A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST WILL BE HELD ON TUESDAY 28TH JULY 2015 AT 3:00PM, BOARDROOM MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence: Lesley Calladine, Jean O’Hara

2 Declarations of Interest

3 Minutes of the Board Meeting held on 23rd June 2015

4 MATTERS ARISING/ACTION POINTS REVIEW

QUALITY

5 Approve Value Based Healthcare

6 For Information Update on Safeguarding Children

7 For Information Update on Safeguarding Adults

STRATEGY

8 For Information Update on AMH Model Implementation

PERFORMANCE AND ACTIVITY

9 Approve the Finance Report – Month 3

10 Approve the Performance Report – Month 3

11 For Information Update on Mandatory Training

GOVERNANCE

12 Approve Audit Committee TOR & Audit Committee Annual Report for information

13 For Information Report from the Chief Executive

14 For Information an Update from the Council of Governors

15 For Information Briefing from the Quality Committee June Meeting

16 For Information Minutes from the SLaM R&D Committee February Meeting

17 For Information Minutes from the Audit Committee June Meeting

18 For Information Minutes from the Business Development Investment Committee

19 For Information Update on Fit and Proper Person Test

20 For Information Update on Workforce

INFORMATION

21 Director’s Reports

22 Actions summary from today’s meeting

23 Reflections on today’s meeting

24 Forward Planner

25 Report from previous Month’s Part II

26 Any other business

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.
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 15th September 2015 – 1:00pm, Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ. Please send apologies to Alison Baker 0203 228 4763 alison.baker@slam.nhs.uk
MINUTES OF THE EIGHTY SEVENTH MEETING OF THE BOARD OF DIRECTORS
OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 23rd JUNE 2015

PRESENT
Robert Coomber  SID and Deputy Chair (chair of meeting)
Dr Martin Baggaley  Medical Director
Dr Neil Brimblecombe  Director of Nursing
Lesley Calladine  Non Executive Director
Gus Heafield  Chief Financial Officer
Dr Julie Hollyman  Non Executive Director
Prof Shitij Kapur  Non Executive Director
June Mulroy  Non Executive Director
Dr Matthew Patrick  Chief Executive

IN ATTENDANCE
Mark Allen  Interim Director of Estates (item 9 onwards)
Chris Anderson  Deputy Lead Governor
Dr Alison Beck  Head of Psychology & Psychotherapy
Emily Buttrum  Commercial Director
Lucy Canning  Service Director, Psychosis CAG
Dr Bruce Clark  Clinical Director, CAMHS CAG
Stephen Docherty  Chief Information Officer
Jo Fletcher  Service Director, CAMHS CAG
Louise Hall  Director of Human Resources
Roy Jaggon  Head of Performance Management
Matthew McKenzie  Council of Governors
Paul Mitchell  Trust Board Secretary
Zoë Reed  Director of Organisation and Community
Steven Thomas  Audit Committee Secretary

APOLOGIES
Alison Baker  PA to Chair & Non Executive Directors
Ellie Bateman  Service Director, Addictions and B&D CAGs
Steve Davidson  Service Director, MAP & Psychological Medicine CAGs
Alan Downey  Non Executive Director
Dr Emily Finch  Clinical Director, Addictions CAG
Angela Flood  Council of Governors
John Muldoon  Lead Governor
Roger Paffard  Chair

DECLARATIONS OF INTEREST
No new declarations to note.

MINUTES OF THE BOARD MEETING HELD ON 26th MAY 2015
The minutes of the meeting held on the 26th May were agreed with the following amendments: BOD 75/15BDIC Summary Report -

Change:
"These discussions had highlighted the requirement for the trust to take advice on issues such as performance and bid bonds. This would also be picked up by via the audit committee".

To:
“The BDIC discussions have highlighted the requirement for the trust to take advice on issues such as performance and bid bonds, particularly in relation to international bids. These issues will also be discussed at the audit committee when required."

Additionally, “the Portman and Tavistock NHS FT” should read “the Tavistock and Portman NHS Foundation Trust”

BOD 92/15 MATTERS ARISING/ACTION POINTS REVIEW
Zoe Reed suggested that item 13 be changed to “Celebrating Diversity event” instead of “BME event”.

BOD 93 /15 COMMERCIAL STRATEGY
Emily Buttrum confirmed that this strategy was discussed at the Board commercial deep dive session on 26\textsuperscript{th} May where the Board had agreed the underlying principles. This paper set out the recommendations and how to manage the implementation.

Emily Buttrum explained that over the next year, the Trust was required to develop commercial governance structures, tighten its decision-making, be able if necessary to refuse bigger acquisitions and to improve its financial position.

The Trust needed to identify priority area for commercial development, eg offender health and to review progress within 12 months.

Matthew Patrick asked that the Quality Improvement paper be discussed at the next board meeting. \textbf{Action: Neil Brimblecombe/Martin Baggaley.}

He also requested the development of dashboards for the measurement of major transformation programmes. \textbf{Action: Gus Heafield.}

It was noted that an associated communications strategy was being developed and would be brought to the Board in September. \textbf{Action: Sarah Crack.}

\textbf{The Board of Directors agreed the Commercial strategy.}

BOD 94/15 SAFER STAFFING UPDATE REPORT
Neil Brimblecombe introduced the third Safer Staffing review to the Board. He confirmed that this issue was nationally mandated and was a consequence of the Francis report. He reported that NICE guidance related to mental health services was awaited. There were challenges with benchmarking data as there were many variables but current information suggested that the Trust was not an outlier. Recruitment was becoming a challenge and the issue of staff shortages had been discussed earlier at the Quality sub-committee.

Neil Brimblecombe confirmed that he was working with the CAGs on the implications of „7 day working”.
The Board of Directors noted the report.

**BOD 95/15 SMOKING CESSATION**

Mary Yates delivered a presentation on the smoking cessation campaign to bring Trust practice in line with NICE and PHE guidance for the provision of secure care in smoke-free environments. There were specific issues relating to mental health services.

Mary Yates explained that the Trust had developed an e-learning course. The Addictions CAG have also developed and delivered a level 2 advanced skills training course which was being rolled out across all CAGs and hospital sites. An associated communication strategy was proving useful in raising awareness of the policy.

Shitij Kapur suggested that it was important to keep records on successful quit rates and asked how the Trust publicises its success. Mary Yates explained that the Trust is working with PHE and have delivered seminars via video link across UK and will host a Smoke Free conference in October. Both NICE and PHE promote the Trust’s service on their websites.

The Board of Directors noted the report.

**BOD 96/15 APPROVE THE FINANCE REPORT – MONTH 2**

Gus Heafield reported that the Trust was on plan for its EBITDA target of £2.6m at Q1, with work continuing on the savings plan. The PMO team were working with CAGs and creating new opportunities for savings, but a combination of cost pressures not being within plan and unmet CIPs were still a challenge, particularly for the Psychosis CAG.

Contracts have been finalised and signed for NHS Lambeth, NHS Southwark and NHS England and contracts for NHS Lewisham and NHS Croydon were being finalised. Martin Baggaley expressed his concern that the Trust was signing up to a contract with NHS Croydon without adequate risk sharing arrangements. Gus Heafield noted that NHS Croydon had invested £8m for 2 years but it had proved a challenge to agree the risk share. **Action: Gus Heafield to provide an update at the next Board meeting.**

Gus Heafield explained that a letter regarding forensic services had been sent to NHSE and that a follow meeting will take place on 14 July.

Gus Heafield further explained that the PMO project plan covers outline plans for CIPs. Detailed plans for CAGs and Trustwide savings were being developed and will be completed by the next Board meeting. **Action: Gus Heafield.**

Julie Hollyman queried the risk to the plan if the AMH programme does not deliver on bed closures. Gus Heafield replied that the challenge would be in the following year as CCGs were expecting significant delivery.

Shitij Kapur commented that there was discussion in the Audit Committee meeting earlier in day on the Monitor consultation on a new system of ratings. It would be a challenge to balance against such a matrix.
There was also increased scrutiny on bank and agency spend. It was also noted that the capital spend against the plan in the paper showed a variance. **Action:** Gus Heafield will review this and report back to the Board.

Matthew Patrick noted that it was good to be on plan particularly for Q1 and that the board recognised the hard work undertaken by staff across the Trust. Delivery at the end of year was, however, the key objective.

The Board of Directors noted the report.

**BOD 97/15 PERFORMANCE REPORT – MONTH 12**

1. **Patient stories**
A patient story was presented via video link and introduced by 3 members of staff from the CAMHS CAG. The story focused on feedback from service users on the food provided by the Trust. Snacks were provided to the Board as samples.

The Board thanked the team for their presentation and commented that this was an exciting project.

2. **Quality and Performance Dashboard**
Following on from last month, a number of issues had been raised.

Physical healthcare continues to be a quality priority. The nurse consultant has been appointed and the recruitment process for a CQUIN lead is underway.

It was reported that the Quality and Performance Dashboard will be formally approved at the end of July.

Mandatory training – there has been some improvement in compliance but more was required.

**Action:** the Quality sub-committee had requested a report on mandatory training and rates will be monitored at this committee.

3. **Safer staffing**
This had been presented earlier in the meeting by Neil Brimblecombe.

The Board of Directors approved the report.

**BOD 98/15 ASSURANCE FRAMEWORK**

It was noted that following approval of the Board Assurance Framework (BAF) at the previous meeting, the key risks had been discussed at the Audit committee and the Quality sub-committee. It was agreed that additional time should be allocated on a 6 monthly basis to review risks and the dashboard in greater detail.

Julie Hollyman suggested the need for more detailed discussion on the external environment as the BAF was predominantly internally focused. Neil Brimblecombe suggested that this should link to the Trust’s preparation for the CQC inspection. Lesley Calladine explained that she had discussed the step-back process with Gus Heafield. Matthew Patrick commented that the current framework does not include the RAG ratings. Roy Jaggon explained that these would be included in the next version of the BAF along with mitigations, actions,
deliverables and identification of a lead director for each risk. **Action: Roy Jaggon.**

It was agreed the Board will review key risks facing the Trust at a Board seminar in September.

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

**BOD 99 /15 REPORT FROM THE CHIEF EXECUTIVE**
Matthew Patrick introduced the report and highlighted a number of issues.

Kristin Dominy, the newly appointed Chief Operating Officer had visited the Trust on the morning of the Board. She will join the Trust on 10 August and a full induction is being planned.

It was noted that the Health Services Journal had reported that SLaM had been voted one of the top 100 places to work within the NHS.

The CQC had inspected the crisis care services and found the services and support arrangements within Lambeth to be commendable. The inspectors were particularly impressed by the co-ordination of the various services across the Borough.

Matthew Patrick had received a letter from Monitor instructing all Trusts to reduce agency spend. The previously agreed plan was progressing.

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

**BOD 100/15 UPDATE FROM THE COUNCIL OF GOVERNORS (COG)**
The report was presented by Chris Anderson, deputy Lead Governor.

The governors’ input to the Quality Accounts was appreciated. Governors welcomed the opportunity to input into the shaping of the Trust’s 5-year Quality Strategy and their involvement early in the development of the strategy.

The Governance committee had met and a considerable amount of their work has been completed. Further work included the SLaM Code of Governance and locally agreed arrangements between the CoG and Board.

It was also noted that the Chief Executive (CE) will retire from his clinical contract as a consultant psychiatrist in August 2015, but be re-appointed on a non-medical contract as CE of SLaM subject to CoG approval in July.

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

**BOD 101/15 QUALITY SUB-COMMITTEE (QSC) MAY MEETING**
Lesley Calladine updated the Board.

The non-attendance of CAG members at the Infection Control committee: was highlighted. An additional meeting will be arranged to discuss waste management. This was particularly important ahead of the CQC visit.
It had been reported that at the Ladywell unit there was a risk of patients going absent from the garden. Mark Allen reported that a range of options were being considered, a resolution was imminent.

Other items to note were:
- Thematic review – Safeguarding: the governors were involved in this review
- Ligature plan: risks will be monitored at QSC
- Safer staffing was also discussed
- Education and training: mandatory training compliance will be monitored
- 6 policies were reviewed and approved
- Risks on PICU availability were discussed and a paper will be presented at the July QSC.

The Board of Directors noted the report.

BOD 102/15 AUDIT COMMITTEE MEETINGS – APRIL AND MAY
Shitij Kapur presented the June Audit Committee report.

The following items were discussed at the meetings:
- Internal audit update report
- It was noted that risk management around legionella had taken place
- Estates and IT were areas for improvement
- KPIs for the development of a transformation dashboard

The Board of Directors noted the report.

BOD 103/15 DIRECTOR’S REPORTS
No Directors reports were received.

BOD 104/15 ACTIONS SUMMARY FROM TODAY’S MEETING
Paul Mitchell would email the updated action tracker following the meeting.
Action: Paul Mitchell

BOD 105/15 REFLECTIONS ON TODAY’S MEETING
There was insufficient time to consider this item.

BOD 106/15 FORWARD PLANNERS
- Involvement strategy to be presented at the September Board meeting.
- BDIC report to be presented at the July and September Board meeting.
- BRC renewal to be presented at the October Board meeting.

The Board of Directors noted the report.

BOD 107/15 REPORT FROM PREVIOUS MONTH’S PART II
The Board of Directors noted the report.

BOD 108/15 ANY OTHER BUSINESS
No other business was discussed.

BOD 109/15 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 28 July 2015 – 3:00pm Board room, Maudsley Hospital, Denmark Hill, London, SE5 8AZ**

Chair
### Board meeting 23 June 2015 – action points

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue</th>
<th>Action</th>
<th>By</th>
<th>When</th>
<th>Status</th>
<th>RAG</th>
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<tbody>
<tr>
<td>1</td>
<td>Lessons learned from CQC inspections</td>
<td>Bring to Board.</td>
<td>NB</td>
<td>June</td>
<td>Now scheduled for seminar in July</td>
<td>🟢</td>
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<tr>
<td>2</td>
<td>Workforce update</td>
<td>Bring to Board.</td>
<td>LH</td>
<td>July</td>
<td>On agenda</td>
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<td>3</td>
<td>Quality strategy</td>
<td>Bring back annually.</td>
<td>NB</td>
<td>Feb 16</td>
<td>On schedule</td>
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<tr>
<td>4</td>
<td>Involve the CoG in discussion on Francis</td>
<td>Forward planner for CoG</td>
<td>PM</td>
<td>June</td>
<td>Now scheduled for September</td>
<td>🟢</td>
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<tr>
<td>5</td>
<td>Review of best practice of how Boards involves patients</td>
<td>Bring back to future Board</td>
<td>ZR</td>
<td>June</td>
<td>Now scheduled for September</td>
<td>🟢</td>
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<tr>
<td>6</td>
<td>Take forward work on role of Speak up Guardians and bring back to Board</td>
<td>Bring back to future Board</td>
<td>NB</td>
<td>July</td>
<td>Now scheduled for September</td>
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<td>7</td>
<td>Experiment on format of Board meetings</td>
<td>Review after Board development programme</td>
<td>RP/PM</td>
<td>Dec</td>
<td>On schedule</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Check progress on IT delivery via Audit Committee</td>
<td>Bring back to Board in September</td>
<td>SD</td>
<td>Sep</td>
<td>On schedule</td>
<td></td>
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<tr>
<td>9</td>
<td>Revise scheme of delegation</td>
<td>Bring to June meeting</td>
<td>GH</td>
<td>June</td>
<td>Going to Audit Committee in June and Board in July</td>
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**April meeting**

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<tr>
<td>10</td>
<td>Social care strategy</td>
<td>Ongoing programme of work. Take forward associated work programme plus specifically consulting with partners relating to parity of esteem for mental health.</td>
<td>CG</td>
<td>Sep</td>
<td>Ongoing and review</td>
</tr>
<tr>
<td>11</td>
<td>Consider holding a Trust wide celebrating diversity event.</td>
<td>Consider format and report back.</td>
<td>ZR</td>
<td>Sep</td>
<td>On schedule</td>
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**May meeting**

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<tr>
<td>12</td>
<td>Workforce equality standard</td>
<td>Publish strategy and action plan to be monitored via QC and add</td>
<td>LH</td>
<td>Dec</td>
<td>On schedule</td>
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<td></td>
<td>to dashboards.</td>
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<tr>
<td>13</td>
<td>IT equipment replacement.</td>
<td>Future proof inventory planning</td>
<td>SD</td>
<td>July</td>
<td>Now scheduled for Sept</td>
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<tr>
<td>14</td>
<td>CQC visit planning</td>
<td>Book Board time to discuss.</td>
<td>PM/NB</td>
<td>July</td>
<td>Seminar scheduled</td>
</tr>
<tr>
<td>15</td>
<td>Finance deep dive</td>
<td>Arrange for later in the year.</td>
<td>PM/GH</td>
<td>Nov</td>
<td>On schedule</td>
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<tr>
<td><strong>June meeting</strong></td>
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<tr>
<td>16</td>
<td>QI strategy</td>
<td>Bring back to future Board</td>
<td>NB/MB</td>
<td>July</td>
<td>On agenda</td>
</tr>
<tr>
<td>17</td>
<td>Front sheet format</td>
<td>Remove “action required” box</td>
<td>PM</td>
<td>July</td>
<td>Done</td>
</tr>
<tr>
<td>18</td>
<td>Communications strategy</td>
<td>Bring to Board</td>
<td>SC</td>
<td>Sep</td>
<td>On schedule</td>
</tr>
<tr>
<td>19</td>
<td>Contract negotiations with CCGs</td>
<td>Update at next meeting</td>
<td>GH</td>
<td>July</td>
<td>On schedule</td>
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<tr>
<td>20</td>
<td>Detailed plans for CAGs and Trustwide savings to be completed by the next Board meeting.</td>
<td>Update at next meeting</td>
<td>GH</td>
<td>July</td>
<td>On schedule</td>
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<tr>
<td>21</td>
<td>Capital spend review</td>
<td>Update at next meeting</td>
<td>GH</td>
<td>July</td>
<td>On schedule</td>
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<tr>
<td>22</td>
<td>Mandatory training</td>
<td>Monitor rates via QC</td>
<td>LH/NB</td>
<td>July</td>
<td>On agenda</td>
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<tr>
<td>23</td>
<td>Review key risks facing the Trust</td>
<td>Discuss at Board seminar</td>
<td>GH</td>
<td>Sep</td>
<td>On schedule</td>
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<tr>
<td>24</td>
<td>KPIs</td>
<td>Develop for transformation dashboard</td>
<td>GH</td>
<td>Sep</td>
<td>On schedule</td>
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<td></td>
<td>BRC renewal</td>
<td>Place on forward planner</td>
<td>PM</td>
<td>Oct</td>
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**Code:**

- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule

PNJM/July 2015
Date of Board meeting: 28th July 2015

Name of Report: Value Based Healthcare Summary

Heading: - Quality

Author: Dr Michael Holland

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

Presented by: Dr Martin Baggaley/Dr Neil Brimblecombe

Purpose of the report:
This paper gives an overview of the Value Based healthcare programme, project milestones and the costs involved to deliver programme.

Recommendations to the Board:
The Board is asked to:
Approve overall plan and agree to progress to procurement of external partner.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
This programme relates to improving all areas of quality, patient safety, providing services in line with best practice to improve patient experience, across the organisation. The purpose is to improve the overall quality of performance of the organisation whilst maintaining or reducing overall cost and maintain financial health for the organisation. Level of assurance - high

Summary of Financial and Legal Implications:
Additional investment is outlined to undertake this programme, however the programme will realise overall cost reductions to delivery of care whilst improving quality.

Equality & Diversity and Public & Patient Involvement Implications:
This programme will need to directly involve public and patients within the underlying programmes of work to deliver it.

Service Quality Implications:
The purpose of this programme is to improve the overall quality of care across the organisation, reducing existing unnecessary variations in care, reducing waste, improving outcomes for patients and improving patient safety.
VALUE BASED HEALTHCARE SUMMARY

BACKGROUND

Value-Based healthcare is a way of thinking and organising services addressing the two major healthcare challenges faced across the world – rising costs and variations in quality of care. At its core, Value-Based healthcare is simple – it’s a way of driving improvement. Unlike existing quality improvement projects, which tend to be standalone initiatives, VBHC aims to improve care across our whole organisation. The key principle can be summed up in one equation:
Value = Health outcomes/Total cost of delivery of outcomes
The aims of this programme are to develop a culture of quality improvement and the use of data for decision-making across the organisation to underpin Value Based healthcare.

APPROACH

We are planning to engage an external partner to help us develop both the internal capability and support the Trust in the delivery of large-scale results oriented programme based on the principles of Value Based healthcare. This engagement would be for a period of 3 years to allow for a fundamental shift in the culture of the organisation to one where improving quality is at the heart of what we do, improving outcomes for patients, improving patient safety, removing unnecessary variations in care and reducing waste. We will also develop a centralised team to help support and deliver this work across the organisation. There will be several aspects to this programme as outlined below:

1) Identifying the outcomes which matter to patients in key mental health cohorts across the full cycle of care from diagnosis to end of disease process.

2) Developing Quality Improvement capability. This will include:
   a. Working with external partner to evaluate current quality improvement capability to inform strategy to build on current skills and expertise.
   b. Gain consensus with leaders on areas of development and development of leadership role in fostering culture centred on quality improvement.
   c. Delivery of training programmes to support the development of quality improvement within the Trust

3) Delivery of Value Based Health care initiative, which will include the development of measurement systems for these key outcomes, costs and underlying processes.

As we develop this model and progress with increased integration across our services, thought will need to be given as to how to facilitate the participation of staff from other agencies. This will be addressed in detailed project plans.
This approach to value based healthcare is supported by the recent review from King’s Fund (which is available upon request) and shown in this figure:

**Figure 1 An agenda for action**

- **Clinical teams**
  - Leading improvements and reducing variation
  - Define what good practice looks like and address variations against it. Standardising care processes where appropriate.
  - Measure activity, costs and outcomes and remove low-value processes.
  - Work with patients to understand what really matters to them.

- **Providers**
  - Placing better value as their overriding priority
  - Develop a strategy for quality improvement and engage staff in its implementation.
  - Adopt a quality improvement method and use it systematically.
  - Invest in leadership development and quality improvement training.

- **Systems of care**
  - Developing models of care across organisational boundaries
  - Work in collaboration to develop system-wide improvement approaches.
  - Integrate services for key population groups and work together across systems to improve population health and wellbeing.
  - Develop system leadership arrangements across organisations.

- **Commissioners**
  - Aligning financial incentives and targeting low-value care
  - Work with providers to reduce low-value and increase high-value care.
  - Pool budgets where appropriate for services that need to be integrated.
  - Use innovations in commissioning and contracting to align incentives for new models of care.

- **National**
  - Creating an environment for change
  - Develop a single strategy for quality improvement across the NHS.
  - Ensure that regulatory and payment systems are aligned with ambitions for more integrated working.
  - Establish a transformation fund for investment in new models of care.
ANNEXE ONE: TEAM STRUCTURE & BRIEF RESPONSIBILITIES

1.1 QUALITY IMPROVEMENT FACILITATOR

- Research project and develop project documentation
- Assess the situation of a project with regards to its readiness for improvement
- Build will for change
- Advise on the most appropriate improvement methodology
- Balance expectations of organization with improvement capability of area and set appropriate aims for improvement work
- Work with project managers to set time scales and project deliverables which are reviewed regularly and take corrective action where required
- Facilitate meetings associated with work-streams including steering groups and learning sessions
- Work with improvement teams to develop PDSA (Plan, Do, Study, Act) Cycles that will test changes in areas of the driver diagram for the project
- Manage knowledge at all levels of project:
  - Research and provide high level information to the project faculty including local and national best practice
  - Ensure that knowledge developed through testing is recorded and shared amongst the teams involved in the project
  - Produce packages of changes at appropriate stages within quality improvement packages
  - Plan and priorities own work to ensure effective support to all areas and delivery of key objectives
  - Marketing QI programmes internally
  - Contribute to the development and continual improvement of the processes and systems of work within the quality improvement directorate.

1.2 PROGRAMME MANAGER

The role of the programme manager is to lead the Quality Improvement team and manage the delivery of all the projects.

- Managing and leading the project team
- Supervising the Quality Improvement facilitators
- Resolving cross-functional issues at project level.
- Managing the budget of the Quality Improvement team.
- Acts as main point of contact between the supplier and the organization
- Ensuring there are clear communication paths within the project team and supplier
- Working closely with key stakeholders to ensure the project meets business needs.
- Ensures the supplier activity meets the defined quality requirements of the Trust and the service
- Liaises with, and updates progress to, project board/senior management.
- Managing project evaluation and dissemination activities.
- Ensure alignment of activity with organizational strategic objectives and direction and defining change management strategy.

1.3 STATISTICIAN

- Consulting with Project Team and agreeing what data to collect.
- Working across the organization to develop analytic and statistical strategies to improve decision making.
- Working with the Centre for Translational Informatics and Centre for Implementation Science to deliver research outputs.
- Advising staff on statistical approaches to use with data for improvement and decision making.
- Leading on the development of analytic approaches for the organization.
- Teaching staff on statistical approaches for management of quality.
- Presenting results to senior managers.

1.4 PROGRAMME SUPPORT

- To provide administrative support to the Programme Manager, ensuring version and change control of Project orientated documentation.
- To contribute to the completion of Project Board Reports Risk and Issues logs.
- To record and disseminate all meeting notes, agendas and minutes to the relevant audiences on time and in an accurate and auditable fashion.
- To Manage general administrative duties.
ANNEXE TWO: RISK MANAGEMENT:

1.1 HIGH LEVEL RISKS
Full risk assessment to be completed once Project Board has been instated. The Project Manager will maintain a Risk and Issues Log throughout the life of the project to monitor:

- Local Trusts’ resources.
- Competing priorities
- Scale of funding and/or lack of funding
- Stakeholder engagement and clinical involvement

1.2 OPERATIONAL RISKS

- **RISK:** There is a risk that we will be unable to recruit to the posts required to deliver this project.
  **MITIGATION:**
  - Regular monitoring of recruitment.
  - Advertise Roles internally & externally.
  - Implement Recruitment Drive across Teams.
  - Position reports to Executive Team and Board via Medical Director.

- **RISK:** There is a risk that staff may not have the capacity to be released for the training sessions.
  **MITIGATION:**
  - Training advertised a minimum of 6 weeks in advance.
  - Training booked on to e’Rostering, to ensure relevant cover is in place.

- **RISK:** There is a risk that the right people may not be involved from Project Initiation. Having the right people involved from the beginning with the right expertise will give the programme the best chance of sustainable success. If the right people are not involved from the start, it will be much harder to engage and involve these people at a later date.
  **MITIGATION:**
  - Project Communication Plan Implemented during Procurement.
  - Project Charters will be developed with all levels of staff during the Project Initiation and throughout.
  - Active engagement with all levels of staff.

- **RISK:** There is a risk that the culture in some teams is not conducive to the adoption of Value Based Methodology.
  **MITIGATION:** This risk will be mitigated via strong engagement sessions with all staff involved in the project, effective communication, training and hand holding exercises throughout the duration of the Project to ensure that all staff is able to adapt to the culture shift.

