of months.

Although the alliance will undoubtedly have operational, financial and staffing implications, the Board is reminded that it is predominantly a service improvement initiative designed to gain more service value for a diminished level of resource.

The alliance will also provide invaluable learning for further and more extensive alliance and integrated care opportunities.

Recommendations to the Board:

- Continue to support the Lambeth rehabilitation alliance opportunity and the Trust’s active role in the alliance.

- Delegate responsibility to enter into the alliance to the CEO on the advice of the CFO and COO and in discussion with the Chair and the Chair of the Audit Committee

Relationship with the Assurance Framework

No direct relationship.

Summary of financial and legal implications:
To be determined, but for the alliance to be feasible and operable, value of net risk/opportunity to the Trust not to exceed minus/plus £100,000.

**Equality and diversity and public and patient involvement implications:**

No direct implications.

**Service Quality Implications:**

The initiative should improve service quality and choice.
Date of Board Meeting: 29th July 2014

Name of Report: Estate Strategy – Maudsley Site – Douglas Bennett House

Heading: Performance & Activity

Authors: Nick Dawe, Chief Operating Officer and Mark Drewe, Head of Estate Strategy

Approved by: Nick Dawe, Chief Operating Officer

Presented by: Nick Dawe, Chief Operating Officer

Purpose of the paper:

The Medium Term Estates Strategy approved by the Board in June this year and the Operational Capital Programme and Statutory Works Programme, approved by the Board last year and this year, all identify the need to both provide new facilities where appropriate and affordable, fully refurbish existing facilities if they have a life of ten years or more and maintain in good condition all other operational facilities.

One of the buildings that it is intended to retain for ten years or more but is in a poor state of repair is Douglas Bennett House on the Maudsley Site. A recent CQC visit identified failings in terms of décor and ligature risk as well as commented on the lack of satisfactory cleaning. Recent estates reviews have indicated more fundamental problems with the building and its services ranging from the need for a full utility refit, to the layout and size of bathrooms being inadequate and access arrangements poor. For this multitude of reasons the building and its services requires a full refurbishment.

The paper identifies that a full refurbishment is the best value for money option when compared to demolish and rebuild and that the option of carrying out minor decorative and improvement works would be a false economy in terms of operating the building, systems safety and the risk of future adverse comments from regulators.

The Board should also note that due to issues of affordability and the impact of building costs on service prices, that the Estates Strategy options that will be brought forward in detail of the next few years will be a mixture of new build and major refurbishment with commonly major refurbishment having half the cost of new build.

The Board should also note that the usage of Douglas Bennett House will be reviewed during the building work period so that the wards and departments located there are the best in terms of co-adjacency, access and layout in line with current and envisaged service strategies.
Action required:

The Board should consider the options summarised in the attached paper and in particular be satisfied that the preferred option is:

- In line with the agreed Estates Strategy.
- Meets current and foreseeable regulatory requirements.
- Offers value for money and is affordable.

Recommendations to the Board:

To approve the proposed major refurbishment of Douglas Bennett House as a key project in delivering the agreed Estates Strategy to a minimum capital cost of £6.1m and a maximum cost of £7.1m and with neutral revenue consequences.

To note that progress with the project will be reported monthly via the normal Capital Review Group mechanisms.

To note that this project will trigger a Trust-wide consideration of the optimum location of wards and departments by site in line with the emerging Operational Strategies and agreed Estates Strategy.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:

The Estates Strategy and the associated Capital Review Group mechanism are key components of the Assurance Framework. This paper refers to a project forming part of the Estates Strategy.

Summary of Financial and Legal Implications:

The net capital spend on the project should not exceed £6m with a 10% contingency being held in excess of the figure. The project will aim to have a neutral revenue impact with improved energy and operational efficiency offsetting increased capital charges.

Equality & Diversity and Public & Patient Involvement Implications:

The Estates Strategy in general and this project in particular will address equality and diversity issues as appropriate, e.g. improve access and improve the quality of the care environment.

Service Quality Implications:

Aim is to significantly improve care environments, their appropriateness, curative nature and their functionality meeting if not exceeding CQC expectations.
# TRUST BOARD - SUMMARY REPORT

**Date of Board meeting:** 29 July 2014

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

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

**Author(s):** Paul Mitchell, Trust 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 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 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 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 the local health economy and nationally in the NHS and Social Care.

## Service Quality Implications:
A number of the national issues listed in the report will have an impact on the quality of services provided by the Trust.
Chief Executive’s Report
July 2014

1. National issues

NHS rated as best healthcare system in the world
In a report conducted by The Commonwealth Fund, the UK’s health system has been ranked first overall in comparison with ten other countries in quality, efficiency, cost and performance. “Mirror, Mirror on the Wall,” scores the UK highly for its quality of care, efficiency and low cost at the point of service, with Switzerland coming an overall second. The US came last, as it has done in four other editions of “Mirror, Mirror” since 2004. The Commonwealth fund is a Washington-based foundation respected for its analysis of the performance of different countries’ health systems. It examined 11 countries, including detailed data from patients, doctors and the World Health Organisation. The full list of countries analysed in the study were: New Zealand, Australia, France, Germany, Norway, Sweden, the Netherlands, Switzerland, Canada, Britain and the US.

Plans to give patients funds to purchase their own care
NHS England chief executive Simon Stevens has announced a major change of policy that could see billions of pounds of health service and local authority budgets handed to the most vulnerable patients to purchase health and social care services in the community after a care plan is agreed with their doctors. From April next year, frail elderly people, disabled children and those with serious mental illness or learning disability will be offered individual sums of money to spend on health and social care services. Mr Stevens said that it would help keep people out of hospital and ultimately save money. Some patients’ budgets will be as little as a few hundred pounds, though most are likely to get more than £1,000.

Block contracts for mental health
Monitor has signalled the end of block contracts currently used to fund NHS mental health providers as part of a major shakeup of the national payment system due to be introduced next year.

In a pre-consultation paper on the national tariff for 2015-16 the regulator said it wants the mental health clustering system to become the main driver of prices. It has also proposed developing a new set of mental health “currencies” as part of any future payment system.

The pre-consultation paper stated: “We expect providers and commissioners to use the adult mental health cluster currency for payment, unless they develop an alternative approach in accordance with the applicable rules, and to submit reference costs data based on the clusters.”

Currently, mental health providers use 21 care clusters to categorise patients according to the severity of their condition and the services they might need. These are used to set prices and feed into the minimum mental health dataset designed to underpin a national payment system.

The paper provided a clear indication of the direction Monitor wants to see the mental health sector take, and follows years of delay and doubt over the development of payment by results for mental health services. The development of such a system has been beset by delays and fears over the quality of the data.
2. Trust issues

Monitor update
As I have reported elsewhere, Monitor has opened an investigation into how the Trust Board is performing following concerns expressed by external consultants.

This investigation is not about the quality or safety of our services, but is focused on matters of governance and assurance, including Board effectiveness and performance along with more technical matters such as committee structures, reporting lines and accountabilities. There is no question that our staff are anything other than highly committed and that they do an excellent job delivering high quality services to our patients, often in challenging circumstances.

The Board has already implemented many positive changes in recent months to address recommendations made by external consultants, including: a review of Board committees; the implementation of a new quality governance structure; the implementation of a revised performance framework and the appointment of two new Non-Executive Directors. The Board has also supported the CEO’s restructuring of the Executive team with the creation of a new Chief Operating Officer role and the appointment of a new Director of Nursing.

We are in dialogue with Monitor and are awaiting details of any further information they require. We will work closely with them and I am confident that their queries can be resolved quickly.

Operational management arrangements
We are now three months into the revised operational management arrangements following the creation of a Chief Operating Officer role and a revision to the monthly Performance Management arrangements and the introduction of separate strategic and operational monthly Executive meetings.

The new arrangements are now increasingly well embedded but to ensure clarity I set out below a summary of the key changes:

- CAGs are accountable for the delivery of the annual and strategic plan objectives to the Chief Operating Officer, (acting on behalf of the Board).

- Monthly CAG Performance Review Meetings are held to ensure planned objectives are being met, action plans produced when targets are not being met. All aspects of performance are considered at the meeting, service delivery, service quality, finance and manpower issues and therefore other parts of the Trust are critical to these endeavours. The CAG management Board is invited to these Performance Review Meetings as are other individuals on an issue by issue basis, e.g. the Programme Manager for the Adult Mental Health Transformation Programme.

- Monthly Operational Executive meetings are held to consider issues of common interest to CAGs, and to agree policies and procedures. The service, Clinical and Research Directors of each CAG together with other executives are invited to these meetings. In addition there are monthly Strategic Executive meetings which I chair.
On an issue by issue basis, other meetings are arranged with individual or groups of CAGs as appropriate, these meetings often requiring both managerial and clinical and research presence.

On a personal basis the above management arrangements are supported by the following regular review and monitoring meetings:

- Regular mentoring and review meetings on an individual basis are held between the Chief Operating Officer and the CAG Service Directors.
- Regular mentoring meetings on an individual basis are held between the Medical Director and CAG Clinical Directors.
- Regular mentoring meetings on an individual basis are held between the Medical Director and CAG Research Directors.

Further enhancements are planned to the above arrangements including:

- Quarterly development workshops to be held between the Chief Operating Officer and CAG Service Directors, (from August).
- Twice a year visits from the Chief Operating Officer to the individual CAG Executive Meetings, (from September).
- Weekly status tele-conferences between the Chief Operating Officer and Service Directors.

3. Commiserations

Sharon Murray
Sadly Sharon Murray, Trust Profile Co-ordinator/Positive Diverse Lead, who retired in 2013, passed away on Tuesday 1 July 2014. Sharon had a significant impact on the working lives and personal development of many people in the Trust and will be greatly missed.

4. Congratulations

Director of NIHR BRC
Following an international search, Professor Matthew Hotopf has been appointed Director of the National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) at South London and Maudsley (SLaM) NHS Foundation Trust and the Institute of Psychiatry (IoP), King’s College London.

Professor Hotopf has been with the BRC since its inception in 2007 and has acted as Interim Director since January 2014. From 2007-2012 Professor Hotopf led the BRC’s Analytic Methodologies theme which developed the innovative Clinical Record Interactive Search (CRIS), the most in depth mental health data resource in Europe. CRIS is used for clinical research purposes and has now been deployed across four other mental health trusts in the UK. He also leads the South East London Community Health Survey, the largest study of urban mental health in the country.

Matthew has a proven track record of success and commitment to the BRC and his
appointment will ensure that it remains under strong leadership and at the forefront of mental health experimental medicine and translational research.

**RCPsych awards**
The outstanding achievements of South London and Maudsley NHS Foundation Trust’s (SLaM) staff have been recognised by the Royal College of Psychiatrists in their annual awards shortlist.

The awards, now in their sixth year, recognise and celebrate excellence in psychiatry and mental health services. The winners will be announced at the RCPsych awards ceremony in London on 6 November 2014.

Seven SLaM colleagues have been shortlisted for an RCPsych Award 2014:

- Dr Sarah Bernard for RCPsych Psychiatrist of the Year.
- Dr Sukhi Shergill for RCPsych Academic Researcher of the Year.
- Dr Fiona Gaughran for RCPsych Psychiatric Trainer of the Year.
- Dr Paola Dazzan for RCPsych Academic Researcher of the Year.
- Dr Alex Langford for RCPsych Core Psychiatric Trainee of the Year.
- Bridget Jones and Matthew McKenzie for RCPsych Carer Contributor of the Year. Matthew is an elected member of SLaM’s Council of Governors.

**5. Information Governance (IG) Statement**
The Information Governance Team is undertaking a Trust-wide review of legacy clinical documents to ensure that no personal confidential data is at risk of loss. The review will be undertaken in two phases; an initial phase to identify volume, and the follow-up phase to digitise and place documents in relevant records on the Trust electronic health records repository. This review follows the large scale digitisation programme that was undertaken when the Trust moved to electronic health records and decommissioned all clinical records archives in 2010.

The Information Governance Audit Programme for 2014-15 is underway. The programme constitutes independent reviews undertaken by Internal Audit alongside an extensive programme of audits undertaken by the Trust Information Governance Team. The key reviews that will be undertaken by the IG Team include staff awareness of IG and training needs, review of the IG training programme, health records and secure flows of confidential information, service user experience with the way their personal data is handled by the Trust. The finding and recommendations arising from the reviews feed into the Trust Information Governance Annual Work Plan. The progress on the Work Plan is monitored by the Trust Caldicott Committee.

The Health and Social Care Information Centre (HSCIC) has released the set of IG standards for Mental Health Trusts for 2014-15. The standards that make up the HSCIC Information Governance Toolkit (version 12) are currently being reviewed by the IG Team as part of a benchmark exercise.
<table>
<thead>
<tr>
<th><strong>Date of Board meeting:</strong></th>
<th>29 July 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Report:</strong></td>
<td>Report from the Council of Governors</td>
</tr>
<tr>
<td><strong>Heading:</strong></td>
<td>Governance</td>
</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Paul Mitchell, Trust Secretary</td>
</tr>
<tr>
<td><strong>Approved by:</strong></td>
<td>Dr Matthew Patrick, Chief Executive</td>
</tr>
<tr>
<td><strong>Presented by:</strong></td>
<td>Noel Urwin, Council of Governors</td>
</tr>
</tbody>
</table>

**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.

**Service Quality Implications:**
The Council of Governors’ bids programme specifically welcomes bids which “improve the patient experience”.
1. **Report from the Nominations Committee**

   The Nominations Committee are meeting on Thursday, 24th July to discuss the skill set required for up to two replacement Non-Executive Directors. The recruitment process will commence in August.

2. **Meeting with the external auditor**

   A number of Governors met with Deloitte, the Trust’s external auditors. This is a regular meeting that is scheduled prior to the September Council of Governors meeting when the auditors comment on the Trust’s annual report, annual accounts and quality report. Deloitte confirmed that they had no concerns relating to service quality.

3. **Bids**

   The deadline for submission of bids was 4th July; so far 193 bids have been received. This has directly led to 55 new members being recruited. The current membership of the Trust is 12,632.

4. **Lead Governor**

   The role of the Lead Governor is to act as a point of contact with Monitor should the regulator have concerns regarding the Trust’s performance. As previously reported the current Lead Governor, Noel Urwin, has indicated that he will not be standing for re-election later in the year.

   Any Governors interested in taking on the role is being asked to make a formal expression of interest by Friday, 15th August. If necessary, an election process will commence so that a new Lead Governor is in place by early September so that a managed handover can be arranged.

5. **FT Constitution**

   A meeting of the CoG Constitution Review group is being scheduled for mid-August as a means of ensuring Governor input to the review.
6. Happy heads festival

The Happy Heads Festival will take place on Saturday 26 July. Hundreds of teenagers have been invited to take part in the unique festival dedicated to improving their mental health and wellbeing.

Live music, a variety of fun and interesting workshops and advice for young people from mental health representatives will all be on offer on the day.

Teenagers can learn how to DJ, take part in a creative writing workshop and find out more about photography while learning how to look after their mental health and improve their general happiness.

Paul Mitchell
Trust Secretary
July 2014
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 21st January 2014

Name of Report: KHP Board Verbal Update

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

Author:

Approved by: (name of Exec Member)

Presented by: Madeliene Long

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

Action required:
The Board of Directors is asked to 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.

Service Quality Implications:
A key driver of the AHSC is the improvement of the quality of the services offered to local people and beyond. This has recently been tested via the accreditation process. Of specific importance to mental health is the closer integration and parity with physical health care.
**Date of Board meeting:** 29 July 2014

**Name of Report:** Risk Management and Assurance Strategy

**Heading:** Governance

**Author:** Jenny Goody, Governance Manager

**Approved by:** Gus Heafield, Chief Financial Officer

**Presented by:** Gus Heafield

**Purpose of the report:**

To present the Trust's Risk Management and Assurance Strategy, which has been updated to reflect recent changes arising from the implementation of the changes arising from the Board reviews of Governance and Performance Management.

**Action required:**

The Board of Directors is asked to review the Trust’s updated Risk Management and Assurance Strategy at Attachment 1.

**Recommendations to the Board:**

- Ratify the Trust's updated Risk Management and Assurance Strategy.

**Trust-wide risk(s) affected by this report and the level of assurance provided (none, low, moderate, high):**

- This paper forms the basis of the on-going review and development of the Assurance Framework.

**Service Quality Implications:**

The Trust’s Risk Management and Assurance Strategy establishes the framework wherein risks to service quality are identified, mitigated and monitored effectively.

**Summary of Financial and Legal Implications:**

The Assurance Framework underpins the Annual Governance Statement signed by the Chief Executive each year.

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

The Assurance Framework enables the Board to assess and manage the organisation's principal risks and ensure the Trust’s strategic aims are achieved.
Risk Management and Assurance Strategy Review

Introduction
Version 7.1 of the Trust's Risk Management and Assurance (RMA) Strategy was presented to the meeting of the Board of Directors in March 2014. When it was agreed, the Board of Directors requested further updates as appropriate to reflect the implementation of the agreed changes to the Governance and Performance Management systems in the Trust.

The Strategy has been updated and is now being presented to the Board of Directors for formal ratification.

Executive Summary
The updated RMA Strategy can be found at Attachment 1, with updates highlighted in yellow:

The principal changes to the RMA Strategy are outlined below:

- The role and responsibilities of CAG and directorate governance meetings. (page 9)
- The role of the Operational Performance Management Review framework. (page 9)

Action
The Board of Directors is asked to ratify the Trust’s updated Risk Management and Assurance Strategy at Attachment 1.
Risk Management and Assurance Strategy

Ratified by the Board of Directors
Date:

Issue date

Version 7.2

Review Date

Document Author Jenny Goody
Governance Manager

Document Lead Gus Heafield
Chief Financial Officer

Document Risk Owner Gus Heafield

Number of Pages 35

Target Audience All Staff

Equalities Compliant Yes (Assessed by policy author, Sep-13)

HRA Compliant Yes (Assessed by Claims and Litigation Manager, Sep-13)

Key Related Documents:

Incident Policy (v2.2, Sep-11)
Health & Safety Risk Assessment Policy (v3.1, Oct-11)
Clinical Risk Assessment and Management of Harm Framework (v6.1, Oct-11)
## Contents

1. **INTRODUCTION**
   - 1.1 Statement of Intent
   - 1.2 Background
   - 1.3 Board of Directors’ Statement on Responsible Risk Taking
   - 1.4 Definitions

2. **STRATEGY OBJECTIVES AND SCOPE**
   - 2.1 Objectives
   - 2.2 Scope

3. **LEAD COMMITTEES AND GROUPS WITH RESPONSIBILITY FOR RISK MANAGEMENT**
   - 3.1 Board of Directors
   - 3.2 Audit Committee
   - 3.3 Quality Committee
   - 3.4 Other Groups
     - Senior Management Team
     - CAG / Directorate Risk Management Meetings
     - CAG Clinical Governance Meetings
     - Chief Executive’s Performance Management Review

4. **RISK MANAGEMENT ROLES AND RESPONSIBILITIES**
   - 4.1 Directors
   - 4.2 Deputy / Assistant Directors
   - 4.3 Managers
   - 4.4 All Staff

5. **RISK MANAGEMENT AND ASSURANCE PROCESSES**
   - 5.1 Process for the Management of Risk
   - 5.2 Risk Escalation
   - 5.3 Board Assurance

6. **RISK MANAGEMENT AWARENESS TRAINING**
   - 6.1 Board of Directors
   - 6.2 Senior Managers
   - 6.3 Other Staff

7. **MONITORING COMPLIANCE**

8. **REVIEW AND VERSION CONTROL**

9. **DISSEMINATION PLAN**

   Appendix A Governance Framework
   Appendix B Risk Analysis Tool
   Appendix C Assurance Framework Template
   Appendix D Corporate Risk Log Template
   Appendix E Risk & Assurance Register Template
   Appendix F Risk Identification Sources
   Appendix G Risk Escalation Process
   Appendix H Terms of Reference of Key Committees
   Appendix I Equality Impact Assessment
1.0 INTRODUCTION

1.1 Statement of Intent

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

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

The Trust has in place a governance model with membership of Non-Executive Directors on each of the Board Committees. The Trust’s continued integration of clinical and all non-clinical risk is in line with Department of Health guidance and Monitor’s Code of Governance. The Risk Management and Assurance Strategy supports the Trust’s operational and 5-year strategic plans, within which quality priorities have been identified.

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

1.2 Background

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

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

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

1.3 Board of Directors’ Statement on Responsible Risk Taking

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

Examples of ensuring responsible risk management include:

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

1.4 Definitions

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

Directorate: For the purposes of this strategy, ‘directorate’ is used to define the corporate and infrastructure directorates within the Trust: ICT, Estates & Hotel Services, Capital Planning, HR, Organisation & Community, Nursing, Clinical Management and Finance.

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

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

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

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

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

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

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

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

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

- The service user is the centre of all we do;
- Provide effective and efficient services that meet the needs of our service users;
- Ensure that our infrastructure, in particular our workforce, ICT and estates can support the delivery of the Trust strategy.

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

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

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

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

**Corporate Risk Log:** The Trust’s Corporate Risk Log comprises the principal operational risks that threaten the achievement of local or Trust objectives. For each risk within the Corporate Risk Log there is a full description, the controls in place to minimise the consequence or likelihood of the risk and any actions planned to further reduce or eliminate it. The identification of sources of assurance is becoming an
increasingly significant aspect of risk management, and details include where assurance can be gained that the risk is adequately controlled and what the assurance is (for example, an Internal Audit Report giving Significant Assurance). The Corporate Risk Log is currently reported in the format of the template at Appendix D; it is held on an Excel spreadsheet and is available for review via the Intranet.

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

- Principal\(^1\) active operational Trust-wide risks and local catastrophic risks, which are not yet fully under control and are expected to be present on CAG and/or directorate Risk & Assurance Registers as well as the Corporate Risk Log, with actions planned to further mitigate them;
- Principal\(^1\) inherent operational Trust-wide risks, which are currently under control and for which the Board (or an appropriate Board sub committee) expects robust assurances. An important function of risk management is to provide assurance that the principal risks facing the Trust are being controlled effectively; this refers especially the inherent risks that would have a significant impact on the Trust if realised. The Corporate Risk Log therefore contains inherent risks gathered from a variety of sources, such as Never Events, CQC Registration and the Infection Control and Safeguarding Children assurance frameworks.

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

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

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

---

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

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

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

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

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

The Trust is committed to continued integration between clinical and non-clinical strands of governance through a unified assurance framework for risk management, an integrated support structure and the use of a consistent methodology for risk assessments. The Trust's governance framework, outlined at Appendix A, ensures a co-ordinated approach to governance and risk management. The framework is reviewed at intervals to ensure that the approach remains effective and fit for purpose.

This section describes how the responsibilities of different Trust committees for risk management and assurance activities are executed. More detail is provided in the Terms of Reference for each committee, which are provided at Appendix H.

3.1 Board of Directors

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

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

CAG Directors attend Board meetings and report back to their local governance meetings on any issues raised.

3.2 Audit Committee

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

3.3 Quality Committee

The Quality Committee, also chaired by a Non-Executive Director, is the focal point for all governance issues and provides assurance to the Board of Directors on the delivery of the Quality Strategy; it examines where there have been failures in service quality and monitors progress against actions planned to address them. It has responsibility for monitoring the effectiveness of the risk management systems that underpin the Quality Strategy and monitors the management of the service quality risks contained within the Assurance Framework and the Corporate Risk Log.
The Quality Committee meets monthly and focusses on one of three areas of governance at each meeting: Safe Services, Caring & Responsive Services and Effective Services. The membership of the Quality Committee, comprising Non-Executive, Executive and CAG Clinical Directors, ensures continuous and measured improvement in the quality of care and service delivery across the Trust by sharing knowledge and experience of quality improvement and discussing areas of interface between services. The Quality Committee has overarching executive responsibility for risk management within the Trust and encourages the early and accurate identification of Trust-wide risks and the agreement of a reasoned, proportionate response commensurate with the need to encourage innovation.

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

3.4 Other Groups

Senior Management Team

Key operational decisions are made by the Senior Management Team, which meets weekly to discuss the principal issues facing the Trust.

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

CAG / Directorate Governance Meetings

Each CAG and directorate is required to have forum where their Risk & Assurance Register is reviewed and new risks are identified and assessed. Risks with a red\(^2\) current risk rating or red\(^3\) delivery status are reviewed monthly; all other risks are reviewed on a quarterly basis. Clinical governance meetings consider reports and bulletins that have an impact on patient safety and review any newly ratified clinical policies, identifying methods of providing clinical staff with the key messages contained within them.

Operational Performance Management Review

The Operational Performance Management Review framework consists of two elements: part one involves meeting CAGs to review a range of issues including statutory & regulatory requirements, education & training, staffing and risks. The focus of part two is the delivery of the 2-year operational plan; issues from part one are escalated to part two on an exception basis.

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

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

4.1 Directors

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

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

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

Chief Financial Officer: has responsibility for managing the development and implementation of the Trust’s Integrated Governance framework as well as for ICT and financial risk management arrangements and the quarterly and annual financial and governance declarations to Monitor; this includes the on-going development and maintenance of the Assurance Framework.

Chief Operating Officer: has responsibility for Performance Management, and has overall responsibility for the continuing fitness of the Trust’s buildings, plant and non-medical devices used by Trust staff. The Chief Operating Officer has particular responsibility for Health & Safety, fire safety, security, waste management and environmental management.

Director of Nursing and Medical Director: have joint responsibility for clinical risk management, which includes clinical governance, medical devices, safeguarding children, safeguarding vulnerable adults, the Mental Health Act, serious incidents (SIs) and complaints. The Director of Nursing and Medical Director also have joint responsibility for NHS Litigation Authority (NHSLA) arrangements and for Care Quality Commission (CQC) registration. The Medical Director leads on Deprivation of Liberty Safeguards and is the nominated Trust Director for Infection Prevention and Control (DIPC).

Director of Organisation and Community: has overall responsibility for external relationships with Overview and Scrutiny Committees (OSCs) and Healthwatch.

Director of Human Resources and Organisational Development: has overall responsibility for Education and Training and for the continuing suitability of the Trust’s staff, ensuring that adequate checks are carried out before they are employed.
Chief Information Officer: has overall responsibility for the Trust’s infrastructure security and Trust’s compliance with NHS ICT Security standards; has overall responsibility for the development, maintenance and communication of Information Governance policies and procedures, although all Directors are responsible for the implementation of Information Governance.

Director of Research and Development: has overall responsibility for the Trust’s research portfolio, which includes ensuring that all research is ethically and scientifically sound and is conducted according the Department of Health’s Research Governance Framework.

4.2 Deputy / Assistant Directors

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

Associate Director Quality and Assurance: is responsible for co-ordinating the process of monitoring compliance with the Care Quality Commission Essential Standards through nominated lead directors; leads on the patient safety and clinical governance agenda, including the development of information relating to clinical quality.

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

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

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

4.3 Managers

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

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

A nominated member of each CAG and Directorate: acts as the conduit for identifying, capturing and assessing risks; they maintain an overview of active CAG risks, taking account of progress in completing actions planned to reduce their likelihood or potential consequences. They ensure that risk management is
incorporated into the operational and business planning processes, ensuring that risk recording and assessments are undertaken in accordance with Trust policy.

4.4 All Staff

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

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

---

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

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

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

5.1 Process for the Management of Risk

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

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

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

The Quality Effectiveness and Safety Trigger Tool (QuESTT) is a specific protocol that provides a framework to enable Managers and Clinical Leads to escalate concerns when teams are experiencing difficulties managing quality safety and effectiveness. The QuESTT monitors key performance indicators to provide an early warning trigger if essential characteristics of quality and safety are absent or at risk.

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

The SMT identifies and assesses new strategic risks as part of the planning cycle.

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

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

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

Newly identified strategic risks are approved by the Quality Committee, the Audit Committee or the Board of Directors.

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

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

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

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

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

CAGs and directorates are required to monitor any Red\(^5\) risks within their Risk & Assurance Registers on a monthly basis and review all risks quarterly. When it is felt that a risk has been fully mitigated (its current risk rating being brought down to its target risk rating by the application of controls), it can be archived by closing it on the Datix system. Closed risks are reviewed annually to confirm that they no longer exist or are still under control and do not pose a threat to the organisation.

The Corporate Risk Log is maintained by the Assistant Director of Governance on an Excel spreadsheet; it is reviewed at monthly meetings of the Quality Committee and the quarterly meetings of the Audit Committee.

The Assurance Framework is maintained by the Assistant Director of Governance on a Word document; it is reviewed at monthly meetings of the Quality Committee and the quarterly meetings of the and Audit Committee, where Trust leads are invited to attend meetings to present the actions underway to mitigate the risk, progress to date and any issues identified, thus providing assurance that the Trust’s principal strategic risks are being managed effectively. The Assurance Framework is reviewed by the Board of Directors quarterly.

### 5.2 Risk Escalation

When a CAG or directorate identifies a potentially Trust-wide operational risk that is rated 12 or above\(^7\), it is raised at a monthly meeting of the Quality Committee, where the decision is made to add it to the Corporate Risk Log and also to all relevant CAG / directorate Risk & Assurance Registers.

A risk that is identified by a CAG or directorate that is specific to them but outside their control also needs to be placed on the Risk & Assurance Register of the CAG / directorate that can control or mitigate it. Such risks are discussed at the Quality

\(^5\) As defined by the Trust's Risk Analysis Tool at Appendix B
Committee but are only added to the Corporate Risk Log if they are deemed to be ‘catastrophic’.

The Quality Committee regularly reviews the active clinical Trust-wide risks within the Corporate Risk Log, which enables the committee to track the status of active operational risks that have an impact across the whole organisation.

The principal risks that threaten the achievement of the Trust’s strategic objectives are represented on both the Corporate Risk Log and the Board’s Assurance Framework; the Quality Committee reviews both documents, and escalates any areas of concern to the Board of Directors. Non-clinical risks are reviewed in detail by the Audit Committee, which reports directly to the Board of Directors.

The Assistant Director of Governance provides a focal point for the consolidation and aggregation of Trust-wide strategic and operational risks for reporting and escalation to the Board of Directors and its sub committees.

A flowchart illustrating the risk escalation process is provided at Appendix G.

5.3 Board Assurance

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

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

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

6.2 Senior Managers
A risk management awareness seminar has been developed to enable Senior Managers\(^6\) to understand the key aspects of risk management, the effective escalation of risks and their risk management role within the Trust.
Risk Management Awareness Training for Senior Managers has been designated as mandatory (Tier 1), and is monitored by the processes outlined in the Training Needs Analysis section of the Education and Training Policy (v8, May-11).

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

7 MONITORING COMPLIANCE
Key individuals within the Trust are responsible for monitoring compliance with this Strategy; the Quality Committee and Audit Committee seek assurance from these key individuals and Internal Audit that the Strategy is observed.

\(^6\) Grade 8a and above, excluding Board members
8 REVIEW AND VERSION CONTROL

This Strategy has been developed in light of currently available information, guidance and legislation, which may be subject to change. It is reviewed annually by the Quality and Audit Committees and any recommendations for change are submitted to the Board of Directors for formal ratification.

Version Control:

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>18/09/2007</td>
<td>Damien Gibson</td>
<td>Final</td>
<td>Initial version</td>
</tr>
<tr>
<td>2.0</td>
<td>22/01/2008</td>
<td>Jenny Goody</td>
<td>Final</td>
<td>Updated to comply with current practice and NHSLA requirements</td>
</tr>
<tr>
<td>2.1</td>
<td>01/09/2008</td>
<td>Jenny Goody</td>
<td>Interim</td>
<td>Updated to reflect changed name / ToR of CGRMC and updated ToRs of CRC, RMC and AC</td>
</tr>
<tr>
<td>3.0</td>
<td>25/11/2008</td>
<td>Jenny Goody</td>
<td>Final</td>
<td>Annual review, further detail added; no significant changes</td>
</tr>
<tr>
<td>4.0</td>
<td>15/02/2010</td>
<td>Jenny Goody</td>
<td>Draft</td>
<td>Annual review, references to non-risk aspects removed, updated to reflect current practices</td>
</tr>
<tr>
<td>4.1</td>
<td>01/09/2010</td>
<td>Jenny Goody</td>
<td>Draft</td>
<td>Updated to clarify the relationship between the Trust’s objectives, the AF, the CRL and local RARs</td>
</tr>
<tr>
<td>5.0</td>
<td>26/07/2011</td>
<td>Jenny Goody</td>
<td>Final</td>
<td>Full policy review</td>
</tr>
<tr>
<td>6.0</td>
<td>30/10/2012</td>
<td>Jenny Goody</td>
<td>Final</td>
<td>Annual review, minor updates</td>
</tr>
<tr>
<td>7.0</td>
<td>22/10/2013</td>
<td>Jenny Goody</td>
<td>Final</td>
<td>Updated to reflect new AF reporting process, to address QGF gaps and IA recommendations</td>
</tr>
<tr>
<td>7.1</td>
<td>25/02/2014</td>
<td>Jenny Goody</td>
<td>Draft</td>
<td>Updated to reflect the Trust’s response to KPMG’s recommendations relating to its governance structure and risk escalation process</td>
</tr>
<tr>
<td>7.2</td>
<td>29/07/2014</td>
<td>Jenny Goody</td>
<td>Final</td>
<td>Updated to reflect current practices</td>
</tr>
<tr>
<td><strong>Title of document:</strong></td>
<td>Risk Management and Assurance Strategy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date finalised:</strong></td>
<td>30/07/2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dissemination lead:</strong></td>
<td>Trust Secretary, <a href="mailto:Paul.Mitchell@slam.nhs.uk">Paul.Mitchell@slam.nhs.uk</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Previous version already being used?</strong></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If yes, in what format and where?</strong></td>
<td>Electronic, available on the Intranet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Proposed action to retrieve out-of-date copies of the document:</strong></td>
<td>Archive previous version</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>To be disseminated to:</strong></td>
<td>All Directors, Senior Managers, Business Managers and Team Leaders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How will it be disseminated, who will do it and when?</strong></td>
<td>A group email will be sent by Paul Mitchell, alerting teams to download the Strategy for local use, once it has been formally ratified by the Board of Directors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Paper or Electronic?</strong></td>
<td>Electronic</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Governance Framework
<table>
<thead>
<tr>
<th>GRADES</th>
<th>OUTCOME</th>
<th>STATUTORY COMPLIANCE</th>
<th>SERVICE CONTINUITY</th>
<th>FINANCE</th>
<th>REPUTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A CATASTROPHIC</td>
<td>• Fatality/Fatalities. (including non-preventable deaths, homicide, suicide, death by accidental causes and sudden and unexpected deaths)</td>
<td>• Sustained failure to meet national professional standards and/or statutory requirements e.g. failure to meet the requirements of: Mental Health Act, HASAWA 74, DDA, Data Protection Act, Medical Records Act, Safeguarding Adults &amp; Children etc.</td>
<td>• Service closed for in-determinant period</td>
<td>&gt; £10M</td>
<td>• National media &gt; 3 day coverage</td>
</tr>
<tr>
<td>B SEVERE</td>
<td>• Injury requiring immediate hospital admission for more than 24 hours (RIDDOR reportable)</td>
<td>• Intermittent Failure to meet professional standards and/or statutory requirements e.g. failure to meet the requirements of Mental Health Act, HASAWA 74, DDA, Data Protection Act, Medical Records Act, Safeguarding Adults &amp; Children etc.</td>
<td>• Service suspended for &gt;24hours</td>
<td>£1M - £10M</td>
<td>• National media &lt; 3 day coverage</td>
</tr>
<tr>
<td>C SIGNIFICANT</td>
<td>• Injury causing member of staff to take an over 7 days absence from work (RIDDOR Reportable)</td>
<td>• Failure to meet internal professional standards and/or national performance standards e.g. failure to meet the requirements of: Mental Health Act, HASAWA 74, DDA, Data Protection Act, Medical Records Act, Safeguarding Adults &amp; Children, Trust policies and procedures etc.</td>
<td>• Service suspended for &lt;24 hours</td>
<td>£100K - £1M</td>
<td>• Regulator Concern</td>
</tr>
<tr>
<td>D MODERATE</td>
<td>• Abrasions/bruises</td>
<td>• Failure to meet internal standards e.g. failure to comply with Trust policies/guidelines</td>
<td>• Some service disruption for &lt; 24 hours</td>
<td>£5K - £100K</td>
<td>• Within unit, Local press coverage on 1 issue</td>
</tr>
<tr>
<td>E LOW</td>
<td>• No injury</td>
<td>• Minor non-compliance</td>
<td>• None</td>
<td>&lt; £5K</td>
<td>• None</td>
</tr>
</tbody>
</table>
### PART 2: RISK RATING MATRIX

#### Likelihood of an occurrence within the next 5 years

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

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

### PART 3: RISK MANAGEMENT - ACTION AND TIMESCALES

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

### Objective:

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

### Source of Assurance:

- Service Users: Service:
- Business:

### GUIDANCE FOR COMPLETING THE ASSURANCE FRAMEWORK TEMPLATE

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

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

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

### GUIDANCE FOR COMPLETING THE RISK & ASSURANCE REGISTER TEMPLATE

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

Risk Identification Sources

Health & Safety risk assessments: the Trust’s Health & Safety Risk Assessment Policy (v3.1, Oct-11) outlines the roles of directors, managers and staff in protecting, where reasonably practicable, all people from risk whilst at work and provides detailed guidance on the management of Health & Safety risks.

Management and investigation of incidents: the Trust has the following policies in place relating to incidents:
  - Incident policy (v2.2, Sep-11)
  - Investigation of incidents, complaints and claims policy (v2.3, Aug-12)
  - Learning and embedding lessons arising from incidents, complaints and claims (v3.1, Nov-11)
  - Aggregation of incidents, complaints and claims (v3.1, Nov-11)
  - Being open policy (v3.2, Nov-11)

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

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

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

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

Clinical Audit: there is extensive clinical audit activity within the Trust both at CAG and corporate (Trust-wide) level. The Trust-wide corporate audit program covers three broad areas to reflect the dimensions of quality highlighted in ‘High Care Quality for All’, namely patient safety, clinical effectiveness and patient focus. Findings from these audits are fed back to appropriate members of staff via newsletters and audit bulletins. Reports are presented to CAG clinical audit and/or Executive groups and to the Quality Committee, where recommendations and action plans are monitored. These processes are described in the Trust’s Clinical Audit Policy (v2.3, Jun-13).
Implementation of Best Practice: the Trust has mechanisms in place to implement the latest guidance and recommendations from the National Institute for Health and Clinical Excellence (NICE) and the relevant National Confidential Enquiries. These processes are described in the Implementation of NICE Guidance and National Confidential Enquiries in SLaM Policy (v3.2, Jul-12).

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

Infection Control assurance framework: the Trust has an assurance framework which demonstrates that infection control is an integral part of Clinical and Corporate Governance. These activities include a review of statistics on the incidence of alert organisms (such as MRSA or clostridium difficile), outbreaks and serious incidents, with an outline of the actions taken to deal with occurrences of infections. An annual audit programme ensures that policies have been implemented; the findings of the audits are fed back to key staff and action plans to address any critical issues are followed up by the Infection Control Team. This process is outlined in the Infection Control Policy (v1, Oct-12).

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

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

1. Risk identified and reported to Business / Service Manager
2. Risk discussed at CAG / Directorate RM or CG committee
3. Risk added to CAG / Directorate Risk and Assurance Register
4. Risks rated 12 or above escalated to Quality Committee
5. Trust-wide risks rated 12+ added to Corporate Risk Log
6. Trust-wide risks reviewed at Quality or Audit Committee
7. Risk concerns escalated to Board of Directors
APPENDIX H

Terms of Reference of Board Sub-Committees to be inserted
(Draft Versions pending final agreement of the Board – agenda items July 2014)

Audit Committee

Quality Committee
# Equality Impact Assessment Summary

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong> If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>4.</strong> Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>5.</strong> If so can the impact be avoided?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>6.</strong> What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>7.</strong> Can we reduce the impact by taking different action?</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Date of Board meeting: Tuesday 29\textsuperscript{th} July 2014

Name of Report:

- (a) Key issues summary (overpage)
- (b) Draft minutes of Audit Committee meeting held 24.Jun.2014
- (c) Draft minutes of Audit Committee meeting held 27.May.2014
- (d) Signed and sealed report (including from R&D department)
- (e) Audit Committee Annual Report 2013/14
- (f) Audit Committee (‘AC’): draft revised terms of reference

Purpose of the reports:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Key issues summary. To inform the Board about key issues noted at the Audit Committee meeting held on 24.Jun.2014</td>
</tr>
<tr>
<td>(b)</td>
<td>Audit Committee draft minutes. To inform the Board about proceedings at the Audit Committee meetings held on 24.Jun.2014 (quarterly meeting) and 27.May.2014 (accounts review meeting)</td>
</tr>
<tr>
<td>(c)</td>
<td>Audit Committee draft minutes. To inform the Board about proceedings at the Audit Committee meetings held on 24.Jun.2014 (quarterly meeting) and 27.May.2014 (accounts review meeting)</td>
</tr>
<tr>
<td>(d)</td>
<td>Signed and sealed report. To inform the Board about documents signed and sealed on behalf of the Trust</td>
</tr>
<tr>
<td>(e)</td>
<td>Audit Committee Annual Report 2013/14. To report in summary to the Board on the Committee’s business for the year 2013/14 in fulfilling its remit</td>
</tr>
<tr>
<td>(f)</td>
<td>Audit Committee draft terms of reference</td>
</tr>
</tbody>
</table>

To obtain the approval of the Board of Directors to the Audit Committee’s draft revised terms of reference

Action required:

All items: review the documentation presented

Recommendations to the Board:

Note the documents a, b, c, d, e. Approve the document f

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

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

Summary of Financial and Legal Implications:

No specific significant implications identified.

Equality & Diversity and Public & Patient Involvement Implications:

No specific significant implications identified.

Service Quality Implications:

Each of the key issues identified overpage may affect service quality, but no specific significant implications have been identified
KEY ISSUES SUMMARY (references are to the 24-Jun.2014 Audit Committee (‘AC’) minutes attached)

Note: the AC Chair may wish to expand or amend the following at the Board meeting

At its meetings on 24-Jun.2014 and 27-May.2014, the AC concluded that no matters required escalation for the attention of the Board (14.1 and 8.1 refer respectively). However the AC considers that the Board should be made aware of the AC’s concerns about the following key potential issues/proposed resolutions noted at the 24-Jun.2014 meeting (key potential issues/proposed resolutions noted at the 27-May.2014 meeting were reported to the Board meeting held on 27-May.2014).