- **RISK:** There is a risk that there is currently a high level of bank and agency staff.
  **MITIGATION:** in-depth planning with Information governance and mandatory training before placement will mitigate the risk.
ANNEXE THREE: HIGH LEVEL PROJECT PLAN

## Draft Timetable

<table>
<thead>
<tr>
<th>Week commencing</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1</td>
<td>3</td>
</tr>
<tr>
<td>April 10</td>
<td>10</td>
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<tr>
<td>April 17</td>
<td>17</td>
</tr>
<tr>
<td>April 24</td>
<td>24</td>
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<td>April 31</td>
<td>31</td>
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<tr>
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<td>September 4</td>
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<td>September 18</td>
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<td>October 16</td>
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<td>November 27</td>
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<td>December 4</td>
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<td>March 19</td>
<td>20</td>
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<tr>
<td>March 26</td>
<td>27</td>
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</table>

### Project Milestones:

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Date</th>
<th>Critical Dependencies</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place OJEU Notice/Issue POQs/tender</td>
<td>Nov-15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue Invitation to Tender documents</td>
<td>Nov-15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment of team</td>
<td>Nov-15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification of improvement programmes for team to lead across organisation</td>
<td>Dec-15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipt of Tender applications</td>
<td>Dec-15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate award against reward criteria</td>
<td>Dec-15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board approval for award of contract</td>
<td>Jan-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team training begins</td>
<td>Jan-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement complete with Contracts signed</td>
<td>Mar-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Planning with Identified Partner</td>
<td>Apr-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project start with Partner</td>
<td>01/05/16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The timing of the specific training programmes and results oriented initiative will be finalised with the external partner once appointed and will be decided by SLAM’s operational requirements. How it will be cascaded across the organisation will also be decided in partnership with the external agency.
### Annexe 4: Estimate of time commitment and back fill costs for non-project specific staff resources

These estimates are indicative only given inherent uncertainty relating to the extent of the time commitment, staff impacted and the necessity to backfill.

<table>
<thead>
<tr>
<th>Time commitment</th>
<th>Participants</th>
<th>Staff grade</th>
<th>Number of staff</th>
<th>Number of days × 8</th>
<th>Total number of days</th>
<th>Assumption</th>
<th>Number of days to be backfilled</th>
<th>Cost per day</th>
<th>Cost (2% of)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Based Initiative</td>
<td>Consultants</td>
<td>Consultants</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>No backfill required</td>
<td>0</td>
<td>190,000</td>
<td>0</td>
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<tr>
<td></td>
<td>Team leaders</td>
<td>Band 7</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>Backfill required</td>
<td>2</td>
<td>55,729</td>
<td>17,648</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>Band 6</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>Backfill required</td>
<td>2</td>
<td>45,575</td>
<td>15,953</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>Various - assume band 5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td>38,506</td>
<td>12,535</td>
</tr>
<tr>
<td></td>
<td>Nine month roll-out programme covering a maximum of 80 teams</td>
<td>Three representatives per team</td>
<td>Consultants</td>
<td>Consultants</td>
<td>30</td>
<td>3</td>
<td>90</td>
<td>50% backfill</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Team leaders</td>
<td>Band 7</td>
<td>30</td>
<td>3</td>
<td>90</td>
<td>50% backfill</td>
<td>45</td>
<td>55,729</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>Band 6</td>
<td>30</td>
<td>3</td>
<td>90</td>
<td>Backfill required</td>
<td>45</td>
<td>45,575</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Directors</td>
<td>6</td>
<td>3</td>
<td>18</td>
<td>50% backfill</td>
<td>9</td>
<td>120,184</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical director</td>
<td>Consultants plus</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>No backfill required</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Assistant clinical director</td>
<td>Consultants plus</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>No backfill required</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deputy service directors</td>
<td>Band 6</td>
<td>6</td>
<td>3</td>
<td>18</td>
<td>50% backfill</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical service leads</td>
<td>Consultants plus</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>50% backfill</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Various</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>50% backfill</td>
<td>6</td>
</tr>
</tbody>
</table>

### Improvement Science in Action

A three day event plus call for 2 hour webinars over 4 months.
Targeted at 3 representatives from across 80 teams.
Circ 100 participants.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Staff grade</th>
<th>Number of staff</th>
<th>Number of days × 8</th>
<th>Total number of days</th>
<th>Assumption</th>
<th>Number of days to be backfilled</th>
<th>Cost per day</th>
<th>Cost (2% of)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>Consultants</td>
<td>30</td>
<td>4</td>
<td>120</td>
<td>50% backfill</td>
<td>60</td>
<td>130,000</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Team leaders</td>
<td>30</td>
<td>4</td>
<td>120</td>
<td>50% backfill</td>
<td>60</td>
<td>130,000</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>18</td>
<td>4</td>
<td>48</td>
<td>50% backfill</td>
<td>20</td>
<td>76,948</td>
<td>26,980</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical service leads</td>
<td>Band 6</td>
<td>10</td>
<td>3</td>
<td>30</td>
<td>50% backfill</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ESA deputies</td>
<td>Band 7</td>
<td>10</td>
<td>3</td>
<td>30</td>
<td>Backfill required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td>Band 8</td>
<td>10</td>
<td>3</td>
<td>30</td>
<td>Backfill required</td>
</tr>
</tbody>
</table>

### Leading and Facilitating Programme

A 4 full day sessions spread over ten weeks.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Staff grade</th>
<th>Number of staff</th>
<th>Number of days × 8</th>
<th>Total number of days</th>
<th>Assumption</th>
<th>Number of days to be backfilled</th>
<th>Cost per day</th>
<th>Cost (2% of)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Leadership Days</td>
<td>Various - assume average director</td>
<td>30</td>
<td>3</td>
<td>30</td>
<td>No backfill required</td>
<td>0</td>
<td>120,184</td>
<td>44,284</td>
</tr>
</tbody>
</table>

### E-learning School

All staff to undertake a series of E-Learning modules.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Staff grade</th>
<th>Number of staff</th>
<th>Number of days × 8</th>
<th>Total number of days</th>
<th>Assumption</th>
<th>Number of days to be backfilled</th>
<th>Cost per day</th>
<th>Cost (2% of)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior clinical staff</td>
<td>Consultants</td>
<td>10</td>
<td>2.25</td>
<td>22.5</td>
<td>50% backfill</td>
<td>16.25</td>
<td>130,000</td>
<td>0</td>
</tr>
</tbody>
</table>

### Improvement Advisor Development Programme

Ten month programme including 164 day learning sessions.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Staff grade</th>
<th>Number of staff</th>
<th>Number of days × 8</th>
<th>Total number of days</th>
<th>Assumption</th>
<th>Number of days to be backfilled</th>
<th>Cost per day</th>
<th>Cost (2% of)</th>
</tr>
</thead>
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<tr>
<td>Improvement Advisor Development</td>
<td>Consultants</td>
<td>Band 7</td>
<td>12</td>
<td>18</td>
<td>216</td>
<td>No backfill required on the basis that this will involve additional project management team roles that are costed separately</td>
<td>0</td>
<td>121.5</td>
</tr>
</tbody>
</table>

### Notes:

1. The above details are based on information and estimates provided by Dr Holland.
2. Excluded from the above are any venue costs that may be required to host the prepared sessions.
3. The above excludes designated programme staff that will need to be recruited and costed separately.
4. Actual requirements of the Value Based Initiative will be determined following the diagnostic period. Accordingly, the above figures are indicative only and may change substantially.
5. The above assumes any VHBI training provided is in addition to existing training commitments and as such is not covered by existing training time included in staff budgets.
6. The learning and facilitating Programme assumptions above are in respect of the programme to train and develop this facilitators. Nothing is included above for the time commitment associated with carrying out the facilitation role across the organisation.
7. The above excludes any element of IT staff resource time that may be required to provide data and modify information reporting requirements.
8. Generally speaking Band 7 or below are assumed to require backfill, whilst senior roles have some scope to absorb the additional commitment - 50% assumed.

### Key issues to consider:

1. To what extent will this training dispel, or be additional to, mandatory or other training received and allowed for in existing team establishments?
2. In practice it is unlikely that full attendance will be secured especially at events with a single fixed date.
3. The value based initiative above is capped at 30 teams, being a restriction imposed by the likely capacity constraints of the VHBI partner. In theory it should be capped out to all teams which would be a much greater commitment.
4. If specific events/programmes are to cover whole team personnel then clearly these events/programmes will need to be delivered via several alternative sessions. The trainer and facilitator resource will need to be sufficient to meet this demand.
5. The above time commitments appear to be mostly focussed on more senior staff (mostly Band 7 and above) in order to try to show the maximum costs involved.
6. Significant uncertainty attaches to the E-learning school and innovation cycle assumptions.
### VBH Project Team

Cost estimate based on assumptions provided by Dr Holland

<table>
<thead>
<tr>
<th>Role</th>
<th>Annual cost per wte</th>
<th>Annual cost</th>
<th>Non-pay costs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme manager (x 1 band 8c)</td>
<td>90,287</td>
<td>90,287</td>
<td>1,500</td>
<td>91,787</td>
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<tr>
<td>QI Facilitators (x5 band 7)</td>
<td>53,279</td>
<td>266,395</td>
<td>7,500</td>
<td>273,895</td>
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<tr>
<td>Statistician (x1 band 7)</td>
<td>53,279</td>
<td>53,279</td>
<td>1,500</td>
<td>54,779</td>
</tr>
<tr>
<td>Administrator (x1 band 5)</td>
<td>38,046</td>
<td>38,046</td>
<td>1,500</td>
<td>39,546</td>
</tr>
<tr>
<td></td>
<td><strong>448,007</strong></td>
<td><strong>12,000</strong></td>
<td></td>
<td><strong>460,007</strong></td>
</tr>
<tr>
<td>Overheads (17% of pay costs)</td>
<td></td>
<td></td>
<td></td>
<td>76,161</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>536,168</strong></td>
</tr>
</tbody>
</table>

Notes:
1. Staff costs are at final gateway
2. Travel cost allowance is a rough estimate subject to number of visits and length of stay
3. Non-pay costs of £1.5k allowed per person to cover PCs, mobile phones, ipdas, mobiles etc
4. Overhead allowance to cover for estate costs and costs of HR, payroll etc…
5. The exact requirement for QI facilitators may change over time depending on how the role out is scoped and individual projects undertaken
6. The above is an estimate of the annual costs. If the team is in place from 1/10/15 as proposed then the FY15/16 costs will be half = £268k
Programme Costs:

Supplier Cost = £942,200

Estimate of Time commitment costs = £275,583 (these are worst case assuming backfill required)

Annual Improvement team costs = £538,211

Total Travel costs for training = £13,000

Costs for 2015/16

Improvement team costs = £268,084 (assuming team in place in October 2015)

Procurement costs = £40,000 (max cost - hire of Interim Procurement manager to deliver Procurement)

Training costs = £62,400 ($16,200/person at $1=£0.67)

Travel costs = £4000 (6 staff to Belfast for 4 days of training)

Cost for 2015/2016 = £374,484 (this excludes supplier costs as contract will not have been signed therefore no cost will be incurred this year)

Costs for 2016/2017 and 2017/2018 will be determined with agreed payment schedule with partner.
Annual costs are Improvement team and further travel to complete training:

Improvement team costs = £538,211

Travel costs = £8000
Date of Board meeting: 28th July 2015

Name of Report: Safeguarding Children

Heading: Quality

Author: Paul Archer

Approved by: Neil Brimblecombe

Presented by: Paul Archer

Purpose of the report:
To update the board on the Trusts current Safeguarding Children position and strategy, following a thematic review in May 2015.

Recommendations to the Board:
- Support recommendation that adjustments are made to current ICT systems (EPJs) within the Trust to enable necessary data recording and capture – to improve quality assurance to CCGs, LSCBs and the Trust
- Support necessary resources to roll out safeguarding supervision across the Trust.
- Support necessary resources to improve Safeguarding training across the Trust.
- Support non-pay budget for Trust Safeguarding resources

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
1) Failure to provide services in line with best practice – Trust workforce lacks necessary knowledge and skills to understand their safeguarding responsibilities and undertake required safeguarding activities commensurate to their role (high)
2) Patient experience – failure to provide the quality of service that is contracted and that service users deserve. Quality of client outcome focused safeguarding activity by Trust staff requires improvement (moderate)
3) ICT Infrastructure – current systems do not enable adequate recording of safeguarding activity or data capture for reporting purposes

Summary of Financial and Legal Implications:
- Financial commitment may be required to ensure adequate resources to provide necessary safeguarding training.
- There is a current review of the financial contribution by SLAM to the Local Safeguarding Children Boards.
- Statutory duties following the Children Act (2004)
- Compliance with CQC Fundamental Standards of Care – Regulation 13 – safeguarding people who use services from abuse and improper treatment (Health & Social Care Act 2008 (Regulated Activities 2014)
- Duty of Candour
**Equality & Diversity and Public & Patient Involvement Implications:**

Good safeguarding knowledge, skills, reporting and safeguarding enquiry processes have a positive impact on equality, discrimination and on good relations for people with protected characteristics. They assure our patients and public that SLAM provides safe services and works in partnership to safeguarding service users from abuse and improper treatment.

**Service Quality Implications:**

The Children Act (2004) places a legal duty on the Trust to cooperate with safeguarding children activity, to undertake safeguarding enquiries if requested by Local. It also requires the Trust to have arrangements in place to safeguard and promote the welfare of children. There is a requirement for all staff to be able to recognise safeguarding concerns and to take active steps to ensure the safety of children. The welfare of the child is paramount.

CQC compliance – Fundamental Standards of Care – preparedness for inspection. Need improvement in quality of safeguarding documentation/recording
Executive Summary

The last year, 2014-2015, has been a year of significant development in safeguarding in the Trust. Safeguarding leadership and governance processes for both children and adults within the Trust have been strengthened to ensure that the Trust meets its statutory duties and responsibilities to protect children and adults who are at risk from abuse and neglect.

Executive and strategic leadership on safeguarding adults and children has been embedded with Dr Neil Brimblecombe, Director of Nursing and Cath Gormally, Director of Social Care, taking up these respective roles. The key senior posts of Trustwide Safeguarding Adults Lead and the Named Nurse for Safeguarding Children have been filled on an interim basis and have now been recruited to substantively with the post-holders taking up their posts in April 2015. Dr Sarah Bernard was also confirmed in post in 2014 as Named Doctor for safeguarding children.

The Terms of Reference of both the Safeguarding Adults and Children Committees have been reviewed and the committees have met regularly throughout the year. The committees provide a direct source of assurance to the Trust Board that effective systems and structures are in place to ensure statutory compliance in safeguarding for both adults and children. They are now chaired by Dr Neil Brimblecombe and any relevant issues of concern or note are escalated to the Quality Sub Committee which is a subcommittee of the Trust Board.

Throughout the year, recommendations and action plans from serious case reviews, multi-agency and domestic homicide reviews have continued to be reviewed and learning embedded into practice through level 3 safeguarding training. Embedding key learning into practice is an on-going process which will continue in the following year.

Section 11 audits have been completed for all the local boroughs which the Trust serves and has partnerships with and action plans have been agreed accordingly.

The Trust’s Safeguarding Children policy has been formally reviewed and revised in accordance with national guidance and was ratified by the Quality Sub Committee in December 2014.

Data collection and reporting to meet quality and performance requirements remains a challenge. However, significant work has been undertaken throughout the year to establish a safeguarding quality dashboard which will be monitored by the Safeguarding Children Committee and the delivery of robust data will remain as a key objective for 2015-2016.

Conclusion

In summary, significant progress and developments have been made in 2014-2015 across both safeguarding adults and children. However, many challenges and areas for further improvement and development remain and will be addressed throughout 2015-2016 by achieving the key objectives for adults and children which are detailed in the body of this report. Work will be focussed on these identified areas with a key priority being the collection and delivery of robust performance data in order to strengthen governance and give assurance to the Trust Board and our external partners that adults and children at risk of abuse and neglect, with whom the Trust comes into contact, are protected.

Cath Gormally
Director of Social Care
Introduction

This annual report will apprise the Trust Board of the activity that has been undertaken during 2014-2015, to ensure that the Trust meets its statutory duties and responsibilities to protect children who are at risk of abuse and neglect.

The report will provide information regarding the activity that has taken place over the past year to meet national and local requirements. It will demonstrate the degree to which the Trust works in partnership with other statutory and non-statutory agencies in relation to the safeguarding children agenda, the internal and external governance arrangements that we are subject to, and the responsibility we have in regard to our regulatory and statutory duties.

It will also identify the key objectives for 2015/16 in relation to the safeguarding children agenda and identify progress against the 2013/s14 work plan.

The Trust provides specialist mental health care to people of all age groups, across a diverse range of community and inpatient settings, CAMHS and low and medium secure forensic settings. The Trust has embedded safeguarding children at the heart of its services and promotes the safety, welfare and wellbeing of children at all times through the following arrangements:

As a health organisation, in relation to Safeguarding, the Trust needs to demonstrate compliance with a range of national and local statutory policy, procedure and guidance. (Appendix 1)

Safeguarding Children Leadership and governance

During this reporting period, the Director of Nursing has held the Trust Board level responsibility for safeguarding children and the Trust Director of Social Care, supported by the interim named nurse and named doctor for children’s safeguarding, have held strategic responsibility as part of their portfolio. The named professionals and the wider network of safeguarding lead professionals are responsible for the promotion of good professional practice and the provision of expert advice, supervision and training to fellow professionals to ensure that the workforce and the organisation protect vulnerable children from abuse and neglect.

The post of Trustwide Safeguarding Children Lead (Named Nurse) has now been recruited to substantively and the post-holder takes up the post in April 2015.

The details of the wider Safeguarding Team are in Appendix 2.

Internal Governance Arrangements

In 2014, the terms of reference for the Safeguarding Children’s Committee were reviewed and revised and the committee has met quarterly, with good attendance, chaired by the Director of Nursing. The Safeguarding Children’s Committee reports to the Quality Sub Committee which is a subcommittee of the Trust Board. The main role and functions of the committee are to ensure that the Trust is able to meet its statutory responsibilities under the

**Progress on key objectives during 2014-2015**

- Section 11 Audits have been completed for Bromley, Kent (for CAMHS), Lewisham, Southwark, Lambeth and Croydon. The associated action plans focus on demonstrating the voice of the child and an increased expectation for the Trust to deliver robust performance data on the range of indicators including: referral data, training, DBS checks on staff and employment compliance and LADO referrals, SLaM staff attendance at child protection conferences. Overall compliance is good but areas in relation to providing robust quality performance data still require improvement. In particular, there has been good compliance with action plans in relation to children and young people’s experiences (through PEDIC reporting) and this has been favourably commented on by several of the Safeguarding Children Boards. Each board now requires quarterly reporting on a wide dataset and additional reporting requirements from NHSE have been implemented. Full compliance with these requests remains a challenge.

- Recommendations and Actions from Serious Case Reviews and Domestic Homicide Reviews continue to progress and learning from both enquiries needs to continue to be embedded into learning and professional practice. However, it is regularly reviewed in Level 3 safeguarding training and staff are prompted to attend serious case review multi-agency training. The Safeguarding Team have been involved in five SCRs, two multi-agency reviews and several domestic homicide reviews during this reporting period. Recommendations from the above reviews have been completed or are being progressed as per action plan.

- The Safeguarding Children Trust Policy has been reviewed and comprehensively rewritten in line with Working Together 2013 and LCPP. The policy was ratified by the Quality Sub Committee in December 2014

- The Trust Supervision policy was reviewed and ratified in 2014 and now includes specific requirements in relation to safeguarding children.

- The Trust has worked in partnership with other agencies and provided staff to work in the Multi Agency Safeguarding Hubs (MASH) in Lambeth and Southwark and information sharing agreements has been signed off.

**Partnership working**

The Trust has maintained good attendance at the local Safeguarding Children Boards to which it is a signatory to partnership working agreements: Lambeth, Croydon, Lewisham, and Southwark and associated sub groups. The Trust has also worked with partner local authorities to ensure that Ofsted inspections are appropriately prepared for. None of the local boroughs has had an inspection in the reporting year.
The Trust has also worked with local CCGs in preparation for safeguarding children CQC inspections and internally, each Clinical Academic Group (CAG), is expected to be aware of their safeguarding children responsibilities and compliance issues with regard to CQC inspections. A series of staff events is being planned to ensure that all staff are aware of and understand their responsibilities in preparation for future detailed inspections. Working in partnership with all agencies is an intrinsic part of safeguarding.

In addition to working with the Local Safeguarding Boards, the safeguarding team demonstrates the Trust's commitment to partnership working through representation at the following committees and steering groups:

- **PREVENT** - is part of the United Kingdom’s counter-terrorism initiative. Its aim is to identify and work with vulnerable people who may be at risk of radicalisation or recruitment by a terrorist organization. The Head of Safeguarding is the Trust’s Prevent lead and attends a monthly regional meeting.

  As part of the 2014/15 NHS Contract it is now a requirement that all staff are trained in relation to Prevent. The Department of Health has produced a standardised training package – to be rolled out across all organisations.

- **Multi-Agency Risk Assessment (MARAC)** - The aim of MARAC is to develop safety plans for the highest risk victims of domestic abuse i.e. those at risk of being murdered or suffering serious harm. The purpose of MARAC is to share information and to develop a risk management plan to provide a professional, co-ordinated approach to all reported incidents of domestic abuse. Each borough provides a MARAC representative from the Trust and the Director of Social Care is currently planning to bring together the MARAC representatives as part of the Trust review of the Domestic Abuse Gap Analysis.

- **Multi-Agency Safeguarding Hub (MASH)** - the aim of this hub is to improve the quality and timeliness of decision making to reduce the potential risk to children and young people. The model has been rolled out across the UK and locates key agencies together in a single work place, to enhance information sharing. The Safeguarding Team has been contributing to the development of the MASH at both strategic and operational level. MASH has now been implemented in all boroughs and the Trust is a key agency in MASH delivery in Lambeth and Southwark. The other boroughs are yet to have Trust staff engaged with MASH and negotiations are continuing.

- **Domestic Homicide Steering Group** – each borough is expected to engage in a relationship with the Community Safety Partnership and/or the Violence against Women and Girls, domestic abuse strategy.

- **Caldicott Guardian Committee.** The Trust named Doctor sits on this group.
Safer Recruitment and Allegations Against Staff

All offers of employment made to prospective employees are subject to an enhanced Disclosure and Baring checks as are all substantive employees every three years. The Head of Human Resources and CAG leads consider any adverse disclosures.

During this reporting period new guidance has been developed in relation to Allegations against Staff to promote a consistent and robust process. The safeguarding team supports human resources in relation to allegations against staff and are involved in complaints when there is a safeguarding element.

LADO Cases of Concern are reported to the Local Authority Designated Officer (LADO) in the Borough where the allegation was made or where the employee is employed and referral rates are currently monitored by local authorities. Future areas of work will include a centralised reporting data system in order to demonstrate that LADO requirements are fully complied with. Appropriate recording of concerns raised regarding members of staff or other professionals who may pose a risk to children is a concern as ePJS is often not the appropriate system for such recording and follow-up.

Plan: The Allegations against staff policy needs to be reviewed

Safeguarding Children Audits

In addition to the S11 audits, qualitative audits to monitor training, child need and risk screen and supervision audit have been completed in the reporting year and an audit plan for 2015 has been developed in conjunction with the clinical audit panel.

A Safeguarding Children Single Agency Audit is underway, examining the quality of Child in Need risk screens completed by Adult Mental Health, which will then be undertaken in substance misuse services and a CAMHS risk assessment is also in the planning stages.

All boroughs take part in the LSCB multiagency audits and efforts are made to cascade the learning from these through the local borough committees across the Trust.

Safeguarding Children supervision

The revised Trust Clinical Supervision Policy now includes specific reference to child safeguarding supervision to ensure that the requirements of Working Together to Safeguard Children (2013) are met and best practice processes are in place. The Named Nurse for Safeguarding Children and Young People provides child protection individual and group supervision to the named leads across the Boroughs and CAGs. The supervision policy also requires safeguarding to be addressed and recorded within both group and individual sessions for all disciplines.

The Named Nurse receives management supervision via Director of Social Care and supervision is available from each designated lead in the CCGs.
Safeguarding Children training

All SLaM staff are expected to undertake safeguarding children training to raise their awareness and understanding of safeguarding children and inter-agency working, including the impact of domestic abuse, honour based violence, forced marriage, FGM and child sexual exploitation on our service users and their families.

The combined level 1&2 training is mandatory as part of the trust induction for all new staff. Level 3 training has been provided either by team training, access to LSCB or provided by the Education and Training Department.

Domestic Abuse (e-learning) training has been developed using the Royal College of GPs package and will count as level 3 safeguarding 3 and will be launched April 2015.

Two page bulletins and Think Family Posters are in the process of being designed.

At the outset of this reporting period, all core training packages were reviewed and updated in line with the Intercollegiate Document Roles and Competencies for Safeguarding Children and Young People 2014 and recent government priorities in relation to CSE, FGM and honour based violence.

The Safeguarding Team have developed and delivered the following core training:

- Induction Level 1&2 combined - Safeguarding Children, Young People at Risk
- Level 1 e-learning - Safeguarding Children and Young People (for non-clinical staff)
- Level 3 face-to-face training - Safeguarding Children and Young People, team based training and Trust ‘mop-up’ training

Uptake of Training

<table>
<thead>
<tr>
<th>Safeguarding Children and Young People Level 1&amp;2 - 2014/15</th>
<th>95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Young People Level 3 - 2014/15</td>
<td>78%</td>
</tr>
</tbody>
</table>

The training figures in the table indicate that uptake for Level 1&2 Safeguarding Children and Young People training has been consistent at 95% or above. However, data for Level 3 demonstrates a dip in performance, which may be attributed to insufficient training courses being available to meet demand and difficulties teams have in ensuring 100% attendance at team based and other LSCB training. These issues will be addressed in 2015.

The Safeguarding Team has also co-developed and presented on the Southwark SCB Multi-agency Training and each LSCB works jointly with the leads in either commissioning or jointly delivering training packages, particularly in relation to parental mental health and children and young peoples’ mental well-being.
Key priorities for 2015/2016

Objectives and Work Programme for 2015/16

The following objectives and work programme for 2015/16 have been identified to support the requirements for safeguarding practice and ensure continuous improvement in practice.

Objectives for forward plan 2015/16:

- To ensure robust data quality and collection is achieved to meet S11/CCG quality and performance requirements.
- To achieve consistent training delivery for level 3 training and improve compliance and to continue to embed learning from SCRs/DHRs/MARs in practice.
- To review training at all levels to ensure compliance with the Intercollegiate document: Safeguarding children and young people: roles and competences for health care staff
- To audit the efficacy of the safeguarding children training provided within the Trust
- The single agency audit plan to be developed including the development of a standard safeguarding children question for the Audit Project Proposal form provided by the Clinical Audit team
- To disseminate the learning from both the Trust single agency audit and borough multi-agency audits
- To ensure full engagement with borough preparation for both CQC and Ofsted inspections
- To agree the single agency Trust wide CAMHS audit
- To develop systems for the recording of referrals to LADO this will include the recording of the outcome.
- To confirm arrangements for MASH in all boroughs
- To complete the domestic violence audit and evaluation of domestic homicide reviews
- To roll out the Trust’s e-learning on Domestic Violence
- To consider Trust wide specific training on female genital mutilation

Key Risks

- Data collection and delivery in line with S.11 LSCB and CCG requirements for each partner Borough/CCG remains a challenge.
- Training delivery for Level 3 training is an on-going challenge with compliance rates remaining at under 80%
Action to Mitigate Risks

- A permanent safeguarding lead named nurse has been appointed.

- Quality dashboards to centrally collect and analyse data in line with the LSCB/CCG requirements are being developed.