<table>
<thead>
<tr>
<th>Key potential issues (as at 24-Jun.2014)</th>
<th>AC mins ref</th>
<th>Actions proposed to address key issues (as at 24-Jun.2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1). Chief Financial Officer’s (CFO’s) reporting to the Board</td>
<td>6.1</td>
<td>The CFO advised that, seeking potential sources of relevant benchmarking information to include in the finance report to the Board, he had written to colleague Directors of Finance at other London Mental Health Trusts and was reviewing other potential sources of benchmarking information.</td>
</tr>
<tr>
<td>(2). Quality Committee: attendance at meetings</td>
<td>7.1</td>
<td>The AC noted that this was a preparatory first meeting of the QC called at relatively short notice, and hence likely not to be representative of future, standard meetings. However the AC recommended that the QC should monitor attendance and requested such monitoring to be included in the quarterly summary reports from the QC seen by the AC.</td>
</tr>
<tr>
<td>(3). Key reports to the AC from SLaM management</td>
<td>8.2</td>
<td>The AC will continue to receive appropriate updates on these matters. Internal audit will review and report to the AC on the implementation of SLaM’s workforce plans, and in Sep.2014 internal audit will advise the AC as to its plans for performing that review.</td>
</tr>
<tr>
<td></td>
<td>8.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td>(4). Assurance framework and testing thereof</td>
<td>12.3</td>
<td>The CFO will (Sep.2014) present a short paper to the AC summarising the process by which the assurance framework was updated, managed and challenged. The paper will cover CAGs. As regards the Maudsley Data Centre the AC Chair considered that as a minimum SLaM should clarify the management process and the accountability process for data quality (including data warehousing) and that in due course the SLaM Executive should receive an assurance from the Chief Executive Officer that appropriate measures are in place. In Dec.2014 the AC will receive an update from the Chief Information Officer.</td>
</tr>
<tr>
<td></td>
<td>12.4</td>
<td></td>
</tr>
<tr>
<td>(5). Single Tender Actions (‘STAs’) and breaches of Standing Financial Instructions (‘SFIs’)</td>
<td>10.1</td>
<td>The CFO and the Head of Procurement: (a) outlined the actions being taken by SLaM to resolve these issues, including regular visits and meetings of Procurement staff with departments, circulation of further guidance and nomination of CAG procurement leads; and (b) will update the AC on progress with these improvements. The CFO will report to the AC on the position regarding SFI breaches and EU law. In future, the AC will request relevant Trust lead(s) to attend AC meetings to discuss and explain significant breaches in areas for which they are responsible.</td>
</tr>
<tr>
<td></td>
<td>12.5</td>
<td></td>
</tr>
</tbody>
</table>
AC MEMBERS PRESENT

<table>
<thead>
<tr>
<th>Name</th>
<th>Inits.</th>
<th>Role</th>
<th>Presence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Coomber</td>
<td>RC</td>
<td>AC Chair and Non-Executive Director (‘NED’)</td>
<td>All items</td>
</tr>
<tr>
<td>Shitij Kapur</td>
<td>SK</td>
<td>AC member and NED</td>
<td>All items</td>
</tr>
</tbody>
</table>

AC SUPPORT FUNCTION

<table>
<thead>
<tr>
<th>Name</th>
<th>Inits.</th>
<th>Role</th>
<th>Presence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steven Thomas</td>
<td>ST</td>
<td>AC Secretary</td>
<td>All items</td>
</tr>
</tbody>
</table>

OTHER PERSONS IN ATTENDANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>Inits.</th>
<th>Role</th>
<th>Presence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gus Heafield</td>
<td>GH</td>
<td>Chief Financial Officer</td>
<td>All items</td>
</tr>
<tr>
<td>Mark Nelson</td>
<td>MN</td>
<td>Assistant Director of Finance</td>
<td>All items</td>
</tr>
<tr>
<td>Dr. Neil Brimblecombe</td>
<td>NB</td>
<td>Director of Nursing</td>
<td>Items 1 to 5 inclusive</td>
</tr>
<tr>
<td>Amanda Pithouse</td>
<td>AP</td>
<td>Assistant Director of Nursing (Practice Excellence)</td>
<td>Items 1 to 5 inclusive</td>
</tr>
<tr>
<td>Matthew Hall</td>
<td>MH</td>
<td>External Audit (Partner – Deloitte)</td>
<td>All items bar item 0</td>
</tr>
<tr>
<td>Angus Fish</td>
<td>AF</td>
<td>External Audit (Senior Manager – Deloitte)</td>
<td>All items bar item 0</td>
</tr>
<tr>
<td>Kevin Limn</td>
<td>KL</td>
<td>Internal Audit (Chief Internal Auditor – TIAA)</td>
<td>All items bar item 0</td>
</tr>
<tr>
<td>Nicola Meeks</td>
<td>NM</td>
<td>Internal Audit (Audit Manager – TIAA)</td>
<td>All items bar item 0</td>
</tr>
</tbody>
</table>

NOTE

The AC Chair decides on the appropriate order in which to take agenda items at AC meetings, and this is not necessarily the order shown below. The minutes focus on recording the information and assurances provided in the meeting, in response to questions and otherwise, rather than on the questions themselves.

0.1 UNMINUTED SESSION: BRIEFING FOR AC

0.1.1 RC, SK, GH, MN and ST held an unminuted session. Referring as necessary to the briefing paper from the Finance Department (item R1) GH and MN briefed the AC, focusing on the 2013/14 Annual Accounts, the 2013/14 Annual Report, and external audit’s 2013/14 reports, and responded to the AC’s questions.

0.1.2 Key areas covered in discussion included: the nature and scope of the external audit from SLaM’s viewpoint; capital spend and capital receipts; provisions for bad debts; employee costs; and SLaM’s consolidated (group) accounts. RC then closed the private session, all present having agreed that formal minutes of this session were not required, and that each party would make their own notes as appropriate.

0.2 UNMINUTED SESSION: REVIEW OF AC’S OPERATIONS FOR 2013/14

0.2.1 The AC decided that discussions would be more meaningful if the session were dealt with after the proposed changes to membership of the AC had been finalised.

1. INTRODUCTION

1.1 RC opened the meeting. Attendees introduced themselves as appropriate. After due discussion the AC noted this agenda item.

2. APOLOGIES FOR ABSENCE
2.1 Apologies for absence were reported from AC member Patricia Connell-Julien (‘PCJ’) and from SLaM’s Chief Operating Officer Nick Dawe, (who until 13.Oct.2013 had acted as interim Finance Director). ST noted subsequently that PCJ had confirmed in an email that she had no comments to make on the agenda papers. After due discussion the AC noted this agenda item, and noted that the meeting was quorate.

3. DECLARATIONS OF INTEREST
3.1 RC asked all present to declare any relevant interest at the appropriate point during the meeting. Routine declarations were made. SK declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. SK advises and consults with pharmaceutical companies periodically. After due discussion the AC noted this agenda item.

4. MINUTES OF PREVIOUS AC MEETING(S)
4.1 The AC considered the final draft minutes of the AC meeting held on Tuesday 25th March 2014. After due discussion the AC approved the minutes and noted the list of action points arising from that and previous AC meetings.

5. SAFE STAFFING REPORT
5.1 NB and AP presented this report advising that, following the Francis Report, safe staffing was seen by the NHS as a key issue and:
(a) NB advised that there is currently no research evidence on what constitutes ‘safe’ staffing in a mental health environment, although NICE will be developing an evidence base over the next 7 years and Monitor will each month publish Trusts’ detailed, analysed rostering information (unfortunately without disclosing patient numbers which would make the information useful for benchmarking);
(b) NB advised that implementation of safe staffing will require about 40 new posts, roughly as envisaged in the budgets produced by GH’s team;
(c) NB and GH advised that different nursing groups in SLaM were adopting different strategies to implement safe staffing; for instance one Clinical Academic Group (‘CAG’) planned to take on an additional nurse as a ‘floater’ across their various sites, whereas another CAG planned to use budgeted funds to engage bank staff as and when required; and
(d) the AC commented and NB agreed that the Board of Directors would review the safe staffing document at its June 2014 meeting, and thereafter at six-monthly intervals; and would receive appropriate monthly updates about safe staffing, probably as part of quality assurance reporting.

5.2 The AC commented that there was a need for SLaM:
(a) in due course, to expand the guidance to cover care for patients other than those in hospital, as the number of such patients as a proportion of total patients under care is increasing. Inpatient care is thus likely to become a rarer and more specialist activity;
(b) in due course, to expand the guidance to cover care provided by specialisms other than nurses;
(c) in due course to expand the guidance in section 9 of the document to clarify how SLaM assures the competence of agency/bank staff involved in patient care;
(d) to obtain appropriate assurance as to the accuracy and reliability of rostering information, given that safe staffing is heavily reliant thereon and that the AC has previously been informed of issues around e-rostering. Such appropriate assurance should include robust monitoring of planned activity against actual activity; and
(e) to consider how SLaM would in future differentiate itself from other Trusts, given that practice may well converge and inpatient care may well become rarer.

5.3 After due discussion the AC noted the agenda item.

6. 2013/14 ACCOUNTS AND RELATED DOCUMENTS

6.1 Draft SLaM audited accounts 2013/14
6.1.1 Background. GH and MN presented the draft SLaM audited accounts for 2013/14 and:
(a) the AC thanked GH, MH and their teams for their hard work in producing and auditing the 2013/14 accounts and related documents to a tight timetable, made more difficult by the need to deal with several key audit and accounting technical requirements taking effect for the first time in 2013/14;
(b) GH referred to the more onerous reporting and disclosure requirements specified by Monitor for 2013/14 and the tighter timetable specified for production and audit of the documents for 2013/14. GH

advised that SLaM’s 2013/14 accounts were the first set to require consolidation of SLaM’s subsidiary charity accounts (and for 2013/14 the Maudsley Charity itself was for the first time required to produce consolidated accounts);

(c) GH and MH advised that the accounts of the Maudsley Charity and its subsidiaries were audited by Kingston Smith, and new time pressures arose from the needs to: (i) coordinate their audit work to ensure that all figures and information included in the consolidated accounts had been audited as appropriate; and (ii) review the valuation of assets recorded in the charity’s accounts, as the accounting standards relevant to those accounts differed from those relevant to SLaM’s consolidated accounts;

(d) GH advised: that SLaM’s risk rating remained at level 3 for 2013/14; and that to retain the risk rating at this level in the future SLaM needed to improve its operating results for 2014/15, accurate five year planning being key to this;

(e) GH noted and accepted external audit’s recommendations for improving the audit and accounts production process for 2014/15; and

(f) the meeting discussed key points including the following.

6.1.2 The meeting discussed the **bad debt provision**, and:

(a) GH outlined issues affecting the level of the bad debt provision, advising that the level of mismatches and disputes had risen since 2012/13. MH advised that other Deloitte audit clients shared a similar experience; and

(b) MN advised that the Department of Health had for 2013/14 modified the method for calculating PDCs, so that average cash balances were now calculated on a daily basis rather than on opening and closing balances for the year. MN advised that there was therefore less incentive for NHS organisations to ‘manage’ year-end debtor/cash balances.

6.1.3 The meeting discussed **employee costs and numbers**, and:

(a) RC noted (note 5 to accounts refers) that total employee costs had risen from £251m (2012/13) to £253m (2013/14) but employee numbers had reduced from 5,190 (2012/13) to 5,093 (2013/14) and thus average employee costs had increased;

(b) RC noted that NB’s report on safer staffing envisaged an increase in staff numbers after 2013/14 of about 40 people (minutes 5.1 refers); and

(c) SK noted that in the NHS there was no compulsory retirement age, which was a factor tending to increase employee costs, other things being equal.

6.1.4 The meeting discussed **property valuations**, and:

(a) RC flagged note 11 to the accounts which showed reductions and impairments to valuations of property held for use in delivering services or for administrative purposes, despite the large sums of money spent on property improvements in 2013/14. MN explained that property valuations for accounts purposes, as advised by the District Valuer, were fairly basic in nature. RC suggested that narrative in the Annual Report could usefully cover this point;

(b) SK flagged note 12 to the accounts which showed significant revaluation gains for the investment properties owned by the Maudsley Charity group, in contrast to the reductions and impairments noted above. MN, MH and AF explained that the investment properties were located in prime central London areas and their valuation was based on rental income, whereas the operating assets covered in accounts note 11 were located in sub-prime South London areas and, in the main, valued at depreciated replacement cost; and

(c) GH confirmed that the public dividend capital (‘PDC’) dividend was based on SLaM’s net asset valuation, not the group’s.

6.1.5 After due discussion the **AC agreed** that the information in SLaM’s draft 2013/14 Annual Accounts was consistent with the AC’s knowledge of SLaM, and the **AC was content** that the Board of Directors should receive and approve SLaM’s 2013/14 Annual Accounts subject to final adjustments.

6.1.6 **Action/(timescale). GH will update the AC about the recoverability of NHS debtors (Jun.2014).**

6.1.7 **Action/(timescale). GH and the Director of Human Resources, Organisational Development, Education and Training (Louise Hall – ‘LH’) will report to the AC on employee costs and employee numbers, covering the points raised in the May 2014 AC meeting and SLaM’s workforce modelling plans (Jun.2014).**
6.2 Draft SLaM Annual Report 2013/14
6.2.1 GH presented SLaM’s draft Annual Report 2013/14, including the draft Annual Governance Statement 2013/14 and the draft Quality Account 2013/14, and in particular:
(a) MH and AF advised that the report needed amendment and expansion, in particular so that it was prepared on a group basis (currently it reflected information pertaining solely to SLaM) and reflected all relevant disclosure requirements. GH and MN concurred; and
(b) after due discussion the AC agreed that the information in SLaM’s draft 2013/14 Annual Report was consistent with that in SLaM’s 2013/14 Annual Accounts, and with the AC’s knowledge of SLaM, and the AC was content that the Board of Directors should receive and approve SLaM’s 2013/14 Annual Report subject to final adjustments.

6.3 Draft 2013/14 external audit reports to the Audit Committee
6.3.1 Final report to the AC on the external audit for the year ended 31 March 2014. MH and AF presented this report, and:
(a) MH advised that the external audit report was prepared on the basis that all outstanding disclosure requirements reported by them to SLaM management would be appropriately dealt with in the final versions of the 2013/14 Accounts and 2013/14 Annual Report, in particular that the subsidiaries of the Maudsley Charity would be appropriately included in SLaM’s consolidated annual report and accounts;
(b) AF flagged each of the key judgment areas identified in the audit: recognition of NHS revenue and bad debts; property valuations; and first time consolidation of the charity. Section 6.1 of these minutes reflects the points made in subsequent discussion;
(c) AF explained external audit’s work around the potential risk of management override of controls;
(d) AF explained that external audit did not propose to reference any issues around value for money in their audit report. In particular AF advised that external audit was content that issues around adherence to the cost improvement programme (‘CIP’) did not threaten service provision given, in particular, the liquidity of SLaM’s cash position;
(e) MH discussed SLaM’s 2013/14 actual versus planned EBITDA performance (‘earnings before interest, taxation, depreciation and amortisation’ – EBITDA) as benchmarked against other Foundation Trusts audited by Deloitte. The AC expressed concern that SLaM ranked 33rd out of 34 Trusts thus benchmarked. MH reported that this actual versus planned EBITDA performance was due to specific issues arising in 2013/14 which were identified by SLaM management on a timescale that was acceptable, albeit marginally so. GH and MN confirmed that the gap between actual and planned EBITDA performance was unusually wide for 2013/14, due to ‘one off’ issues not expected to recur;
(f) MH advised that the external audit team had verified the completeness and accuracy of disclosures in the 2013/14 Accounts and the 2013/14 Annual Report by reference to comprehensive checklists prepared centrally by Deloitte’s UK technical department;
(g) MH explained external audit’s work on SLaM’s compliance with law and regulations (especially changes therein) and fraud. In particular MH explained that the work included review of journals using computer audit screening techniques, review of reports from SLaM’s counter fraud function and review of reports of visits by the Care Quality Commission (‘CQC’);
(h) GH expanded on the CQC’s visits to the Bethlem site in 2013 following allegations made by a ‘whistleblower’; and
(i) MH flagged the draft letter of representation forming Appendix 3 of external audit’s report. GH and the AC were content that SLaM management should sign this letter.

6.3.2 Draft report to the AC from the 2013/14 quality report external assurance review. MH and AF presented this report, and:
(a) MH advised: that Deloitte had almost finished their review work; that further information and explanations from SLaM were required before Deloitte could finalise their report; that SLaM had corrected the issue that was the cause of the modified limited assurance opinion for 2012/13; and that Deloitte anticipated expressing an unmodified (‘clean’) limited assurance opinion in their final report for 2013/14;
(b) MH explained that references to a ‘limited assurance opinion’ did not imply an adverse conclusion to the report, merely that the review is based on performance of a set of procedures specified by Monitor, and so the level of assurance provided by such a review is less than that provided by an audit; and
(c) the AC noted that the report appeared straightforward.
6.3.3 After due discussion the AC noted the agenda item.

6.4 Draft internal audit annual report 2013/14 (including Head of Internal Audit (‘HoIA’) opinion)

6.4.1 KL presented the report, and:
(a) KL explained that the overall ‘significant assurance’ HoIA opinion for 2013/14 reflected all the individual internal audit conclusions from reports produced for 2013/14 (as listed in the HoIA opinion in Appendix A of the report). Post meeting note: TIAA uses a scale of four levels of assurance in their HoIA opinions, ‘significant assurance’ being the second highest level;
(b) KL flagged three areas in which internal audit work had identified key issues for 2013/14: estates strategy; management of cost improvement programmes (‘CIPs’), quality innovation productivity and prevention (‘QIPPs’) programmes and quality; and the Lambeth Criminal Justice Mental Health Service (‘LCJMHS’). KL and NM explained that issues identified in the first two areas had been reported to the AC during 2013/14, and that internal audit’s report on their LCJMHS review would shortly be completed and then reported to the June 2014 AC meeting;
(c) as regards LCJMHS, KL and NM explained that the main issue identified was management of project expenditure, which was significantly greater than planned. KL and NM confirmed that: internal audit and SLaM’s counter fraud specialist had identified no evidence of fraudulent activity; and the final internal audit report would include recommendations about SLaM’s review of other projects and how to avoid future issues arising on future projects. KL and NM confirmed that internal audit findings related to this specific project and did not seem to indicate wider Trust or systemic issues;
(d) KL and NM confirmed that the nature, significance and scope of the issues identified in (b) and (c) above and the action taken or planned by SLaM management to address those issues, were such that an overall ‘significant assurance’ HoIA opinion was appropriate; and
(e) after due discussion the AC noted the agenda item.

6.4.2 Action/(timescale). GH and KL will update the next AC meeting about the current position for individual areas that received a ‘limited assurance’ internal audit opinion for 2013/14 (Jun.2014).

6.5 Draft AC report to Council of Governors 2013/14

6.5.1 RC and ST presented this agenda item. After due discussion the AC noted that it was content with the report, subject to final review by, and amendments being agreed between, RC and ST.

7. MANAGEMENT OF CHANGES TO DOCUMENTS SUBSEQUENT TO AC MEETING

7.1 After due discussion the meeting agreed that all significant points had been discussed and agreed that detailed management of changes to documents would be dealt with outside of the meeting if and as appropriate.

8. CPD NEEDS, MATTERS FOR ESCALATION TO THE BOARD AND ANY OTHER BUSINESS

8.1 After due discussion the AC concluded that:
(a) all agenda items and supporting agenda papers had received due consideration;
(b) Continued Professional Development (‘CPD’) matters would be discussed outside of the meeting; and
(c) no matters required escalation for the attention of the Board of Directors, but ST would prepare and agree with RC a summary of key points arising from the meeting to be brought to the attention of the Board of Directors later on 27 May 2014. Post meeting note: this was done.

7.2 There being no further AC business, RC closed the meeting.

Date of next meeting
The next quarterly meeting will be held on Tuesday 25th June 2013 (starting at 09:30am) in the Boardroom, Maudsley Hospital, Denmark Hill.

ACTION POINT (‘AP’) LIST (SEE OVERPAGE – deleted from document presented to the Board)

Note to SLaM the July.2014 meeting of the Board. The minutes of the AC’s 24-Jun.2014 meeting (also included in this agenda pack for the Board’s consideration) include an AP list that supersedes the AP list attached to these minutes of the AC’s 27-May.2014 meeting. Therefore the AP list that was overpage has been deleted in this document as now presented for the Board’s consideration.
MINUTES OF AUDIT COMMITTEE (‘AC’) MEETING
Tuesday 24th June 2014: 09:00 to 11:00
BOARDROOM, MAUDSLEY HOSPITAL, DENMARK HILL, LONDON

Draft for approval by the AC

NOTE
The AC Chair decides on the appropriate order in which to take agenda items at AC meetings, and this is not necessarily the order shown below. The minutes focus on recording the information and assurances provided in the meeting, in response to questions and otherwise, rather than on the questions themselves.

1. NON-MINUTED SESSION: AGREE APPROACH TO REVIEW OF AC’S OPERATIONS FOR 2013/14
1.1 After due discussion the AC decided that discussions about the review approach would be more meaningful if the session were dealt with at the September 2014 AC meeting, by which time the proposed changes to membership of the AC will have been finalised.

2. APOLOGIES FOR ABSENCE
2.1 RC opened the meeting. Attendees introduced themselves as appropriate. Apologies for absence were reported from AC member Shitij Kapur (‘SK’) and from Matthew Hall (External Audit Partner – Deloitte). After due discussion the AC noted this agenda item, and noted that the AC meeting was quorate.

3. DECLARATIONS OF INTEREST
3.1 RC asked all present to declare any relevant interest at the appropriate point during the meeting. Routine declarations were made. PCJ declared an interest as a former employee of King’s College London and as Trustee of Southside Certitude Support. After due discussion the AC noted this agenda item.

4. MINUTES OF PREVIOUS AC MEETING(S)
4.1 The AC considered the final draft minutes of the AC meeting held on Tuesday 27th May 2014 together with the schedule showing comments received on the prior draft of those minutes and resolutions of those
comments in the final draft. After due discussion the AC approved the minutes, noted the list of action points arising from that and previous AC meetings and the AC Chair approved deletion of action points flagged on the list for deletion as resolved.