- An external trainer has been recruited to provide additional L3 training. The key safeguarding risks that may have an impact on the reputation of the Trust Board and the Partner arrangements with local Safeguarding Boards are identified and mitigated, via an action plan, reporting to the Trust Quality Committee and Executive Trust Board.
APPENDIX 1

National policy, procedure and guidance in relation to safeguarding children and young people:

- Working Together to Safeguarding Children (2015) and pan-London procedures
- The NICE guidance on When to Suspect Child Maltreatment
- Intercollegiate document: Safeguarding Children and Young people: roles and competencies for health care staff 2014

Statutory requirements and recommendations include:

- Appropriate representation on Local Safeguarding Children Boards and sub-groups
- Co-operation and sharing of responsibility for the effective discharge of the Safeguarding Boards functions
- Ensuring effective arrangements and funding is in place to support the function of named professionals
- Comprehensive single and multi-agency policies and procedures to safeguard and promote the welfare of vulnerable children
- Appropriate infrastructures that provide advice and expertise to all healthcare professionals working in the health organisation and support staff to act on their concerns and fulfil their responsibilities in line with the procedures
- The delivery of effective and accessible training (single or multi-agency) to staff targeted to assessed training needs so that staff are competent and able to identify early indicators of potential abuse or neglect and know how to act on their concerns in line with procedures
- Ensuring safe recruitment practice at the outset of employment and at periodic updates
## APPENDIX 2

<table>
<thead>
<tr>
<th>Role</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Named Nurse for Safeguarding Children</td>
<td>1.0</td>
</tr>
<tr>
<td>Named Doctor for Safeguarding Children</td>
<td>0.1</td>
</tr>
<tr>
<td>Lead Borough Nurse Lambeth (CAMHS)</td>
<td>0.5</td>
</tr>
<tr>
<td>Children and Young People’s Manager</td>
<td>1.0</td>
</tr>
<tr>
<td>Lead Borough Nurse – Croydon</td>
<td>0.5</td>
</tr>
<tr>
<td>Lead Borough Nurse Southwark (CAMHS)</td>
<td>0.5</td>
</tr>
<tr>
<td>AMH Safeguarding Children Manager Southwark</td>
<td>1.0</td>
</tr>
<tr>
<td>Lead Borough Nurse Lewisham</td>
<td>0.5</td>
</tr>
<tr>
<td>Lead Nurse Children and Adults B&amp;D CAG</td>
<td>1.0</td>
</tr>
<tr>
<td>Professional Lead Older Adults - Children and Adults</td>
<td>1.0</td>
</tr>
</tbody>
</table>

In addition to the above posts on protected time there are safeguarding lead professionals in N&S CAMHS and AMH CAGS across the Trust.
Safeguarding Children

Thematic Review – presented at the Quality Sub Committee
19th May 2015

Paul Archer
Trustwide Safeguarding Children Lead
Introduction

“All those who come into contact with children and families in their everyday work, including practitioners who do not have a specific role in relation to safeguarding children, have a duty to safeguard and promote the welfare of children.”

Legislative Framework

- Children Act (1989)
- Children Act (2004) – Section 11
- The UN convention of the right of the child (1988)
- Pan London Safeguarding Procedures (2014)
Current Drivers

- Female Genital Mutilation (FGM), Honor Based Abuse, Forced Marriage and Domestic Abuse
- Child Sexual Exploitation (CSE):
  - Rochester
  - Rotherham
  - Oxford
- Neglect
- Saville Enquiry
- Miles Bradbury – paediatrician in Cambridge
- PREVENT agenda
Local Position

- Reporting to all the CCGs and Safeguarding Children Boards where SLAM services are provided
- KPIs in place for Level 1, 2 and 3 safeguarding training. New requirement for PREVENT training
- Implementation of safeguarding supervision
- Representation at Local safeguarding children’s boards and sub-groups
- Trust Policies and procedures
- Completion of Section 11 audits
Current Risks

• Vacant posts within safeguarding children
• Safeguarding supervision evidence
• Safeguarding training evidence
• Data quality reported to CCGs and LSCBs
• Documentation
• Updated risk assessments
• Serious case reviews
• Mechanisms for identifying vulnerable children
## Quality Indicators

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Measurement</th>
<th>Frequency of reporting</th>
<th>Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Supervision</td>
<td>% of eligible staff</td>
<td>Quarterly to CCG and Safeguarding Committee. Annual to Trust Board and Section 11 Audits</td>
<td>Compliance % against set target. Agreed plan for capturing supervision via EPJS</td>
</tr>
<tr>
<td>Safeguarding Training</td>
<td>% of eligible staff</td>
<td>Quarterly to CCG and Safeguarding Committee. Annual to Trust Board and Section 11 Audits</td>
<td>Compliance % against set target. Data cleansing: wired Vs CAG held records</td>
</tr>
<tr>
<td>Safeguarding referrals</td>
<td>Number per Borough</td>
<td>Quarterly to CCG and Safeguarding Committee. Annual to Trust Board and Section 11 Audits</td>
<td>Datix alerts EPJS How many lead to an enquiries? Quality of referrals</td>
</tr>
<tr>
<td>Action Plan</td>
<td>Deadline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safeguarding Training</strong></td>
<td>Creation of a training strategy and review of current training delivered including reporting mechanisms</td>
<td>Current training strategy in draft – will be presented at the Safeguarding Children's Committee in June 2015.</td>
<td></td>
</tr>
<tr>
<td><strong>Safeguarding Supervision</strong></td>
<td>Review of current supervision arrangements underpinned by trust policy. Adequate documentation and reporting of supervision</td>
<td>Draft appendix sent for peer review May 2015. Take and finish group to be established. Completion by August 2015</td>
<td></td>
</tr>
<tr>
<td><strong>Data Quality</strong></td>
<td>Creation of adequate reporting mechanisms (EPJS and DATIX) to enable to Trust to report meaningful data to the Trust Board, CCGs and LSCBs</td>
<td>Meeting between the safeguarding service (Adults and Children) and the Information Department to be arranged</td>
<td></td>
</tr>
<tr>
<td><strong>Risk assessments</strong></td>
<td>Qualitative audit of EPJS risk assessment updates</td>
<td>Audit proposal to be drafted June 2015. Audit to be completed July/August 2015. Results to be presented September 2015</td>
<td></td>
</tr>
<tr>
<td><strong>Safeguarding Policy</strong></td>
<td>For the safeguarding children's policy to be updated to reflect changes in statutory guidance</td>
<td>Currently under peer review. To be completed by July 2015</td>
<td></td>
</tr>
</tbody>
</table>
Conclusion

• Quality data reporting needed to ensure the Trust can evidence that it is compliant with The Children Act (2004)
• Training and supervision needs to be „fit for purpose“
• Once these key areas are addressed, the Trust will be in a better position to provide assurance to its key partners that it has adequate arrangements in place for safeguarding and promoting the welfare of children and young people
Update

- Training Strategy agreed by the Safeguarding Children Committee July 2015
- Safeguarding policy updated and agreed by the Safeguarding Committee July 2015
- Safeguarding training updated
- Supervision policy being updated
  - Chaperone policy
  - Domestic abuse policy
  - Allegations policy
  - Prevent training
- Use of DATIX considered for safeguarding referrals (not viable)
- Borough based data not being provided via wired
- Improved data and narrative being provided to the CCGs
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 28th July 2015
Name of Report: Safeguarding Adults
Heading: Quality
Author: Louise Rabbitte
Approved by: Neil Brimblecombe
Presented by: Neil Brimblecombe

Purpose of the report:
To update the board on the Trusts current Safeguarding Adults position and strategy, following a thematic review in May 2015.

Recommendations to the Board:
- Support recommendation that adjustments are made to current ICT systems (Datix and EPJs) within the Trust to enable necessary data recording and capture – to improve quality assurance to CCG and Local Authority partners
- Commission additional specialist Safeguarding Adults Training to enable required staff to undertake robust quality safeguarding enquiries – as expected in line with Care Act safeguarding expectations
- Support necessary resources to roll out PREVENT strategy and required WRAP training to clinical staff
- Consider need for dedicated safeguarding adults role within CAGs (particularly Psychosis)
- Support non-pay budget for Trust Safeguarding resources

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
1) Safety of patients, staff and public – high levels of violent & aggressive behaviour by patients on patients are a safeguarding concern (moderate)
2) Failure to provide services in line with best practice – Trust workforce lacks necessary knowledge and skills to understand their safeguarding responsibilities and undertake required safeguarding activities commensurate to their role (high)
3) Patient experience – failure to provide the quality of service that is contracted and that service users deserve. Quality of client outcome focused safeguarding activity by Trust staff requires improvement (moderate)
4) ICT Infrastructure – current systems do not enable adequate recording of safeguarding activity or data capture for reporting purposes

Summary of Financial and Legal Implications:
- Financial commitment may be required to ensure adequate resources to provide necessary safeguarding and Prevent training.
There is now an expectation of a financial contribution by SLAM to the new Safeguarding Adults Boards across our 4 aligned boroughs.

Statutory duties following implementation on 01.04.15 of The Care Act (2014)

Compliance with CQC Fundamental Standards of Care – Regulation 13 – safeguarding people who use services from abuse and improper treatment (Health & Social Care Act 2008 (Regulated Activities 2014)). Also new Duty of Candour

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

Good safeguarding knowledge, skills, reporting and safeguarding enquiry processes have a positive impact on equality, discrimination and on good relations for people with protected characteristics. They assure our patients and public that SLAM provides safe services and works in partnership to safeguarding service users from abuse and improper treatment.

**Service Quality Implications:**

Care Act places legal duty on the Trust to cooperate with safeguarding adults’ activity, to undertake safeguarding enquiries if requested by Local Authorities and to ensure that safeguarding adults’ best practice is embedded in the organisation. There will be a requirement for SLAM staff to undertake/lead safeguarding enquiries and understand the shift in focus from process driven to client led outcomes.

Safeguarding Adults Annual Report

March 2015

Authors:

Cath Gormally
Director of Social Care

Heather Williams
Safeguarding Adults Lead (Interim)
Executive Summary

The last year, 2014-2015, has been a year of significant development in safeguarding in the Trust. Safeguarding leadership and governance processes for both children and adults within the Trust have been strengthened to ensure that the Trust meets its statutory duties and responsibilities to protect children and adults who are at risk from abuse and neglect.

Executive and strategic leadership on safeguarding adults and children has been embedded with Dr Neil Brimblecombe, Director of Nursing and Cath Gormally, Director of Social Care, taking up these respective roles. The key senior posts of Trustwide Safeguarding Adults Lead and the Named Nurse for Safeguarding Children have been filled on an interim basis and have now been recruited to substantively with the post-holders taking up their posts in April 2015. Dr Sarah Bernard was also confirmed in post in 2014 as Named Doctor for safeguarding children.

The Terms of Reference of both the Safeguarding Adults and Children Committees have been reviewed and the committees have met regularly throughout the year. The committees provide a direct source of assurance to the Trust Board that effective systems and structures are in place to ensure statutory compliance in safeguarding for both adults and children. They are now chaired by Dr Neil Brimblecombe and any relevant issues of concern or note are escalated to the Quality Sub Committee which is a subcommittee of the Trust Board.

The last year has been a particularly important year for safeguarding adults, with the introduction of the Care Act 2014, which came into force on 1st April 2015. The Trust established a Care Act Implementation group in November 2014, following the publication of the statutory guidance, to ensure readiness and statutory compliance with the Act in relation to all the relevant provisions, including safeguarding adults.

As a result, the Trust Safeguarding Adults at Risk policy has been reviewed and revised to ensure compliance with the Care Act and will be revised again when the Pan London Guidance is published later in the year. The Service Directors now represent the Trust at the Safeguarding Adults Partnership Boards in the four boroughs of Lewisham, Lambeth, Southwark and Croydon, to ensure the Trust is a strong and active partner at the respective boards.

In accordance with safeguarding children, a safeguarding quality dashboard has been developed for adult safeguarding to ensure consistent and accurate data collection and performance which will be monitored by the Safeguarding Adult Committee. Work is ongoing to devise a single safeguarding adults’ referral form, which will also enable effective reporting of safeguarding adults’ data in the future. Currently, like safeguarding children, the collection of robust data and reporting to meet quality and performance requirements remains a challenge but is a key objective for 2015-2016.

Work has continued throughout the year to ensure statutory compliance with staff training requirements for safeguarding adults and quality assurance on practice under the Mental Capacity Act.

Conclusion

In summary, significant progress and developments have been made in 2014-2015 across both safeguarding adults and children. However, many challenges and areas for further
improvement and development remain and will be addressed throughout 2015-2016 by achieving the key objectives for adults and children which are detailed in the body of this report. Work will be focussed on these identified areas with a key priority being the collection and delivery of robust performance data in order to strengthen governance and give assurance to the Trust Board and our external partners that adults and children at risk of abuse and neglect, with whom the Trust comes into contact, are protected.

Cath Gormally
Director of Social Care
Introduction

The Safeguarding Adults at Risk Policy and Procedures have been reviewed and revised and will be submitted for ratification by the Quality Sub Committee in April 2015. This takes account of the changes introduced by the Care Act 2014 that came into force on the 1st April 2015 and will be revised again, when the Pan London Safeguarding Adult Policy and Procedures are published in August of this year. The revised policy is available to all staff on the Trust intranet and staff are being made aware of the revised policy via the communications team and raised at a local level at team meetings and via mandatory safeguarding training.

Each of our CAGs (Clinical Academic Groups) will continue to have nominated leads to provide day-to-day advice and represent the CAG at internal and external events. This provides a robust structure and focus on safeguarding adults and working in partnership with external partners into the future.

There are currently a number of initiatives underway for Safeguarding Adults within the Trust in order to create a greater staff awareness and ensure performance and practice is embedded within the day-to-day operational teams linked to each Local Authority’s needs.

This report provides information and data for the period April 2014 – March 2015, to provide assurances to the Trust Board and partner agencies, with regard to safeguarding procedures and the adult safeguarding priorities for the next year.

Statutory guidance

The Trust Safeguarding Adults policy provides guidance to staff to ensure that the principles of safeguarding adults are embedded in all aspects of Trust practice.

From 1st April 2015, the Care Act 2014 has replaced all previous safeguarding legislation and guidance. The Care Act will now provide the statutory guidance for adult safeguarding work and Safeguarding Adults Boards. Chapter 14 of the Care Act Statuary guidance covers safeguarding and replaces the No Secrets guidance.

The guidance “Protecting Adults at risk: London multi-agency policy & procedures to safeguard adults from abuse “(SCIE 2011) are being revised in accordance with the Care Act and publication is planned for August 2015.

Safeguarding Governance

The Trust has strengthened its governance arrangements and has an established Safeguarding Adults Committee and Safeguarding Children Committee. Both committees are now chaired by the Director of Nursing, Dr Neil Brimblecombe and the Safeguarding Adults Committee is attended by internal and external partners. Both these committees report directly to the Quality Sub Committee which is a sub-committee of the Trust Board. This provides enhanced transparency, oversight and scrutiny of safeguarding practice and performance. Progress has also been made on developing the infrastructure to enable the delivery of good safeguarding practice:
A Safeguarding Quality Dashboard has been developed to ensure consistency and compliance with safeguarding and the Mental Capacity Act across the Trust.

The development of the Trust intranet site enabling staff access to information, guidance and policy. Further development is planned to hyperlink guidance via ePJS

Significant changes have been made to the electronic patient record system, ePJS to include a prompt for staff to consider safeguarding and the need for further action.

**Safeguarding adults and Mental Capacity Act data**

The Trust collects data on safeguarding adults and provides regular returns to the local boroughs of Lewisham, Lambeth, Southwark and Croydon on safeguarding adults’ activity. The referral process is different for each local authority and dependent on whether the team is integrated and subject to a Section 75 agreement. The referral process is recorded on the Trust’s Safeguarding Intranet pages.

As part of the S75 Delivery Board governance arrangements, social care indicators will be agreed together with a comprehensive social care dashboard to ensure that we are meeting the CCGs and local authority’s expectations of safeguarding performance indicators.

The Safeguarding Adults at Risk Audit Tool identified key areas of development which include developing a transparent, consistent and robust quality assurance system. The Trust is working with each local authority to develop a quality assurance system that will ensure a consistent approach with the local authority returns. The Trust is working towards developing our own quality assurance and audit tools to meet the required data requirements. A full report for safeguarding data will be presented in the next annual report.

**Summary of quality assurance auditing of safeguarding adults work**

The Trust has developed a safeguarding quality dashboard. The dashboard will ensure consistency and quality across the Trust. It will be shared with the Local Safeguarding Adult Partnership Boards for agreement and to ensure consistency with each Local Authority and SAPB.

Work has been on-going to devise a single safeguarding enquiry form. Once completed, this will enable detailed, effective reporting of safeguarding data to both the Trust and external partners. It will also ensure transparency and integrate safeguarding into practitioner’s daily professional practice. The plan is for documentation to include data requirements from Lambeth’s health themed provider reports, including the outcomes that the service user identifies at the start of the safeguarding process. Once completed, agreement will be sought from each local authority to enable SLaM to use one safeguarding referral form.

**Summary of quality assurance auditing of Mental Capacity Act 2005 work**

The Trust governance for the Mental Capacity Act is through the Mental Capacity Act group and Mental Health Law Committee. There is a Trust Mental Capacity Lead who is currently revising the training for the Mental Capacity Act, developing a practice guidance tool and there will be a monthly one day Mental Capacity Act workshop provided. The Trust lead is also in the process of completing an internal audit of Mental Capacity Act assessments to look at how the Mental Capacity Act is being applied in practice – also on specific aspects such as use of restriction under the provisions of the Mental Capacity Act, staff competence...
and confidence. Examples of good practice case examples will be shared with the Trust through the intranet and training.

**Training and Awareness**

Safeguarding training is available to staff under the Core Skills Framework training. Equality, Diversity and Human Rights are also now part of the mandatory skills suite. SLaM’s mandatory training requirements conform to the National Skills Training Framework (NSTF) which has set the minimum national standards for the NHS in 10 core subjects. Safeguarding Adults training is also dictated and locally governed by the Safeguarding Adults Board.

Safeguarding training is mandatory for all staff with no exceptions but the levels of training are dictated by the individual’s role to ensure that the standards are met according to the NSTF & Safeguarding Boards. At the outset of this reporting period, all core training packages were reviewed and updated in line with the Intercollegiate Document Roles and Competencies for Safeguarding Children and Young People 2014 and recent government priorities in relation to CSE, FGM and honour based violence. There is currently a review of safeguarding adult training in process.

**Training requirements:**

- Induction Level 1&2 combined - Safeguarding Children, Young People at Risk
- Level 1 e-learning - Safeguarding Children and Young People (for non-clinical staff)
- Level 3 face-to-face training - Safeguarding Children and Young People, team based training and Trust ‘mop-up’ training
- Safeguarding Adults Alerters Training is for all Non Clinical staff
- Safeguarding Adults Alerters Plus Training is for all clinical staff
- Mental Capacity Act Training & Deprivation of Liberty Safeguards training is mandatory for all inpatient qualified nurses, junior doctors and ward managers
- Equality, Diversity and Human Rights became mandatory for all staff in April 2014
- Evidence of training is monitored monthly by the Education and Training dept. monthly reports are sent to all departments and quarterly reports go the Safeguarding Boards.
- Compliance with mandatory training is monitored through the Mandatory Training Committee and at CEOPMR. Low compliance is highlighted and monitored by both E & T and Strategy and Business.
- Action plans are required to be in place to address areas of concern and how they can be improved.
- Annual training targets are set at the beginning of each year in order to ensure that we can achieve the compliance targets and reported on quarterly at the Education and Training Trust Committee.
Prior to April 2014 Safeguarding Adults Alerters and Alerters Plus compliance were not being recorded separately. The statistics are for training provided by the Trust and does not include training figures for training provided by the Local Authority (LA). In relation to Children’s, where a dip in training has been identified, staff may have been unable to attend LA training due to high demand. Work is in progress to enable effective reporting on training statistics.

**Compliance with Training**

<table>
<thead>
<tr>
<th>Compliance with Training</th>
<th>Safeguarding Adult Alerters 2014/15</th>
<th>78.37%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safeguarding Adults Alerters Plus 2014/15</td>
<td>61.58%</td>
</tr>
</tbody>
</table>

**Safer recruitment**

- **DRB Compliance**

The Trust is no longer structured on a borough basis so currently reports performance data on a Clinical Academic group (CAG) basis. Work is on-going to provide borough based information and data to each borough and Safeguarding Adults Partnership Board. The Trust has a three-year rolling programme for carrying out DBS (former CRB) for those undertaking regulated activities. This is co-ordinated through the Employee Services Team.

Please see below table for current data on compliance with DBS checks

<table>
<thead>
<tr>
<th>CAGS</th>
<th>Staff In Post</th>
<th>Valid DBS</th>
<th>Expired</th>
<th>% Expired against SIP</th>
<th>Not Required</th>
<th>No Records on ESR (New Starters)</th>
</tr>
</thead>
<tbody>
<tr>
<td>334 Addictions CAG</td>
<td>171</td>
<td>153</td>
<td>6</td>
<td>3.51%</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>334 Behavioural and Development Psychiatry CAG</td>
<td>435</td>
<td>392</td>
<td>23</td>
<td>5.29%</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>334 Child &amp; Adolescent Services</td>
<td>575</td>
<td>566</td>
<td>8</td>
<td>1.39%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>334 Clinical Support Services</td>
<td>75</td>
<td>72</td>
<td>1</td>
<td>1.33%</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>334 Corporate Directorate</td>
<td>665</td>
<td>285</td>
<td>11</td>
<td>1.65%</td>
<td>369</td>
<td>0</td>
</tr>
<tr>
<td>334 MHOA and Dementia CAG</td>
<td>387</td>
<td>346</td>
<td>24</td>
<td>6.20%</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>334 Mood, Anxiety and Personality</td>
<td>528</td>
<td>497</td>
<td>9</td>
<td>1.70%</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>334 Psychological Medical CAG</td>
<td>516</td>
<td>468</td>
<td>29</td>
<td>5.62%</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>334 Psychosis CAG</td>
<td>1157</td>
<td>1055</td>
<td>44</td>
<td>3.80%</td>
<td>57</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>4509</td>
<td>3834</td>
<td>155</td>
<td>3.44%</td>
<td>513</td>
<td>7</td>
</tr>
</tbody>
</table>

- **Staff trained in safer recruitment**
The Trust does not currently keep statistics on people trained in safer recruitment. The Trust runs recruitment and selection courses and meets the requirements of safer recruitment through ensuring the processes are in place and followed to ensure safer recruitment happens. The Trustfully adheres to safer recruitment standards through the following:

- Occupational health clearance
- References and employment history checks
- DBS
- Professional registration check
- Right to Work
- Identity check.
- The above are monitored and reported monthly and exceptions followed up.

**Key priorities for 2015/2016**

1. **Implementation of the Care Act 2014**
   - Trust Care Act Implementation Group commenced in November 2014 and will continue to ensure the principles and functions of the Care Act are embedded in practice.
   - Policies and procedures to be revised again in August 2016 in accordance with the publication of the Pan London Policy and Procedures.
   - Staff training and awareness
   - Public awareness

2. **Quality assurance and data collection – Implementation of the Safeguarding Quality dashboard across the Trust and for ratification by LSAB to ensure the dashboard will meet LSAB requirements.**

3. **Work will continue to develop a single safeguarding enquiry form which will also be able to provide key quality performance data.**

4. **The Trust will continue to increase awareness and expertise in the Mental Capacity Act and DoLS across the Trust.**

5. **Work will continue to ensure there is clarity between Serious Incident reporting and safeguarding reporting referrals to the Local Authorities and CCGs- Safeguarding leads will to develop guidance on pathways and thresholds.**

6. **The Prevent agenda will be progressed and will have a strong focus on service user outcomes as part of the quality assurance process which needs to be developed. Structures, systems and training are required to be embedded around Prevent – how to refer and when to be alerted, to improve the reporting response and data**
collection. Monthly returns are now sent to NHS England. The Trust Safeguarding Adult Lead; CAG Safeguarding leads and Security Specialist are in the process of undertaking training as WRAP3 Health Facilitators. The Trust Safeguarding Adult Lead is working with Education and Training department to develop a training analysis and incorporate prevent into current training. Prevent champions for each CAG are to be established.

7. Quality assurance audit tool to be developed on outcomes for service users and if they feel safer as a result of the safeguarding process – the Trust wide Safeguarding Lead and Hidden Voices (HealthWatch) are carrying out an audit on service user outcomes

8. The Trust will continue to ensure that service users, families and carers have access to information about Safeguarding Adults, including who to contact if they are concerned about an Adult at Risk. The SLaM external website will be reviewed and leaflets to be developed.

9. Review of Safeguarding Adults training and development will continue.
Safeguarding Adults

Thematic Review (QSC May 2015) Updated for Trust Board
28th July 2015
Louise Rabbitte – Trust Safeguarding Adults Lead
Introduction

Adult safeguarding is the process of protecting adults with care & support needs from abuse or neglect. Key responsibility is with Local Authorities in partnership with the NHS & Police. Now a statutory duty to work together & share information.

6 key principles: Empowerment, Prevention, Proportionality, Protection, Partnerships, Accountability.

Making Safeguarding Personal – ‘No decision about me without me’ & the ‘wellbeing principle’.