6. MATTERS ARISING
6.1 EBITDA (‘earnings before interest taxation depreciation and amortisation’) reporting. GH and RC reported on action point 387 which states: ‘RC and GH will review the information underlying Deloitte’s EBITDA benchmarking report and will agree how to report this matter to the Board of Directors’. RC considered that, especially given the new Board memberships, it would be appropriate for GH’s Board reporting to include relevant comparative/benchmarking information and commentary, in particular as regards EBITDA. GH advised that, seeking potential sources of relevant benchmarking information to include in the finance report to the Board, he had written to colleague Directors of Finance at other London Mental Health Trusts and was reviewing other potential sources of benchmarking information. After due discussion the AC noted this.

6.2 AC Terms of Reference (‘TOR’). GH tabled a copy of the AC’s TOR highlighting proposed amendments to reflect more specific reference to escalation, communications and close working between the AC, the Business Development and Investment Committee and the Quality Committee, and:
(a) RC commented that paragraph 5.7 of the draft amendments should be clarified to refer to a risk report which also flags any concerns about how risk is managed;
(b) PCJ commented that the AC and other committees would also benefit from highlight reports from the Mental Health Act (‘MHA’) Committee. Post meeting note: in due course reporting on mental health law matters will be via the Quality Committee; and
(c) after due discussion the AC agreed that, subject to amendment for these points, it was content with the proposed revisions to the AC TOR. Post meeting note. GH and ST circulated revised draft AC TOR reflecting these and other points subsequently raised by AC members, and AC members were content with the revisions.

7. KEY POINTS FROM RECENT QUALITY COMMITTEE (‘QC’) MEETING(S)
7.1 GH presented this item, agreeing to feed back any key points as appropriate, and:
(a) GH confirmed that this first QC meeting was preparatory; future meetings would be chaired by a NED and the QC itself would comprise three NEDs;
(b) RC and PCJ noted the wide range both of the QC’s remit and of the reports that the QC would consider and noted the consequent challenge presented to the QC. RC commented that as part of their induction new NEDs might usefully visit or liaise with other appropriately highly rated Mental Health Foundation Trusts to update their background knowledge;
(c) NM noted the relatively high number of apologies for absence from this meeting, especially regarding Clinical Academic Group (‘CAG’) leaders. The AC noted that this was a preparatory first meeting of the QC called at relatively short notice, and hence likely not to be representative or future, standard meetings. However the AC recommended that the QC should monitor attendance and requested such monitoring to be included in the quarterly summary reports from the QC seen by the AC; and
(d) after due discussion the AC noted the agenda item.

8. REPORTS FROM AND DISCUSSIONS WITH SLaM MANAGEMENT (OTHER THAN FINANCE)
8.1 Support services
8.1.1 GH presented this report, advising that he had discussed matters with internal audit, had provisionally agreed some further internal audit work as part of the internal audit plan, and intended to bring back an update report to the next AC meeting. After due discussion the AC noted the agenda item.

8.2 E-rostering and mandatory training
8.2.1 LH gave a verbal report on e-rostering, and:
(a) LH explained that, after consultation, the decision was taken some 6 months ago to provide support at CAG level (rather than centrally). LH advised that relevant administrative staff were engaged in each CAG, and each CAG received appropriate training and identified ‘super users’ (e-rostering experts who could provide local level advice and support);
(b) RC stressed that it was vital that e-rostering covered junior doctors, doctors and consultants in order to ensure safe staffing. LH explained that SLaM was procuring version 10 of the e-rostering system which would allow e-rostering of junior doctors, doctors and consultants in addition to the non-medical
workforce which the current e-rostering system covered. LH advised that appropriate procurement, implementation and communication about version 10 would take around 5 months; and
(c) after due discussion the AC noted the agenda item.

8.2.2 JP gave a verbal report on mandatory training, and:
(a) JP explained that this was a major exercise, aligned with a national programme;
(b) JP advised that: (i) SLaM’s new approach came into force in April 2014, which allowed mandatory training to be more tailored to individual requirements and allowed use of e-learning; (ii) SLaM’s corporate induction was also reviewed and amended, and is now carried out over a three-day period, allowing more flexibility for new starters; and (iii) the changes to corporate induction have been very well evaluated;
(c) JP advised that mandatory training attendance had risen from around 65% to 75% as at April 2014, which is a busy time of year at which attendance rates historically have been low. JP considered this an encouraging indication, but stated that she was not complacent and was aware that CAGs typically found compliance to be difficult. JP reported that mandatory training was part of CPD (‘Continuing Professional Development’) requirements, and this provided an incentive for completing mandatory training. LH commented on other means of ensuring mandatory training compliance through a blend of incentives and penalties;
(d) JP advised that feedback from course attendees was positive; and
(e) RC stressed the importance of obtaining assurance that mandatory training requirements are met in all significant risk areas, and that SLaM has a system to ensure that personnel who do not attend a mandatory training session do attend the next relevant available session.

8.2.3. Action/(timescale). LH will update the AC about progress in implementing, and assurance obtained as to: (a) e-rostering version 10 (to include junior doctors, doctors and consultants within e-rostering); and (b) the new mandatory training regime introduced in April 2014 and levels of compliance with that regime (Dec.2014).

8.3 Employee costs and numbers, and workforce modelling plans

8.3.1 LH gave a verbal report about employee costs and numbers. LH advised that a recent review had shown that:
(a) numbers of consultants and clinical staff had risen, but numbers of contract and agency staff and locums had fallen. LH commented that it may be possible for some clinical work to be delegated appropriately to nursing staff;
(b) permanent staff were not necessarily lower cost than staff engaged through NHS Professionals;
(c) there is a need to reduce spend on administrative and clerical staff (including those in CAGs) as total spend in this area is some £48m; and
(d) sickness rates had fallen.

8.3.2 PCJ noted that this review work was vital. After due discussion the AC noted the agenda item.

8.3.3 LH gave a verbal report about workforce modelling, and:
(a) LH advised that: (i) over the course of the plan SLaM would make a significant reduction in workforce costs to meet the economic challenge and maintain SLaM’s financial viability; (ii) SLaM has set an ambitious target to reduce workforce costs by 2016, whilst maintaining the quality of care that SLaM already provides to service users and the community at large; (iii) this level of reduction goes beyond that assumed in SLaM’s financial plan but reflects both the scale of SLaM’s ambition and recognition of the risks and timeframe associated with such a proposal. GH commented that the cost reduction target is challenging but necessary, as radical change is required; and
(b) RC noted that LH’s predecessor had outlined similar plans, but as SLaM is a devolved organisation it had proved a difficult process to manage. RC noted that flexible working was one key, given that the drive to reduce costs might result in an unusual mix of staff

8.3.4 Action/(timescale). KL and NM will add to the 2014/15 internal audit workplan a review of the implementation of SLaM’s workforce plans, and the AC will review the 2014/15 internal audit workplan at its next meeting (Sep.2014).

8.4 Cost improvement programmes (‘CIPs’): Procurement’s contribution
8.4.1 TM and GH presented this report, and:
(a) TM outlined key themes upon which the report was based: alignment of CIPs across SLaM/CAGs; engagement of procurement leads within CAGs; enhanced governance around procurement; and engagement with higher procurement hubs such as the London Procurement Partnership (‘LPP’);
(b) GH explained that in the main NHS National Framework arrangements had been derived with Acute Trusts in mind, and thus did not cover some significant areas of SLaM’s spend. GH advised that a key issue at SLaM was the need to reduce spending on agency/contract staff;
(c) TM advised that CAG procurement leads would be identified shortly;
(d) RC noted that the Procurement team as depicted in the report appeared well-staffed and so should be able to implement improvements quickly;
(e) GH advised that, for efficiency, many contracts procured by KHP partner bodies were drafted so that other KHP members like SLaM could adopt those contracts; and
(f) after due discussion the AC noted the agenda item.

8.4.2 Action/(timescale). GH and TM will update the AC about progress with the CIP/Procurement initiative (Sep.2014).

9. EXTERNAL AUDIT
9.1 2013/14 follow up matters
9.1.1 AF reported to the AC and:
(a) AF and GH advised that external audit and SLaM would review the 2013/14 process to identify ways to enhance the efficiency of the 2014/15 audit (commenting that a number of, albeit minor, matters were resolved at quite a late stage in the 2013/14 audit);
(b) the AC thanked GH, the Finance team and external audit for their hard work to ensure an efficient and effective audit process for 2013/14;
(c) all present at the AC meeting confirmed that they were not aware of any significant post balance sheet events requiring to be disclosed to Monitor by GH on Thursday 26 June 2014 (this being a standard disclosure sought by Monitor relevant to year end accounting); and
(d) after due discussion the AC noted the agenda item.

10. INTERNAL AUDIT (INCLUDING ICT AUDIT AND CLINICAL AUDIT IF RELEVANT)
10.1 Progress report
10.1.1 KL and NM presented this agenda item (12.4 of these minutes refers as regards discussion of the Data Warehousing internal audit review which received a 'limited assurance' assurance opinion) and:
(a) KL introduced the report flagging (section 3) the key issues identified from the individual reports included in this progress report, and (section 8) a technical briefing, which RC noted was valuable;
(b) Lambeth Criminal Justice Mental Health Service. Responding to PCJ, KL explained that the major issues found in this review were localised issues around roles and management which may well have arisen because of the method of funding of the project, and hence were unlikely to apply to other SLaM projects. NM reported that internal audit would produce a checklist for CAG leaders, summarising factors indicative of complex projects more likely to cause issues such as those around roles, management and funding. GH confirmed that SLaM had duly considered taking action against the two IT consultancy companies involved;
(c) Safe staffing. The meeting discussed how internal audit could be relevant to this. NM advised that internal audit work on e-rostering (version 10) was relevant (8.2 above refers);
(d) the meeting discussed the agreed action plan for the internal audit report on 'Developing Trust efficiency programmes'; and
(e) after due discussion the AC noted the agenda item.
10.1.2 Tender waivers (internal audit report section 6.1). TM explained that he had liaised with internal audit in their drafting of this report section, and:
(a) the meeting discussed possible reasons for the sudden increase in the number/value of tender waivers reported to the March 2014 AC meeting, compared with those reported to previous AC meetings. GH’s view was that the underlying cause was poor planning;
(b) TM outlined the steps taken to resolve this issue, including introduction of a Procurement presence one day per week in the IT department;
(c) the meeting discussed the importance of resolving the issue quickly, so as to minimise major threats such as potential damage to SLaM’s reputation, lack of value for money and legal challenge; and
(d) KL commented that SLaM’s transparency of reporting was good; the tender waivers had been reported appropriately, not simply ignored as had happened at some organisations of which he was aware.

10.1.3 Action/(timescale). KL and NM will carry out an overview of key data sources relevant to the safe staffing programme, so as to report to the Dec.2014 AC meeting on the extent to which internal audit work done or planned covers those key data sources (Dec 2014).

10.1.4 Action/(timescale). TM and GH will update the AC about progress in reducing the number and value of requests to waive formal tender processes (Dec.2014).

11. LOCAL COUNTER FRAUD SPECIALIST (‘LCFS’)

11.1 Progress report with summary cover sheet

11.1.1 DK presented this report and:
(a) DK flagged the key points noted in the LCFS summary cover sheet;
(b) DK reported on liaison with SLaM management, advising that LCFS had now visited all SLaM’s sites;
(c) DK reported that Human Resources Department had raised two referrals in the quarter;
(d) DK reported that attempted squatting on Trust premises was an increasing risk, but that the Trust had resolved all attempts to date;
(e) DK flagged a case (PAA 6091) involving an ex-employee and a significant amount of valuable IT equipment that appeared now to be ‘missing’. DK advised that the case was in its early stages and so it was possible that more equipment would be discovered as ‘missing’. GH advised on some ways to gain further information about the ex-employee;
(f) the AC noted that it was content with LCFS’s proposed workplan; and
(g) after due discussion the AC noted the agenda item.

12. RISK MANAGEMENT AND FINANCE

12.1 Report from Director of Finance on items 12.2 onwards

12.1.1 GH reported as appropriate within agenda items 12.2 to 12.5 below. After due discussion the AC noted this.

12.2 Update on recoverability of NHS debtors

12.2.1 GH presented the summary report, advising:
(a) some improvement in the recovery of NHS debtors relating to 2013/14;
(b) a small improvement in the NHS Southwark debtor relating to 2013/14. GH further advised that senior management from SLaM and NHS Southwark would meet in July 2014 seeking to resolve matters; and
(c) after due discussion the AC noted the agenda item.

12.3 Assurance framework (and Corporate Risk Log)

12.3.1 GH presented the Assurance Framework and the Corporate Risk Log, the meeting discussed these documents and:
(a) RC commented that the process by which the Assurance Framework was managed/challenged would benefit from clarification; and
(b) after due discussion the AC noted the agenda item.

12.3.2 Action/(timescale). GH will present a short (say 2-page) paper (perhaps a flowchart) summarising the process by which the assurance framework is updated, managed and challenged. The paper should cover CAGs (Sep.2014).

12.3.3 Action/(timescale). GH will update the AC about progress at the meeting to finalise Southwark Clinical Commissioning Group (‘CCG’) and NHS England transfers (assurance framework risk area 6 refers, for which GH is risk lead) (Sep.2014).

12.4 Testing of the assurance framework

12.4.1 ST and internal audit had liaised to select an appropriate entry on the assurance framework for discussion at the AC with the relevant Trust risk lead. The entry selected was risk area 9 ‘ICT infrastructure’ which is flagged red for risk and progress, and for which a key action is implementation of the Maudsley Data Centre, which implementation recently received a ‘limited assurance’ internal audit report. AS is the relevant risk lead. NM outlined the internal audit report, and:
(a) AS explained the nature of the Data Warehouse, noting that it dealt with pre-validated data (including patient data) from systems including EPS, Finance systems and Datix;
(b) AS explained that guidance on data quality was available, and that the internal audit review had been a useful exercise, highlighting key issues for resolution;
(c) the meeting discussed the most appropriate way to allocate responsibility for management of data quality (including data warehousing) given that, as GH advised, the Chief Financial Officer, Chief Operating Officer, Chief Information Officer and Medical Director all have relevant interests and CAGs do not currently adopt a consistent approach. One possibility discussed was a programme of oversight meetings of these senior management members;
(d) RC considered that as a minimum SLaM should clarify the management process and the accountability process for data quality (including data warehousing) and that in due course the SLaM Executive should receive an assurance from the Chief Executive Officer that appropriate measures are in place; and
(e) after due discussion the AC noted the agenda item.

12.4.2 Action/(timescale). The Chief Information Officer and AS will report to the AC on progress in resolving issues identified around data warehousing (Dec.2014).

12.5 Signed and sealed documents, SFI breaches and STAs
12.5.1 GH presented the ‘signed and sealed’ report, the ‘single quote/tender action submissions’ (‘STA’) report, and the ‘breaches of Standing Financial Instructions’ (‘SFIs’) report. GH advised as follows about each of the areas in which SFI breaches had occurred:
(a) the ICT breaches are part of a project which was included in a number of contracts some of which were not subject to a procurement process. Procurement has since been in close contact with ICT and has met with the senior managers there to help with any processes going forward and to ask for any plans that they have. This will then be included on a workplan and subject to the proper process. The engagement continues and Procurement meets with ICT every two weeks. Most of these invoices came in pre the end of financial year;
(b) the Estates and Facilities breaches were explained by them as misunderstandings because of the integration between the Estates system and the Finance system. The order number was issued to the supplier before the order had been approved. We will adopt a similar approach of close liaison as we have implemented in ICT. Further guidance will be issued around use of waivers and the procedure for breaches; and
(c) Child and Adolescent Mental Health Services (‘CAMHS’) has been approached regarding their breaches, with a proposal that there is a procurement lead for each CAG going forward who will attend (on a quarterly basis and when needed) management meetings within the CAG to outline the procurement process, provide support and increase communications so that the proper process is undertaken whenever money is spent.

12.5.2 after due discussion the AC noted the agenda item and approved the proposal that the signed and sealed report be appended to the draft minutes of the AC meeting when these are taken to the Board of Directors for information.

12.5.3 Action/(timescale). GH will report to the AC on the position regarding SFI breaches and EU law. ST will liaise with TM so that relevant Trust lead(s) attend the AC to discuss/explain significant breaches in areas for which they are responsible (Sep.2014).

12.6 Losses and special payments: annual report to AC for 2013/14
12.6.1 GH presented these reports, and:
(a) GH advised that they showed a reduction in the losses record in 2013/14 compared with previous years;
(b) GH advised that whilst the numbers of losses can vary from year to year and are unpredictable, the trends indicate that there are no major control issues or weaknesses and are in line with GH’s expectations;
(c) GH advised that SLaM is continuing to work on ensuring losses are minimised; and
(d) after due discussion the AC noted the agenda item.

13. AC-RELATED MATTERS
13.1 AC Annual Report 2013/14
13.1.1 ST presented the report. After due discussion the AC approved the report subject to any final drafting points to be agreed with the AC Chair. Post meeting note. No such drafting points arose.

13.2 AC workplan for the year ahead
13.2.1 ST presented the workplan. After due discussion the AC approved the workplan, subject to any updating required to reflect points raised in the meeting and to reflect that the AC is keen to continue inviting the attendance of SLaM/CAG management to discuss key issues as these arise in the year.

14. CPD NEEDS, ESCALATION OF MATTERS TO THE BOARD AND ANY OTHER BUSINESS
14.1 After due discussion the AC concluded that all agenda items and supporting agenda papers had received due consideration, that no significant training (Continued Professional Development – ‘CPD’) needs had been identified for AC members, and that (except where otherwise noted in these minutes) no matters required escalation for the attention of the Board. The AC agreed that the AC will consider CPD at its September 2014 meeting. There being no further AC business, RC closed the meeting.

15. DATE OF NEXT MEETING
15.1 The AC agreed to consider outside of the meeting the date/time of its next (September) quarterly meeting.

ACTION POINT (‘AP’) LIST
Excluded from the AP list below are actions previously agreed by the AC as completed and actions agreed by the AC Chair as completed.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action point</th>
<th>Action lead</th>
<th>Date to complete</th>
<th>Notes/evidence that completed (or ref to relevant agenda item)</th>
<th>AC Chair sign off</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.03.14 385</td>
<td>1.3 ST will schedule a 15 minute session in the May 2014 AC meeting to deal with a more formal review of the AC’s operations, based on completed assessment checklists that ST will issue in April 2014 to external audit, internal audit and LCPS (Apr.2014)</td>
<td>ST</td>
<td>Sep.14</td>
<td>Post meeting note. Carry forward to a future AC meeting per minutes of 27.May.2014 AC meeting paragraph 0.2.1</td>
<td></td>
</tr>
<tr>
<td>25.03.14 386</td>
<td>9.1.2 Internal audit (KL, NM) will add into their 2014/15 workplan a review of contracts/income from commissioners and will report to the AC regarding: (i) (report in Sep.2014) the appropriateness of contracts in place; and (ii) (report in Mar.2015) payments from commissioners and recoverability of related debtors</td>
<td>KL, NM</td>
<td>Sep.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.06.14 395</td>
<td>8.2.3. LH will update the AC about progress in implementing, and assurance obtained as to: (a) e-rostering version 10 (to include junior doctors, doctors and consultants within e-rostering); and (b) the new mandatory training regime introduced in April 2014 and levels of compliance with that regime</td>
<td>LH</td>
<td>Dec.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.06.14 396</td>
<td>8.3.4 KL and NM will add to the 2014/15 internal audit workplan a review of the implementation of SLaM’s workforce plans, and the AC will review the 2014/15 internal audit workplan at its next meeting</td>
<td>KL, NM</td>
<td>Sep.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.06.14 397</td>
<td>8.4.2 GH and TM will update the AC about progress with the CIP/Procurement initiative</td>
<td>GH, TM</td>
<td>Sep.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.06.14 398</td>
<td>10.1.3 KL and NM will carry out an overview of key data sources relevant to the safe staffing programme, so as to report to the Dec.2014 AC meeting on the extent to which internal audit work done or planned covers those key data sources</td>
<td>KL, NM</td>
<td>Dec.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.06.14 399</td>
<td>10.1.4 TM and GH will update the AC about progress in reducing the number and value of requests to waive formal tender processes</td>
<td>GH, TM</td>
<td>Dec.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.06.14 400</td>
<td>12.3.2 GH will present a short (say 2-page) paper (perhaps a flowchart) summarising the process by which the assurance framework is updated, managed and challenged. The paper should cover CAGs</td>
<td>GH</td>
<td>Sep.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date arising</td>
<td>AC action point</td>
<td>Action lead</td>
<td>Date to complete</td>
<td>Notes/evidence that completed (or ref to relevant agenda item)</td>
<td>AC Chair sign off</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------</td>
<td>-------------</td>
<td>------------------</td>
<td>------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>25.06.14</td>
<td>12.3.3 GH will update the AC about progress at the meeting to finalise Southwark Clinical Commissioning Group (‘CCG’) and NHS England transfers (assurance framework risk area 6 refers, for which GH is risk lead)</td>
<td>GH</td>
<td>Sep.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.06.14</td>
<td>12.4.2 The Chief Information Officer and AS will report to the AC on progress in resolving issues identified around data warehousing</td>
<td>CIO, AS</td>
<td>Dec.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.06.14</td>
<td>12.5.3 GH will report to the AC on the position regarding SFI breaches and EU law. ST will liaise with TM so that relevant Trust lead(s) attend the AC to discuss/explain significant breaches in areas for which they are responsible</td>
<td>GH, ST</td>
<td>Sep.14</td>
<td>Sep.14</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>Date</td>
<td>Description</td>
<td>Between</td>
<td>And</td>
<td>Signature</td>
</tr>
<tr>
<td>--------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>114</td>
<td>07/04/2014</td>
<td>Deed of Surrender in respect of Holmhurst Day Centre (1st and 2nd Floor) (1 copy)</td>
<td>SLaM</td>
<td>London Borough of Southwark</td>
<td>Nick Dawe</td>
</tr>
<tr>
<td>115</td>
<td>22/04/2014</td>
<td>Engrossments in respect of 36-42 Hare Street, Woolwich. Underlease relating to part of the basement, ground floor, part of 1st and 2nd floor offices (1 copy), Licence to underlet relating to part of the ground floor and basement, part of the 1st and 2nd floor offices (2 copies)</td>
<td>SLaM</td>
<td>Tesco Store Ltd Trustees of the Dalgelish Executive Pension Scheme</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>116</td>
<td>22/04/2014</td>
<td>Renewal leases in respect of 88 &amp; 90 Camberwell Road (1 copy for each address)</td>
<td>SLaM</td>
<td>John Roy Bloomfield</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>Number</td>
<td>Date</td>
<td>Description</td>
<td>Between</td>
<td>And</td>
<td>Signature</td>
</tr>
<tr>
<td>--------</td>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>---------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>406</td>
<td>07/04/2014</td>
<td>A short contract in respect of planned capital small works</td>
<td>SLaM</td>
<td>Vinci Construction UK Ltd</td>
<td>Nick Dawe</td>
</tr>
<tr>
<td>407</td>
<td>07/04/2014</td>
<td>Terms of Engagement to act as Auditors for SLaM</td>
<td>SLaM</td>
<td>Deloitte</td>
<td>Martin Baggaley</td>
</tr>
<tr>
<td>408</td>
<td>07/04/2014</td>
<td>Contract Amendment No 1 in respect of the Clinical Trials Agreement for</td>
<td>SLaM</td>
<td>Audiometers</td>
<td>Martin Baggaley</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alzheimer's Disease led by Clive Ballard (4 copies)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>410</td>
<td>08/05/2014</td>
<td>Memorandum of Agreement (2 copies)</td>
<td>SLaM</td>
<td>Kier Construction</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>411</td>
<td>08/05/2014</td>
<td>Agreement in respect of the Cycle to Work Scheme (1 copy)</td>
<td>SLaM</td>
<td>Asset Finance Management Ltd</td>
<td>Paul Mitchell</td>
</tr>
<tr>
<td>412</td>
<td>08/05/2014</td>
<td>Agreement for Dementia Research Informatics Support D-CRIS Information</td>
<td>SLaM</td>
<td>Oxford Health NHS FT</td>
<td>Paul Mitchell</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Processing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>413</td>
<td>08/05/2014</td>
<td>Programme grant - NIHR reference RP-PG-1211-20016 - Improving outcomes</td>
<td>SLaM</td>
<td></td>
<td>Paul Mitchell</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for people with Autism spectrum disorders by reducing mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>problems led by Professor Simonoff (2 copies)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>Date</td>
<td>Description</td>
<td>Between</td>
<td>And</td>
<td>Signature</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>03/06/14</td>
<td>Site Agreement in respect of ELAD Trial</td>
<td>SLAM</td>
<td>Imperial College London</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>24/03/14</td>
<td>NIHR Amendment in respect of ECHO Trial</td>
<td>SLAM</td>
<td>NIHR</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>24/03/14</td>
<td>NIHR Amendment in respect of &quot;Improving physical health and reducing substance use in severe mental health illness&quot;</td>
<td>SLAM</td>
<td>NIHR</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>12/03/14</td>
<td>NIHR Amendment in respect of &quot;Developing a recovery focus in mental health services in England&quot;</td>
<td>SLAM</td>
<td>NIHR</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>24/03/14</td>
<td>Site Agreement in respect of &quot;Minocycline in Alzheimer's Disease Efficacy&quot; (MADE)</td>
<td>SLAM</td>
<td>Nottinghamshire Healthcare NHS Trust</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>03/04/14</td>
<td>Amendment to Clinical Trial Site Agreement in respect of &quot;Minocycline in Alzheimer's Disease Efficacy&quot; (MADE)</td>
<td>SLAM</td>
<td>Berkshire Healthcare NHS Foundation Trust</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>24/04/14</td>
<td>Site Agreement in respect of &quot;Minocycline in Alzheimer's Disease Efficacy&quot; (MADE)</td>
<td>SLAM</td>
<td>NHS Forth Valley</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>24/04/14</td>
<td>Site Agreement in respect of &quot;Minocycline in Alzheimer's Disease Efficacy&quot; (MADE)</td>
<td>SLAM</td>
<td>Cornwall Partnership NHS Foundation Trust</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>20/05/14</td>
<td>Collaboration Agreement in respect of &quot;Medically Unexplained Persistent Physical Symptoms (MUPPS): A System Change and Evaluation&quot;</td>
<td>SLAM</td>
<td>King's College London</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>08/05/14</td>
<td>Collaboration Agreement in respect of DISCOVER</td>
<td>SLAM</td>
<td>King's College London</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>20/05/14</td>
<td>Variation to Sub-contract in respect of REFOCUS</td>
<td>SLAM</td>
<td>King's College London</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>20/05/14</td>
<td>Site Agreement in respect of &quot;Minocycline in Alzheimer's Disease Efficacy&quot; (MADE)</td>
<td>SLAM</td>
<td>Manchester Mental Health and Social Care NHS Trust</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>04/06/14</td>
<td>Collaboration Agreement in respect of &quot;Improvising outcomes for people with autism spectrum disorders by reducing mental health problems&quot;</td>
<td>SLAM</td>
<td>King's College London</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>20/05/14</td>
<td>Site Agreement in respect of &quot;Minocycline in Alzheimer's Disease Efficacy&quot; (MADE)</td>
<td>SLAM</td>
<td>Bradford District Care Trust</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>03/06/14</td>
<td>Site Agreement in respect of &quot;Minocycline in Alzheimer's Disease Efficacy&quot; (MADE)</td>
<td>SLAM</td>
<td>The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust</td>
<td>Gill Dale</td>
<td></td>
</tr>
<tr>
<td>09/04/14</td>
<td>Sub-contract in respect of &quot;Minocycline in Alzheimer's Disease Efficacy&quot; (MADE)</td>
<td>SLAM</td>
<td>University of Oxford</td>
<td>Martin Baggaley</td>
<td></td>
</tr>
</tbody>
</table>
1. About this report

1.1 This report builds on the in-year reporting by the Audit Committee (‘AC’) to the Board of Directors (‘the Board’) of key relevant issues as these are identified. The report focuses on matters relating to the year ended 31 March 2014 (‘2013/14’, or ‘the year’) but may refer to other matters where considered helpful.

1.2 As agreed with the AC Chair, the plan for review and consideration of this report is as follows:

- 24 June 2014: AC meeting reviews this draft report;
- 29 July 2014: Board meeting considers the final version of this report; and
- 16 September 2014: Council of Governors meeting considers a summary of this report.

1.3 This report takes account of guidance in most recent, 2011, version of the ‘The Audit Committee Handbook’ issued by the Department of Health. In format and general content the report is consistent with the AC’s Annual Reports produced for previous years.

2. The AC and its conclusions for the year 2013/14

2.1 Purpose. The overall role of the AC is ‘... to promote the efficient and effective management of risk and excellent financial management and governance within SLaM’ (AC Terms of Reference (‘TOR’) 2.1 refers).

Key conclusions for the year 2013/14

2.2 The AC has reflected on and reviewed its constitution (as set out in its TOR), its work for the year and the reports and other information provided to it by SLaM management, external audit, internal audit and the Local Counter Fraud Specialist (‘LCFS’). On that basis, the AC confirms that (noting that some further specific improvements are required and are being implemented):

(a) the Assurance Framework, and the associated systems and procedures that support it, are generally satisfactory for their purpose of risk management (AC TOR 2.1(a) refers);

(b) the financial systems and procedures used within SLaM are generally satisfactory for their purpose of financial reporting and control (AC TOR 2.1(b) refers);

(c) the AC reviewed SLaM’s 2013/14 Annual Accounts and Annual Report and considered that it was appropriate for the Board to approve those documents (AC TOR 4.2 refers); and

(d) the performance of SLaM’s external auditors Deloitte (including the quality and value of the work, the timeliness of reporting and the external audit fee) is and has been appropriate. The AC recommends that Deloitte should continue as SLaM’s external audit provider.

2.2 To the extent possible from knowledge gained through membership of the Board and its committees, including the AC, during the year AC members have commented to the Board as appropriate on key issues and initiatives. Appendix A summarises the issues thus flagged to the Board by the AC for 2013/14.

3. Constitution of the AC

3.1 AC membership. The Board keeps under review the balance of skills and experience of the AC’s members, and the need for rotation of roles. Details of AC members are as follows:

(a) Robert Coomber (AC Chair) joined SLaM as a Non Executive Director (‘NED’) and AC member in May 2007 and took on the role of AC Chair in June 2007. In June 2013 his role as NED and AC Chair was confirmed for a further three years;

(b) Dr Patricia Connell-Julien was appointed as a NED in June 2008 and was re-appointed in July 2011 for a further term of three years. Dr Connell-Julien became an AC member in March 2012; and

(c) Prof Shitij Kapur was appointed as a NED in September 2010 and in September 2013 his role was confirmed for a further four years. Prof Kapur became an AC member in March 2012.
3.2 The AC considers that the AC has maintained at all times an appropriate balance of skills and experience, including clinical, social and health care matters and the recent relevant financial experience of the AC Chair.

3.3 **AC meetings: fitness for purpose.** The Chief Financial Officer ('CFO') has a standing invitation to attend all AC meetings as do SLaM’s external auditors, internal auditors and counter fraud specialists. Other members of the Board may attend if they wish. The AC invites the attendance of the Trust Chair, the Chief Executive, other Executive Directors and Non Executive Directors and senior SLaM management if and as necessary given the business planned for each AC meeting. AC meetings must be held not less than four times a year. In addition to those meetings, a special purpose AC meeting is held each year to consider SLaM’s draft audited accounts and related documents. The AC has an annual work plan, integrated with SLaM’s workplan, and schedules its meetings to consider and act on specific issues within that plan, and to consider other key relevant issues if and as these become apparent. Appendix B to this Annual Report shows the AC’s meetings held in the year, all of which were quorate.

3.4 **AC reporting during the year.** After each AC meeting the AC Chair reports to the next Board meeting any key relevant issues identified by the AC. That report is accompanied by full draft minutes of the AC meeting, and by a report on documents signed and sealed on behalf of SLaM.

4. **The AC’s work for the year 2013/14**

4.1 The main ways in which the AC fulfils its remit are as follows, explained in turn further below:

(a) **internal processes**: review of assurances requested from SLaM’s management;

(b) **independent assurances**: review of assurance reports from external auditors, internal auditors and counter fraud further to the AC’s overall direction of their work; and

(c) **360° annual assessment**: by/of the AC and other parties each year.

4.2 **Review of assurances from SLaM’s management**

4.2.1 The AC calls for SLaM management (including CAG Service Directors/Leaders) to attend its meetings to provide reports and assurance, and to update the AC about progress on implementing recommendations following audit and other assurance reviews. Appendix B shows the members of SLaM's management team who attended the AC’s meetings in the year. Key areas which the AC is monitoring in this way, and the AC’s views thereon, are summarised in Appendix A. The AC’s discussions with CAG Service Directors/Leaders in these areas were particularly helpful and the AC plans to invite CAG Service Directors/Leaders to AC meetings in 2014/15.

4.3 The AC SLaM’s progress in addressing agreed corrective actions. requests and receives reports from internal audit to assist the AC in monitoring

4.4 The AC integrates its operations with those of the other committees of the Board, for instance through:

(a) the reporting, by committee Chairs at each Board meeting, of any key issues identified at committee meetings;

(b) consideration at each AC meeting of any key matters which the Chair of the Service Quality Improvement Sub-Committee (now replaced by the Quality Committee) considers should be reported to the AC; and

(c) cross-membership of committees, as noted in SLaM’s 2013/14 Annual Report and Accounts. For example Dr Connell-Julien’s Board responsibilities include chairing the Trust-wide Mental Health Law Committee and membership of the Quality Committee.

4.5 SLaM’s annual accounts for 2013/14 received an unqualified (‘clean’) audit opinion from the external auditors.

4.6 In addition to reports on relevant key financial issues arising during the year, the Chief Financial Officer also reported to the AC on:

(a) documents signed and sealed on behalf of the Board;

(b) breaches of the procurement requirements set out in SLaM’s Standing Financial Instructions;

(c) agreed waivers of the procurement requirements set out in SLaM’s Standing Financial Instructions; and
(d) write-offs of losses and special payments including write-offs and compensation for claims to damage to staff belongings and property.

4.7 In line with its terms of reference, at each of its quarterly the AC reviews and comments on the Assurance Framework.

Review of independent assurance reports from auditors and others

4.8 Based on its consideration of the Assurance Framework, audit reports and other information received during the year such as Board agenda papers, the AC has directed audit resources to carry out risk-based reviews of SLaM’s systems, including review of specific issues and follow-up reviews on areas previously audited, as summarised below.

External Audit

4.9 In March 2014 the AC reviewed and was content with external audit’s plans for its work for 2013/14, and with the fee of £95,000 proposed for the audit under Monitor’s Code. In reviewing that fee, the AC noted the following information about Deloitte’s 2013/14 fees.

  Fees relating to SLaM
  - The £17,000 increase from the 2012/13 audit fee of £78,000 comprised an increase of some £2,000 in line with general inflation as measured by the RPI, and an additional fee of £15,000 representing a change in audit scope arising from a new requirement to prepare group accounts
  - £25,000 fee for a Board development and governance review
  - £7,000 fee for tax advice regarding the set-up of an operation in Abu-Dhabi

  Fees relating to the Maudsley Charity
  - £25,000 lease advisory services
  - £30,000 other property services

4.10 The work of external audit falls into four broad areas. The work for areas (b), (c), and (d) is specified by Monitor, and the level of assurance provided by that work is inherently less than that provided by the work for area (a):

(a) audit of SLaM’s annual accounts to provide an opinion thereon including a ‘true and fair view’ opinion on the financial state of affairs at the year end and of the results for the year;
(b) assessment of SLaM’s use of resources (‘value for money’ – ‘VFM’ work);
(c) review of SLaM’s annual quality report; and
(d) consideration of the completeness of disclosures in SLaM’s Annual Governance statement.

4.11 External audit reported to the AC on 27 May 2014 on the results of their work in all four areas. External audit noted that their work was substantially complete and that they anticipated expressing unqualified (‘clean’) opinions in all four areas. Subsequent to the AC meeting, having completed their work, external audit did indeed express unqualified (‘clean’) opinions in all four areas.

4.11 During 2013/14 the AC received regular progress reports from external audit about their work, and received additional reports and briefings about sector and other developments as appropriate.

Internal Audit

4.12 Internal audit provides an independent, objective assurance and consulting service designed to add value and improve an organisation’s operations. As such, its role comprises two key areas:

(a) the provision of an independent and objective opinion to the ‘Accountable Officer’ (the Chief Executive), the Board and the AC on the degree to which risk management, control and governance support the achievement of SLaM’s agreed objectives; and

(b) the provision of an independent and objective consultancy service specifically to help line management improve SLaM’s risk management, control and governance arrangements.

4.13 Parkhill has acted as SLaM’s internal audit provider since September 2011. On 01 October 2013 Parkhill merged with TIAA Limited, and since then TIAA has acted as SLaM’s internal audit provider. The annual opinion (4.12 (a) refers) from the Head of Internal Audit was therefore provided by TIAA, placing reliance on internal audit work and assurances previously reported by Parkhill.
4.14 The AC has regularly reviewed commented on and approved internal audit’s plans, with amendments where necessary, and the planned internal audit work supported the 2013/14 Head of Internal Audit Opinion.

4.15 TIAA’s key overall conclusion for 2013/14 is that: *Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk*’ (TIAA 2013/14 Annual Report page 8 refers).

4.16 TIAA states that the basis for forming their opinion is: ‘an assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and an assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management’s progress in respect of addressing control weaknesses. Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances’ (TIAA 2013/14 Annual Report page 8 refers).

4.17 The following summarises the risk-based audit assignments carried out this financial year to date (Appendix C shows more detail) with comparatives for 2012/13. Some care must be taken in comparing these figures, because in many cases different areas were audited in the two years. Given that caveat, in overview the assurance profile for 2013/14 appears significantly weaker than that for 2012/13. Note that all the core financial systems audited in 2013/14 received ‘substantial assurance’ opinions, as was the case for 2012/13.

<table>
<thead>
<tr>
<th>Level of assurance</th>
<th>2013/14 (No.)</th>
<th>2013/14 (%)</th>
<th>2012/13 (No.)</th>
<th>2012/13 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial</td>
<td>5</td>
<td>33%</td>
<td>16</td>
<td>73%</td>
</tr>
<tr>
<td>Substantial/Adequate</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Adequate</td>
<td>6</td>
<td>40%</td>
<td>5</td>
<td>23%</td>
</tr>
<tr>
<td>Substantial/Limited</td>
<td>1</td>
<td>7%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Limited</td>
<td>3</td>
<td>20%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total (including drafts)</td>
<td>15</td>
<td>100%</td>
<td>22</td>
<td>100%</td>
</tr>
</tbody>
</table>

Selected individual audit areas (included above)

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core financial systems audits: substantial assurance</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Core financial systems audits: other levels of assurance</td>
<td>n/a</td>
<td>0</td>
</tr>
<tr>
<td>Board Assurance Framework: substantial assurance</td>
<td>n/a</td>
<td>1</td>
</tr>
<tr>
<td>Board Assurance Framework: adequate assurance</td>
<td>n/a</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: internal audit Annual Reports for 2013/14 (pages 8 and 9) and 2012/13 (pages 9 and 10)

4.16 The AC has:
(a) monitored regular progress reports requested from internal audit on internal audit’s delivery of internal audit plans, and
(b) influenced changes to the plan to direct work to risk areas identified as internal audit work progressed; and flagged to the Board key issues noted from the foregoing.

**LCFS (‘Local Counter Fraud Specialist’)**

4.17 SLaM’s LCFS service is provided by TIAA (previously by Parkhill, with which TIAA merged on 01 October 2013) through a service level agreement separate from that applying to internal audit services.

4.18 As requested by the AC to meet mandated requirements, LCFS has prepared an Annual Report for 2013/14 outlining delivery of the counter fraud plan through work on the prevention and detection of fraud, and through investigation into specific instances of suspected fraud. The AC will review that Annual Report at its meeting set for 24 June 2014.
4.19 The AC requested and received regular updates on fraud issues from LCFS during 2013/14.

**Other independent assurances about SLaM’s operations**

4.20 To help it to maintain and enhance the efficiency and effectiveness of its operations, in selected areas SLaM uses the consultancy and advisory services of some of the major independent accountancy firms. Significant points from their reports, and SLaM’s corrective actions in response, are flagged at AC meetings and/or dealt with at Board level if and as appropriate.

4.21 For example SLaM engaged:

(a) KPMG to review and report on governance, quality and estates matters in the light of Monitor’s stage 2 review in 2013; and

(b) Deloitte to perform certain non-audit reviews (4.9 above refers).

**360° assessment of the AC and other parties**

4.22 In line with best practice the AC structures and monitors its operations through processes such as the following:

(a) ongoing monitoring of progress against an agreed AC annual work programme;

(b) review/amendment of the AC’s own terms of reference for continued relevance, for subsequent review/approval by the Board, most recently in April 2014;

(c) private discussions with SLaM management, external audit and internal audit, as noted in Appendix B;

(d) annual assessment of the efficiency and effectiveness of its operations (see below) and

(e) ongoing use of an appropriately experienced chartered accountant as AC Secretary.

**Annual 360° assessment**

4.23 The AC annually assesses the efficiency and effectiveness of its operations as part of a 360° exercise to assess the contributions to efficient and effective audit/governance (with reference in particular to cost control, quality reporting and change management) of the following parties: the AC; the Board; external audit; internal audit; and LCFS.

**Assessment for 2012/13**

4.24 For the prior two years (2012/13 and 2011/12) the AC decided to adopt a more flexible, discursive approach than that used in previous years, but to ensure year to year consistency referred as necessary to a checklist based on that used in the exercises for previous years. In summary as regards 2012/13, the minutes of the March 2013 AC meeting noted that: ‘in summary, after due discussion, it was agreed that all parties had performed well and had contributed appropriately to efficient and effective audit/governance arrangements. However, in common with other Trusts, SLaM faced significant challenges. All parties should therefore remain alert and should continue to seek to improve their performance’. As appropriate, the AC has actioned development points noted from previous 360°assessments.

**Assessment for 2013/14**

For 2013/14 the AC decided to revert to the more formalised approach adopted in 2010/11 and previous years. The AC has obtained assessments from internal audit and the LCFS function. At its meeting in May 2014 the AC decided that a discussion session to finalise the assessment for 2013/14 would be more meaningful if that session were dealt with after the proposed changes to membership of the AC had been finalised. The assessment is therefore still in progress.

**5. AC Developments**

5.1 The AC and the Board have taken and continue to take steps further to improve the efficiency and effectiveness of the AC’s operations. This includes taking account of 360°assessments (section 4 refers).