Additional categories abuse – Self-Neglect including hoarding, domestic abuse, domestic servitude, human trafficking, hate crimes.
Legislative Framework

- Care Act (2014) Implemented 01.01.15 – Section 42 – 47 Safeguarding Adults at Risk
- The Counter-Terrorism & Security Act (2015) – Section 29, *The Prevent Duty* and Sections 36-41 *The Channel Duty* from 01.07.15
- New London Multi-Agency Policy & Procedures (due summer 2015)
Current Drivers

- Implementation of The Care Act since 1\textsuperscript{st} April 2015
- New statutory duty for safeguarding adults – presence at and financial contribution to local SAB’s, cause to cooperate/share information & make safeguarding enquiries
- Update policies & training for Care Act compliance
- PREVENT agenda – legal duty, policy, mandatory training & Channel Panels
- CQC Fundamental Standards: Regulation 13 – preparing for planned inspections
Local Position

- Reporting to all the CCGs and Safeguarding Adults Boards where SLAM services are provided
- KPIs in place for Level 1 & 2 safeguarding adults training. New requirement for Prevent training
- Delegated functions/historic Sec. 75 agreements within CMHTs – impact of Care Act?
- Representation at local safeguarding boards sub-groups & NHSE London SA & Prevent Networks
- Trust Policies in line with Pan London guidance
- Completion of NHSE/LGA +/- CCG annual audits
Current Risks

- Poor quality assurance/informatics – no centralised mechanisms for capturing safeguarding activity data (referrals to LA, Categories Enquiries, Outcomes)
- Data quality reported to CCGs/SAB’s – lack of appropriate safeguarding process recording system within Trust – templates need building into EPJs
- Safeguarding & Prevent training provision & data / safeguarding competencies
- Inadequate safeguarding resources within CAGs (CAG SA Leads are mostly ‘nominal’ – time & knowledge restraints)
- CQC Inspection preparedness – safeguarding/MCA & DOLS
## Quality Indicators

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Measurement</th>
<th>Frequency of reporting</th>
<th>Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of safeguarding adults referrals *</td>
<td>Total no. referrals made                                     Source of referral</td>
<td>Quarterly – CCG Annual – NHSE / Safeguarding Adults Boards: Lambeth Southwark Lewisham Croydon Bromley?</td>
<td>Datix alerts SA referrals by SLAM to Local Authority* # Enquiries led via SLAM* # Complaints SI HR Processes</td>
</tr>
<tr>
<td>Prevent alerts</td>
<td>Total number Prevent alerts Source of alert Source of concern e.g: service user / employee/volunteer No. of Prevent alerts referred on to Channel No. Channel cases</td>
<td>Quarterly - NHSE</td>
<td>Datix Alerts # Devise internal database#</td>
</tr>
<tr>
<td>Channel Referrals</td>
<td>% Eligible staff at each level Source of abuse/harm Source of abuse/ harm Total number of enquiries Outcomes</td>
<td>Quarterly – CCG &amp; NHSE Annual – NHSE / Safeguarding Adults Boards</td>
<td>Compliance % against set targets Number of available training sessions Number cancellations (by E&amp;T / by attendee) Number DNA’s CAG/service/borough* performance</td>
</tr>
<tr>
<td>Training Compliance: Safeguarding Adults Basic Prevent Awareness WRAP MCA /DOLS DV</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Data needs to be available by Borough in addition to by CAG

# Internal monitoring system not yet in place/available
<table>
<thead>
<tr>
<th>Issue</th>
<th>Action Plan</th>
<th>Deadline</th>
</tr>
</thead>
</table>
| Safeguarding Training         | Review training strategy & current safeguarding adults training content – to reflect need for Safeguarding Enquiry responsibilities | By end July 2015  
Board Update: E&T Committee 24.07.15  
Audit Questionnaire sent to all clinical staff on 02/07/15 |
| Data Quality                  | Creation of adequate reporting mechanisms (EPJS and DATIX) to enable to Trust to report meaningful data to the Trust Board, CCGs and LSCBs.  
Dashboard  
Develop Trust standardised templates for documenting safeguarding process – initially Word documents. Build into EPJs. | Board Update: Meeting with the Clinical Information Systems Manager to agree timeframes & required work took place on 28/05/15. Aim to build into EPJs by April 2016  
Datix changes & templates by August 2015 |
| Safeguarding & Prevent Policies | Rewrite the safeguarding adults policy to reflect statutory changes post Care Act  
Write Prevent policy for SLAM | To be completed by September 2015 – awaiting new Pan London guidance By July 2015  
Board Update: Delay in publication. New completion deadline December 2015. |
| Safeguarding Adults: understanding of roles & responsibilities | Work with trust audit team to survey staff regarding safeguarding adults knowledge and understanding  
Audit of Datix & EPJS safeguarding recording  
Discuss with CAG Service Directors about safeguarding adults resources/expertise within CAGs | By end August 2015  
Board Update: On target  
Paper outlining proposed core functions of CAG SA Leads to NB – June 2015. For discussion with CAG Service Directors |
| Prevent Strategy              | With Education & Training Deputy Director, devise Prevent training plan  
Increase WRAP Facilitator provision across CAGs  
Commence WRAP sessions for clinical staff – training commenced July 2015 | Over 3500 clinical staff will require 1 hour WRAP session over next 3 years - 2018  
Over 1000 non clinical staff will require Basic Prevent Awareness  
3 additional Prevent WRAP Facilitators by end May 2015 (total across Trust = 5) |
Conclusion

• Quality data reporting and improved safeguarding processes needed to ensure the Trust can evidence that it is compliant with Care Act (2014), Prevent Duty (2015) and NHSE Safeguarding assurance requirements

• Safeguarding Policies review required, including Managing Safeguarding Allegations against Staff policy

• Training and supervision needs to be ‘fit for purpose’ to ensure a workforce with safeguarding competency

• Once these key areas are addressed, the Trust will be in a better position to provide assurance to its key partners that it has adequate arrangements in place for safeguarding adults with care & support needs
# TRUST BOARD OF DIRECTORS – SUMMARY REPORT

<table>
<thead>
<tr>
<th>Date of Board meeting:</th>
<th>21&lt;sup&gt;st&lt;/sup&gt; July 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Report:</td>
<td>AMH Model Implementation update</td>
</tr>
<tr>
<td>Heading: - (Strategy, Quality, Performance &amp; Activity, Governance)</td>
<td>Strategy</td>
</tr>
<tr>
<td>Author:</td>
<td>Fran Bristow</td>
</tr>
<tr>
<td>Approved by: (name of Exec Member)</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Fran Bristow, Programme Director AMH Programme</td>
</tr>
</tbody>
</table>

## Purpose of the report:
For information

## Recommendations to the Board:
None

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

## Summary of Financial and Legal Implications:
None

## Equality & Diversity and Public & Patient Involvement Implications:
EIA completed for the full business case no adverse indications found. The implementation of the programme has been agreed the local scrutiny committees in each Borough where implementation is in progress

## Service Quality Implications:
It is anticipated that service quality will improve as access to services will be earlier and increased evidence-based interventions will be available
1. Executive Summary

- The AMH model was implemented in Lambeth and Lewisham in mid September 2014 and a formal launch held in November 2014.
- Implementation of phases 1 & 2 of the model in Croydon are currently in progress.
- Implementation in Southwark has commenced and it is hoped will be fully implemented by December 2015 subject to further local consultation within the CCG and the outcome of the social care review.
- Implementation of the model contributes to other interlinked Trust strategies including demand management for bed based services, the estates strategy and IT strategy for mobile working.
- Development of team based outcome reports allow for comparison across teams and examination of the impact of differences in practice between teams.
- Next steps include:
  - Finalisation of plans for phases 3 & 4 of the programme for Croydon.
  - Continued efforts to gain funding for a formal research evaluation of the model.
  - Development of the service in lines with integration with primary care supporting the SLIC Programme and local integration initiatives in Lewisham and Croydon.

2. Background

The AMH model full business case was presented to the Trust Board of Directors at their meeting of 28th May 2013. In approving the business case it was acknowledged that a traditional approach to savings would result in the service becoming unsafe and that the AMH service transformation was at its heart a clinical and social solution to a demographic, system and financial problem.

The AMH model means a decisive shift for SLaM towards a better balance between excellence in specialist provision and real quality local services. AMH also provides a platform to build service provision towards an enhanced model of primary care, general practice and social care, prevention and empowerment of local people.

The model has required integrated working across the Psychosis, Psychological medicine and MAP CAGs. It provides a step change in the treatment provided to improve patient outcomes and experience of the service. An investment into the community services (appendix 1) leads after 18 months to an anticipated reduction in reliance on bed based services and creates greater flexibility to meet future financial and service challenges.
Due to the scale of the changes required it was agreed to implement the model in Lambeth and Lewisham only in the first instance. Service changes were made in May 2014 in these boroughs and an update on the implementation provided to the July 2014 meeting of the Trust Board. Regular updates have also been provided to the quality sub-committee of the board, most recently to the June meeting.

Croydon and Southwark CCGs expressed an interest in the AMH model for their boroughs following changes in Lambeth and Lewisham and the model is currently being implemented in both.

3. The Model

The model has been described in previous reports, however is set out here for those new to the service.

The AMH model is comprised of three main elements:

i. **Enhanced Assessment Services**
   A single point of access for people referred to services ensuring they are seen promptly and correctly signposted to the services within primary care, third sector organisations and, where required, within secondary care that can best meet their assessed needs.

ii. **Relapse Reduction**
   Through the introduction of a revised clinical and operational model which focuses on intervening early in crisis and proactive treatments to support recovery. The treatment teams provide increased availability of interventions, decreased caseload sizes and a focus on service user engagement. The increased availability of Home Treatment as an alternative to in-patient admission and discharge co-ordination to support timely discharge along-side the treatment teams reduces the requirement of bed based services

iii. **Support for transfers back to Primary Care**
   Support is provided to people transitioning back to Primary care. It is also provided to primary care practices to develop their capacity to provide a service and support to people with severe enduring mental health problems who are at low risk of relapse and are on their recovery path.

4. Evidence Base

The AMH model is an innovative solution implementing approaches that have not been adopted elsewhere at scale with this client group. This means that it is unclear how effective it will be in practice, and means that SLaM is at the forefront of delivering the KHP vision of the translation of research into practice at scale. However, support for the approach taken by the model can be seen more widely in:

- The recommendations of Rethink Mental Illness’s Schizophrenia Commission, which included adoption of the Early Intervention Service Model and interventions into general community teams.
- The Nice Guidelines for Serious Mental Illness recommendations based on their review of the available research evidence.
• Investing in Recovery – the business case for effective interventions for people with schizophrenia and psychosis developed by Rethink, the London School of Economics and the Department of Health.

The model is being monitored closely to note the impact of the changes and to ensure the benefits of the model are clear and transferable to other geographies.

5. Implementation

5.1 Programme Governance

The AMH Programme Board was established in October 2013, with five work streams reporting to it. The work stream leads report to the Programme Board’s monthly meeting, which is chaired by the Medical Director and oversees and co-ordinates the programme.

1. Communications
   Director of Organisation and Community
2. Monitoring and Evaluation
   Clinical Director, Psychosis CAG
3. Buildings and IT
   Chief Operating Officer
4. Clinical & operational models
   Associate Clinical Directors Lambeth & Lewisham
5. HR & Organisational Development
   Director, SLaM Partners and HR representative

5.2 Communication

A short video has been developed and is available on the SLaM YouTube site (youtube.com/slamnhsft) and a range of information leaflets have been developed with clinical staff, service users and carers. The leaflets are currently being printed and will be available in all team bases by early August.

A formal launch of the model for Trust staff was held in November 2014.

Engagement events for service users and carers were held in Lambeth and Lewisham prior to implementation of the model and further events have been held during the roll out. An audit of service users experience of the changes in Lewisham was also undertaken. The service user and carer events have all been supported by the CAG PPI leads; local CCGs and CAG staff.

Events are currently being undertaken within Croydon with a programme of events for local stakeholders, including GP networks, 3rd sector organisations, service users and carers continuing across the implementation phase. The staff consultation has been concluded and further engagement events for staff are currently being planned.

The CCG has held events in Southwark and the AMH team with local staff and CAG PPI leads have attended a number of service user groups. Further events for staff and service users and carers will be undertaken over the coming months as plans progress.

5.3 Monitoring and Evaluation

This workstream has designed a range of reports including a CCG report for each Borough, an internal KPI report, a set of fidelity measures to show whether the teams are delivering the agreed level of interventions and service changes as well as progress on the key Indicators and team level reports based on activity and patient data behind the KPI reports.
The AMH Senior information analyst has worked closely with the HI team and BRC to develop the agreed reports. Reports for Lambeth and Lewisham are produced monthly and are available to the CCGs, OPM, AMH Board meeting and AMH Performance meetings. The internal KPI dashboard for Lambeth and Lewisham is attached (appendix 2). Baseline data for Croydon and Southwark is currently being collected.

Team level reports are available to all of the Lambeth and Lewisham teams included in the programme on a monthly basis, they focus on the activity and patient data behind the KPI dashboards. The reports are used in team business meetings to focus discussions on areas of good practice and areas for further change. The reports also allow comparison across teams within a pathway and thus an examination of any differences in practice between teams.

Staff and service user measures have been collected to monitor satisfaction with the service changes.

Reports have been constructed to allow a formal research evaluation of the model, however funding for analysis of the data is yet to be gained.

5.4 Buildings and IT

Community buildings are generally poor, with a lack of suitable interview room space and waiting room space. The introduction of the AMH teams has exacerbated the issues in the buildings as it has increased the number of staff and also the number of interventions being provided in the team bases.

A specific workstream has been set up in Croydon where the problems are greatest. The workstream links estates and IT with the view to increased IT support for mobile working reducing reliance on buildings.

5.5 Clinical and Operational Models

The Clinical and operational workstreams have supported the development of the operational policies.

Fortnightly interface meetings have been held in Lambeth and Lewisham to develop local agreements between the teams. A number of cross borough workshops have also been held to allow sharing of ideas and networking.

The operational policy has been amended to meet local needs in each of Lambeth and Lewisham and in addition to the full policy “quick guides” have been developed for staff. These document will shortly be available to all on an AMH intranet site.

Local interface meetings for Croydon and Southwark are in the process of being set up and will be running fortnightly from early Autumn.

5.6 HR and Organisational Development

This workstream as over seen by the staff consultation and restructure process and also the training and development aspects of the programme.
Staff consultation was held in Lambeth and Lewisham in spring 2014 and in Croydon in spring 2015. Job descriptions were developed and evaluated for all new roles within the service and appraisals and PDPs undertaken as staff were appointed to their new roles.

Recruitment to vacant posts following the consultation included a Psychosis specific open afternoon and several rounds of external advertisements. A standard assessment process was agreed for posts at the same level across the boroughs. Full recruitment was achieved in Lewisham and in Lambeth MAP services by early 2015. However 7 band 6 care co-ordinator posts remain vacant in Lambeth (see section 5.7.1 for further detail).

Leadership training has been led by SLaM Partners for Team Leaders and consultants. The Psychosis CAG has developed a 5 day training programme for all staff in the promoting recovery pathway which has been delivered in Lambeth and Lewisham and will be rolled out across Croydon and Southwark by end of March 2016. Map Cag has also developed specific training for the assessment and liaison teams and for treatment teams. This training has been provided across all four boroughs with a rolling programme continuing this year.

Further leadership training from SLaM Partners will be provided within Croydon and Southwark this year.

5.7 Borough Implementation

5.7.1 Lambeth and Lewisham

The service has been running in Lambeth and Lewisham since mid September 2014, following a consultation process and restructure of the teams. The key indicators of the changes are being monitored closely with monthly reports as stated above (section 5.3)

Recruitment to band 6 care co-ordinator roles has been challenging. All posts in Lambeth MAP Services and all Lewisham services have now been recruited to, however some posts remain vacant due to usual turnover of staff. In the Lambeth Promoting Recovery Teams (psychosis CAG) recruitment has been very challenging. Prior to implementation of the model there were a number of vacancies across these teams and a further 20 new posts were created.

To help address recruitment in the Promoting Recovery Teams the skill mix within the Promoting Recovery South Lambeth team and Lewisham Neighbourhood 3 team was altered as a pilot, based on skill mix within teams in Hamburg, Germany. Within this team the skill mix has a higher number of Consultant Psychiatrists and Psychologists as well as Advanced Nurse Practitioners, Occupational therapists and AMHPs who all act as care co-ordinators. The team also has two peer support workers employed within it supporting the team by providing practical support and guidance to service users.

7 vacant care co-ordinator posts remain within the three remaining Lambeth Promoting Recovery teams. The Trust has a number of initiatives to enhance recruitment reporting to the Director of Nursing, these include mentorship and training programmes and a marketing strategy. The AMH Programme team are working closely with these initiatives.
5.7.2 Croydon

Croydon CCG are investing in the implementation of the AMH model within Croydon. The model will be implemented in four phases over the next three years. Phases one and two of the model are currently being implemented. These include development of the assessment and liaison teams providing a single point of access for GPs and an increase in the Primary Care Mental Health support Service, a team who support the move of people from secondary care back to primary care. There is also an investment into the Home Treatment Team to support Clozapine Initiation in the community and to work earlier with people in crisis to reduce the length and severity of crisis and so reduce the number of people admitted to hospital and support early discharge for those who are admitted.

In preparation for future phases of AMH in Croydon a restructure of the Promoting Recovery teams is also taking place, the teams are moving from two geographically based teams to four teams that map to the GP networks within the Borough.

Recruitment to services is underway and it is anticipated that the new teams will be fully up and running by October 2015.

Baseline data is being collected and reported. Team level reports will be available from October once the team changes are complete. There is a local CQUIN on training within the Promoting Recovery and MAP teams to be achieved this year.

Estates in Croydon is problematic and there is a workstream in the implementation focusing on this. We are currently looking for properties in the north of the borough to support the network model and reduce overcrowding at Tamworth Road Resource Centre.

Teams in Croydon will be piloting mobile devices to support ore flexible mobile working to reduce the footfall in overcrowded buildings.

5.7.3 Southwark

Southwark CCG agreed the assessment part of the AMH model last year and the service has been restructured to support its implementation. Funding for the remaining aspects of the model has now been agreed. The MAP treatment elements of the model will be in place by 1st October 2015. The Home Treatment and Promoting Recovery elements should be in place by 1st January 2016 subject to confirmation following the outcome of the social care review and further CCG led consultation processes.

6. Next Steps

Next steps for the AMH Programme include:

- Finalisation of plans for phases 3 & 4 of the programme for Croydon
- Continued efforts to gain funding for a formal research evaluation of the model
- Development of the service in lines with integration with primary care supporting the SLIC Programme and local integration initiatives in Lewisham and Croydon
AMH Dashboard - Pathway Measures

Home Treatment - Admissions Gatekept by HTT

Baseline FY 13/14 TOTAL: 96.5%

- HTT - Gatekept Admissions
  - Target: 95%

MAP Accepted Referrals Rate

- Lewisham Accepted Referrals Rate
- Lambeth Accepted Referrals Rate

MAP/AM Treatment - DX back to Primary Care

- MAP Referrals
- PRT Referrals

HTT Accepted Referrals Rate

- Lewisham HTT Referrals Rate
- Lambeth HTT Referrals Rate

Lewisham MAP Referrals

- July-14 to June-15
- Accepted Referrals Lewisham
- All Referrals Lewisham

Lambeth MAP Referrals

- July-14 to June-15
- Accepted Referrals Lambeth
- All Referrals Lambeth

HTT Accepted Referrals

- July-14 to June-15
- Lewisham HTT Accepted Referrals
- Lambeth HTT Accepted Referrals

MAP Treatment - Caseload & Reduction

- MAP Total Caseload
- PRT Total Caseload

PRT - DX back to Primary Care

- MAP Referrals
- PRT Referrals

Latest Update: Jun-15
## Appendix 1c: AMH Investment in Lewisham

£000s

<table>
<thead>
<tr>
<th></th>
<th>FY13/14 Per FBC</th>
<th>FY14/15 Per FBC</th>
<th>FY15/16 Per FBC</th>
<th>FY13/14 Budget</th>
<th>FY14/15 Budget</th>
<th>FY15/16 Budget</th>
<th>FY13/14 Diff</th>
<th>FY14/15 Diff</th>
<th>FY15/16 Diff</th>
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<tr>
<td>Core AMH investment:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting recovery teams Psychosis</td>
<td>201</td>
<td>537</td>
<td>537</td>
<td>0</td>
<td>571</td>
<td>698</td>
<td>(201)</td>
<td>34</td>
<td>161</td>
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<tr>
<td>Assessment and treatment teams MAP</td>
<td>160</td>
<td>411</td>
<td>411</td>
<td>100</td>
<td>308</td>
<td>411</td>
<td>(60)</td>
<td>(103)</td>
<td>0</td>
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<tr>
<td>Home Treatment Teams PMed</td>
<td>41</td>
<td>188</td>
<td>220</td>
<td>0</td>
<td>165</td>
<td>220</td>
<td>(41)</td>
<td>(23)</td>
<td>0</td>
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<tr>
<td>Discharge coordinators Psychosis</td>
<td>22</td>
<td>43</td>
<td>43</td>
<td>0</td>
<td>32</td>
<td>43</td>
<td>(22)</td>
<td>(11)</td>
<td>0</td>
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<tr>
<td><strong>Total</strong></td>
<td>424</td>
<td>1,179</td>
<td>1,211</td>
<td>100</td>
<td>1,076</td>
<td>1,372</td>
<td>(324)</td>
<td>(103)</td>
<td>161</td>
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<table>
<thead>
<tr>
<th></th>
<th>FY13/15</th>
<th>FY14/15</th>
<th>FY15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>External funding</td>
<td>100</td>
<td>533</td>
<td>1,483</td>
</tr>
</tbody>
</table>

Breakdown of the difference:
- Slippage re delayed start date: (424) (294)
- HTT investment advanced: 30
- Early A&T investment: 100
- Additional PRT costs: 161 161

### Notes:
1. Actual costs will differ from budgeted costs due to the net impact of the cost of agency premiums, earlier recruitment and recruitment slippage.
2. The investment in Lewisham did not commence until FY14/15
Date of Board meeting: 28th July 2015

Name of Report: Finance Report (Month 3 FY15/16)

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 2015 (month 2 FY 15/16).

Recommendations to the Board:
The Trust is, overall, on Plan at Q1. However, important elements of the plan are out of balance and with £3.6m of CIP savings phased into the second half of the year without detailed plans the position could deteriorate. The Trust has been working hard to mitigate against such a scenario and an update will be given at the Board. To ensure that the Trust remains on Plan it is recommended that:

- We have individual schemes in place to cover the full CIP programme (including replacement schemes where appropriate) and that these need to have detailed project plans in place as soon as possible

- All current expenditure must be managed within the plan targets and if there is potential for slippage individual directorates and teams must identify local contingency measures in order to hit the targets

- The SMT agree a series of contingency plans to mitigate risks to the financial position to ensure the Trust protects its CoSRR of 3

- We should review the scope of investments in order to ensure the schemes can be progressed to deliver benefits but within resources available

- The costs of transition to new developments not scoped in the plan must be minimised and managed within available resources

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
The report is a key component of risk item 6 of the Board Assurance Framework (ensuring financial sustainability) in terms of the effective and efficient management of resources. The level of assurance provided by the report is currently moderate.
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. The Operational Plan for the Trust requires it to meet an EBITDA target of £12.4m at Q4 and EBITDA of £2.6m for Q1. The Target CoSSR is 3 (made up of a debt service ratio metric of 2 and liquidity metric of 4).

Equality & Diversity and Public & Patient Involvement Implications:
The report identifies activity and financial pressures that if not resolved as part of the delivery of the FY15/16 plan, 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.
Key Issues

1) Cost Drivers
- The positions on acute overspill and ward nursing costs have deteriorated.
- The temporary loss of PICU and Triage beds in the Trust has had a significant impact in June.
- The temporary loss of PICU and Triage beds in the Trust has had a significant impact in June
- Over 15 months. Over half of this variance concerns the PICU wards which rely upon external beds to provide sufficient capacity. A review of PICU capacity is currently taking place to assess the current configuration and introduce measures to mitigate pressure in the system.
- Complex placement budgets were increased this year following investment by Lambeth and Southwark CCGs which should enable a balanced position to be achieved. Although Lewisham CCG increased their investment, this only amounted to 50% of what the Trust had bid for. The expectation from the CCG is that placements can be managed within this resource and are developing a plan to sit alongside this assertion. However at month 3, placements are £211k over plan of which 60% relates to Lewisham CCG.

2) Directorate Positions
- Psychosis is £1m overspent after 3 months. The overspend is largely due to PICU nursing costs, overspill above plan, complex placements expenditure above plan, inpatient complex care income below plan and use of agency staff. There has been significant investment into the Directorate and with it, a clear expectation that costs will not exceed this uplifted budget.
- Estates – a £250k ytd overspend spread over a number of service lines
- The ICT position is under review to ensure that the annual planned expenditure does not exceed the funding made available. The current overspend continued into month 3 with high use of agency staff. There has been significant investment into the Directorate and with it, a clear expectation that costs will not exceed this uplifted budget.

3) CIPs
- The current plan is showing a £0.64m adverse variance which is not expected to change significantly by year end.
- However, this assumes that £3.6m of saving schemes, due to come on stream from Q3 are further developed and implemented successfully. The Programme Office team are supporting Service Directors in this process but this remains a considerable area of risk until detailed schemes are progressed and signed off

Key Financial Drivers
- Performance v CIP - £0.64m - 16% < target
- Ward Nursing - £0.52m overspent
- Acute Overspill - £0.28m overspent excluding impact of risk share
- Complex/Non Secure Placements - £0.21m overspent
- Cost per Case/Cost & Volume - £0.07m ytd < target
Section A – Headlines & Key Issues

1) Headlines

- At Quarter 1 the Trust delivered £2.5m of EBITDA, an adverse variance of £0.1m against its planned position.
- The Operational Plan performance shows a Continuity of Service Risk Rating (CoSRR) of 3 with a liquidity rating of 4 and a debt service ratio of 2 based on our EBITDA at month 3.
- The EBITDA target increases in the second half of the year due to the increasing profile and proportion of savings that are expected to be made. The majority of savings are backed by detailed plans. Whilst progress has been made during the first quarter, however, the detailed scoping and implementation programmes are yet to be finalised for schemes with a value of over £3m. We are developing contingency plans to mitigate against the risk that these plans do not fully deliver in 2015/16.
- A number of key cost drivers, particularly associated with pressures on acute beds, are not in balance at month 3. Given the Trust has only planned for a small contingency and has less headroom than in previous years on its risk rating, it is important that such drivers are managed appropriately and contained within existing resources.
- Although funding has been set aside for various schemes within the Plan, approval is being sought for a number of additional investments. Unless these are self-funding or contained within existing funding envelopes, they would represent a further call on the contingency fund.

2) Key Issues

i) CIPs

- The current plan is showing a £0.64m adverse variance which is not expected to change significantly by year end.
- However, this assumes that £3.6m of saving schemes, due to come on stream from Q3 are further developed and implemented successfully. The Programme Management Office team are supporting Service Directors in this process but this remains a considerable area of risk until detailed schemes are finalised and signed off.

ii) Cost Drivers

- Whilst the improvement in cost and volume income continued this month, the positions on acute overspill and ward nursing costs deteriorated.
- The temporary loss of PICU and Triage beds in the Trust has had a significant impact in June with use of acute beds outside the Trust increasing above that originally planned for. The target level of overspill beds is also dropping in line with the expected impact of AMH investment. In total the Trust used 25 overspill beds in June (12 more than planned). Risk share arrangements only provide a degree of protection (with no risk share in Croydon and unplanned reductions in
Trust capacity not covered). The Triage beds are due to re-open but not until September.

- Ward staffing costs have continued to increase recording their highest in month variance from budget for over 15 months. Over half of this variance concerns the PICU wards which rely upon external beds to provide sufficient capacity. Reported levels of acuity on our own wards have been rising when external beds are not available resulting in use of additional temporary staff. PICU nursing costs are running £0.3m higher than Q1 last year, 45% of which relates to use of temporary staff compared to 32% last year. A review of PICU capacity is currently taking place to assess the current configuration and introduce measures to mitigate pressure in the system.

- Complex placement budgets were increased this year following investment by Lambeth and Southwark CCGs which should enable a balanced position to be achieved provided targeted move ons take place and growth remains within planning assumptions. Although Lewisham CCG increased their investment, this only amounted to 50% of what the Trust had bid for. The expectation from the CCG is that placements can be managed within this resource and are developing a plan to sit alongside this assertion. However at month 3, placements are £211k over plan of which 60% relates to Lewisham.

**iii) CAG/Directorate Positions**

- Psychosis is £1m overspent after 3 months. The overspend is largely due to PICU nursing costs, overspill above plan, complex placements expenditure above plan, inpatient complex care income below plan and use of agency staff in community teams. In addition to these cost pressures, the CAG have yet to identify clear plans against their remaining CIP target (due to be phased in from month 7). The CAG are undertaking a series of actions to help mitigate the position but are forecasting a £2.8m overspend at year end

- MHOA – a £250k ytd overspend across ward and residential units with high observations, various non pay items and unmet income targets

- Estates – a £250k ytd overspend spread over a number of service lines including planning, transport and unmet CIPs

- The ICT position is under review to ensure that the annual planned expenditure does not exceed the funding made available. The current overspend continued into month 3 with high use of agency staff. There has been significant investment into the Directorate and with it, a clear expectation that costs will not exceed this uplifted budget.

**iv) Further Investment**

- As reported at the last Board, since the Plan was approved, there have been further calls to make additional investments. As these were not built into the Plan, any approval will require funding to be found from within existing budgets or to be charged against, what is a relatively small contingency of £2m.

The financial plan of the Trust in 15/16 is extremely tight with little headroom and only a small contingency. Important parts of the Plan are already out of balance, as indicated above, and with an additional £3.6m of CIP savings phased into the second half of the year, the position could rapidly deteriorate if the current cost drivers are not tightly managed, outstanding CIPs schemes aren’t rapidly progressed and consideration isn’t given to manage our internal investment programme within the available resources. Additional measures are also likely to be required given our small contingency and current rate of progress against these key issues.