Robert Coomber
Audit Committee Chair
June 2014
### APPENDIX A: KEY POTENTIAL ISSUES FLAGGED TO THE BOARD BY THE AC

<table>
<thead>
<tr>
<th>Key potential issues (as at date of Committee meeting)</th>
<th>Actions proposed to address key issues (as at date of Committee meeting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 May 2014 Committee meeting</td>
<td>Not applicable</td>
</tr>
<tr>
<td>25 March 2014 Committee meeting</td>
<td>The Chief Operating Officer agreed to advise the Board of Directors accordingly in Part 2 of the meeting to be held later in the day on 25 March 2014.</td>
</tr>
<tr>
<td>Estates Strategy. The Audit Committee Chair stressed the need for a still more specific timescale for development and completion of the Estates Strategy</td>
<td>The Audit Committee Chair will discuss this issue further with relevant parties</td>
</tr>
<tr>
<td>2013/14 performance indicators specified for external audit review. External audit advised that SLaM’s performance for 2013/14 quarter 1 was such that it was impossible for SLaM’s average performance for 2013/14 to meet the required 95% target (the likely actual average figure is 94%)</td>
<td>The Audit Committee Chair and the Chief Financial Officer will review the information underlying the benchmarking report and will agree how to report this matter to the Board of Directors</td>
</tr>
<tr>
<td>EBITDA performance (9 months to 31 Dec. 2013). External audit’s report of SLaM’s EBITDA (‘earnings before interest, tax, depreciation and amortisation’) performance against that of their other NHS clients showed SLaM near the bottom, at 33rd out of 34 NHS clients</td>
<td>The CFO advised that to prevent reoccurrence of this issue, the senior management team has implemented a weekly forward planner, has allocated additional resource to the Procurement Department, and Procurement Department staff is now liaising with the Information Technology Department. Also, internal audit will review and report on the reasons for the large number and large individual value of the STAs reported at the March 2014 AC meeting, whether these reasons indicate a possible ongoing issue, and will recommend how SLaM should avoid any reoccurrence</td>
</tr>
<tr>
<td>Single Tender Actions (‘STAs’). The AC noted the large number and large individual value of STAs reported. The Chief Financial Officer (‘CFO’) and Interim Chief Operating Officer (‘COO’) explained each of the major STAs. The COO advised that estates-related STAs arose as ‘one off’ interim measures in the period during which new framework agreements were being settled. These agreements have since been finalised. The CFO advised that other STAs were a ‘one off’ event mainly due to lack of preparation in the Information Technology Department, adding that alternative actions had been duly considered and that in each case an STA had been considered preferable on balance.</td>
<td>The CFO advised that to prevent reoccurrence of this issue, the senior management team has implemented a weekly forward planner, has allocated additional resource to the Procurement Department, and Procurement Department staff is now liaising with the Information Technology Department. Also, internal audit will review and report on the reasons for the large number and large individual value of the STAs reported at the March 2014 AC meeting, whether these reasons indicate a possible ongoing issue, and will recommend how SLaM should avoid any reoccurrence</td>
</tr>
<tr>
<td>17 December 2013 Committee meeting</td>
<td>The Director of Finance and Corporate Governance will arrange that the Executive will report on SLaM’s support services as regards quality of service, compliance with NHS and statutory requirements, assurances on these matters and governance of these functions. Internal audit will consider and report on the Executive’s report. Timescale: June 2014</td>
</tr>
<tr>
<td>Estates and possibly catering and other support functions: issues with compliance with NHS and statutory requirements</td>
<td>The Director of Finance and Corporate Strategy will ensure that the Board and the Audit Committee receive an updated timescale for development of the Strategy including a firm, realistic date for completion. Timescale: February 2014</td>
</tr>
<tr>
<td>Estates: issues with development and implementation of an appropriate Estates Strategy on an appropriate timescale</td>
<td>The Director of Finance and Corporate Governance will ensure that the Board and the Audit Committee receive an updated timescale for development of the Strategy including a firm, realistic date for completion. Timescale: February 2014</td>
</tr>
<tr>
<td>E-rostering: benefits may not have been realised as (per Audit Committee report to Board October 2013) SLaM had not conducted a post-implementation review</td>
<td>The Audit Committee now has no major concerns, other than to stress that SLaM should make a firm decision as to the balance between local and central management of e-rostering. Timescale: not specified by the Audit Committee</td>
</tr>
<tr>
<td>Mandatory training: issues with attendance, and with categorisation of training as ‘mandatory’</td>
<td>SLaM needs to resolve the issues around fire safety training and infection control training (timescale: March 2014) and, if the Board accepts the proposals for amending mandatory training arrangements, the amendments should be implemented (timescale: within 12 months)</td>
</tr>
<tr>
<td>Audit of performance indicators: SLaM needs to avoid the type of issues that arose for the 2012/13</td>
<td>The Director of Finance and Corporate Governance will ensure that SLaM performs an appropriate pre-audit review of</td>
</tr>
<tr>
<td>Key potential issues (as at date of Committee meeting)</td>
<td>Actions proposed to address key issues (as at date of Committee meeting)</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>audit of performance indicators, and Monitor has not yet finalised its requirements as to the audit thereof for 2013/14</td>
<td>performance indicators Timescale: as soon as this is possible</td>
</tr>
<tr>
<td><strong>10 September 2013 Committee meeting</strong></td>
<td></td>
</tr>
<tr>
<td><strong>E-rostering (10.1.1(d))</strong>: internal audit reports that the benefits of e-rostering may not have been realised, as SLaM has not conducted a post-implementation review</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>Cost Improvement Programme – ‘CIP’(10.1.2)</strong>: the Audit Committee noted several issues indicating a possible need for CIP planning processes and commissioning negotiations to start earlier in the year</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>Key committees (10.1.5)</strong>: the Audit Committee Chair will informally recommend to the Board that officer attendances at meetings of key committees be reviewed, aiming to ‘streamline’ attendances</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>Mandatory training (10.1.7)</strong>: the Audit Committee Chair will formally recommend that the Board takes steps to: (a) encourage, and enforce, full attendance at mandatory training (this includes disciplinary action where appropriate); and (b) re-assess the categorisation of training as ‘mandatory’</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>25 June 2013 Committee meeting</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Competitive marketing/benchmarking</strong> As flagged in the AC’s minutes for Mar.13, the new environment means that SLaM needs to understand competitive marketing/benchmarking (including commissioners’ needs) and internal audit is seeking to adjust the focus of their audit work to allow them to comment on this (10.1 refers).</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>Estates and Facilities</strong> GH updated the AC on progress in addressing these issues, including legal support and the appointment of two interim managers</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>21 May 2013 Committee meeting</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Competitive marketing/benchmarking</strong> SLaM needs to understand competitive marketing/benchmarking (including commissioners’ needs) so that SLaM has hard evidence to demonstrate the superior quality of SLaM’s service</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>Estates Department management issues</strong>. These issues include the timescale for resolution of issues, and identification/resolution through the performance management system</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>Planning and risk management</strong>. Improvements are necessary to improve the ‘realism’ of planning (including cost improvement planning) and risk management</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
<tr>
<td><strong>The impact of the KHP process</strong>. The impact of the KHP process, for example on strategic management capacity</td>
<td>Noted by the Board of Directors (specific proposed actions were not part of standard reporting at this time)</td>
</tr>
</tbody>
</table>
## APPENDIX B: AC MEETINGS AND ATTENDANCES FOR 2013/14

<table>
<thead>
<tr>
<th>AC members (all Non Executive Directors)</th>
<th>2013/14</th>
<th>21 May</th>
<th>25 Jun</th>
<th>10 Sep</th>
<th>17 Dec</th>
<th>25 Mar</th>
<th>27 May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Coomber (AC Chair)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Dr Patricia Connell-Julien</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prof Shitij Kapur</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

**In attendance**

<table>
<thead>
<tr>
<th>Committee support function</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Steven Thomas (AC Secretary)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SLaM management</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acting Chief Executive</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Director of Finance and Corporate Governance/Chief Financial Officer</th>
<th></th>
<th></th>
<th></th>
<th>Y</th>
<th>Y</th>
<th>Y</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim Director of Finance and Corporate Governance</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deputy Director of Finance</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Director of Finance</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim Chief Operating Officer</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Nursing</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Director of Nursing (Practice Excellence)</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim Director of Human Resources, Organisational Development, Education and Training</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Director of Child and Adolescent Mental Health Services (‘CAMHS’) Clinical Academic Group (‘CAG’)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Communications</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance Manager</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External providers of assurance</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>External Audit: Engagement Lead</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>External Audit: Engagement Senior Manager</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Internal Audit: Account Director</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Audit: Chief Internal Auditor</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Internal Audit: Head of Computer Audit</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Counter Fraud</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Observer from same firm as external audit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultancy: Senior Manager</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Quorum:** Two AC members (AC TOR 12.1 refers)

**Y** denotes attendance

The Committee received apologies for absence where appropriate from non-attendees

Note 1. Special purpose AC meeting to review 2012/13 draft Accounts, Annual Report and related documents

Note 1. Special purpose AC meeting to review 2013/14 draft Accounts, Annual Report and related documents
APPENDIX C: KEY INTERNAL AUDIT WORK FOR 2013/14

The information below, extracted from internal audit’s Head of Internal Audit Opinion report for 2013/14, seeks to summarise the work of SLaM’s internal auditors for 2013/14 and the main results of that work.

The following risk-based audit assignments were carried out this financial year to date

<table>
<thead>
<tr>
<th>Risk-based audit area</th>
<th>Level of assurance</th>
<th>Substantial</th>
<th>Adequate</th>
<th>Substantial/Limited</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaning Lessons from Internal Incidents &amp; Complaints</td>
<td></td>
<td></td>
<td>Y</td>
<td>(see below)</td>
<td></td>
</tr>
<tr>
<td>Management of CIPS, QIPPs and Quality</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementing External Recommendations</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit of Local Management Practices</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estates Strategy</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Financial Systems</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payroll</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing Trust Efficiencies</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Assurance Framework</td>
<td></td>
<td></td>
<td>(draft)</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Service Management Virtualisation</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disaster Recovery</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malware and Interface</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Governance Toolkit v11</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lambeth Criminal Justice Mental Health Service</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL: 15 (No.)</td>
<td></td>
<td></td>
<td>5</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

Internal audit commented as follows on each of the four audits which received a full or partial ‘limited assurance’ opinion.

Management of CIPS, QIPPs and Quality (Substantial/Limited assurance)
We awarded an opinion of Limited Assurance in respect of the delivery of CIP and QIPP programmes in general. This was based on current performance (at the time of the review) being inadequate to meet the CIP targets set and overall compliance with the controls in place over the management of the CIP and QIPPs.

Estates Strategy (Limited assurance)
We awarded the review limited assurance based on the level of control in place over the development and implementation of the Estates Strategy and the overall compliance with those controls. Testing confirmed that there was historically poor compliance in the following key statutory estates areas: asbestos re-inspection, fire safety compliance management issues, water storage tank chlorination, and portable appliance testing. Since April 2013 significant effort has been put into improving the situation. Non-compliance with these statutory maintenance requirements could put patients and members of staff lives at risk. Further to this, there was an apparent lack of supporting documentation and documented methodology for the indicators stated in the Compliance summary.

Developing Trust Efficiency Programmes (Limited assurance)
Our review was limited to a review of programmes within the Psychosis CAG and our opinion was based on the current poor levels of compliance with the targets set for efficiencies relating to improvement of sickness absence and in the use of Bank & Agency staff.

Lambeth Criminal Justice Mental Health Service (Limited assurance)
We concluded that the project was inadequately governed and managed with a significant lack of financial control. Although steps had been taken to improve management of the project, Trust processes needed to be reviewed and strengthened to manage this and other similar projects.
1 Composition
1.1 The Committee is a standing committee of the Board of Directors (‘the Board’) of South London and Maudsley NHS Foundation Trust (‘SLaM’) and is responsible to the Board. The Committee’s members are appointed by the Board from its non executive members. The Committee shall consist of at least three members of which one shall have relevant financial experience. The Board or the Chair of the Board will also appoint the Committee’s Chair.

2 Role of Committee
2.1 The overall role of the Committee is to promote the efficient and effective management of risk and excellent financial management and governance within SLaM. It will do this by putting in place arrangements:
   (a) generally to review and periodically report to the Board on the adequacy of the Assurance Framework and the associated systems and procedures which support it; and
   (b) specifically to monitor, review and periodically report to the Board on the adequacy of the financial systems and procedures used within SLaM.

3 Assurance Framework
3.1 The Assurance Framework is the strategic system for assessing, recording monitoring and managing all significant risks across SLaM. The role of the Committee is to ensure that risks are properly assessed, recorded and responded to in a manner which promotes the best possible use of resources and patient care and meets all appropriate governance and care standards.

3.2 The role of the committee is periodically to review the composition of the assurance framework in order to determine if it is both current and proportionate and to test the management systems which support it in order to assess the effectiveness and efficiency of risk management throughout SLaM.

3.3 To enable the Committee to fulfil this role, a risk report to the Committee from executive management should accompany the assurance framework. The risk report should identify changes to assessed risks, action taken to manage risks and decisions taken by each of the executive groups responsible for managing risks. The Committee will review the risk report with the aim of: ensuring that risks are being effectively managed; identifying areas of disagreement in the assessment of risk or the action taken; and where necessary escalating the Committee’s views to the Board.

4. Financial Assurance
4.1 The Committee shall have specific responsibility for ensuring that the principal systems and processes associated with financial management and financial governance within SLaM are efficient, effective and fit for purpose. These shall include:
   (a) internal control including arrangements for the prevention and detection of fraud and corruption;
   (b) internal audit;
   (c) external audit; and
   (d) financial management arrangements associated with resource planning, accounting, control, reporting and compliance.

4.2 The Committee shall review the annual financial statements (Trust accounts) and any formal public announcements related to financial performance before submission to the Board, focusing
particularly on: (a) changes in, and compliance with, accounting policies and practices; (b) major judgmental areas; and (c) significant adjustments resulting from the audit.

5. Operation of the Committee
5.1 The Committee may investigate any activity within its terms of reference and will be given unrestricted access to SLaM’s employees, its records, and documentation except that relating to confidential patient information which will only be available on an exception need to know basis. The same access shall generally be afforded to internal and external audit.

5.2 One of the principal resources available to the Committee will be internal audit which will report to the Committee both formally and informally as required and independently when requested.

5.3 External Audit will also report to and advise the Committee within their statutory independent framework.

5.4 The Chief Financial Officer will be responsible for ensuring that the Committee is kept informed of all significant financial risks, predicted changes in risk status and any significant weakness in SLaM’s financial management arrangements.

5.5 The Committee may obtain outside legal or other independent professional advice and may secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Operation of the Committee – Close Working Between Board Sub-Committees

5.6 In order for the Audit Committee to provide assurance for the Board on the efficient and effective management of risk and oversight of the functioning of the Trust systems of control, there needs to be a very close working relationship between the Audit Committee, The Quality Committee and the Business Development and Investment Committee. Each committee will be considering issues of risk and potential decisions on investment which have an impact on quality and finance.

5.7 The Audit Committee will receive a report at each regular quarterly meeting from the Quality Committee and from the Business Development Committee on key issues arising with a particular focus on risk and where there are concerns over the management of risk or variations and changes to the way risks are being managed. The feedback should cover any significant areas of risk or gaps in controls or assurance. The Audit Committee will consider whether to provide an update specifically for these committees on particular issues where this is not covered by the routine Board escalation reports.

5.8 Where possible the Board will consider the opportunity for explicit joint membership of the NEDs between these committees.

5.9 The chairs of each of the sub-committees should meet together at least twice in each financial year (including one meeting immediately before the Audit Committee meeting to review the final draft annual audited accounts) in order to discuss the escalation reports and issues arising to ensure that there are no gaps in assurance or control emerging which have not been considered appropriately. The fact that these meetings have occurred should be recorded in the minutes of the respective committees.

5.10 The Audit Committee will schedule time at its meetings at least once a year to which the chairs of the Quality and Business Development Committees will be invited to discuss common issues and assurances. There will be a standing invitation for the Chair of each committee to attend the meetings of the other committees.
5.11 Each Board sub-committee will consider the effectiveness of these arrangements as part of their annual review and report to the Board.

6. Internal Control and Risk Management
6.1 The Committee shall review the establishment and maintenance of systems and procedures associated with the management and control of SLaM’s financial assets and liabilities in order to ensure that:
(a) those systems and procedures are efficient, effective and compliant with current legislative and national standards;
(b) those systems promote the detection and prevention of error, fraud or corruption; and
(c) financial regulations and procedures are current, relevant and complied with.

7. Internal Audit
7.1 The Committee will:
(a) in conjunction with the Chief Financial Officer determine the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal;
(b) review and approve the internal audit programme, consider the major findings of internal audit investigations and the adequacy of the management response. The Committee shall receive regular reports updating the Committee on the extent to which recommended changes have been implemented;
(c) ensure that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
(d) annually assess the independence, objectivity, efficiency and effectiveness of the internal audit function.

8 External Audit
8.1 The Committee will:
(a) annually report to the Council of Governors as to the performance of the external auditor (including details such as the quality and value of the work, and the timeliness of reporting and fees) to enable the Council of Governors to consider whether or not to reappoint the external auditor. The Committee will also make recommendations to the Council of Governors as to the appointment, reappointment, termination of appointment and fees of the external auditor and (if the Council of Governors rejects the Committee’s recommendations) prepare an appropriate statement for the Board to include in the Annual Report;
(b) review the annual audit program in conjunction with the external auditor and the Chief Financial Officer;
(c) review external audit reports, including value for money reports and management letters, together with the management response, and the annual governance report (or equivalent);
(d) develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance on this matter; and
(e) annually assess the independence, objectivity, efficiency and effectiveness of the external audit function.

9 Key Trust documentation
9.1 The Committee will review proposed changes to Standing Orders and Standing Financial Instructions for approval by the Board.

10. Whistleblowing’ arrangements
10.1 The Committee should review arrangements by which SLaM’s staff may raise, in confidence, concerns about possible improprieties in matters of: financial reporting and control; clinical quality; patient safety; or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

11 Frequency of Meetings
11.1 Meetings will be held at least four times a year. In addition, the Committee’s Chair or the Board may convene one or more special meetings of the Committee. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

12. Quorum
12.1 A quorum shall be two members.

13. Record Keeping
13.1 Archives of minutes and papers relating to Committee meetings are kept on SLaM’s shared drive. The Personal Assistant to the Chief Financial Officer is responsible for maintaining the archive.

14. Other matters
14.1 Attendance at Committee meetings. All Committee members are expected to attend each Committee meeting. The Chief Financial Officer, the Head of Internal Audit, the Local Counter Fraud Specialist (‘LCFS’) or a nominated representative and a representative of the external auditors shall normally attend meetings. Other members of the Board may attend if they wish. No other party may attend without the Committee’s specific invitation. The Committee has the overriding authority to restrict attendance at a meeting if the Committee considers this to be appropriate in the specific circumstances of that meeting.

14.2. Private meetings with auditors and LCFS. At least once a year the Committee may wish to meet with the external and internal auditors and LCFS without any executive Board director present. This is without prejudice to the unrestricted right of access to the Committee’s Chair by the external auditor and/or the Head of Internal Audit.

14.3. Liaison with Council of Governors. The Committee’s Chair will report to the Council of Governors: annually on the Committee’s work; and (if and as the Committee considers it necessary) on matters needing action or improvement, and the corrective steps to be taken.

14.4. Availability of terms of reference to the public. These terms of reference shall be made available to the public upon request and shall be included on SLaM’s website.

15 Chart of relationships to other meetings: (not applicable)
### 16. Revision log

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2005</td>
<td>Audit Committee Chair</td>
<td>Terms of Reference formally adopted by Board (of Directors).</td>
</tr>
<tr>
<td>September 2006</td>
<td>Audit Committee Secretary</td>
<td>Terms of Reference updated for recent DH guidance and approved by Audit Committee.</td>
</tr>
<tr>
<td>October 2006</td>
<td>Audit Committee Secretary</td>
<td>Terms of Reference reformatted to fit Trust template and approved by Board (of Directors).</td>
</tr>
<tr>
<td>December 2006</td>
<td>Audit Committee Secretary</td>
<td>Terms of Reference updated for Foundation Trust status (including Sep 06 Foundation Trust Code of Governance).</td>
</tr>
<tr>
<td>September 2007</td>
<td>Audit Committee Secretary</td>
<td>Update for changes in Chair and Members, and for minor style points.</td>
</tr>
<tr>
<td>June/July 2009</td>
<td>Audit Committee Secretary</td>
<td>Minor clarification, update and style revision, also reflecting a review against the Foundation Trust Code of Governance and the AC's review.</td>
</tr>
<tr>
<td>February 2011</td>
<td>Audit Committee Secretary</td>
<td>Update, reformatting and clarifications, also taking account of the latest current version of the Foundation Trust Code of Governance (March 2010 version) and the Bribery Act 2010.</td>
</tr>
<tr>
<td>December 2012</td>
<td>Audit Committee Secretary</td>
<td>References to the ‘Board Assurance Framework’ have been replaced with references to the ‘Assurance Framework’ to reflect current nomenclature. The AC meeting of 11 December 2012 considered that no further amendments were required and that the TOR were appropriate for Board approval.</td>
</tr>
<tr>
<td>March 2014</td>
<td>Audit Committee Secretary</td>
<td>Minor update to reflect current nomenclature.</td>
</tr>
<tr>
<td>June 2014</td>
<td>CFO</td>
<td>Update to section covering operations of the Committee to incorporate more specific reference to escalation, communications and close working between the Audit Committee, Business Development and Investment Committee and Quality Committee paragraphs 5.6 to 5.11. New paragraph 3.3 clarifies the reports from SLAM management required by the Committee to enable it to fulfil its role regarding the Assurance Framework.</td>
</tr>
</tbody>
</table>
### Date of Board meeting:
29 July 2014

### Name of Report:
Key Points and Minutes from the
Quality Sub Committee

### Heading:
Governance

### Authors:
Jenny Goody, Governance Manager

### Approved by:
Neil Brimblecombe, Director of Nursing

### Presented by:
Neil Brimblecombe

### Purpose of the report:
To present a brief summary of the key points discussed at the meeting of the Quality Sub Committee of the Board held on 9 July 2014, drawing the Board’s attention to key points for consideration.
To present the draft minutes of the meeting of the Quality Sub Committee of the Board held on 9 July 2014.