Gus Heafield
Chief Financial Officer
July 2015
## Section B - Finance Analysis

### 1) Financial Summary

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Full Year Live Budgets (£)</td>
<td>Current Month Actual (£)</td>
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<tr>
<td>01. Psychosis</td>
<td>101,215,700</td>
<td>9,145,200</td>
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<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>0</td>
<td>(64,300)</td>
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<tr>
<td>03. Mood, Anxiety, Personality</td>
<td>2,800,200</td>
<td>182,000</td>
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<td>04. Psychological Medicine</td>
<td>846,500</td>
<td>16,000</td>
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<td>05. Child &amp; Adolescent Service</td>
<td>2,386,600</td>
<td>28,900</td>
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<td>06. MHOA And Dementia</td>
<td>0</td>
<td>149,500</td>
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<td>07. Addictions</td>
<td>0</td>
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<td>08. Clinical Support Services</td>
<td>1,528,400</td>
<td>121,200</td>
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<td>09. Infrastructure Directorates</td>
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<td>10. Corporate Income</td>
<td>(101,442,200)</td>
<td>(8,361,600)</td>
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<td><strong>Operational Deficit</strong></td>
<td>60,783,200</td>
<td>6,391,400</td>
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<td>11. Corporate Other</td>
<td>(77,229,500)</td>
<td>(7,207,500)</td>
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<td>12. Contingency - planned</td>
<td>2,000,000</td>
<td>0</td>
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<tr>
<td>14. Other reserves/provisions released</td>
<td>1,961,200</td>
<td>0</td>
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<tr>
<td><strong>Corporate Other</strong></td>
<td>(73,268,300)</td>
<td>(7,207,500)</td>
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**EBITDA**

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<tr>
<td><strong>CAGs</strong></td>
<td>(307)</td>
<td>(428)</td>
<td>(4,297)</td>
<td>(91)</td>
<td>(703)</td>
<td>(242)</td>
<td>(1,036)</td>
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<td>(2,708)</td>
<td>(242)</td>
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<td><strong>Corp Income</strong></td>
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<td><strong>Other reserves/provisions released</strong></td>
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<td>(226)</td>
<td>182</td>
<td>227</td>
<td>(40)</td>
<td>762</td>
<td>949</td>
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<td><strong>Use of Reserves</strong></td>
<td>2,326</td>
<td>590</td>
<td>7,205</td>
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<td>1,218</td>
<td>(314)</td>
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<td><strong>Total EBITDA</strong></td>
<td>459</td>
<td>(1,316)</td>
<td>(2,138)</td>
<td>7</td>
<td>(130)</td>
<td>43</td>
<td>(80)</td>
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</table>
Performance against the main cost drivers is detailed below –

- **Acute/PICU Overspill**

Pressure on beds has increased. Overall, 25 beds (747 obds) were used outside the Trust in June, an increase of 9 compared to the previous month. This is 4 beds above the year to date plan based on the contract baselines agreed with Lambeth, Southwark and Lewisham CCGs adjusted for the impact of AMH. However it is 12 beds above the plan for June and is resulting in a £278k overspend in Psychosis. Discussions continue with Croydon to agree a realistic baseline in line with the AMH proposals. Planned overspill activity is due to fall over the next 3 months due to the impact of AMH community investment in Lambeth and Lewisham but this is being impacted upon by the decision to reduce admission/activity levels on Croydon Triage (by 8 beds) to ensure continued safety and quality whilst staffing level issues are resolved. This unit is not expected to be back to full capacity until September.

- **Ward/Unit Nursing Costs**

At month 3 ward nursing costs overspent by £283k (£526k ytd). This position is after an additional investment over the last 12 months of £4.1m for safer staffing. The table below shows the impact that additional funding made in the middle of 2014/15 but since then, the costs of ward nursing have steadily risen such that June is the highest variance for 15 months.

The main areas of concern at month 3 continue to be the PICU wards. In total these are £286k overspent across the Psychosis and B&D CAGs and largely relate to the requirement for staff to cover 1:1 and 2:1 observations. The male PICUs have been running at full capacity and reporting that acuity and complexity have risen partly due to a change in patient
mix following the closure of the third male PICU ward in 2014. Medical input has increased and discussions taken place with the private provider of block beds to reduce instances of non-acceptance of SLaM patients when they are considered to unwell for admission.

Other areas of concern include Chelsham and Ann Moss Domus (both MHOA facilities) which are £162k overspent on nursing after 3 months due to high use of observations.

Additional funding will also be going into a place of safety team to ensure improved access to PoS whilst the longer term solution for a centralised service is being developed.

- **Complex Placements**

  Following an overspend of £2.49m in 2014/15, additional resource was secured from Lambeth, Southwark and Lewisham CCGs to help fund this increase in placement activity. As a result, the position has improved but is still showing a year to date overspend of £210k, largely related to Southwark and Lewisham. The Lewisham position has deteriorated (£126k over ytd) following our bid for additional placements funding being reduced in the final Lewisham contract. The Joint Commissioning Lead at Lewisham CCG has been tasked with developing an agreed recovery plan with SLaM to ensure placement expenditure is kept within resources available. Although risk shares are in place, these are relatively small, in recognition of the resource uplift this year and the expectation that the Trust will now manage its placements within Plan.

- **Cost per Case/Cost and Volume Income**

  Overall the variance position has continued to improve. This is being driven by the performance in B&D, in particular the high occupancy levels in the National Autism Unit. Outside of B&D the main shortfalls in income have occurred in –

  i. Psychosis – the Rehab Units are occupied by Lambeth patients who attract no additional income, at this stage, under the Alliance contract arrangements. The plan
was for these beds to be freed up by enabling more rapid move on and preventing admissions using the resources of the Alliance partnership. These beds could then be sold to other purchasers. To date this has not happened resulting in a year to date shortfall of £104k against the planned non Lambeth income target. However this adverse position could deteriorate more rapidly over the coming months with Lambeth commissioning a further 15 less beds by August and a further 7 by March.

ii. Psychological Medicine – not meeting activity/income targets in several outpatient services particularly memory disorders. This will addressed following the employment of a locum consultant to

iii. MHOA – Lambeth CCG reduced the number of beds they purchased in Greenvale from April. In order to breakeven, £450k of spare capacity (c4 beds) must now be sold to other purchasers. To date only 1 bed has been sold on.

<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>
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<tr>
<td>Psychosis</td>
<td>1,176</td>
<td>1,115</td>
<td>(61)</td>
<td>(38)</td>
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<tr>
<td>Behavioural &amp; Dev</td>
<td>5,095</td>
<td>5,376</td>
<td>281</td>
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<td>Psychological Med</td>
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<td>Mood and Anxiety</td>
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<td>CAMHS</td>
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<td>5,550</td>
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<td>(42)</td>
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<td>MHOA</td>
<td>114</td>
<td>26</td>
<td>(88)</td>
<td>(58)</td>
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<tr>
<td>Addictions</td>
<td>195</td>
<td>198</td>
<td>(3)</td>
<td>(4)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>19,577</strong></td>
<td><strong>19,509</strong></td>
<td><strong>(68)</strong></td>
<td><strong>(180)</strong></td>
</tr>
</tbody>
</table>

3) **Cost Improvement Programme (CIP) & CCG QIPP**

a) **Trust CIP (Table 1)**

The Trust plan requires it to make £21m of CIP savings split £8.5m over the first 6 months of the year and £12.5m over the second. At Q1 £3.9m (19%) of the CIP plan has been phased in.

At month 3, the Trust is reporting a £643k (16%) adverse variance from plan which is forecast to remain at a similar level by year end. The main areas of variance reflect the current overspend on complex placements, a lower than planned settlement from contract negotiations with NHSE and various CAG schemes which have been delayed or where schemes with reduced values have not been fully offset with new schemes.

The main risk on CIPs however concerns the £3.6m of savings that are due to be delivered in the second half of the year. This is made up of £2.2m of CAG/Infrastructure savings and £1.4m of Trustwide savings where detailed plans are still being finalised. The current forecast assumes that these will be met but this will need revising if schemes are not progressed. The Programme Office Team continue to meet with Service Directors to support them in reviewing and improving planning for CIPs and seeking to develop new ideas for cost savings. In addition there are £1.1m of HR driven initiatives (agency, e-rostering, sickness, recruitment) that are expected to result in reduced expenditure across all parts of the Trust.

b) **CCG QIPP (Table 2)**

QIPP plans have been agreed with Lambeth, Southwark and Lewisham CCGs totalling c£4m. The majority of the savings (89%) relate to a reduction in the purchase of beds – both adult and elderly. These targets rely upon replacing
reductions in activity with new funded activity (e.g. income targets at Greenvale) or reducing existing capacity and saving costs (e.g. closure of Inglemere Road). At month 3 a variance of £343k against Plan is being reported. This is largely due to acute obd reductions not being made in Southwark (the adverse impact will be partly offset under the current risk share arrangements) and not achieving income targets at Greenvale where spare capacity created by Lambeth CCG disinvestment was to be sold.

4) Local CCG/NHSE Contract Positions

Since last month agreement has been reached with NHS Lewisham about the application of £1m of additional funding. This will now support investment into the AMH model but results in a smaller amount available to fund complex placements in 2015/16. This was agreed on the basis that the CCG will take the lead on work to determine what is the correct level of funding for this service in future. The contract documentation for Lewisham has therefore been signed. The contract with NHS Croydon has also been signed but a number of investments remain subject to business case approval (including community AMH). Formal decisions on these cases are expected shortly.

5) Capital Expenditure

The capital expenditure plan for 2015/16 is £18.8m and includes a provision for slippage of £3m. The forecast expenditure at month 3 is £17.5m (93% of the plan). As at month 3, capital expenditure was £2.5m, £0.3m below plan (a 9% variance). The main variances from plan (> £100k) at month 3 were –

- £410k staff attack alarms slippage
- £248k replacement transport fleet slippage
- £198k Marina house refurb slippage
- £170k Luther King and Nelson bathrooms underspend
- £143k digital observations project slippage
- £123k Wi-Fi roll-out slippage
- £103k Chelsham refurb and anti-ligature slippage

Less

- £500k release of slippage contingency
- £301k Witley – ward in community ahead of plan
- £203k Ladywell ward refresh ahead of plan
- £202k Ladywell staff attack alarms ahead of plan
- £163k ICT PC / thin client ahead of plan

The Annual plan for disposals is £4.9m with the first disposal due in Q2.

Tim Greenwood & Mark Nelson
Finance Department
July 2015
<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMH</td>
<td>Adult Mental Health – used in this report to cover a programme of investment in community schemes that aim to reduce the usage of acute/triage beds in the Trust</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bring together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CIPs</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating (CoSRR)</td>
<td>A combination of 2 indicators focussing on liquidity and ability to service capital and debt that help to indicate the level of risk to the financial sustainability of a Trust ranging from 1 (high risk) to 4 (low risk)</td>
</tr>
<tr>
<td>CPC/C&amp;V</td>
<td>Cost per Case and Cost and Volume income varies depending upon the amount of clinical activity being undertaken</td>
</tr>
<tr>
<td>EBITDA</td>
<td>Earnings before interest, tax, depreciation and amortisation is an accounting measure used as a proxy for an organisation's current operating profitability</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>MHOA</td>
<td>Mental Health of Older Adults</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit - provide mental health care and treatment for people whose acute distress, absconding risk and suicidal or challenging behaviour needs a secure environment beyond that which can normally be provided on an open psychiatric ward</td>
</tr>
<tr>
<td>PoS</td>
<td>Place of Safety – under section 136 of the Mental Health Act, the police have the power to take an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a “place of safety” where they may be assessed by a doctor</td>
</tr>
<tr>
<td>QIPP</td>
<td>The Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help reduce the cost of services to the CCG</td>
</tr>
<tr>
<td>Triage</td>
<td>Triage ward – used to admit patients for a short period of time where their needs are assessed before being either discharged to the care of community teams or transferred to an acute ward</td>
</tr>
<tr>
<td>YTD</td>
<td>Year To Date</td>
</tr>
</tbody>
</table>
### Table 1 - SLAM summary CIP status report

**Jun-15**

<table>
<thead>
<tr>
<th>£000s</th>
<th>Plan YTD</th>
<th>Actual YTD</th>
<th>YTD variance from Plan</th>
<th>Value of Additional Schemes YTD</th>
<th>Full year Plan</th>
<th>Full year Forecast</th>
<th>Full year variance from Plan</th>
<th>Full year Forecast of Additional Schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAG schemes:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,547</td>
<td>1,254</td>
<td>(293)</td>
<td></td>
<td>87</td>
<td>6,468</td>
<td>6,376</td>
<td>(92)</td>
<td>602</td>
</tr>
<tr>
<td><strong>Corporate schemes:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>665</td>
<td>712</td>
<td>46</td>
<td></td>
<td>139</td>
<td>3,215</td>
<td>3,567</td>
<td>352</td>
<td>482</td>
</tr>
<tr>
<td><strong>Trust wide schemes:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,702</td>
<td>1,306</td>
<td>(396)</td>
<td></td>
<td>-</td>
<td>9,055</td>
<td>8,141</td>
<td>(914)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td>3,914</td>
<td>3,271</td>
<td>(643)</td>
<td>227</td>
<td>18,738</td>
<td>18,084</td>
<td>(654)</td>
<td>1,085</td>
</tr>
</tbody>
</table>

### Overview comment

There are a number of CAGs where schemes have been delayed or where schemes with reduced values have not been fully offset with new schemes. The most significant loss of value is in B&D

Most areas are on track with the Plan with significant upsides from additional schemes in Estates and E&T. There remains some significant uncertainty especially re the pathology contract savings.

The YTD and full year shortfalls reflects overspends on Complex care Placements (£356K) and lower than planned outcome from negotiations with NHSE (£525k). There remains £1.4m of savings not yet backed by detailed plans. The workforce schemes are largely assumed to be delivered.
## Table 2

### 2015/16 CCG QIPP Plan - Actual Versus Target (at month 3)

#### 1) By CAG

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>YTD</th>
<th>YTD</th>
<th>YTD</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Target</td>
<td>Achieved</td>
<td>Variance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,995</td>
<td>359</td>
<td>120</td>
<td>239</td>
<td></td>
</tr>
<tr>
<td>MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>229</td>
<td>57</td>
<td>57</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>MHOA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,916</td>
<td>313</td>
<td>209</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4,141</td>
<td>729</td>
<td>386</td>
<td>343</td>
<td>Excludes QIPP currently earmarked for specialist C&amp;V activity (CCG risk)</td>
</tr>
</tbody>
</table>

---

14/15 Lambeth CCG prescribing QIPP carried forward but no agreed plan yet to reduce costs. Awaiting feedback/analysis on primary care savings from CCG Pharmacy Lead before agreeing with CCG a way forward. Total acute beds are overperforming against the funded plan (£186k).

Savings in IAPT services agreed and being implemented.

Service in Woodlands transferred in 2014 but building not disposed of or re-used. Lew CCG reduction in beds on Hayworth does not realise a QIPP because StAl is not able to sell spare capacity. This loss has been built into the Plan in 15/16 and hence no variance BUT requires an agreed plan for 2016/17. CAG also required to sell £450k of spare capacity (c4 beds) at Greenvale following a reduction in Lambeth CCG purchased beds. To date, 1 bed has been sold.

#### 2) By CCG

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>YTD</th>
<th>YTD</th>
<th>YTD</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Target</td>
<td>Achieved</td>
<td>Variance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lambeth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,436</td>
<td>257</td>
<td>100</td>
<td>157</td>
</tr>
<tr>
<td>Southwark</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>301</td>
<td>232</td>
<td>46</td>
<td>186</td>
</tr>
<tr>
<td>Lewisham</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,637</td>
<td>240</td>
<td>240</td>
<td>0</td>
</tr>
<tr>
<td>Croydon</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>138</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4,141</td>
<td>729</td>
<td>386</td>
<td>343</td>
</tr>
</tbody>
</table>

---

14/15 Lambeth CCG prescribing QIPP carried forward but no agreed plan yet to reduce costs. Awaiting feedback/analysis from CCG Pharmacy Lead before agreeing with CCG a way forward. Greenvale required to sell £450k of spare capacity - £0 income to date.

Acute total reductions not being realised.

CAG QIPP (Target Versus Actually Achieved)

### CCG QIPP (Target Versus Actually Achieved)

![Graph showing CCG QIPP Target, Actual, and Forecast](image-url)
**Date of Board meeting:** 28<sup>th</sup> July 2015  
**Name of Report:** Performance Report, Month 3, 2014/15  
**Heading:** - (Strategy, Quality, Performance & Activity, Governance) Performance  
**Author:** Roy Jaggon, Head of Performance Management  
**Approved by:** Neil Brimblecombe, Director of Nursing  
**Presented by:** Roy Jaggon, Head of Performance Management  

**Purpose of the report:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>To report the Trusts’ performance against a range of key indicators for 2015/16, 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 and available.</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations to the Board:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>To approve the report noting the ongoing development of the Trust performance reporting.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Performance Framework is an operational control with an assurance level of moderate.</td>
<td></td>
</tr>
</tbody>
</table>

**Summary of Financial and Legal Implications:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified where relevant in the report.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The report identifies performance and activity issues 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</td>
<td></td>
</tr>
</tbody>
</table>

**Service Quality Implications:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The report identifies performance and activity and issues that if not resolved may have implications on the Trust’s ability to deliver its quality commitments as set out in the Annual Plan</td>
<td></td>
</tr>
</tbody>
</table>
INTRODUCTION

This report consists of the following elements:

1. Quality and Performance Dashboard
2. Monitor Q1 Return
3. Safer Staffing
4. Patient Stories

1. Quality and Performance Dashboard - Updates July 2015

There are no specific performance areas of concern for the month other than those already listed in the ‘Issue tracker’.

Of note there is work currently underway on care-planning including:

- Care Plan Summary development on PJS
- Training programmes across all CAGs
- Focus groups with frontline staff to explore simplifying and improving existing care planning processes
- New reporting and audit tools

I. Issue tracker

In the tracker there are a number of items of focus as follows:

1. Physical Health: Communication with GP CQUIN and Discharge communications to GP

Physical Health continues to be a quality priority and a CQUIN. Physical Health CQUIN leads are meeting regularly. The project plan incorporates regular feedback reports to clinicians and providing training where required. A project proposal regarding audit parameters is currently being devised with the relevant CQUIN lead. A meeting with E&T to develop a training package is scheduled. In addition to meetings with consultant leads, Physical Health will also be addressed in junior doctors’ induction. There will be amendment to GP communications and discharge notifications on PJS to capture CQUIN information. Final parameters have been agreed with commissioning leads and a variation document has been submitted by the commissioners to reflect our local variations to the national CQUIN.

A new overall CQUIN project manager is in post and interview scheduled for Nurse project lead.

2. Do you feel safe?’ (on the ward) target >90 % (2014/15 result was 81%)
The most recent PEDIC data indicates similar levels performance, although with an increase in May. This remains a Trust Quality Priority in 2015/16.

A thematic review of violent incidents and action plans is included in the July Quality Sub-Committee papers. The Four Steps to Safety plan and Reducing Restrictive Interventions plan will support improving patients’ feelings of safety.

A holistic view is also required considering those initiatives which will have most impact on patients' responses to the question “do you feel safe”. This includes environmental issues, ligature works, improving patient sight lines of staff and improving engagement and accessibility of staff.

Other issue log items:

**Mandatory Training**

Education & Training have received corrected Staffing data from all CAGs this will now be updated onto the WIRED system.

With the completion of the appraisal process, which includes review of mandatory training, there is an expectation that compliance levels will continue to rise.

**Patient Experience Reporting (PEDIC and Family and Friends)**

The reporting flow has been re-established earlier this year and regular reports are being received. The contract is in the process of being re-tendered with a new contract start date of October 2015.

2. **Monitor Q1 Return**

The Trust has met all of the eight indicators for Q1 as outlined in Monitor’s Risk Assessment Framework. These are:

- Care Programme Approach (CPA) follow up within 7 days of discharge
- Care Programme Approach (CPA) formal review within 12 months
- Admissions had access to crisis resolution / home treatment teams
- Meeting commitment to serve new psychosis cases by early intervention teams
- Minimising MH delayed transfers of care
- Data completeness, MH: identifiers and outcomes
- Compliance with requirements regarding access to healthcare for people with a learning disability
3. Safer Staffing

The safer staffing report for May 2015 is enclosed. 28% (15) wards breached in May. 88% of the breaches in May are due to Support workers covering qualified nurses & NHSP being unable to fill shifts. This remains consistent with previous months. The Lead for Safer Staffing has started work with teams specifically looking at management of the health roster (AL, setting rules, adherence to policy) and on the process of advanced planning and booking of NHSP, how they can be improved with the aim of reducing last minute requests and increasing the fill rate.

The NHSP platform in healthroster is now entering wave 2 with 8 wards now using the system and it will be rolled out to all inpatient teams over the next few months. The Lead for Safer Staffing is working with E-Roster team to plan the roll out of the Safe Care platform which will give Team Leaders & Senior Managers real-time view of staffing levels, patient acuity and dependency across the wards and therefore enable day to day operational changes and efficient use of staff.

4. Patient Stories

5. The PALS team has kindly agreed to present a story through a carer. She will describe in person her mixed experiences when her son was referred to and assessed by the Maudsley’s ADHD service. She posted about her experience on NHS Choices and was responded to by the Trust Lead Bill Berry, who worked with her and the team to try and resolve the difficulties she encountered.

Martin Black
Stephanie Hamilton
Performance Management
July 2015
<table>
<thead>
<tr>
<th>Clinical Academic Group Name</th>
<th>Hospital Site</th>
<th>Ward name</th>
<th>Breach %</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Levels in Inpatient Wards - May 2015</td>
<td>Wandsworth Prison</td>
<td>Addison ward</td>
<td>26%</td>
<td>Breaches due to NHSP unable to provide staff</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Brook Ward</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Chaffinch Ward</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Effra Ward</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>National Autism Unit (NAU)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Norbury Ward</td>
<td>26%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Spring Ward</td>
<td>26%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Thames Ward</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Waddon Ward</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>Ward in the Community (WIC)</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Acorn Lodge Children’s Unit</td>
<td>11%</td>
<td>11% of total breaches planned due to decreased patient occupancy.</td>
</tr>
<tr>
<td></td>
<td>Woodland House</td>
<td>Ash Adolescent Unit</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Bethlem Adolescent Unit (BAU)</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Woodland House</td>
<td>Oak Adolescent Unit</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maudsley Hospital</td>
<td>Snowfields Adolescent Unit</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ann Mox Way</td>
<td>Ann Mox Specialist Care Unit</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maudsley Hospital</td>
<td>Audrey Lewis 1 Ward (AL1)</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Chelsham House</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Voss Court</td>
<td>Greenvale Specialist Care Unit</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ladywell Unit</td>
<td>Hayworth Ward</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inglemere Road</td>
<td>Inglemere Specialist Care Unit</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Croydon Triage</td>
<td>26%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Eating Disorders Unit (EDU)</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>Lambeth Triage</td>
<td>62%</td>
<td>15% of total breaches planned due to decreased patient occupancy. Majority of breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Ladywell Unit</td>
<td>Lewisham Triage</td>
<td>19%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Mother and Baby Unit (MBU)</td>
<td>24%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Maudsley Hospital</td>
<td>Audrey Lewis 3 Ward (AL3)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>Bridge House</td>
<td>6.3%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Ladywell Unit</td>
<td>Clare Ward</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>Eden Ward</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maudsley Hospital</td>
<td>Eileen Skellern 1 Ward (ES1)</td>
<td>26%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Maudsley Hospital</td>
<td>Eileen Skellern 2 Ward (ES2)</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Foxley Lane</td>
<td>Foxley Lane</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Gresham 1 Ward</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Gresham 2 Ward</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heather Close</td>
<td>Heather Close Rehabilitation Inpatient Ward</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maudsley Hospital</td>
<td>Jen Boley Unit (JBU)</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maudsley Hospital</td>
<td>John Dickson Ward</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ladywell Unit</td>
<td>Johnson PICU</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>Lambeth Early Onset Ward (LEO)</td>
<td>32%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>Luther King Ward</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>McKenzie Rehabilitation Inpatient Ward</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>National Psychosis Inpatient Ward (Fitzroy II)</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Nelson Ward</td>
<td>13%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Ladywell Unit</td>
<td>Powell Ward</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maudsley Hospital</td>
<td>Ruskin Ward</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>Tony Hills Unit</td>
<td>33%</td>
<td>Majority of breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Westways Rehabilitation Inpatient Ward</td>
<td>64%</td>
<td>Breaches due to NHSP unable to provide staff</td>
</tr>
<tr>
<td></td>
<td>Ladywell Unit</td>
<td>Wharton Ward</td>
<td>6%</td>
<td></td>
</tr>
</tbody>
</table>
Date of Board meeting: 28th July 2015
Name of Report: Education and Training report on mandatory training (MT) compliance
Heading: Performance & Activity
Author: Jacquie Pryke
Approved by: Louise Hall
Presented by: Louise Hall

**Purpose of the report:**
To provide the Board with an update on Mandatory Training compliance, outline current gaps and proposals for remedial action.

**Recommendations to the Board:**
This report highlights actions taken and further recommendations to improve compliance to the set target of 85% compliance.

**Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:**
Mandatory training is an integral part of the Trust Assurance Framework and will be subject to assessment and inspection by the CQC.

**Summary of Financial and Legal Implications:**
If staff is not up to date with their mandatory training, this may have significant patient safety, financial and legal consequences. All Staff are required to ensure they have completed their mandatory training in order to provide safe and effective services.

**Equality & Diversity and Public & Patient Involvement Implications:**
Mandatory training is applicable and accessible to all staff.

**Service Quality Implications:**
Non-compliance with mandatory training and remaining up to date with clinical skills, especially those around resuscitation and management of violence and aggression can lead to poor interventions and affect the quality of the service delivered.
We need to ensure that staff are safe and skilled to provide high quality services to our patients.
Introduction

The purpose of this report is to provide an update to the Board on the present level of compliance across the Trust for Mandatory Training. This report looks at the contributing factors that have affected compliance and identifies ways to improve and promote mandatory training across the trust to ensure that we reach and maintain the required level of compliance.

Mandatory training compliance targets for the *10 core subjects are set nationally at 85%, with the exception of Information Governance which has a national target of 95%. Compliance with mandatory training has reduced over the last year and is below the target of 85%, we are currently only achieving this in four of the core subjects.

*From April 1st 2015 Prevent training was made a statutory requirement for all NHS Trusts, this means that there are now 11 subjects in Level A. Prevent training is being rolled out from August 2015.

Compliance Monitoring:

Mandatory training compliance had previously been recorded on the Manual Training Logs. The move to WIRED encountered a number of problems and challenges with the reconciliation of data between source systems which then impacted on the mapping of staff to WIRED. A large reconciliation process commenced jointly with Education and Training, CAGs/ and Finance to ensure the data in WIRED is correct. This has been a resource intensive process and has now been handed over to Finance to upload into the ESR hierarchy data has now been collated and this has been handed over to finance so that the changes can be made to ESR hierarchy moving forward. A number of issues with the training data raised by CAGs have been reviewed and some important anomalies have been identified:

- Staff not completing the correct level of training for their role.
- An incorrect refresher period on the training log resulting in expired training.
- Staff unaware of the frequency of refreshers.
- Training logs are corrupted and the conditional formatting is not working and so showing as compliant instead of expired.
- Over 200 staff that signed up to eLearning aligned themselves with the wrong Trust and so we did not receive the data.
- Staff completing mandatory training external to the Trust such as Local Authority. This has been addressed with teams and registers for Local Authorities registers are now being sent and monitoring of this is improving.
Current levels of compliance:

Compliance levels during the last financial year from April 1st 2014 to March 31st 2015 showed a considerable decrease in compliance of the core subjects (see Appendix 1). Since April 2015 compliance has slowly started to improve, this will be due a combination of the recent changes that have been made to Trust induction and DNA’s to improve compliance.