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

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

### Trust-wide risk(s) affected by this report and the level of assurance provided (none, low, moderate, high):
The Quality Sub Committee provides assurance to the Board that the principal risks to service quality, recorded within the Assurance Framework and Corporate Risk Log, are being correctly identified, correctly judged and classified and, most importantly, are being actively managed and mitigated by named staff.

### Service Quality Implications:
The primary objective of the Quality Sub Committee is to ensure that there are processes in place to monitor service quality effectively.

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

### Equality & Diversity and Public & Patient Involvement Implications:
Equality & Diversity and Public & Patient Involvement are reviewed by the Quality Sub Committee on a regular basis.
Key points from the meeting of the Quality Sub Committee
held on 9 July 2014
Theme: Caring & Responsive Services

Action Point Tracker
The committee received the Quality Sub Committee’s Action Point Tracker, which comprises the outstanding actions gathered from the disbanded committees that it replaces: the Service Quality Improvement Sub Committee, Complaints Monitoring Committee, Serious Incidents Committee, Quality Governance Committee and Risk Management Committee, as well as actions identified at the preparatory meeting of the QSC held in June.

The Board’s attention is drawn to the role of the Quality Sub Committee in monitoring the outstanding issues from the disbanded committees that it replaces.

Quality Account - 2013/14
The committee received the Trust's Quality Account for 2013/14, which includes feedback from SLaM’s major stakeholders in the four boroughs: Healthwatch organisations, Clinical Commissioning Groups (CCGs) and the Council of Governors. The committee’s attention was drawn to the Council of Governors’ view that quantitative data is not always an acceptable way to describe quality of care, and Healthwatch organisations commented that more effort is required to show how the culture of compassion is being addressed across the Trust. The CCGs were pleased to see that ending the use of private beds is a quality priority for the coming year.

The Board’s attention is drawn to stakeholders’ responses to the Quality Account.

Quality Indicator Dashboard
The committee received the first iteration of the QSC’s Quality Indicator Dashboard, which outlines performance against the nine quality targets within the Trust's Quality Account and a number of other key quality indicators agreed at the June meeting of the QSC. Indicators relating to workforce, QUeSTT and social care will be added at a later date and the dashboard will be refined as the committee develops a consensus on what indicators are required. Further discussions are required to confirm data flows and how they will be resourced. The red rated indicators were reviewed in detail to understand how shortfalls are being addressed.

The Board’s attention is drawn to the assurance provided by the Quality Indicator Dashboard and the need to identify resources to develop it fully.

Quality Strategy 2014/19
The committee received a proposed approach to the Trust’s Quality Strategy for discussion and consultation. The proposal describes a framework for the Trust's quality objectives, aligned to the objectives with in the Trust's 5-year strategic plan; the next step is to discuss the proposed Quality Strategy with CAG clinical governance forums.

The Board’s attention is drawn to the progress being made towards finalising the Trust’s Quality Strategy.

Assurance Framework Review
The committee received a report outlining the principal strategic risks facing the Trust within the Board’s Assurance Framework (AF), which have been updated for 2014-15 and have been assigned to an appropriate monitoring committee: Caring & Responsive Services QSC / Safe Services QSC / Effective Services QSC / Audit Committee.

The two strategic risks relating to Caring & Responsive Services were reviewed by this themed committee, with updates provided by the Addictions, MAPD and Psych Med CAGs (also from CAMHS, but this missed the deadline for papers). The need for timely updates was stressed and a flowchart outlining the AF maintenance cycle is being drafted and will be distributed to members of the committee for comment.

The Board’s attention is drawn to the ongoing development of its Assurance Framework, which will be presented to the September Board meeting.
Corporate Risk Log Review
The committee received a report of the active Trust-wide operational risks within the Corporate Risk Log (CRL), which have been designated as Caring & Responsive, Safe or Effective to align with the themes of QSC meetings, the non-clinical risks being reviewed by the Audit Committee. Updates from Trust leads on the risks to Caring & Responsive services were highlighted in blue text.

Compliance Issues
The committee received a round-up of quality governance issues that don’t appear anywhere else on the agenda:
- Two Preventing Future Deaths notices have been received from the coroner; the Trust is working on a response to this.
- There are two outstanding compliance issues arising from recent CQC inspections relating to the quality of the environment at the Ladywell and Maudsley sites; a programme of refurbishment is underway, with a redecoration project at Ladywell starting in July. The committee noted the changes to the CQC’s method of carrying out inspections: in future a formal team of inspectors will carry out a full-scale inspection, giving the Trust 6 weeks’ notice before they arrive.
- The HSE Improvement Notice for the Maudsley site relating to Legionella has still not been lifted. The committee will receive regular updates on these compliance issues at future meetings.

The Board’s attention is drawn to the ongoing monitoring of compliance issues undertaken by the QSC.

Patient Experience update
The committee received a report on the PEDIC and Patient Experience CQUIN results for 2013/14. The Trust secured an income of £90,000 from this CQUIN last year, and a programme of Link workers is being set up to visit patients on the wards to discuss their quality priorities to ensure continuing success. This year’s PLACE visits have just been completed; again Service Users were involved and there has been a marked improvement over last year.

The Board’s attention is drawn to the assurance gained from this Patient Experience update.

Complaints Review
The committee received the Management of Complaints Annual Report 2013/14, which indicates a slight increase in the number of complaints over the last year, the main areas being staff attitude and dignity & respect. Complaints about discharge arrangements were also high, either that this was happening too early or without sufficient notice.

The committee also received a verbal update on the way in which the Croydon East MAPD team have addressed recent complaints caused by large caseloads and high referral rates; the number of complaints has reduced significantly, but a more integrated service is required to address the lack of understanding of when to refer to IAPTS and when to refer to the Assessment & Liaison service.

The Board’s attention is drawn to the assurance gained from Croydon East MAPD team’s response to recent complaints.

Eliminating Mixed Sex Accommodation
The committee received a report outlining the current situation relating to mixed sex accommodation, which has not been eliminated completely (site closures and refurbishments have resulted in breaches within the MHOAD CAG). Issues have been raised with Estates and Capital Planning and an action plan has been drafted to address these breaches. The Trust’s position on where transgender and gay patients are placed was raised; an update on this question will be given to the next Caring & Responsive themed meeting of the QSC.

The Board’s attention is drawn to the ongoing issues relating to mixed sex accommodation; the committee is seeking clear timelines for future Estates action.

Sub-committee highlights: Patient Information
The committee considered the Patient Information update provide by the Patient Information Manager; the lack of a central budget for patient information represents a significant risk to the Trust as it relates to an important CQC standard.

The Board’s attention is drawn to the lack of a central budget for patient information and the compliance implications this represents.
MINUTES OF THE
MEETING OF THE QUALITY SUB COMMITTEE
HELD ON: 9th JULY 2014 at 14:00
AT: The Boardroom, Maudsley Hospital

Present:
Patricia Connell-Julien (Chair) Non-Executive Director (PCJ)
Matthew Patrick Chief Executive (item 1) (MP)
Neil Brimblecombe Director of Nursing (NB)
Gus Heafield Chief Financial Officer (GH)
Michael Holland Associate Medical Director (MH)
Cliff Bean Associate Director Quality & Assurance (CB)
Rosalind Ramsey Acting Clinical Director, Psychosis CAG (RR1)
Hugh Jones Clinical Director, MAPD CAG (HJ)
Ranga Rao Clinical Director, Psych Med CAG (RR2)
Emily Finch Clinical Director, Addictions CAG (EF)
Bruce Clark Clinical Director, CAMHS CAG (BC)
Justin Sauer Clinical Director, MHOAD CAG (JS)
Alison Beck Head of Psychology (AB)
Gabrielle Richards Head of Occupational Therapy (GR)
Roy Jaggon Head of Performance Management (RJ)
Rosie Peregrine-Jones Head of Clinical Audit & Effectiveness (RPJ)
Jenny Goody Governance Manager (JG)
Jo Kent Deputy Director, MAPD CAG (JK)
Tom Whitfield Estates Manager (TW)
Janet Hoskins Hotel Services Manager (JH)
Adella Habib Social Care Lead, MHOAD CAG (AH)
Anne Middleton Assistant Director of Nursing (AM)
Mary O’Donovan Assistant Director of Complaints & SIs (MOD)
Myrna Harding Trust Investigation Facilitator (MH)
Bill Berry Service Improvement Manager (Item 16) (BB)

In Attendance:
Gareth Evans (Minutes)
Kelly Reid Internal Audit, TIAA
Iris H Work Experience Student

Apologies:
Lesley Calladine Non-Executive Director
Martin Baggaley Medical Director
Nick Dawe Interim Chief Operating Officer
Catherine Gormally Director of Social Care
Jean O’Hara Clinical Director, BADP CAG
Tom Fahy Clinical Director, BADP CAG
Ray Johanssen- Chapman PPI Lead
Gabrielle Richards Head of Occupational Therapy
<table>
<thead>
<tr>
<th>Item</th>
<th>Business Item</th>
<th>Action by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Apologies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>As received above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NB reiterated the purpose of the Quality Sub Committee (QSC), stating that the Trust has radically reviewed its governance structure and the QSC represents a central sub-committee of the Board where quality issues can be discussed. Its purpose is largely to provide assurance, but the QSC should also identify quality improvement issues. The importance of senior clinical representation from every CAG was stressed, and at the end of each meeting the Chair will ask how the meeting can be improved. Although not a formal member, MP stressed the importance of this committee and stated that he will always be happy to be invited.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Declarations of interest / notifications of any other business</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No declarations of interest were received at this point.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPJ asked that the Trust-wide priorities for the 2014/15 Clinical Audit Plan be reviewed under any other business.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Minutes of QSC preparatory meeting held on 11 June 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agreed as an accurate record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Action Point Tracker: Outstanding Actions &amp; Closures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>JG presented the Quality Sub Committee’s Action Point Tracker, which comprises the outstanding actions gathered from the committees it replaces: the Service Quality Improvement Sub Committee (SQISC), Complaints Monitoring Committee (CMC), Serious Incidents Committee (SIC), Quality Governance Committee (QGC) and Risk Management Committee (RMC), as well as actions identified at the preparatory meeting of the QSC held in June.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actions in grey text are not yet due; actions shaded green have been addressed since the last meeting and the committee agreed that all but action 24 can be closed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Action 24: The number of personal budgets (enabling choice and personalisation) has been proposed as a social care quality indicator to be included in the Quality Indicator Dashboard; CB is working to facilitate this.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Quality Account - 2013/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CB presented the Trust’s Quality Account for 2013/14, explaining that all Foundation Trusts have to produce such an account and that this is the 5\textsuperscript{th} one that SLaM has produced; published on the internet in August, it will provide the public with an awareness of how the Trust is performing. A draft report was approved by the Board in May; the QSC was asked to approve this final Quality Account on their behalf.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Quality Account includes feedback from SLaM’s major stakeholders in the four boroughs: Healthwatch organisations, Clinical Commissioning Groups (CCGs) and the Council of Governors. CB drew the committee’s attention to a comment from the Council of Governors that quantitative data collection is not always acceptable as means of describing quality of care; alternative forms of regular feedback should be considered to broaden the overall feedback base. Healthwatch organisations were particularly interested in the Trust’s culture of compassion and commented that more effort is required to show how this is being addressed across the Trust. The CCGs were pleased to see that ending the use of private beds is a quality priority for the coming year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>It was noted that the smoking cessation target for 2013/14 was not met, nor was the target relating to inpatients’ access to HIV tests. RR2 stated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Business Item</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>6. Quality Indicator Dashboard</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CB introduced the first iteration of the Quality Indicator Dashboard, which outlines performance against the nine quality targets within the Trust’s Quality Account and a number of other key quality indicators agreed at the preparatory meeting of the QSC held in June. The dashboard is still being developed; indicators relating to workforce, QUeSTT and social care will be added at a later date. The dashboard will be refined as the committee develops a consensus on what indicators are required and how they should be presented. Further discussions are also required to agree RAG rating thresholds and to confirm data flows and how they will be resourced. It was agreed that the red rated indicators should be reviewed in detail to understand how shortfalls are being addressed.

- **Violence reduction:** GH noted that this indicator relies heavily on the roll-out of the Care Delivery System and questioned why this is voluntary; MH responded that there are currently resource issues; it will become mandatory in the longer term.
- **Use of private beds:** this indicator is red but CB commented that the figures for the current quarter have improved significantly. RR2 commented that it still very difficult to obtain a bed and that other data should be taken into account.
- **Recovery & Support plans:** this is part of a CQUIN target, and staff are currently being trained to complete R&S plans correctly.
- **HTT Gatekeeping:** the Trust failed to meet its 95% target in Q1, with extensive financial implications. NB asked if there are any plans to improve this; RR2 responded that there is plan in place to address this for Q2 but the target is not likely to be reached until Q3.
- **Physical Health screening:** AM commented that there are always a few patients who have not had an annual health check, often with good reasons that are explained to their commissioners. GH queried the implications in terms of the Trusts’ quality strategy, and NB stressed that this is an important quality indicator that needs to be reviewed in detail at a future meeting of the QSC.

**Action:** Present an update on physical health screening at a future meeting of the QSC.

<table>
<thead>
<tr>
<th>Item</th>
<th>Business Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Quality Strategy 2014/19</td>
</tr>
</tbody>
</table>

CB presented a proposed approach to the Trust’s Quality Strategy for discussion and consultation. The proposal describes a framework for the Trust’s quality objectives, which need to be aligned to the objectives with in the Trust’s 5-year strategic plan that will be published imminently. BC commented that the HR policy within the 5-year strategic plan has a number of hard-hitting items that are very challenging for staff; it was agreed that the next step is to discuss the Quality Strategy with CAG.

<table>
<thead>
<tr>
<th>Action by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>Feb-15</td>
</tr>
<tr>
<td>AM</td>
<td>Sep-14</td>
</tr>
<tr>
<td>Item</td>
<td>Business Item</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
</tr>
<tr>
<td>8.</td>
<td><strong>Assurance Framework Review</strong>&lt;br&gt;JG presented the principal strategic risks facing the Trust within the Board's Assurance Framework, which have been updated for 2014-15 and have been assigned to an appropriate monitoring committee: Caring &amp; Responsive Services QSC / Safe Services QSC / Effective Services QSC / Audit Committee.&lt;br&gt;In future, only two strategic risks will be reviewed by this themed committee; updates were provided for these by the Addictions, MAPD and Psych Med CAGs (also from CAMHS, but this missed the deadline for papers). NB suggested that some red-rated risks have improved; JG responded that the current quarterly update cycle means that some risk details are out of date.&lt;br&gt;GH stressed the need for timely updates - maximum engagement is required with minimum bureaucracy; he stated that a flowchart outlining the AF maintenance cycle is being drafted and will be distributed to members of the committee for comment.&lt;br&gt;<strong>Action:</strong> Distribute the draft AF maintenance cycle to QSC members for comment and present an updated version for agreement to the next meeting of the QSC.</td>
</tr>
<tr>
<td>9.</td>
<td><strong>Corporate Risk Log Review</strong>&lt;br&gt;JG presented a report of the active Trust-wide operational risks within the Corporate Risk Log (CRL), explaining that they have been designated as Caring &amp; Responsive, Safe or Effective to align with the themes of QSC meetings, the non-clinical risks being reviewed by the Audit Committee. Updates from Trust leads on the risks to Caring &amp; Responsive services were highlighted in blue text.&lt;br&gt;The committee noted these updates and confirmed that the CRL represents the principal operational risks currently facing the Trust and that each risk has been assigned to the most appropriate area of governance.</td>
</tr>
<tr>
<td>10.</td>
<td><strong>Compliance Issues</strong>&lt;br&gt;CB presented a round-up of quality governance issues that don't appear anywhere else on the agenda.&lt;br&gt;Two Preventing Future Deaths notices have been received from the coroner, the most recent relating to specialist physicians visiting inpatient units when there are patients with severe physical issues; the Trust is working on a response to this.&lt;br&gt;There are two outstanding compliance issues arising from recent CQC inspections relating to the quality of the environment at the Ladywell and Maudsley sites. A programme of refurbishment is underway, with a redecoration project at Ladywell starting today. CB updated the committee on the CQC’s method of carrying out inspections, saying that in future a formal team of inspectors will carry out a full-scale inspection, giving the Trust 6 weeks’ notice before they arrive. NB stressed the need to strengthen the Trust’s approach to CQC inspections.&lt;br&gt;GH questioned when the issues raised by this report will be signed off; RJ responded that there is a plan to address the issue of ligature points, with agreed timescales to complete. NB requested an update on the ward refurbishment programme for next meeting.</td>
</tr>
</tbody>
</table>

The table contains information on actions and dates for various business items, including assurance framework reviews, corporate risk log reviews, and compliance issues. The details cover topics such as clinical governance forums, quality strategy, assurance framework updates, risk log reviews, and compliance issues.
<table>
<thead>
<tr>
<th>Item</th>
<th>Business Item</th>
<th>Action by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>Action: Provide an update on the ward refurbishment programme at the next meeting of the QSC. The HSE Improvement Notice for the Maudsley site relating to Legionella has still not been lifted; PCJ requested an update for the next meeting. Action: Provide an update on the Legionella issues at the Maudsley site at the next meeting of the QSC.</td>
<td>ND</td>
<td>Aug-14</td>
</tr>
<tr>
<td>11.</td>
<td>Being Open and Duty of Candour Policy</td>
<td>ND</td>
<td>Aug-14</td>
</tr>
<tr>
<td></td>
<td>MHa presented the updated Being Open and Duty of Candour Policy, which has been changed extensively to reflect recently introduced duty of candour legislation. The policy applies to all moderate or severe incidents involving death, and failure to comply will result in a £10,000 fine and the obligation to publish the breach on the Trust’s website. The updated policy needs to be disseminated throughout the Trust; there are plans to feature the updated policy in SLaM news and a Purple Light bulletin. After due consideration, the QSC ratified the Being Open and Duty of Candour Policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Medicines Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The updated Medicines Policy, which now incorporates rapid tranquilisation, was distributed to members of the QSC three weeks prior to meeting, with the expectation that issues would be raised with the policy lead; no issues were raised. BC questioned whether the use of placebos was adequately covered by the policy; Shubhra Mace, the policy lead, was not present, and so BC was asked to raise this with her individually. In the meantime and after due consideration, the QSC ratified the Medicines Policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Transportation of Inpatients Policy</td>
<td>CB</td>
<td>Aug-14</td>
</tr>
<tr>
<td></td>
<td>CB introduced the new Transportation of Inpatients Policy, which has been written in response to a Serious Incident involving a SLaM patient. BC questioned whether using transport with a separate driver’s compartment has been stipulated, in response to a recent BLI recommendation. NB suggested that the choice of transport should be risk-based, but BC countered that there is not always an opportunity to carry out a full risk assessment before transport is required; RR2 stated that a secure ambulance should be used if there is any doubt about a patient’s behaviour. The committee agreed that the Transportation of Inpatients Policy should be updated to reflect the issues discussed above and brought back to a future meeting for ratification. Action: Update the Transportation of Inpatients Policy and present it to the next meeting of the QSC for ratification.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>CPA Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This is an established policy, with minor changes relating to the wording of Recovery and Support planning. After due consideration, the QSC ratified the CPA Policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Stalking Policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This is an established policy, with minor updates following recent legislation and providing a more detailed equality impact assessment. After due consideration, the QSC ratified the Stalking Policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Patient Experience update</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BB presented a Patient Experience update on behalf of the PPI Lead.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