Table 1: Current Trust levels of compliance

<table>
<thead>
<tr>
<th>Core Subject</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key: Red = Below 64%,</td>
<td></td>
</tr>
<tr>
<td>Fire awareness</td>
<td>73%</td>
</tr>
<tr>
<td>Basic Life Support Level 1</td>
<td>87%</td>
</tr>
<tr>
<td>Basic Life Support Level 2</td>
<td>65%</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>62%</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>66%</td>
</tr>
<tr>
<td>Conflict resolution/PSTS Awareness</td>
<td>91%</td>
</tr>
<tr>
<td>PSTS Disengagement</td>
<td>56%</td>
</tr>
<tr>
<td>PSTS Teamwork</td>
<td>67%</td>
</tr>
<tr>
<td>Health &amp; Safety Awareness</td>
<td>79%</td>
</tr>
<tr>
<td>Moving &amp; Handling Level 1</td>
<td>63%</td>
</tr>
<tr>
<td>Moving &amp; Handling Level 2</td>
<td>43%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>56.5%</td>
</tr>
<tr>
<td>Infection Control Level 1</td>
<td>90%</td>
</tr>
<tr>
<td>Infection Control Level 2</td>
<td>71%</td>
</tr>
<tr>
<td>Safeguarding Adults Alerters</td>
<td>80%</td>
</tr>
<tr>
<td>Safeguarding Adults Alerters Plus</td>
<td>66%</td>
</tr>
<tr>
<td>Safeguarding Children Levels 1</td>
<td>83%</td>
</tr>
<tr>
<td>Safeguarding Children Levels 1 &amp; 2</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Children Levels 3</td>
<td>83%</td>
</tr>
</tbody>
</table>

For full data of CAG and Corporate compliance levels see Appendix 2.

Gaps or Areas requiring greatest improvement:

The areas identified in red above need urgent solutions to improve compliance and will be targeted by E & T to ensure that additional face-to-face courses are available and staff are supported if they experience difficulties in accessing or completing the eLearning options.

Analysis of compliance / Contributing Factors to decrease in compliance.

Through review a number of important factors have been identified which have had an adverse effect on mandatory training compliance during 2014/15.

Impact of changes to Trust Corporate Induction (TCI) from April 2014:

In April 2014, the TCI was streamlined and reduced from 5 days to 3 days resulting in only 5 of the core subjects being covered. The following mandatory subjects were removed and compliance for these subjects has dropped significantly over the last year.
• Manual Handling of Loads: compliance has dropped from 80% in March 2014 to 67% in March 2015
• Manual Handling of Patients: compliance has dropped from 82% in March 2014 to 43% in March 2015
• Clinical Risk: compliance has dropped from 73% in March 2014 to 45% in March 2015
• Mental Health Law – (Mental Health Act & Mental Capacity Act)

The following courses were kept on as an optional day 4. Managers could opt to choose for their staff to stay and complete these elements of Mandatory training before going to their work areas:-

• Information Governance: compliance has dropped from 71% in March 2014 to 46.5% in March 2015
• Health & Safety: compliance has dropped from 89% in March 2014 to 79% in March 2015
• Equality, Diversity & Human Rights only became mandatory in April 2014

Impact of 6 month DNA/Late Withdrawal Charges Amnesty

The 6 month amnesty on DNA and late withdrawal charges had a significant impact on attendance to courses. During this period DNA/late withdrawals rose to 709 compared to 182 in the previous six months, this was an increase of 289.5%.

Release of staff

It is reported through Trust E & T committee and Mandatory Training Committee that CAGs are struggling to release staff for training. E & T have provided additional team training to support CAGs in the following subjects:

• Safeguarding Adults Alerters and Alerters Plus
• BLS/FAAW/ILS
• Equality, Diversity & Human Rights
• Moving & Handling
• Fire Awareness and Infection control
• Clinical Risk
• PSTS awareness and PSTS disengagement

All core subjects, with the exception of the physical competency based ones (BLS/ILS and PSTS disengagement and Teamwork), have eLearning options that can be completed instead of face to face courses, eLearning generally is a quicker option can impacts less on release time.

Actions taken to address issues identified in analysis of compliance:

Trust Corporate Induction

It has been agreed that the optional day 4 on induction becomes a mandatory attendance day like days 2 & 3 to help improve compliance on Information Governance,
Health & Safety and Equality, Diversity & Human Rights. This came into effect on April 1st and an improvement in compliance is already evident:-

- Information Governance: compliance has risen from 47% in March 2015 to 56.5% currently
- Health & Safety: compliance has risen from 76% in March 2015 to 79% currently
- Equality, Diversity & Human Rights only became mandatory in April 2014 but compliance has improved from 58% in March 2015 to 66% currently

DNA Amnesty on charges

The amnesty on charges was an untenable situation to continue with as it was having a severe effect on courses, compliance and delivery for E & T. After a review of the six month amnesty charges were re-instated as from April 1st 2015. Courses that were specifically affected and had the highest DNA’s rates were: Immediate Life Support & PSTS Teamwork course (5 day course).

Release of staff

E & T recognise that it can be difficult to release staff from clinical areas, but this could improve through better planning and mapping of training requirements throughout the financial year by the teams and CAGs which included releasing staff in a co-ordinated way.

E & T will work proactively with the CAGs and Teams that have the lowest compliance to find ways of addressing this and will encourage staff to complete eLearning as an alternative.

E & T recently completed a Subject Matter Expert review on all mandatory topics to look at how we can improve access for staff and initiate both online pre-assessment and refreshers for the majority of subjects, and develop ‘block mandatory training days’ and review all eLearning so that it is fit for purpose. This work will be completed by Dec 2015.

Further recommendations to improve compliance:

Appraisal/PDR Form

A recent audit on Education and Training made a recommendation that an employee should be made more accountable for completing their mandatory training. To further support this recommendation E & T request that the section relating to mandatory training, which was previously on the old Appraisal form, be put into the new PDR form.

Identification of staff for mandatory training

Levels of mandatory training are separated into two categories: Level A is the 10 core subjects identified by Skills for Health Core Skills Framework and requirements to complete these are aligned with national standards and guidance. Levels B subjects are identified as mandatory according to national/local/Trust policy, specific to an individual’s role or CAG requirement. E.g. Clinical risk/MEWS/Mental Capacity Act/Deprivation of liberties etc. Presently it is the responsibility of the CAG to identify these subjects and
their target groups. This allows for more autonomy to decide which group of staff have to do which training and is something that was highly supported by CAGs and services initially.

Mapping of Level B courses on WIRED has been slow to initiate as there has been a limited response from CAGs to identify these courses to enable E & T to map them on WIRED. Many of the Local E & T committees are now saying that they want E & T and this to be centrally determined a Trust-wide level which means reverting back to the old system. However E & T feel there are advantages and disadvantages to this:

- This would not support the philosophy of giving the CAGs some control and responsibility over the levels of Mandatory Training and whom it applies to.
- Would revert to using terms like ‘all clinical staff’ or all ‘non-clinical’ staff and would not allow for specific exceptions to be mapped.
- This would reduce flexibility to prevent staff attending unnecessary training.
- It would allow E & T the ability to apply all courses to WIRED database which will improve monitoring data.

In is the intention that this issue will be discussed further at the Trust E & Committee on 24th July 2015.

Changing the message about Mandatory Training

Mandatory training is sometimes not universally viewed as part of an individual's development or seen to be of importance. We need to start to create a positive message about why mandatory training is so important. It is essential that senior management continue to support mandatory training so that staff understand that the standards and criteria are set in accordance with National guidelines and provide a key part of assurances for the Trust that staff are safe and skilled to provide high quality services to our patients.

Monitoring of compliance

E & T will continue to monitor compliance through a number of forums and will continue to provide reports to the Quality sub-Committee, Health & Safety Executive and OPM. It is important that Team leaders and managers prioritise mandatory training above any other training and use WIRED to monitor. It is essential to reinforce the personal responsibility through supervision. Completion of changes to ESR should improve the mapping process of staff data on WIRED, so that all roles are aligned to the correct level of training required.

Summary

E & T are proactively working with services to improve the compliance of mandatory training. This includes providing additional training interventions through classroom, team training and eLearning courses. With this increased support we would expect to see a considerable improvement in compliance by the end of August compared to April 2015.
Appendix 1: Comparison of compliance— those subjects highlighted in red show a decrease in compliance during the last financial year

<table>
<thead>
<tr>
<th>Course Title</th>
<th>End of year compliance March 2014</th>
<th>End of year compliance March 2015</th>
<th>Current compliance July 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Awareness</td>
<td>78%</td>
<td>68%</td>
<td>73%</td>
</tr>
<tr>
<td>Basic Life Support Level (Combined total for level 1 &amp; 2)</td>
<td>74%</td>
<td>71%</td>
<td>76%</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>82%</td>
<td>50%</td>
<td>62%</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>N/A</td>
<td>58%</td>
<td>66%</td>
</tr>
<tr>
<td>PSTS 1/2 Awareness or conflict resolution</td>
<td>79%</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>PSTS 1 day disengagement</td>
<td>79%</td>
<td>62%</td>
<td>56%</td>
</tr>
<tr>
<td>PSTS teamwork (including 5 day or 3 day refresher)</td>
<td>84%</td>
<td>69%</td>
<td>67%</td>
</tr>
<tr>
<td>Health &amp; Safety Awareness (non-management)</td>
<td>89%</td>
<td>76%</td>
<td>79%</td>
</tr>
<tr>
<td>Moving &amp; Handling Loads</td>
<td>80%</td>
<td>69%</td>
<td>63%</td>
</tr>
<tr>
<td>Moving &amp; Handling Clinical</td>
<td>82%</td>
<td>38%</td>
<td>43%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>71%</td>
<td>47%</td>
<td>56.5%</td>
</tr>
<tr>
<td>Infection Control (Combined total for level 1 &amp; 2)</td>
<td>74%</td>
<td>76%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Safeguarding Adults Averters</td>
<td>86%</td>
<td>79%</td>
<td>80%</td>
</tr>
<tr>
<td>Safeguarding Adults Averters Plus</td>
<td>60%</td>
<td>62%</td>
<td>66%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>88%</td>
<td>81%</td>
<td>83%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 &amp; 2</td>
<td>91%</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 (Refresher for 1&amp;2)</td>
<td>81%</td>
<td>80%</td>
<td>83%</td>
</tr>
</tbody>
</table>
## Appendix 2: Compliance by CAG for each core subject:

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Fire Safety Awareness %</th>
<th>Basic Life Support Level 1 (non-clinical)</th>
<th>Basic Life Support Level 2 (Inpatient Clinical staff up to band 4, Community Nurses and Consultants, AHP's)</th>
<th>Immediate Life Support (medical staff/IP nurses band 5 and above)</th>
<th>Equality, Diversity and Human Rights</th>
<th>PSTS Awareness / Conflict Resolution (non-clinical)</th>
<th>PSTS Disengagement (Community &amp; AHP's)</th>
<th>PSTS Team Work (Inpatient nurses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions CAG</td>
<td>82%</td>
<td>95%</td>
<td>62%</td>
<td>48%</td>
<td>73%</td>
<td>94%</td>
<td>61%</td>
<td>28%</td>
</tr>
<tr>
<td>Behavioural and Development Psychiatry CAG</td>
<td>73%</td>
<td>79%</td>
<td>63%</td>
<td>53%</td>
<td>73%</td>
<td>84%</td>
<td>58%</td>
<td>70%</td>
</tr>
<tr>
<td>Child &amp; Adolescent Services</td>
<td>75%</td>
<td>90%</td>
<td>70%</td>
<td>67%</td>
<td>65%</td>
<td>96%</td>
<td>54%</td>
<td>70%</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>83%</td>
<td>87%</td>
<td>59%</td>
<td>N/A</td>
<td>80%</td>
<td>100%</td>
<td>64%</td>
<td>N/A</td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>70%</td>
<td>87%</td>
<td>45%</td>
<td>14%</td>
<td>72%</td>
<td>91%</td>
<td>58%</td>
<td>N/A</td>
</tr>
<tr>
<td>MHOA and Dementia CAG</td>
<td>75%</td>
<td>77%</td>
<td>76%</td>
<td>59%</td>
<td>62%</td>
<td>92%</td>
<td>61%</td>
<td>49%</td>
</tr>
<tr>
<td>Mood, Anxiety and Personality</td>
<td>76%</td>
<td>88%</td>
<td>67%</td>
<td>63%</td>
<td>68%</td>
<td>89%</td>
<td>59%</td>
<td>0%</td>
</tr>
<tr>
<td>Psychological Medical CAG</td>
<td>74%</td>
<td>92%</td>
<td>65%</td>
<td>66%</td>
<td>70%</td>
<td>93%</td>
<td>51%</td>
<td>66%</td>
</tr>
<tr>
<td>Psychosis CAG</td>
<td>70%</td>
<td>91%</td>
<td>62%</td>
<td>65%</td>
<td>55%</td>
<td>N/A</td>
<td>55%</td>
<td>73%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Title</td>
<td>Health, Safety and Welfare %</td>
<td>Moving and Handling - Level 1 - Group 1 (loads)</td>
<td>Moving and Handling - Level 1 - Group 2 (loads)</td>
<td>Moving and Handling - Level 1 - Group 3 (loads)</td>
<td>Moving and Handling - Level 2 - Group 1 (patient)</td>
<td>Moving and Handling - Level 2 - Group 2 (patient)</td>
<td>Moving and Handling - Level 2 - Group 3 (patient)</td>
<td>Information Governance</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Addictions CAG</td>
<td>81%</td>
<td>N/A</td>
<td>28%</td>
<td>73%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>71%</td>
</tr>
<tr>
<td>Behavioural and Development Psychiatry CAG</td>
<td>80%</td>
<td>N/A</td>
<td>N/A</td>
<td>68%</td>
<td>N/A</td>
<td>37%</td>
<td>N/A</td>
<td>61%</td>
</tr>
<tr>
<td>Child &amp; Adolescent Services</td>
<td>80%</td>
<td>N/A</td>
<td>N/A</td>
<td>58%</td>
<td>N/A</td>
<td>44%</td>
<td>N/A</td>
<td>95%</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>85%</td>
<td>N/A</td>
<td>N/A</td>
<td>75%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>76%</td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>84%</td>
<td>94%</td>
<td>N/A</td>
<td>76%</td>
<td>N/A</td>
<td>71%</td>
<td>N/A</td>
<td>60%</td>
</tr>
<tr>
<td>MHOA and Dementia CAG</td>
<td>72%</td>
<td>100%</td>
<td>N/A</td>
<td>74%</td>
<td>44%</td>
<td>0%</td>
<td>N/A</td>
<td>67%</td>
</tr>
<tr>
<td>Mood, Anxiety and Personality</td>
<td>73%</td>
<td>N/A</td>
<td>N/A</td>
<td>61%</td>
<td>N/A</td>
<td>22%</td>
<td>N/A</td>
<td>57%</td>
</tr>
<tr>
<td>Psychological Medical CAG</td>
<td>80%</td>
<td>N/A</td>
<td>N/A</td>
<td>64%</td>
<td>N/A</td>
<td>33%</td>
<td>49%</td>
<td>55%</td>
</tr>
<tr>
<td>Psychosis CAG</td>
<td>78%</td>
<td>N/A</td>
<td>N/A</td>
<td>63%</td>
<td>N/A</td>
<td>41%</td>
<td>N/A</td>
<td>43%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>79%</strong></td>
<td><strong>94%</strong></td>
<td><strong>28%</strong></td>
<td><strong>67%</strong></td>
<td><strong>44%</strong></td>
<td><strong>40%</strong></td>
<td><strong>46%</strong></td>
<td><strong>56%</strong></td>
</tr>
<tr>
<td>Course Title</td>
<td>Infection Control Level 1 (non-clinical)</td>
<td>Infection Control Level 2 (clinical)</td>
<td>Safeguarding Adults Alerters (non-clinical)</td>
<td>Safeguarding Adults Alerters Plus (clinical)</td>
<td>Safeguarding Children Level 1 (non-clinical)</td>
<td>Safeguarding Children Level 1 and 2 (clinical)</td>
<td>Safeguarding Children Level 3 (clinical)</td>
<td>Target = 85.00</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Addictions CAG</td>
<td>96%</td>
<td>65%</td>
<td>91%</td>
<td>70%</td>
<td>100%</td>
<td>96%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Behavioural and Development Psychiatry CAG</td>
<td>85%</td>
<td>77%</td>
<td>75%</td>
<td>70%</td>
<td>81%</td>
<td>94%</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Child &amp; Adolescent Services</td>
<td>92%</td>
<td>79%</td>
<td>78%</td>
<td>68%</td>
<td>83%</td>
<td>94%</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>97%</td>
<td>N/A</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>90%</td>
<td>67%</td>
<td>84%</td>
<td>72%</td>
<td>84%</td>
<td>82%</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>MHOA and Dementia CAG</td>
<td>90%</td>
<td>61%</td>
<td>69%</td>
<td>59%</td>
<td>73%</td>
<td>91%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>Mood, Anxiety and Personality</td>
<td>91%</td>
<td>67%</td>
<td>75%</td>
<td>65%</td>
<td>81%</td>
<td>90%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>Psychological Medical CAG</td>
<td>88%</td>
<td>66%</td>
<td>80%</td>
<td>64%</td>
<td>80%</td>
<td>89%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>Psychosis CAG</td>
<td>88%</td>
<td>72%</td>
<td>74%</td>
<td>64%</td>
<td>81%</td>
<td>90%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>90%</strong></td>
<td><strong>71%</strong></td>
<td><strong>80%</strong></td>
<td><strong>66%</strong></td>
<td><strong>83%</strong></td>
<td><strong>91%</strong></td>
<td><strong>83%</strong></td>
<td><strong>Target = 85.00</strong></td>
</tr>
</tbody>
</table>
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: Tuesday 28th July 2015

Name of Report: (a) Audit Committee’s 2014/15 Annual Report (b) Proposed updated Audit Committee’s Terms of Reference

Purpose of reports
Item (a) Annual Report: for information
Item (b) Terms of Reference: for approval

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

Author: Steven Thomas (Audit Committee Secretary)

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

Presented by: June Mulroy (Audit Committee Chair and NED)

Purpose of the report:
The following reports are presented for the Board’s information/approval as indicated
Item (a) Annual Report (for information). To report in summary to the Board on the Audit Committee’s business for the year 2014/15 in fulfilling its remit.
Item (b) Terms of Reference (for approval). To obtain the approval of the Board of Directors to the Audit Committee’s draft revised terms of reference. The draft attached is ‘marked up’ to show the changes proposed to the current version.

Recommendations to the Board:
Review the documents, and:
item (a) – note the Annual Report, in particular the AC’s key conclusions for 2014/15 summarised on page 1 of the Annual Report; and
item (b) – approve the draft revised terms of reference.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
No specific significant implications identified. The Audit Committee’s role includes review 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:
No specific significant implications identified.
1. About this report

1.1 This report builds on the in-year reporting by the Audit Committee (the ‘AC' or ‘the Committee') 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 2015 (‘2014/15', or ‘the year') but may refer to other matters where considered helpful.

1.2 The AC has reviewed and approved this report through the following process. The AC meeting on 23 June 2015 reviewed and approved a first draft of this report, subject to a final draft being circulated reflecting comments made at the meeting. That final revised draft was subsequently circulated on 14 July 2015 to all who had attended the AC meeting.

1.3 This report takes account of guidance in ‘The Audit Committee Handbook’ issued by the Department of Health. As agreed at the AC’s meeting on 26 May 2015, 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 2014/15

2.1 Purpose. ‘The overall role of the Committee 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 2014/15

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) certain issues were identified with the Assurance Framework, and the associated systems and procedures that support it, which affected risk management (AC TOR 2.1(a) refers). Internal audit issued a ‘limited assurance’ opinion on the assurance framework earlier in 2014/15 and by the time of this Annual Report key recommendations remained to be implemented. 4.13 to 4.19 and Appendix C give further information about this;

(b) the financial systems and procedures used within SLaM are now generally satisfactory for their purpose of financial reporting and control (AC TOR 2.1(b) refers). Internal audit issued three ‘limited assurance’ opinions earlier in 2014/15 and by the time of this Annual Report significant progress had been made with implementing these recommendations. 4.13 to 4.19 and Appendix C give further information about this;

(c) the AC reviewed SLaM’s 2014/15 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 for the 2015/16 audit.

2.3 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 2014/15.

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 to 28 February 2015) 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. Mr Coomber’s role as AC Chair ceased on 28 February 2015, and he remains as an AC member;
(b) June Mulroy (AC Chair from 01 March 2015) joined SLaM as a NED and AC member on 12 January 2015 and took on the role of AC Chair on 01 March 2015;
(c) Dr Patricia Connell-Julien, an existing NED, became an AC member in March 2012 and ceased as a NED and AC member on 09 January 2015 and
(d) Prof Shitij Kapur, an existing NED, 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. A representative from the Council of Governors attends AC meetings as an Observer (this has applied from the 23 October 2014 AC meeting onwards). 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 and other meetings are held if and as the AC considers it necessary. 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 the 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 2014/15**

4.1 The main ways in which the AC fulfils its remit are as follows, each of which is explained 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) **Annual assessment** of the AC.

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

4.2 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 continue to invite CAG Service Directors/Leaders to AC meetings in 2015/16.

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

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 Quality Committee and the Chair of the Business Development and Investment Committee consider should be reported to the AC; and
(c) cross-membership of committees, as noted in SLaM’s 2014/15 Annual Report and Accounts. For example Robert Coomber chairs the Charitable Funds Committee.
4.5 SLaM's annual accounts and quality accounts for 2014/15 received unqualified ('clean') audit opinions 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.

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 At its meeting in December 2014 the AC reviewed and was content with external audit’s reported plans for its work for 2014/15, and with the fee of £95,000 (2013/14: £95,000) proposed by external audit for the audit under Monitor’s Code. In reviewing that fee, the AC noted external audit’s confirmations as to: the independence of the auditors; potential threats to their independence; and the safeguards implemented to ensure their independence (including non-involvement in audit work of partners and staff involved in providing non-audit services). At the AC’s meeting in May 2015, external audit reaffirmed the confirmations made at the December 2014 AC meeting, and updated certain fee figures as noted below.

<table>
<thead>
<tr>
<th>Year</th>
<th>2014/15</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information as presented by external audit to the AC meeting at its meeting in</td>
<td>May 2015</td>
<td>March 2015</td>
<td>2014</td>
</tr>
<tr>
<td>SLaM: services to SLaM</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Audit under Monitor’s Code</td>
<td>95</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>The 2014/15 audit fee reflects an increase (calculated at RPI of 3.2%) of £2,400; a reduction of £5,000 to remove first year implementation costs of the transition to preparing group financial statements last year; and an increase of £2,500 relating to the additional costs of preparing the enhanced auditor report (this was a new requirement for 2014/15)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLaM: non-audit services provided to SLaM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance review</td>
<td>18</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>VAT advice</td>
<td>21</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Party Wall Act work</td>
<td>0</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Maudsley Charity: non-audit services provided to the Charity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Party Wall Act work</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lease advisory services</td>
<td>3</td>
<td>13</td>
<td>35</td>
</tr>
<tr>
<td>Other property services</td>
<td>27</td>
<td>40</td>
<td>23</td>
</tr>
</tbody>
</table>

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 26 May 2015 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.
4.12 During 2014/15 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**

4.13 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.

4.14 Since September 2011 Parkhill acted as SLaM’s internal audit provider. On 01 October 2013 Parkhill merged with TIAA Limited, and since then TIAA has acted as SLaM’s internal audit provider.

4.15 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 2014/15 Head of Internal Audit Opinion.

4.16 TIAA’s key overall conclusion for 2014/15 is that: ‘Reasonable 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 2014/15 Annual Report Annex A refers). The Head of Internal Audit advised that: TIAA’s overall reporting scale changed from that used last year; the prior year’s overall opinion was ‘significant assurance’; and (using last year’s reporting scale) the current year’s overall opinion would have been ‘significant assurance with exceptions’ (minutes of AC May 2015 meeting para 5.4 refer).

4.17 TIAA states that the basis for forming their opinion is as follows: 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. During the course of the year four limited assurance opinion reports have been issued. A summary of each is provided ...’ in Appendix C to this AC Annual Report (TIAA 2014/15 Annual Report Annex A refers).

4.18 The following summarises risk-based audit assignments carried out (Appendix C shows more detail) with comparatives for 2013/14 and 2012/13. Some care must be taken in comparing these figures, because in many cases different areas were audited in the different years. Given that caveat, in overview the assurance profile for 2014/15 appears a little weaker than that for 2013/14, which itself appeared significantly weaker than for 2012/13. Note that:

(a) all the core financial systems audited in 2014/15 received ‘substantial assurance’ opinions, as was the case for the prior two years; however

(b) the opinion on the Board Assurance Framework has moved from substantial (2012/13), to adequate (2013/14), to limited (2014/15).

<table>
<thead>
<tr>
<th>Year (No.)</th>
<th>2014/15 (No.)</th>
<th>2014/15 (%</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 (for 2012/13 includes 1 ‘substantial/adequate’)</td>
<td>5</td>
<td>33%</td>
<td>5</td>
<td>33%</td>
<td>17</td>
<td>77%</td>
</tr>
<tr>
<td>Reasonable (prior years: Adequate)</td>
<td>6</td>
<td>40%</td>
<td>6</td>
<td>40%</td>
<td>5</td>
<td>23%</td>
</tr>
<tr>
<td>Substantial/Limited</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>7%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Limited</td>
<td>4</td>
<td>27%</td>
<td>3</td>
<td>20%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total (including drafts)</strong></td>
<td>15</td>
<td>100%</td>
<td>15</td>
<td>100%</td>
<td>22</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Selected individual audit areas**
4.19 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’)
4.20 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.

4.21 As requested by the AC to meet mandated requirements, LCFS has prepared an Annual Report for 2014/15 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 23 June 2014.

4.22 The AC requested and received regular updates on fraud issues from LCFS during 2014/15.

Other independent assurances about SLaM’s operations
4.23 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.

Annual assessment of the AC
4.24 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 July 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.

4.25 As recorded in the minutes of the AC’s December 2014 meeting (1.1.1 refers): ‘After due discussion the AC decided that the AC’s operations had been acceptably reviewed, in particular: external audit, internal audit and LCFS had provided their views earlier in the year; the AC had been included in the review by external consultants of SLaM’s committee arrangements; the AC considered its operations informally on an ongoing basis; and the AC Chair had considered potential improvements to the AC’s operations as part of planning for his handover to the incoming AC Chair (item 1.2)’. The AC considered that this provided an acceptable annual assessment, reflecting that 2014/15 was a year of transition for SLaM in many areas and that the Board, with the support of external consultants, is conducting a full review of all its committees’ operations and arrangements.

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. For instance:
(a) this includes taking account of the results of the assessment process noted above; and
(b) the template cover papers for AC agenda items now emphasise that ‘it is the responsibility of the person preparing the report to prepare [the] summary report sheet to a standard that enables the AC to review the report efficiently and effectively. Therefore it is vital to state clearly and concisely the purpose of the report, the action required, and the recommendation(s) to the AC. This requires (in the ‘purpose of the report’ section above) a short summary of the background/context to the report UNLESS this is clear from the report.’
June Mulroy  
Audit Committee Chair  
July 2015  

APPENDIX A: KEY POTENTIAL ISSUES FLAGGED TO THE BOARD BY THE AC DURING 2014/15  

Listed below are the key issues already reported to the Board by the Committee arising from the Committee’s meetings during 2014/15 on the dates shown.

The Committee considered that the Board should be made aware of the Committee’s concerns about the following key potential issues/proposed resolutions noted at the Committee’s meetings.

Note: the terms ‘the Trust’ and ‘the AC’ are synonymous with ‘SLaM’ and ‘the Committee’ respectively.

<table>
<thead>
<tr>
<th>Key potential issues (as at the date of the Committee meeting)</th>
<th>AC mins ref</th>
<th>Actions proposed to address key issues (as at the date of the Committee meeting)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>26 May 2015 AC meeting (special focus meeting to consider annual accounts and related documents)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At the Board meeting held in the afternoon of 26 May 2015, the AC Chair gave a verbal report of key issues arising from the AC meeting held in the morning of the same day. Key action points arising from that AC meeting are as shown opposite.</td>
<td>0.1.3</td>
<td>The CFO will begin arrangements for a ‘deep dive’ on the Finance function to be held and reported to the Board of Directors (‘the Board’) at an appropriate time in 2015/16 quarter 3, together with an update on progress in achieving CIPs. The aim is to enhance: (1) Board members’ appreciation of the volume of reporting required by Monitor via the Finance function (Finance will keep the Board updated on the nature and volume of reporting requests from Monitor); and (2) Board members’ and CAG leaders’ awareness of the method/process of allocating overheads to departments/CAGs and that the primary responsibility for managing recovery of such overheads rests with department/CAG leadership, not with Finance.</td>
</tr>
<tr>
<td><strong>28 April 2015 AC meeting (special focus meeting to consider financial planning and commissioning)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| (1). SLaM’s risk and financial planning 2015/16 onwards. The AC broadly supported the proposed approach of making the budget and savings plan more realistic compared with the approach adopted in previous years of setting ambitious targets backed with significant contingency provisions. However the AC had a number of significant concerns as noted in section 5.2 of the AC minutes, to which the Board’s attention is drawn. In particular the AC noted that the success of the proposed approach required a cultural change in behaviours and attitudes as to the importance of achieving the targets set, as the ‘safety net’ of contingencies would have been removed; success also required clinical leaders to take financial responsibility: at present this tended to be seen as Finance Department’s role; and the AC noted that improvements in transparency was required in the monthly reporting to the Board of progress against budget and savings plan, so that the leaders of each CAG can see the effect of the steps that their CAG is taking | 5.2 5.3 5.5 | Internal audit will include in their 2015/16 workplan a review of SLaM’s approach to developing/monitoring the 2015/16 budget and savings plan. The AC recommends that the Board considers whether Board members would benefit from a ‘teach in’ about the financial framework within which SLaM operates.  

AC Chair additional comment. This would include the move away from block contracts, overhead calculations allocation and controls, and asset utilisation and controls especially as regards premises. |
<p>| (2). AMH programme. The CFO explained the background to the project for transforming the Adult Mental Health programme (‘AMH’), which had started a few years ago. The AC noted that the Board did not appear to have received updates on progress/outcomes for this project, despite the significant sums invested; | 5.4 | The AC recommends that leadership of the AMH programme, with the CFO, reports to the Board as to the progress/outcomes of the AMH transformation, including comparison with what was initially agreed by the Board. |</p>
<table>
<thead>
<tr>
<th>Key potential issues (as at the date of the Committee meeting)</th>
<th>AC mins ref</th>
<th>Actions proposed to address key issues (as at the date of the Committee meeting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(3). Improving effective communication with commissioners. The CFO advised that SLaM’s relationships with each commissioner were improving, particularly as regards strategic matters, and SLaM generated net real returns with each commissioner. The CFO advised that each commissioner, especially Croydon, was experiencing major issues as regards financing. The AC Chair warned of the risk of SLaM effectively ‘stepping in’ to fund service where commissioners were unable to do so in order to maintain service levels. The CFO advised that SLaM had recognised this.</td>
<td>6.1 6.2</td>
<td>The AC recommends that the CFO updates the Board as to progress made with commissioning, the consequences of the most recent round of commissioning, and the need for SLaM to ‘educate’ commissioners as to respective responsibilities in funding. <strong>AC Chair additional comment.</strong> In particular, this would cover the consequences of holding back funding until further negotiations in Quarter 4. This is of greater importance when predicted volumes in contracts are substantially exceeded.</td>
</tr>
<tr>
<td>(4). Organisational matters. During discussion of internal audit plans, the AC discussed the consolidation of the Maudsley Charity and its subsidiaries. The AC noted that the subsidiaries were created at a time when it was intended that the charity would become independent from SLaM, so perhaps their usefulness should be reviewed.</td>
<td>7.1 7.2</td>
<td>Internal audit will update the 2015/16 plan to include reviews of: KHP governance; the AMH programme; and the background/history to the current position regarding consolidation of the Maudsley Charity and its subsidiaries.</td>
</tr>
<tr>
<td>24 March 2015 Committee meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1). Committee working and remits. The AC discussed ‘synchronising’ issues dealt with at meetings of the AC, Quality Committee (‘QC’), Business Development and Investment Committee (‘BDIC’) and the Board. The AC also discussed rationalising the terms of reference/schemes of delegation relating to the AC, QC, BDIC and Board so that issues are dealt with efficiently and effectively.</td>
<td>1.1 1.2</td>
<td>All those attending will contact the AC Chair with any views on how best to ‘synchronise’ issues dealt with at meetings of the AC, QC, BDIC and Board, so that a ‘running routine’ is created between the various meetings to deal with issues efficiently and effectively.</td>
</tr>
<tr>
<td>(2). Maudsley Charity. The AC discussed the Maudsley Charity, its constitution and governance, and issues around the relationships of SLaM and of the Charity with the ORTUS learning centre.</td>
<td>1.1 1.3 9.4</td>
<td>External audit and internal audit will report to the AC Chair with views on governance at the Maudsley Charity, in particular giving an opinion on whether it needs an audit committee.</td>
</tr>
<tr>
<td>(3). Qatar performance bonds. The AC Chair and the CFO advised that they had concerns about the request, in the terms of a document requesting bids for large consultancy opportunity in Qatar, for SLaM to provide a performance bond.</td>
<td>7.2 7.4</td>
<td>The CFO will discuss with the Commercial Director (and LCFS) the legality and risks around SLaM providing a performance bond regarding the potential Qatar contract, and will report back to the AC Chair.</td>
</tr>
<tr>
<td>(4). Monitoring Monitor. The AC was advised that Monitor was issuing an increasing number of reporting requests, despite an initial commitment to a ‘light touch’ reporting regime.</td>
<td>8.1</td>
<td>Points to cover in future AC agendas will include a standing item as to Monitor’s requirements (including a summary of reports required by Monitor, with timings).</td>
</tr>
<tr>
<td>(5). Assurance framework. The AC discussed the assurance framework presented, including improvements required.</td>
<td>10.2</td>
<td>The CFO will discuss matters with external audit and internal audit outside the AC meeting, with a view to improving the assurance framework and related systems.</td>
</tr>
<tr>
<td>(6). Benchmarking report. The AC discussed a progress report from external audit (Deloitte) including reports benchmarking SLaM against other NHS bodies.</td>
<td>11.1</td>
<td>The CFO will circulate Deloitte’s report to Board members and the QC Chair with a brief introductory note flagging the key issues of waiting times and CIP performance.</td>
</tr>
<tr>
<td>(7). Bribery Act. The meeting discussed the implications of the Bribery Act 2010.</td>
<td>12.1</td>
<td>A Trust policy has been drafted and will be ratified and publicised as soon as possible.</td>
</tr>
<tr>
<td>16 December 2014 Committee meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1). Use of agency staff. The AC meeting noted SLaM’s high use of agency staff relative to other Trusts (external audit’s report shown on agenda page 58 refers). The AC noted that this was not necessarily inappropriate, but required justification.</td>
<td>8.1.1</td>
<td>The AC recommended that the SLaM Board should consider SLaM’s use of agency staff and should agree an appropriate level for agency staffing, justified in terms of cost and risk, and an action plan for achieving that level.</td>
</tr>
<tr>
<td>(2). Mandatory training: compliance. It was reported to the AC that the executive had reviewed a report on mandatory training compliance, and had</td>
<td>8.1.2</td>
<td>The AC recommended that the Chief Executive should consider SLaM’s compliance with mandatory training and should give an appropriate assurance</td>
</tr>
</tbody>
</table>
### Key potential issues (as at the date of the Committee meeting)

<table>
<thead>
<tr>
<th>AC mins ref</th>
<th>Actions proposed to address key issues (as at the date of the Committee meeting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>concluded that the levels of compliance were unacceptables, as were the variations in compliance levels shown by the different systems used to record compliance.</td>
<td>to the Board.</td>
</tr>
</tbody>
</table>

#### (3). ICT plans and funding

The AC considered a report from the recently appointed Chief Information Officer ('CIO'). The AC Chair noted his initial reaction that the CIO’s approach appeared reassuring, but flagged the difficulties (mainly related to organisational capacity to deliver change) SLaM had experienced with developing and implementing the Estates Strategy.

8.2 The CIO will concisely update the AC about: key risks (distinguishing those related to staff and to IT matters); and SLaM’s organisational capacity to deliver the new ICT Strategy (March 2015).

#### (4). ICT: progress in resolving issues around data warehousing

The AC Chair noted that the overall pace of implementation appeared too slow.

8.3 The CIO and Head of Health Intelligence will present an updated action plan summary (agenda page 35) to the AC (March 2015).

#### (5). Working with strategic partners, and quality governance arrangements

The AC received reports from internal audit on these two matters. The AC noted that to work efficiently and effectively with strategic partners, SLaM needed to develop a means of prioritising competing demands on time and resources.

10.1 RC will flag to the Chief Executive the AC’s recommendations: (1) that the Chief Executive should coordinate production of a strategy or other means of prioritising competing demands on time and resources when dealing with strategic partners; and (2) that the Board should consider the internal audit report on quality governance arrangements as a means of improving the efficiency and effectiveness of Board and committee operations generally (January 2015).

#### (6). Update on single tender actions 117 and 122 re ORTUS and report on implications around the relationship with SLaM

The Chief Financial Officer ('CFO') advised that there were some tensions between SLaM and the learning company, for example as regards room bookings. The CFO advised that he and the Commercial Director were working to resolve these tensions.

The AC recommended that the CFO and Commercial Director should in the next few months report to the Board (Part 2 of its agenda) on implications around the relationship between SLaM and the learning company and should report on progress to the AC (March 2015).

### 23 October 2014 Committee meeting

#### (1). Consideration by the AC of certain Board reports with implications for the Trust’s estate

At the most recent meeting of the Board, the Trust Chair had requested the AC to consider four papers with implications for the Trust’s estate, namely:

- Contracting: 2014/15 Lessons Learnt;
- Estates Operational Standards Proposal;
- Estates Compliance Proposals Phase 2; and

1.2 ND (COO) and GH (CFO) will feedback the AC’s comments from this session to SLaM management as appropriate.

ND (COO) and GH (CFO) will obtain internal audit’s independent assessment of the Estates Department, including benchmarking it with other departments, and will report back to the AC and Board.

#### (2). Procurement’s contribution CIPs: update

GH (CFO) reported that, as confirmed by PM (Trust Board Secretary), this action point (formal escalation process for all committees) had been implemented, as evidenced in the Board papers since July 2014.

8.1 GH (CFO) and TM (Head of Procurement) will present a comprehensive report on Procurement’s contribution to CIPs to the next AC meeting. This should specify which contracts have been reviewed.

#### (3). Committees and management: implementation of actions from Deloitte’s report

GH (CFO) reported that, as confirmed by PM (Trust Board Secretary), this action point (formal escalation process for all committees) had been implemented, as evidenced in the Board papers since July 2014.

8.3 PM (Trust Board Secretary) will report to the next AC meeting on the position as to implementation of all the action points raised in the Deloitte report.

#### (4). Internal audit report: ICT Service Review

The meeting discussed the ICT Service review report, which RC (AC Chair) considered reported

10.1 GH (CFO) and the new CIO will update the next AC meeting about ICT’s plans and funding.
<table>
<thead>
<tr>
<th>Key potential issues (as at the date of the Committee meeting)</th>
<th>AC mins ref</th>
<th>Actions proposed to address key issues (as at the date of the Committee meeting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>some major issues in particular lack of appropriate funding to enable an appropriate pace and scale of investment. GH (CFO) advised that SLaM had engaged a new Chief Information Officer ('CIO') starting at SLaM on 10.Nov.2014. GH (CFO) considered that internal audit’s report gave the CIO an excellent starting point for planning improvements, and that the CIO would brief the Board at its 16.Dec.2014 meeting. GH (CFO) advised that, service management recognised the need for significant investment in ICT and was content with the planned level of funding;</td>
<td></td>
<td>12.5 GH (CFO) and PM (Trust Board Secretary) will update the next AC meeting about STAs 117 and 122 re ORTUS, and will report on implications around the relationship with SLaM, such as SLaM’s use of the facility, any commercial issues, any potential conflicts of interest and implications for the grant process.</td>
</tr>
<tr>
<td>(5). SFI breaches and Single tender Actions ('STAs')</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RC (AC Chair) noted that management needed to receive a strong message about accountability. GH (CFO) and TM (Head of Procurement) agreed and outlined the steps taken to ensure that the process is appropriately formalised and documented. GH (CFO) confirmed that the Board approved sale of properties, and that the rigour of this process needed improvement. RC (AC Chair) queried the ORTUS STA (STAs 117 and 122 – each for £598,000) and also queried whether this was a single duplicated item.</td>
<td>24 June 2014 Committee meeting</td>
<td></td>
</tr>
<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>The AC considered that in future it would be appropriate for the CFO’s Board reporting to include relevant comparative/benchmarking information and commentary, in particular as regards EBITDA (‘earnings before interest, taxation, depreciation and amortisation’)</td>
<td></td>
<td></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>The AC reviewed notes of the QC’s inaugural meeting. The relatively high number of apologies for absence from this meeting was noted, especially those from Clinical Academic Group (‘CAG’) leaders.</td>
<td></td>
<td></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>The AC was updated about SLaM’s progress in addressing the following key areas: (a) e-rostering and mandatory training; (b) employee costs and numbers, and workforce modelling plans; and (c) Procurement Department’s contribution to cost improvement programmes (‘CIPs’)</td>
<td>8.3</td>
<td></td>
</tr>
<tr>
<td>(4). Assurance framework and testing thereof</td>
<td>8.4</td>
<td>The CFO will (Sep.2014) present a short paper to the AC summarising the process by which the assurance framework is updated, managed and challenged. The paper will cover CAGs.</td>
</tr>
<tr>
<td>The AC Chair commented that the process by which the Assurance Framework was managed and challenged would benefit from clarification. The AC had selected for detailed discussion risk area 9 ‘ICT infrastructure’ and in particular the key action to ‘implement the Maudsley Data Centre ... by June 2014’. That implementation recently received a ‘limited assurance’ report from internal audit</td>
<td>12.3</td>
<td>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>Key potential issues (as at the date of the Committee meeting)</td>
<td>AC mins ref</td>
<td>Actions proposed to address key issues (as at the date of the Committee meeting)</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>(5). Single Tender Actions ('STAs') and breaches of Standing Financial Instructions ('SFIs')</td>
<td>10.1 12.5</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>
</tbody>
</table>

**27 May 2014 Committee meeting**

The Committee meeting and the Board meeting were held on the same day, so the following alternative procedure was adopted. The Committee Secretary prepared a summary for the Committee Chair of key points arising from the Committee meeting. The Committee Chair reported verbally to the Board taking account of that summary.
## APPENDIX B: AC MEETINGS AND ATTENDANCES FOR 2014/15

<table>
<thead>
<tr>
<th>AC members (all Non Executive Directors)</th>
<th>27 May</th>
<th>24 Jun</th>
<th>23 Oct</th>
<th>16 Dec</th>
<th>24 Mar</th>
<th>28 Apr</th>
<th>26 May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Coomber (AC Chair to 28 February 2015)</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>June Mulroy (AC Chair from 01 March 2015)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Dr Patricia Connell-Julien</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y</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></td>
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</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>Y</td>
</tr>
</tbody>
</table>

### SLaM management

| Chief Financial Officer                    | Y      | Y      | Y      | Y      | Y      | Y      | Y      |
| Deputy Director of Finance                 |        |        |        |        |        |        | Y      |
| Assistant Director of Finance              | Y      |        |        |        |        |        |        |
| Chief Operating Officer                    |        |        |        |        |        |        | Y      |
| Chief Information Officer                  |        |        |        |        |        |        | Y      |
| Director of Nursing                        | Y      |        |        |        |        |        | Y      |
| Assistant Director of Nursing (Practice Excellence) | Y      |        |        |        |        |        |        |
| Director of Human Resources, Organisational Development, Education and Training | Y      |        |        |        |        |        |        |
| Assistant Director of Education and Training | Y      |        |        |        |        |        | Y      |
| Finance and Development Manager for CAMHS CAG |        |        |        |        |        |        | Y      |
| Directorate Accountant for CAMHS CAG       |        |        |        |        |        |        | Y      |
| Head of Procurement                        | Y      | Y      | Y      |        |        |        |        |
| Head of Health Intelligence                | Y      |        |        |        |        |        | Y      |

### External providers of assurance

| External Audit: Engagement Lead            | Y      | Y      | Y      | Y      | Y      | N/A    | Y      |
| External Audit: Engagement Senior Manager | Y      | Y      | Y      | Y      | Y      | N/A    | Y      |
| Internal Audit: Chief Internal Auditor     | Y      | Y      | Y      | Y      | Y      | Y      |        |
| Internal Audit: Senior Audit Manager       | Y      | Y      | Y      | Y      | Y      | Y      |        |
| Counter Fraud                              | N/A    | Y      | Y      | Y      | Y      | N/A    | N/A    |

### Observers

| Governor Observer                          | N/A    | N/A    | Y      | Y      | Y      | N/A    | N/A    |

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

‘Y’ denotes attendance, ‘N/A’ denotes not applicable

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

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

Note 2. Special focus meeting to discuss risk, financial planning and internal audit plans 2015/16 onwards.

‘CAMHS CAG’ denotes Child and Adolescent Mental Health Services – Clinical Academic Group
APPENDIX C: KEY INTERNAL AUDIT WORK FOR 2014/15

The information below, extracted from internal audit’s Head of Internal Audit Opinion report for 2014/15, seeks to summarise the work of SLaM’s internal auditors for 2014/15 and the main results of that work.

### Assurance Assessments 2014/15

<table>
<thead>
<tr>
<th>System</th>
<th>Substantial Assurance</th>
<th>Reasonable Assurance</th>
<th>Limited Assurance</th>
<th>No Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forward Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Financial Systems</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payroll</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tender Waivers</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Quality Governance</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research and Development</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Review of BAF and Risk Management Arrangements</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>LCRN Funding</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with Strategic Partners</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mandatory Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of CIPs, QIPPs and Quality</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Decommissioning of Electronic Equipment</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>ePJS E-Discharge Notifications to Primary Care</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IG Toolkit v12 Part 2</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT Service Desk</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>TOTAL (15 assurance review reports in total)</strong></td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

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

**Tender Waivers.** The key issues raised were:
- Better planning could improve avoidance of waivers.
- Four of the six orders tested exceeded OJEU thresholds, but were not fully advertised in line with the OJEU directives.
- The level of scrutiny and challenge relating to waiver requests could be strengthened.

**BAF and Risk Management Arrangements.** The key issues raised were:
- The Trust is re-designing its risk management arrangements which is work in progress and findings should be read in this context.
- The lack of clarity in how the Trust has articulated its strategic objectives and linked them to strategic risks in the BAF requires attention.
- The risk management team is currently under resourced.
- The BAF document requires further refinement in terms of layout and content to improve its effectiveness.
Although still work in progress, the risk management process is strengthening. A detailed follow up of recommendations will be performed during 2015/16.

Management of CIPs, QIPPs and Quality

- Through deep dive assessments of two CAGs, Psychosis and CAMHS, both demonstrated sound understanding of CIP. However, such control frameworks were not advocated across the board and Psychosis was significantly behind with delivery.
- As at month 10, year to date CIP variance £3m (QIPP £950k) with an unidentified savings gap of £2.25m.
- The introduction of Zero Based Budgeting (ZBB) to freshen up the budget setting process was considered innovative. However, operationally it lacked support and guidance.
- The timetabling for ZBB was rushed and training needs were not adequately assessed. This had an impact on CIP and QIPP planning. ZBB is no longer adopted for 2015/16.

IT Service Desk

- The Service Desk model was not adequately addressing business requirements.
- The Service Desk SLA was out of date.
- The Service Desk was lacking in documented operating procedures and staff handbook.
- There was no formal review of individual Service Desk staff performance through the use of metrics or quality reviews.
- Service Desk ticket trend analysis was not performed.
- Benchmarking data highlighted significant under resourcing of the IT Service Desk Function.
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 Committee and the Business Development Committee 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. Counter Fraud function
8.1. The Committee will:

(a) in conjunction with the Chief Financial Officer determine the appointment of the counter fraud service, the fee and any questions of resignation and dismissal;

(b) consider and comment on counter fraud’s proposed work programme (produced to meet mandated requirements), consider progress reports from the counter fraud function and the adequacy of the management response;

(c) ensure that the counter fraud function is adequately resourced and has appropriate standing within the organisation; and

(d) annually assess the independence, objectivity, efficiency and effectiveness of the counter fraud function.

9. External Audit
9.1. 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.

10. Key Trust documentation
10.1. The Committee will review proposed changes to Standing Orders and Standing Financial Instructions for approval by the Board.

11. ‘Whistleblowing’ arrangements
11.1. 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.

12. Frequency of Meetings
12.1. 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.

13. Quorum
13.1. A quorum shall be two members.

14. Record Keeping
14.1. 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.

15. Other matters

15.1 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. A representative of the Council of Governors will attend as an observer. 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.

15.2. 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.

15.3. 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.

15.4 Liaison with the Maudsley Charity. Arrangements for such liaison are currently under discussion.

15.5. 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.

16. Chart of relationships to other meetings: (not applicable)
### 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/July 2014</td>
<td>Chief Financial Officer and Audit Committee Secretary</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>
<tr>
<td>June 2015</td>
<td>Audit Committee Secretary</td>
<td>Minor interim update pending a fuller review of the terms of reference of all SLaM’s committees. The interim update includes: the Counter Fraud function (section 8 – the Counter Fraud function has confirmed it is content with this wording); the Governor Observer role (section 15.1); and liaison with the Maudsley Charity (section 15.4).</td>
</tr>
</tbody>
</table>
## TRUST BOARD - SUMMARY REPORT

<table>
<thead>
<tr>
<th>Date of Board meeting:</th>
<th>28 July 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Report:</td>
<td>Chief Executive’s report</td>
</tr>
<tr>
<td>Heading: - (Strategy, Quality, Performance &amp; Activity, Governance, Information)</td>
<td>Governance</td>
</tr>
<tr>
<td>Author(s):</td>
<td>Paul Mitchell, Trust Secretary</td>
</tr>
<tr>
<td>Approved by (name of Executive member):</td>
<td>Dr Matthew Patrick, Chief Executive</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Dr Matthew Patrick, Chief Executive</td>
</tr>
</tbody>
</table>

### 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.

### 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 2015

1. Trust issues

Trust team wins top quality of care award
Congratulations to the Family Work and Support service who won the quality of care category at the HSJ patient safety awards at a ceremony in Birmingham on 6 July. The service was introduced 18 months ago on Gresham 1 and 2 wards at Bethlem Royal Hospital and enables staff to work more effectively with carers and families as soon as a patient is admitted.

I would like to congratulate all the staff members who have worked tirelessly over the past 18 months in taking this excellent new service forward. Families and carers form a significant part of the work we do with patients at SLaM so it is excellent news that this has been officially recognised by the HSJ.

Deloitte review
Deloitte have concluded their visit to the Trust. This comprised a mixture of interviews with senior staff, observation of Board and CAG meetings plus work with selected focus groups, including governors, staff and service users. The draft report is expected to be received at the end of the month.

CQC preparation
The following is a snapshot of the Trust Wide Work currently underway:

In-depth planning has been undertaken with Human Resources, to ensure that bank and agency staffs have been blocked booked and clear Rotas are in place within each CAG. Each CAG has been encouraged to overbook staff, as CQC will require two full time members. An Induction Guidance sheet has been developed for Ward Managers.

Previous CQC Feedback highlighted that Care Plans were not all personalised and didn’t demonstrate Service User Involvement. A Trust Wide Project Plan has been developed, work to date includes; Template set up on EPJS – quickly shows you if you have patients without care plans, Guidance sheets distributed, core standards have been agreed, Training is currently being scheduled and audits due to be completed every three weeks.

CQC Prep Visits have been undertaken scoring against CQC Five Core Areas – Safe, Effective, Caring, Responsive and well led; action plans and themes have been developed and fed back to individual CAG Leads. Common themes were picked up i.e. Care Planning, Staff Guarding, Mental Health Acts, Risk Management, Staffing Levels and ligatures. Trust Wide Plans have been put in place to address the key development areas.

Mental Health Act Visits currently underway across the Trust, each CAG is being provided with individual action plans. Review is currently underway to estimate how the Trust will score against the CQC Pathways.

Supervision and Appraisal reports are generated twice weekly and fed back to the CAGs individually highlighting areas of concern. Trust will have 100% completion rate by the end of July.
Monthly meetings are held with CAG Link Leads, to review Local Quality Plans, Risk & Issues.

CQC Prep visits highlighted that staff are not all sufficiently familiar with the Safe Guarding process. Louise Rabbite and Paul Archer are currently undertaking Safe Guarding Training. Compliance rates currently stands at 65% within Adults and 75% within Children. Staff will be 80% compliant by the end of August.

Patient complaints and Serious Incidences for the last three years have been fed back to all CAGs to ensure that they all have clear mitigation plans in place and have been resolved. Lessons learnt workshop is being hosted on the 10th August.

Two Governance Folders are being created, the first for Key Trust Policies and the second to contain key evidence documents, which may be of interest to CQC. These Governance Folders will be reviewed mid-August to ensure that they are compliant.

Weekly Q&A Sessions are being hosted across the Trust every Wednesday Morning across the Trust, sessions completed to date include, Denmark Hill, Ladywell, Tamworth Road, Bethlam etc. CQC Hotline and email account have been set up. CQC Homepage has been developed displaying key facts, Q&Qs and Time Table of events. Posters, Brochures are Banners are currently being printed.

Common themes picked up from CQC Practice Site Visits was that staff did not feel confident in expressing things that they feel that they do well. CAG Speed Dating has been arranged for the 10th August, to enable the Teams to work collaboratively and share good practice. Each Team has been asked to pick three areas of Quality Improvement Work or Good Practice to share with their colleagues. Each CAG will select their best initiative and a wall of fame will be created within Trust Head Quarters.

2. National issues

Improving Acute In Patient Psychiatric Care for Adults in England

In January 2015 the Royal College of Psychiatrists asked for a review of the provision of acute inpatient psychiatric care for adults and make recommendations for improvement. This interim report is based on the Commission’s initial observations about acute inpatient psychiatric services for adults in England and its discussions with patients, carers, advocates, health and social care professionals and policy makers.