114 of 191
<table>
<thead>
<tr>
<th>Item</th>
<th>Business Item</th>
<th>Action by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td><strong>Complaints Review</strong></td>
<td>MOD</td>
<td>Oct-14</td>
</tr>
<tr>
<td></td>
<td>MOD presented the Management of Complaints Annual Report 2013/14, prior to its presentation to the Board of Directors later in the month. There has been a slight increase in the number of complaints over the last year, the main areas being staff attitude and dignity &amp; respect. Complaints about discharge arrangements were also high, either that this was happening too early or without sufficient notice. JK gave a verbal update on the way in which the Croydon East MAPD team have addressed recent complaints caused by large caseloads and high referral rates: new staff have been added to teams and the MAPD CAG are talking with the CCG to stabilise the situation. 10 new clinicians (band 7 assessors) have been introduced to respond to the influx of referrals and significant funding has just been received to improve the Improving Access to Psychological Therapies Service (IAPTS). The number of complaints has reduced significantly, but a more integrated service is required to address the lack of understanding of when to refer to IAPTS and when to refer to the Assessment &amp; Liaison service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td><strong>Eliminating Mixed Sex Accommodation</strong></td>
<td>AM</td>
<td>Oct-14</td>
</tr>
<tr>
<td></td>
<td>AM presented the Trust's current mixed sex accommodation situation, which has not been eliminated completely, as site closures and refurbishments have resulted in breaches within the MHOAD CAG; data is being recorded on a monthly basis and reported to the commissioners. The Trust is aware of the challenging environment, issues have been raised with Estates and Capital Planning and an action plan has been drafted. NB stated that this is not an acceptable situation: a date when issues are expected to be resolved is required as a matter of urgency. AM responded that the refurbishment of Lishman ward has been discussed with Capital Planning and that minor refurbishments are planned. NB commented that the committee needs to be assured that there is an action plan in place to address the mixed sex breaches, with a timescale of when it will be completed. PCJ commented that there are issues within issues, which the Board should be made aware of. GH added that the Trust has to make some choices and needs to ensure that they are appropriate. <strong>Action:</strong> Provide a clear timeline for future Estates action on these issues and report back to the next Caring &amp; Responsive themed meeting of the QSC. BC questioned the Trust's position on transgender and gay patients, and where they are placed; AM responded that this has not been considered, but will be now, and an update will be given to the next Caring &amp; Responsive themed meeting of the QSC. <strong>Action:</strong> Provide an update on the placement of transgender and gay patients to the next Caring &amp; Responsive themed meeting of the QSC.</td>
<td>ND</td>
<td>Oct-14</td>
</tr>
<tr>
<td>Item</td>
<td>Business Item</td>
<td>Action by</td>
<td>Date</td>
</tr>
<tr>
<td>------</td>
<td>---------------</td>
<td>-----------</td>
<td>------</td>
</tr>
<tr>
<td>19.</td>
<td>Sub-committee highlights: Patient Information</td>
<td>RB</td>
<td>Aug-14</td>
</tr>
</tbody>
</table>
|      | The committee considered the Patient Information update provided by Roslyn Byfield (RB), the Patient Information Manager. CB commented that the lack of a central budget for patient information represents a significant risk to the Trust as it relates to an important CQC standard; it was agreed that this should be followed up.  
**Action:** Provide an update on patient information funding to the next meeting of the QSC. | | |
| 20.  | CAG Highlights | NB/JG     | Aug-14 |
|      | A highlight report comprising successes, lessons learned, risks and issues was provided by the BADP CAG in response to an agreed action at the preparatory meeting of the QSC held in June. JG complimented the BADP CAG on their excellent report and hoped that other CAGs would provide similar reports for future meetings. EF stated that this information is already shared at Operational Performance Management Review (OPMR) meetings and to present it at the QSC would be to duplicate effort; JG responded that OPMR reports are not shared with other CAGs, but RJ countered that this information is available on the shared drive. EF suggested that one CAG could present this information at each meeting (providing an 8-monthly updated cycle) and GH agreed that a discussion focussing on best practice would be more beneficial than receiving monthly reports.  
**Action:** Discuss and agree the most pragmatic way to facilitate the escalation of CAG issues to the QSC. | | |
| 21.  | Forward Planner | NB        | Aug-14 |
|      | NB informed the committee that the dates agreed at the preparatory meeting of the QSC cannot now go forward as the new Non Executive Chair is not available on the second Wednesday of each month; the August date will stand, but future meetings will take place on a Tuesday, the times and dates to be confirmed with the Chair. | | |
| 22.  | Any Other Business | BC        | Aug-14 |
|      | The Trust-wide priorities for the 2014/15 Clinical Audit Plan were noted by the committee.  
NB requested feedback on how this first meeting had functioned: RJ commented that there had been an excessive amount of papers; JG responded that the number of policies requiring ratification had built up and that fewer papers will be produced for future meetings. BC questioned whether it would be appropriate for a Service Director to deputise for a Clinical Director; NB responded that CAG representatives should ideally have a clinical background. | | |
| 23.  | Feedback to Board of Directors & Audit Committee | BC        | Aug-14 |
|      | It was agreed that the issue of mixed sex accommodation should be highlighted to the Board, ensuring that the Chief Operating Officer is aware of this escalation. The Board of Directors and Audit Committee will also receive a highlight report comprising a précis of the meeting minutes for information. | | |
| 24.  | Dates of next meeting: | All meetings will be held in the Board Room at the Maudsley Hospital | |
|      | Wednesday, 13 August at 2pm  
Future meeting dates to be confirmed by the QSC Chair | | |
Attached are the Terms of Reference following discussion at the Board and following further discussion at the Quality Sub Committee.
Quality Sub-Committee
Of the Trust Board of Directors

Terms of Reference
July 2014

Overall Purpose:
The main role of the committee is to provide assurance to the Board of Directors on the delivery of the Trust’s Quality Strategy. It will have a role in examining where there have been failures in service or clinical quality and monitor progress against action plans to address them.

Key objectives:
- Develop the Trust’s strategy for service and clinical quality.
- Monitor progress against the Trust’s strategic quality goals, the quality priorities as published in the annual Quality Account and other quality targets, such as CQUINs.
- Monitor service performance against the Care Quality Commission’s essential standards of quality.
- Examine where there have been failures in service quality and monitor progress against action plans to address them.
- Identify risks related to service and clinical quality and provide assurance to the Board that the principal risks threatening quality are being managed appropriately at all levels within the Trust.
- Seek assurance that major service transformation and significant QIPP and CIP programmes will not have a detrimental impact on service quality as patients experience it.
- Ensure that Quality Improvement support resources are targeted where they are most needed.
- Ensure that there are processes in place to monitor quality effectively.
- Receive and consider national policy and strategy as it impacts on safety, effectiveness and patient experience within the Trust.
- Receive & monitor Social Care data relating to quality.
- Receive reports from 3rd parties, such as Healthwatch, and address & monitor any issues raised.
- Approve Trust policies relating to all aspects of quality.
- Ensure that senior clinical staff, including senior nurses, play a key role in quality strategy development and monitoring.
- Promote an organisational culture that enables high quality and compassionate care, using the Trust’s five commitments and four Francis elements to guide behaviour and decision making.
- Consider any issues escalated by the committees accountable to the Quality Sub-Committee.
Chair: Non-Executive Director

Members: Two Non-Executive Directors (in addition to the Chair)
Director of Nursing – Executive lead
Medical Director
Director of Social Care
Chief Operating Officer
Associate Medical Director
Clinical Directors x 7
Heads of Profession x 2 (OT and Psychology)
Associate Director Quality & Assurance
Assistant Director Corporate Governance
Head of Performance Management
Clinical Audit & Effectiveness Manager

For every Safe Services meeting:
  Director of Pharmacy & Pathology
  Head of Patient Safety

For every Caring & Responsive Services meeting:
  PPI Strategy Lead
  Head of Complaints & PALS

For every Effective Services meeting:
  Director of Research & Development
  Assistant Director of Nursing (physical & public health)

All members are expected to attend every meeting or nominate a delegated representative.

Other Trust directors, managers and clinicians will be required to attend to address specific issues as they arise.

The Chief Executive, Chief Financial Officer, Director of Organisation & Community and HR Director will be expected to attend at least one meeting per year.

Responsible to: Trust Board of Directors

The Quality Committee will provide a briefing note, flagging key issues, to the Board of Directors and Audit Committee after each of its meetings; urgent issues will be raised verbally by the Quality Committee Chair at the Board meeting following directly after their meeting.

Working between Board Sub Committees:

In order for the Quality Sub Committee to fulfil its objectives and fulfil its role for the Board of Directors there needs to be a very close working relationship with the Quality Sub Committee. Each committee will be considering issues, which may have an impact on quality and finance.

Where possible the Board will consider the opportunity for explicit joint membership of the NEDs between these committees

The chairs of each of the sub-committees should meet together regularly in order to discuss the escalation reports and issues arising to ensure that there are no gaps in assurance or control emerging which have not been considered appropriately. The fact that these meetings have occurred should be recorded in the
minutes of the respective committee.

Each Board sub-Committee will consider the effectiveness of these arrangements as part of their annual review and report to the Board.

**Accountable for:**

Refer to Chart of Relationships to Other Meetings and also to Appendix A.

As a minimum, these committees are required to escalate any concerns relating to quality to the Quality Sub Committee and provide an Annual Report; they are also required to present areas of specific interest or concern at the request of the Committee.

**Roles and Responsibilities:**

The Nursing Business Manager will act as Secretary to the Committee.

**Frequency of Meetings:**

The Committee will meet monthly.

**Quorum:**

The meeting will be quorate when there are a total of two Board Directors present, including one Non-Executive Director.

**Record Keeping:**

The minutes and papers of meetings will be kept and archived by the Committee Secretary.

**Terms of reference review:**

The Chair, Executive Lead and Secretary will review the effectiveness of the committee after each meeting.

The Terms of Reference will be reviewed annually; (Next review date: July 2015).

---

1 No meeting in August
Chart of relationships to other meetings:

Board of Directors

- Quality Committee (Safe Services)
  - Sub committees:
    - PMVA (Prevention & Management of Violence & Aggression)
    - Medicines Safety
    - Medical Devices
    - Safeguarding Adults
    - Safeguarding Children
    - Health, Safety & Fire
    - Infection Control
    - ECT
    - KHP Clinical Biological Safety
    - Education & Training

- Quality Committee (Caring Services)
  - Sub committees:
    - EPIC (Engaging Patients Involving Carers)
    - Patient Information
    - Education & Training

- Quality Committee (Effective Services)
  - Sub committees:
    - Physical Health
    - Drugs & Therapeutics
    - TPPAC (Psychology & Psychotherapy Advisory Committee)
    - Education & Training
Appendix A: Topics and themes

For every meeting:

- Quality Priorities (Quality Indicator dashboard)
- Regulatory compliance issues, including CQC inspections
- Trust-wide operational risk review\(^2\) (Corporate Risk Log)
- Strategic risk review\(^2\) (Assurance Framework)
- Policy ratification

For every Safe Services meeting:

- Violence & Aggression
- Serious Incidents

Annual themed review at one quarterly Safe Services meeting:

- Safeguarding Adults / Children
- Self-Harm / Suicide
- Medicines Management

For every Caring & Responsive Services meeting:

- Patient Experience (including PALS, access to services and carer feedback)
- Complaints

Annual themed review at one quarterly Caring & Responsive Services meeting:

- Care Environment (PLACE)
- Francis Action Plan
- Safe Staffing Review (six-monthly)

For every Effective Services meeting:

- CQUINS
- Integrated Care Pathways
- Clinical Audit
- NICE Guidelines
- Education & Training
- Research & Development (From Bench to Bedside Report)

Annual themed review at one quarterly Effective Services meeting:

- AMH Transformation
- Forensic Transformation
- Physical Health / Nutrition
- Mental Health Legislation

At the end of each agenda item, the following questions should be asked:

- Is the committee assured that this item is being dealt with appropriately?
- Is there anything more that needs to come to a future meeting?
- Is there anything that needs to be brought to the attention of the Board of Directors?

The committee will agree a Forward Plan that will schedule agenda items over the year and will include the publication of key documents and annual reports on key areas of governance.

\(^2\) As they relate to Safe, Caring & Responsive or Effective services
Trust leads will be asked to provide a highlight report on the areas covered by each Quality Committee meeting, comprising lessons learned, successes and issues, with the potential to present an agenda item if deemed appropriate.
<table>
<thead>
<tr>
<th><strong>TRUST BOARD - SUMMARY REPORT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of Board meeting:</strong></td>
</tr>
<tr>
<td><strong>Name of Report:</strong></td>
</tr>
<tr>
<td><strong>Heading:</strong> (Strategy, Quality, Performance &amp; Activity, Governance, Information)</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
</tr>
<tr>
<td><strong>Approved by (name of Executive member):</strong></td>
</tr>
<tr>
<td><strong>Presented by:</strong></td>
</tr>
<tr>
<td><strong>Purpose of the report:</strong></td>
</tr>
<tr>
<td><strong>Action required:</strong></td>
</tr>
<tr>
<td><strong>Recommendations to the Board:</strong></td>
</tr>
<tr>
<td><strong>Relationship with the Assurance Framework (Risks, Controls, and Assurance):</strong></td>
</tr>
<tr>
<td><strong>Summary of Financial and Legal Implications:</strong></td>
</tr>
<tr>
<td><strong>Equality &amp; Diversity and Public &amp; Patient Involvement Implications:</strong></td>
</tr>
<tr>
<td><strong>Service Quality Implications:</strong></td>
</tr>
</tbody>
</table>
MINUTES OF THE BUSINESS DEVELOPMENT AND INVESTMENT COMMITTEE
MEETING HELD ON WEDNESDAY 17TH JULY 2014

PRESENT:  
Alan Brown Interim Chief Information Officer  
Emily Buttrum Commercial Director  
Gus Heafield Chief Financial Officer  
Matthew Patrick Chief Executive  
Nick Dawe Chief Operating Officer

IN ATTENDANCE:  
Paul Mitchell Trust Board Secretary

APOLOGIES:  
None

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDIC/01/14</td>
<td>DECLARATIONS OF INTEREST</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>It was noted that declarations of interest could be given at any point of time during the meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDIC/02/14</td>
<td>OUTCOMES, KEY PERFORMANCE MEASURES AND INFORMATION REQUIREMENTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Matthew Patrick explained that the first meeting of the BDIC was in the form of an Executive set up meeting. It was noted that there will be a NED Chair. The key was to decide how to make it work effectively and add value to the organisation. The agenda planning would need to be streamlined so as to ensure that future tenders were considered by the committee at the right time and with the appropriate level of supporting documentation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The draft Terms of Reference were considered and agreed. The objectives must be succinct and measurable. They should provide the oversight of the commercial context within which the Trust was working. The KHP context was also critical as it provided an opportunity to maximise synergistic potential.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An annual report of commercial activity would be produced for the Board. A quarterly report would be made to the P2 meeting of the Board.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The KPIs were discussed and agreed. These will be included in the ToR once discussed further with the Trust Chair and BDIC Chair.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The value of commercial activity to be considered by the committee was set at an annual value of £500k.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>It was agreed that it would be useful to discuss with the Chair and Chair of the committee about the use of other NEDs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The committee will consider the current major tenders at the next meeting.

<table>
<thead>
<tr>
<th>BDIC/03/14</th>
<th>NEXT MEETING</th>
<th>To be arranged.</th>
<th>PM</th>
</tr>
</thead>
</table>

PNJM / July 2014
Business Development and Investment Sub-Committee
of the Trust Board of Directors

Terms of Reference
July 2014

DRAFT

Overall Purpose: The Business Development and Investment Committee will scrutinise the development and implementation of the Trust's commercial strategy, approve major investment decisions including proposals for new business and scrutinise the strategy for the improvement of efficiency and productivity in order to enable delivery of the Trust's strategic and operational objectives.

Key objectives:

- providing assurance to the Board over the development and implementation of the Commercial Strategy for the Trust
- evaluating and providing assurance to the Board on the identification and appropriate consideration of commercial opportunities based on their business case including particular consideration of appropriate due diligence arrangements
- evaluating and providing assurance to the Board on the identification and appropriate consideration of tenders for new or existing NHS contracts based on their business case
- advising the Board on potential options and the best uses of available resources in order to maximise value added
- overseeing the development of appropriate guidance for the content of business cases to be submitted for consideration
- evaluating and providing assurance to the Board for the assessment of opportunities and potential strategic partners for the Trust and appropriate models such as joint ventures, integration horizontally or vertically.
- ensuring appropriate consideration of the appropriate guidance and best practice and in particular “Risk Evaluation for Investment Decisions by NHS Foundation Trusts” as published by Monitor
- reviewing and providing assurance to the Board on the financial and commercial arrangements relating to investments, developments, disinvestments and decommissioning plans. The committee will approve of business cases for major investment and disinvestment decisions within limits delegated to it by the Board.
- evaluating and providing assurance to the Board over the development and implementation of the strategy for improving efficiency and productivity in the Trust, including developing and scrutinising the key financial deliverables for the Trust including a minimum 5% EBITDA performance
- providing advice to the Board on necessary actions or improvements required to address potential issues identified
- identifying and keeping under review appropriate arrangements whereby decisions or advice from the committee can be obtained at short notice arising from the specifics of a particular transaction or proposal
Chair: Non-Executive Director

Members: Non-Executive Director (in addition to the Chair of the Committee)  
Chief Executive  
Chief Financial Officer – Executive lead  
Medical Director (with cover from Director of Nursing if required)  
Chief Operating Officer (Executive lead for Estates)  
Commercial Director  
Chief Information Officer  

All members are expected to attend every meeting or nominate a delegated representative.

Other Trust directors, managers and clinicians will be required to attend to address specific issues as they arise.

Responsible to: Trust Board of Directors

The Business Development and Investment Committee will provide a briefing note to flag any key issues to the Board of Directors after each of its meetings and the Chair of the Committee will feed back any urgent issues verbally at the next Board meeting following the committee meeting.

The Committee will provide the Board with a review of its activities and assessment of its effectiveness and value added on an annual basis.

The Committee is authorized to obtain outside legal or other professional advice as appropriate in order to fulfill its terms of reference.

In order for the Business Development and Investment Committee to fulfill its objectives and fulfill its role for the Board of Directors there needs to be a very close working relationship between the Business Development and Investment Committee, the Audit Committee and the Quality Committee. Each committee will be considering issues of risk and potential decisions on investment which have an impact on quality and finance.

The Business Development and Investment Committee will provide a report to the Audit Committee at each regular quarterly meeting on key issues arising, with a particular focus on risk and where there are concerns over the management of risk or variations and changes to the way risks are being managed. The feedback should cover any significant areas of risk or gaps in controls or assurance. The Audit Committee will consider whether to provide a separate update from the Board escalation reports for these committees on particular issues.

Where possible the Board will consider the opportunity for explicit joint membership of the NEDs between these committees.

The chairs of each of the sub-committees should meet together at least twice in each financial year in order to discuss the escalation reports and issues arising to ensure that there are no gaps in assurance or control emerging which have not been considered appropriately. The fact that these meetings have occurred should be recorded in the minutes of the
respective committee.

The Audit Committee will schedule time at its meetings at least once a year to which the chairs of the Quality and Business Development Committees will be invited to discuss common issues and assurances. There will be a standing invitation for the Chair of each committee to attend the meetings of the other committees.

Each Board sub-committee will consider the effectiveness of these arrangements as part of their annual review and report to the Board.

<table>
<thead>
<tr>
<th>Roles and Responsibilities:</th>
<th>The Board Secretary will act as Secretary to the Committee until such time as the commercial team is established when this responsibility will transfer to them.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Meetings:</td>
<td>The Committee will meet quarterly, although there may be a requirement to meet more frequently at times during the year in order to meet its objectives. There may be a need to convene the committee at very short notice or virtually and to make decisions via email where this is required at very short notice – such arrangements will be established in principle by the committee with the approval of the Board.</td>
</tr>
<tr>
<td>Quorum:</td>
<td>The meeting will be quorate when there are a total of three Board Directors present, including one Non-Executive Directors.</td>
</tr>
<tr>
<td>Record Keeping:</td>
<td>The minutes and papers of meetings will be kept and archived by the Committee Secretary.</td>
</tr>
<tr>
<td>Terms of reference review:</td>
<td>The Chair and Secretary will review the effectiveness of the committee after each meeting.</td>
</tr>
<tr>
<td></td>
<td>The Terms of Reference will be reviewed initially within six months and at least annually thereafter;</td>
</tr>
<tr>
<td></td>
<td>(next review date: October 2014)</td>
</tr>
<tr>
<td>Date</td>
<td>Title</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>16th Sept</td>
<td>Service Quality Improvement Committee Report</td>
</tr>
<tr>
<td></td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td></td>
<td>Finance Report</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
</tr>
<tr>
<td></td>
<td>Update – Associate Hospital Manager Paper Reviews (action from Jan)</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
</tr>
<tr>
<td></td>
<td>Eliminating Mixed sex accommodation report</td>
</tr>
<tr>
<td></td>
<td>Annual IC programme and audit strategy</td>
</tr>
<tr>
<td></td>
<td>Complaints Annual Report</td>
</tr>
<tr>
<td></td>
<td>Assurance Framework (added by Jenny)</td>
</tr>
<tr>
<td></td>
<td>KHP Update</td>
</tr>
<tr>
<td>28th Oct</td>
<td>Finance Report</td>
</tr>
<tr>
<td></td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
</tr>
<tr>
<td></td>
<td>KHP Update</td>
</tr>
<tr>
<td></td>
<td>Risk Management &amp; Assurance Strategy Review</td>
</tr>
<tr>
<td></td>
<td>Risk Management Committee Structure Review</td>
</tr>
<tr>
<td></td>
<td>Update on Paper Only Hearings (action from June)</td>
</tr>
<tr>
<td></td>
<td>Maudsley International</td>
</tr>
<tr>
<td>25th Nov</td>
<td>Finance Report</td>
</tr>
<tr>
<td></td>
<td>Safe Staffing Report – Update</td>
</tr>
<tr>
<td></td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
</tr>
<tr>
<td></td>
<td>KHP Update</td>
</tr>
<tr>
<td></td>
<td>R&amp;D Annual Report</td>
</tr>
<tr>
<td>16th Dec</td>
<td>Service Quality Improvement Committee Report</td>
</tr>
<tr>
<td></td>
<td>Author(s)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Performance Management Framework</td>
<td>Roy Jaggon/Nick Dawe</td>
</tr>
<tr>
<td>Finance Report</td>
<td>Tim Greenwood/Gus Heafield</td>
</tr>
<tr>
<td>Council of Governors Update</td>
<td>Paul Mitchell/ Matthew Patrick</td>
</tr>
<tr>
<td>Chief Executive Report</td>
<td>Paul Mitchell/ Matthew Patrick</td>
</tr>
<tr>
<td>KHP Update</td>
<td>Robert Lechler/Madeliene Long</td>
</tr>
<tr>
<td>HR Annual Report</td>
<td>Louise Hall/Matthew Patrick</td>
</tr>
<tr>
<td>Jan 2015</td>
<td>EPIC Update</td>
</tr>
<tr>
<td>Feb</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td></td>
</tr>
<tr>
<td>Jul</td>
<td>EPIC Annual Report</td>
</tr>
<tr>
<td>Aug</td>
<td></td>
</tr>
<tr>
<td>Sept</td>
<td></td>
</tr>
</tbody>
</table>