Five main themes have emerged:
1 The so-called bed or admission crisis is very significantly a problem of discharges and alternatives to admission and can only be addressed through changes in services and the management of the whole system.
2 There is a spectrum of pressure and performance ranging from units with demoralised staff who are trapped in a constant process of crisis management to those where staff work purposefully to deliver high quality care and services.
3 Although the Commission heard many positive stories of care, it is clear that many patients and carers feel disenfranchised and excluded. There is a need for greater engagement and implementation of best practice.
4 There is a significant data and information shortfall, with inconsistent definitions and processes and a lack of agreed outcomes. This makes it very difficult to understand what is happening throughout the system, to measure variation and to bring about improvements.
5 In many services there is a need for greater staff support, training and motivation in order to improve care and services.

The findings are very consistent with our experience here at SLaM, and indeed the report reflects a number of aspects of our submission. The Commission will now be deepening its understanding of each of these themes over the next few months prior to publishing a final report and making recommendations for improvement in early 2016.

**NHS England publish safe staffing framework for mental health wards**

NHS England has published safe staffing guidance for mental health inpatient settings. The mental health staffing framework, which focuses on inpatient care, is an interactive guide designed to equip mental health leaders with the skills and knowledge to plan and deliver safe staffing and also provide a means of assessing their services against agreed best practice. The framework was commissioned as part of the NHS England compassion in practice programme, and was developed by an independent group of nursing directors who undertook a review of the available evidence and drew on their extensive experience. Work is underway on a similar guide for community mental health services. It will feed into the work of the mental health taskforce on establishing the right balance of staff in the many settings treating those with mental illness which is expected to publish at the end of the year.

**2015 Budget: headline summary for the NHS**

There will be a £8bn increase in spending per year above inflation by 2020 to meet a £30bn per year funding gap by the end of the decade identified by Simon Stevens.

The Stevens plan says that the gap would be filled through £22bn in efficiency savings, requiring an extra £8bn in governmental spending a year by 2020 over and above increases in line with inflation. This will come on top of the extra £2bn announced in the autumn statement.

NHS England currently has an annual budget of £102bn. With the Chancellor’s pledge factored in, this is forecast to increase in cash terms to £112 by 2020.

There will also be four more years of public sector pay restraint. The chancellor said public sector pay would rise by only one per cent a year for the next four years.

**Government's 25 year vision for health**

The Secretary of State’s speech at The King’s Fund earlier this month had a clear emphasis on transparency, choice, empowered patients and local decision making. It signalled a move away from a target driven culture to one of learning and improvement with an overall ambition for the NHS to become the world’s largest learning organisation.

He outlined changes to the regulation architecture and a renewed focus on improvement: NHS Improvement was announced as the new operating name for a jointly led NHS Trust Development Authority and Monitor. The new joint body will be chaired by Ed Smith, currently Vice-Chair of NHS England, supported by Ara Darzi as a new non-executive director. The recruitment for a chief executive of NHS Improvement will commence immediately and will be completed by the end of September.

The safety function currently at NHS England and led by Dr Mike Durkin will transfer to NHS Improvement. NHS Improvement will also host a new Independent Patient Safety Investigation Service.
There will be the introduction of international buddying programme. Initially five NHS Trusts will be buddied with Virginia Mason in Seattle, with an expectation to develop further international partnerships in the future.

The Secretary of State announced changes to the consultant contract to enable a seven-day NHS. The opt out clause for weekend working will be removed from the consultant contract for newly qualified hospital doctors. Doctors currently in service will still be able to exercise weekend opt-outs, but the off-contract payments for this activity will be reformed. The British Medical Association (BMA) has been offered a six week window to discuss and agree the changes with the government, after which a new contract will be imposed.

The government had accepted in principle the 19 recommendations within the recently published Rose report ‘Better leadership for tomorrow’.

The government published ‘Learning not blaming’ today, its response to Sir Robert Francis QC’s Freedom to Speak Up review, the Public Administration Select Committee report on investigating clinical incidents in the NHS, and Dr Bill Kirkup’s independent report on the Morecambe Bay investigation.

Proposals include: improving incentives for staff to speak out against poor quality care in the NHS; the establishment of an independent agency to investigate patient safety incidents to be hosted by NHS Improvement; modernising the supervision of midwifery.

GPs will be asked to inform patients of the Care Quality Commission rating and waiting time data at hospitals.

NHS England will develop proposals for introducing meaningful patient choice and control over their care offered in services for maternity, end of life care and long term conditions.

3. Personal

Finally, some sad news to report about two long serving and dedicated members of staff.

Claudia Fullalove
Claudia Fullalove died peacefully on Wednesday 1 July 2015, surrounded by her family.

Claudia’s nursing career began in the early 80’s and her early dealings with predecessor parts of the organisation were in Lewisham, where she worked in the voluntary sector. Claudia spent the majority of her time in the Trust working in Lambeth mental health services. She originally worked in rehabilitation services in management positions, before moving onto a senior nursing leadership role as nurse advisor, Lambeth. In October 2010 at the formation of Clinical Academic Groups, Claudia was recruited to the role of head of nursing, promoting recovery and complex care in the Psychosis CAG.

Many senior and junior staff who worked with Claudia clearly remember her commitment, compassion, courage and passion for her work and doing a good job.

Ada Casis

It is with equal sadness that we announce the death of Ada Casis, a primary nurse who worked for many decades at SLaM predominately on the Crisis Recovery Unit at Bethlem Royal Hospital.

Whilst Ada retired a number of years ago, she returned once a week for some time to run the night shift.
Ada was a kind, caring professional who was loved and respected by her patients and colleagues. She managed a 'challenging' group of residents with utter safety, kindness and maternal firmness.

Dr Matthew Patrick  
Chief Executive  
July 2015
Date of Board meeting: 28 July 2015

Name of Report: Report from the Council of Governors

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

Author: Paul Mitchell, Trust Secretary and CoG working group chairs

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

Presented by: John Muldoon, Lead Governor

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

Recommendations to the Board:
To note the report.

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”.

TRUST BOARD OF DIRECTORS – SUMMARY REPORT
Council of Governors update report  
July 2015

1. Membership and Communications Group (Dr Dele Olajide)
A panel is meeting on Wednesday, 22 July to interview companies for the provision of an electronic voting service for future governor elections. The outcome will be reported to the meeting.

2. Planning and strategy (Angela Flood)
The PSWG last met on 14 July 2015 (re-scheduled from 9 June). As part of the update related to thematic areas in the Strategic Plan 2014-2019, two presentations were given to the group:

a) Estates Strategy (Places and Spaces Transformation Strategic Outline Programme). Mark Allen, Director of Estates and Capital Planning, gave a presentation on the development and implementation of the estates strategy, an ambitious and exciting programme of transformation to support the creation of spaces that are both inspiring and fit for purpose, enable agile working and improve patient experience and outcomes. Discussions focused on: project funding; risks associated with doing or not doing the project; timescales for consultation and implementation; essential alignment with other strategies.

b) Procurement: Tom Medhurst, Head of Procurement, described the procurement cycle, its role in the development and implementation of strategies to ensure achievement of the Trust’s goals and maximisation of value, the importance of procurement being involved in the early stages of strategic development and the changing face of procurement in an increasingly complex business environment.

Council of Governors (CoG) annual cross borough members/public meetings: dates and venues have now been confirmed by the Task and Finish Group and will take place in October with follow-up meetings in May 2016 using a ‘You said…We did…’ approach. We would encourage attendance not only by governors, but also by executive and non-executive directors and service heads to add importance and value to the event and demonstrate that service user, carer and public participation is valued. Dates and venues as follows:

- Thursday 1st October, 5-7pm: MIND at Croydon, Fairfield House, 10 Altyre Road, Croydon CR0 5LA
- Wednesday 14 October, 2-4pm: Blackfriars Settlement, 1 Rushworth Street, London SE1 0RB
- Tuesday 20 October, 5-7pm: Weare336, 336 Brixton Road, London SW9 7AA
- Thursday 29 October, 2-4pm: Lewisham Civic Suite, Lewisham Town Hall, Catford Road, London SE6 4RU

Business Development and Investment Committee (BDIC) Governor Observer: A key issues summary has been circulated by the group’s Governor Observer (Angela Flood). Key themes that are also transferable to other areas include: effective communication within and across the Trust; ensuring strong governance is in place;
lessons learned papers as part of due diligence; development of strategic partnerships informed by evidence of need and risk assessment; regular reporting and building in resources at the beginning of a project or process.

**Help/Hinder Matrix:** the Trust Secretary and the Chair of the PSWG are meeting to discuss the matrix in more detail. Some activities related to desired outcomes have either been actioned or are in development including: Board dashboard to be shared with the PSWG; review of the CoG annual members/public events; nomination of governor observers to the Audit Committee and BDIC; active participation of other key strategic areas in PSWG meetings; skills audit and mentoring scheme under development; more robust reporting mechanisms.

3. **Involvement and Social responsibility group** (Mark Ganderton)

At our most recent Meeting (14th July) we discussed EPIC and the Involvement Register, with the main focus on SLaM's forthcoming adoption of NSUN's 4Pi Standards. The group agreed to formerly write to the Director of Organisation and Community on a number of issues around responsiveness, NSUN/4Pi, the Involvement Register, the Governor Feedback Events planned for this Autumn and the suggested audit.

The group agreed to issue a position paper in response to the Service User Strategy document which is currently out to consultation.

ISR Group member Gill Sharpe is now officially our Governor observer on the Mental Health Act Law Committee, receiving Agendas/Minutes and reporting back to our group on a quarterly basis.

4. **Governance sub-committee** (Chris Anderson)

Chris Anderson has taken over as Chair of the sub-committee. Interim ToRs will be drafted. The role of the sub-committee will be to implement proposals agreed by CoG, develop agreed work and consider other items that arise.

A number of agreed items will be brought forward for discussion with the Chair on 30 July. Other work is continuing for approval at the September meeting of the Council of Governors.

As previously reported, the Chief Executive, Matthew Patrick, who is employed as a consultant psychiatrist, wishes to retire from his clinical contract but to be re-appointed on a non-medical contract for a further period as Chief Executive at SLaM. The NEDs have agreed the appointment, following the Remuneration Committee agreeing terms in line with national guidance. A meeting of the CoG has been arranged to be held on Thursday, 30 July to approve the appointment.

Paul Mitchell
Trust Secretary
July 2015
Date of Board meeting: 28th July 2015
Name of Report: Briefing from the Quality Sub Committee
Heading: Governance
Authors: Neil Brimblecombe
Approved by: Neil Brimblecombe, Director of Nursing
Presented by: Lesley Calladine/Neil Brimblecombe

Purpose of the report:
To present a brief summary of key points discussed at the meeting of the Quality Sub Committee of the Board held on 23rd June 2015, drawing the Board’s attention to key points for consideration.

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
The Quality Sub Committee draws the following items to the attention of the Board for noting and for consideration as to whether further briefing is required.
1. Policies agreed

- Clinical Records
- Complaints
- Pharmacy Needle Exchange Guidelines
- CDAT Needle Exchange Guidelines
- Learning Lessons
- End of Life

2. Draft strategy - service user involvement

The draft service user involvement strategy was presented to consult and obtain feedback from the committee members. The strategy has been co-developed with service users and incorporates national involvement standards. A further consultation period is planned before presenting a final draft to the Board.

3. Recruitment

An overview of the Trust recruitment strategy was provided by Human Resources. Ensuring safer staffing levels on inpatient wards is a key issue for CAGs due to difficulties with recruitment. To address this, a number of strategies have been put in place. CAMHS and Psychosis CAG reported progress with filling posts successfully. This will be monitored monthly via the safer staffing reports and reviewed fully 6 monthly.

4. Education and Training

An update report was received from Education and Training. Mandatory training is now reviewed on a monthly basis at Performance Management. This has shown some improvement in completion rates. It was noted that Clinical Risk Training was absent from the top priority training list. This is currently being addressed by Education and Training and will be monitored going forward at Performance Management.

5. Risk Registers

Processes relating to the operational and corporate risk registers and Board Assurance Framework were discussed by the committee.

The Chair raised the need to have further discussions at the Board regarding the assurance processes underlying the risk registers.

6. CQC project plan

An update on progress with preparation for the CQC hospital inspection in September was provided. The project plan is on schedule. A monthly update will be provided to the committee.

Next meeting: 21st July 2015
## Purpose of the report:

R&D Committee Report to the Board

## Recommendations to the Board:

To note for information

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

Objective 8 of the Assurance Framework (financial) - maximising potential R&D income sources.

## Summary of Financial and Legal Implications:

The Committee considered ways in which R&D income could be enhanced

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

Key strategic objective for R&D is the reduction of discrimination

## Service Quality Implications:

Research needs to be at the core of our clinical services in order that our clinical practice is based on the best evidence and to facilitate the opportunity for better treatments, service improvements and innovation. It is important that our staff are embedded in a culture where all of our patients are encouraged and given the opportunity to take part in research.
MINUTES OF THE
SLaM Research & Development Committee Meeting

Thursday 5th February 2015

Maudsley Boardroom, 14:00 – 16:00

Present:
Tom Craig (TC), Chair SLaM Director of R&D
John Strang (JS) Addictions CAG lead
Gus Heafield (GH) Chief Financial Officer, SLaM
Khalida Ismail (KH) LCRN Division 4 Leadership representative
Philip McGuire (PM) Psychosis CAG leader
Rob Howard (RH) Mental Health of Older Adults and Dementia CAG leader
Emily Simonoff (ES) Child and Adolescent Mental Health CAG leader
Paul Stokes (PS) MAP CAG, on behalf of Allan Young
Carmine Pariante (CP) Psychological Medicine CAG/BRC on behalf of Matthew Hotopf

In attendance:
Krean Naicker (KN) R&D Contracts Manager, SLaM
Melissa Grout (MG) R&D Finance Business Partner, SLaM
Jenny Liebscher (JL) R&D Governance Manager, SLaM/IoPPN
Carol Cooley (CC) R&D Administrator SLaM/IoPPN

Apologies:
Gill Dale (GD) Director of Research Quality
Declan Murphy (DM) Behavioural and Developmental Psychiatry CAG leader
Allan Young (AY) Mood and Personality CAG Academic Director
Matthew Hotopf (MH) Psychological Medicine CAG Academic lead, BRC Director
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| 1.   | Welcome and apologies  
Received as above. |  |
| 2.   | Paper 1 received for discussion - Draft Terms of Reference and Membership  
TC introduced the overall aim of the committee which is to oversee the Trust’s position with respect to Research and Development, with a particular focus on:  
• the Trust’s R&D contractual obligations to the National Institute for Health Research (NIHR) / Department of Health  
• the Trust’s requirements to comply with the Department of Health’s Research Governance Framework for Health and Social Care  
• the Trust’s responsibilities as Sponsor of research  
• national R&D performance metrics and targets  
The key objectives of the committee are:  
• To act as a forum for discussion of matters concerning any aspect of NHS R&D for SLaM  
• To make recommendations to the Trust Board and other Committees of the Trust (e.g. Clinical Governance) as required and partner organisations on any other issues arising in the context of NHS R&D)  
TC advised that the committee will meet three times per year, once per term.  
TC advised that the remit of the SLaM committee would be distinct from committees such as the IoPPN Research & Innovation Committee and the KHP Research Committee and that focus would be from a Trust perspective, covering aspects of undertaking clinical research - including upcoming changes to sponsorship, funding, contracting and focusing on output that the Trust is responsible for reporting, as well as to promote the Trust as being clinically relevant and research-friendly. TC would ensure that the scope of both the IoPPN Research and Innovation Committee and the SLaM R&D Committee would be bridged, and that as the Dean and GD attended both committees, this would also ensure there would be no duplication.  
KI asked whether there was enough SLaM clinical representation on the committee, and suggested inviting Consultants/Clinicians to attend alongside CAG academic leads, to better represent the clinical side of the Trust. The committee agreed and TC suggested the CAGs should select the appropriate people.  
**Action:** R&D office to invite CAG clinical leads to SLaM R&D Committee. | R&D Office |
| 3.   | Paper 2 received for discussion - The NHS R&D Landscape  
i) TC reported that SLaM has had considerable success with NIHR direct funding, but in terms of NHS service support / infrastructure, income has dropped. The other R&D income sources are from the NIHR Local Clinical Research Network (LCRN) and through NIHR Research Capability Funding (RCF), from which CAGs benefit directly. CAGs are encouraged to apply for NIHR funding as much as possible.  
(ii) Excess Treatment Costs (ETC) – committee members suggested implementing a strategy to lobby the Dept. of Health (DH) to cover ETC and to mediate discussion between DH and commissioning groups. TC suggested approaching Geraldine Strathdee (National Clinical Director for Mental Health at NHS England).  
**Action:** TC to arrange for three/four committee members to discuss strategy for lobbying funding commissioning groups, potentially with Geraldine Strathdee  
(iii) MG advised the committee that there has been an example of successful lobbying to the clinical commissioning group (CCG) for substantial costs for one | TC, MG |
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<td>particular study. The committee was keen to understand how this was achieved and to raise awareness for other CAGs.</td>
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<td><strong>Action:</strong> MG to ask Christopher Chaplin, Business Partner at SLaM for further information on lobbying in this case and report back to committee</td>
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<td>(iv)</td>
<td>TC outlined the changed reporting requirements to DH/NIHR - where SLaM now has to meet various benchmarks, with financial penalties if these are not met, also impacting on future funding.</td>
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<td>(v)</td>
<td>JL gave an overview of the sponsorship role of SLaM/KCL and discussed how from 01 January 2015 the Health Research Authority had taken over responsibility from the Department of Health for issuing guidance for research in England in place of the Research Governance Framework (RGF). The HRA is introducing a single NHS approval which will be introduced in a phased manner and should be implemented by December 2015. This will impact the way that applications for NHS ethics and R&amp;D are managed and will also involve a change in the role of Trust R&amp;D staff.</td>
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<td>4.</td>
<td><strong>Paper 3 received for discussion: Finance Reporting</strong></td>
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<td>(i) GH and MG requested thoughts on the financial reporting for CAGs. Some indication that CAG academic leads were unaware of details of R&amp;D funding to CAGs. GH and MG stated that they will work with CAGs and will review the provision of overall BRC budget breakdowns and reporting so this is more transparent to CAGs.</td>
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<td><strong>Action:</strong> TC asked that before next term, there would be CAG-tailored R&amp;D funding attribution to help manage CAGs.</td>
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<td>5.</td>
<td><strong>Paper 4 received for discussion: R&amp;D Performance Metrics and Reporting Requirements</strong></td>
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<td>i) TC and JL reported that SLaM are performing reasonably well in meeting DH/NIHR benchmarks for initiating and delivering research, presenting summary reports to the SLaM R&amp;D Committee. SLaM is performing very well in time taken for the R&amp;D office to issue R&amp;D approval. JL stated that the R&amp;D office manages this by engaging with researchers at an early stage.</td>
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<td>(ii) GH and TC stated that there is an issue with commercial trial performance, where metrics show underperformance. RH suggested that the IoPPN/SLaM should recruit P.I.'s with industry track record and instil a culture change. TC cited Surrey and Borders NHS Foundation Trust as a good example of a Trust that has maximised its potential in this respect.</td>
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<td>7.</td>
<td><strong>Paper 5 received for discussion: Enhancing SLaM's R&amp;D position</strong></td>
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<td>(i) The committee discussed how to build on the concept of SLaM being a teaching and research hospital, promoting the idea that this will provide better treatment to its patients. JS stated that we should change our language to ‘research-engaged’ and it was agreed that the Trust needed to raise its profile as a teaching research trust. The committee agreed that SLaM needs to have a research strategy or mission statement for the Trust.</td>
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<td><strong>Action:</strong> To explore how to acknowledge the importance of research for all Trust staff, including at the time of appointment, – R&amp;D office to contact SLaM HR for discussion</td>
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<td>8.</td>
<td><strong>Papers 6a – 6d received for discussion: Risk Assessment Committee meeting minutes</strong></td>
<td>JL</td>
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<td>(i) TC introduced the RAC meeting minutes to the committee and established that RAC remit was to assess risk for clinical trials involving medicines and devices (excluding novel interventions) prior to KCL/SLaM study sponsorship. Due to the absence of Allan Young, the papers were not presented in detail and members were asked to read the minutes provided. GH requested that the RAC could provide a half-page lay summary of RAC minutes.</td>
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<td><strong>Action:</strong> JL to request that the RAC will provide a half page summary highlighting the key points of the RAC meeting minutes.</td>
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<td>9.</td>
<td><strong>Paper 7 received for discussion: The R&amp;D Team</strong></td>
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<td>Paper 7 is provided for information, so that the committee is aware of the up-to-date members of the R&amp;D team.</td>
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<td>10.</td>
<td><strong>Any other business</strong></td>
<td>TC &amp; JL</td>
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<td>Recording trial participation in medical notes: TC raised the issue of flagging patient participation in a clinical trial in the patient clinical notes – this is done for clinical drug trials but not always for non-drug trials, for example trials of psychological interventions (flagging patient participation only in the case of an intervention, not necessarily a questionnaire). The committee agreed that all participation in interventional trials should be recorded in the medical records.</td>
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<td><strong>Action:</strong> Participation in all clinical trials should be recorded in the patient notes - a photocopy of the consent form should be provided for the patient, the researcher, the patient notes and the GP. TC and JL to ensure that this is communicated to all relevant staff.</td>
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<td>10.</td>
<td><strong>Date of next meetings – next term, Summer 2015:</strong></td>
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<td>Thursday, June 18th 2 – 4pm, Maudsley Boardroom.</td>
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**TRUST BOARD OF DIRECTORS – SUMMARY REPORT**

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<th>Date of Board meeting:</th>
<th>Tuesday 28&lt;sup&gt;th&lt;/sup&gt; July 2015</th>
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</table>
| Name of Report:       | (a) Key issues summary (overpage) \(\)
|                       | (b) Draft minutes of Audit Committee meeting held 23<sup>rd</sup> June 2015 \(\)
|                       | (c) Signed and sealed report \(\)

**Purpose of the report**

For information

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

**Author:** Steven Thomas (Audit Committee Secretary)

**Approved by:** June Mulroy (Audit Committee Chair and Non Executive Director – ‘NED’)

**Presented by:** June Mulroy (Audit Committee Chair and NED)

**Purpose of the report:**

<table>
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<th>The following reports are presented for the Board’s information</th>
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<td><strong>Item (a): key issues summary.</strong> To inform the Board about key issues noted at the Audit Committee meeting held on Tuesday 23&lt;sup&gt;rd&lt;/sup&gt; June 2015</td>
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<td><strong>Item (b): Audit Committee draft minutes.</strong> To inform the Board about proceedings at the Audit Committee meeting held on Tuesday 23&lt;sup&gt;rd&lt;/sup&gt; June 2015</td>
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<td><strong>Item (c): signed and sealed report.</strong> To inform the Board about documents signed and sealed on behalf of the Trust</td>
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**Recommendations to the Board:**

Review and note the documents

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

No specific significant implications identified.

**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.
At its meeting on 23rd June 2015 the AC concluded that no matters required escalation for the attention of the Board (14.1 refers). 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 meeting.

### Key potential issues (as at 23rd June 2015)

<table>
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<tr>
<th>Key potential issues</th>
<th>AC mins ref</th>
<th>Actions proposed to address key issues (as at 23rd June 2015)</th>
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| **(1). MAPS CAG and CIPs.** Mood Anxiety and Personality Services (‘MAPS’) CAG management gave a verbal report, outlining factors contributing to the success of the MAPS CAG as regards Cost Improvement Programmes (‘CIPs’) performance, reducing agency costs etc. The key points flagged were:  
(a) the CAG had a mature working ethos focusing on trust, collaboration and financial balance;  
(b) the CAG used ‘Borough leads’ – clinicians who manage and coordinate services and specialisms provided to Boroughs; and  
(c) CAG management sought to play a full part in the financial decision-making process;  
MAPS CAG management noted that the main frustrations experienced were Estates (the lack of space for IAPT services) and IT, in particular that the IAPT services used a different IT system that did not link well with systems in use elsewhere. | 9.1 | The AC Chair will flag these issues to the Board, to be cascaded as Board members consider is appropriate |
| **(2). Monitoring Monitor’s requirements.** The CFO tabled a report summarising reports required by Monitor from SLaM over the period since January 2015. The meeting discussed this, and in particular the CFO advised that he was not aware of any discussions with Monitor prior to Monitor issuing any of the requirements for these reports. | 9.2 | The CFO will continue to maintain the tabled report, which would provide the Board and the Trust Chair with useful information. It is intended that this will be included in the ‘deep dive’ on the Finance function to be reported to the Board later in 2015. |
| **(3). Procurement’s contribution to CIPs: update.** The Chief Financial Officer (‘CFO’) advised that a thorough review of the Procurement function at SLaM is currently being undertaken by the London Procurement Partnership (‘LPP’), and a final report from LPP is due in July/August 2015. The CFO advised that SLaM’s Procurement function performed well as regards dealing with transactions, but Procurement strategy was in a period of transition and needed further improvement. The CFO advised that if SLaM opts to outsource certain aspects of the Procurement service, this would be subject to tender, the terms of which would allow other KHP partners to use it. | 9.3 | The AC Chair agreed to discuss this further with the CFO outside of the AC meeting |
| **(4). Internal audit.** The AC meeting discussed the ‘mock CQC reports’ prepared by internal audit (TIAA) based on one-day visits to each of five SLaM units by ex-CQC inspectors who were now working with TIAA. The AC noted that the reports identified many examples of good practice, but there were also a number of major issues, for example involving lack of a legionella risk assessment and ligature risks. Internal audit advised that these types of finding were fairly typical based on experience at other Trusts. | 12.1 | The AC Chair will recommend to the Board that the Board considers the performance of ‘mock CQC visits’ on a cyclical basis, perhaps focusing more on remote units. Post meeting note: a verbal recommendation was made to the Board meeting held on 23 June 2015. |
MINUTES OF THE
AUDIT COMMITTEE (‘AC’)
HELD ON: Tuesday 23 June 2015

AT: Room 3, Employee Relations, Human Resources Department, Maudsley Hospital

Present: Title Initials (presence for items)
June Mulroy AC Chair. Non Executive Director (‘NED’) JM (All items)
Robert Coomber AC Member, NED RC (All items)
Shitij Kapur AC Member, NED SK (All items)
Steven Thomas AC Secretary ST (All items)

In attendance:
Gus Heafield Chief Financial Officer (‘CFO’) GH (All items)
Jo Kent Deputy Director, MAPS CAG JK (Item 9.1)
Christopher Chaplin Finance Business Partner, PMed/MAPS CAG CC (Item 9.1)
Matthew Hall External Audit (Partner – Deloitte) MH (All items)
Kevin Limn Internal Audit (Chief Internal Auditor – TIAA) KL (All items bar 13.1 onward)
Thanzil Khan Internal Audit (Internal Audit Manager – TIAA) TK (All items)
Christopher Chaplin Finance Business Partner, PMed/MAPS CAG CC (Item 9.1)
Matthew Hall External Audit (Partner – Deloitte) MH (All items)
Kevin Limn Internal Audit (Chief Internal Auditor – TIAA) KL (All items bar 13.1 onward)
Thanzil Khan Internal Audit (Internal Audit Manager – TIAA) TK (All items)
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Kevin Limn Internal Audit (Chief Internal Auditor – TIAA) KL (All items bar 13.1 onward)
Thanzil Khan Internal Audit (Internal Audit Manager – TIAA) TK (All items)

Apologies for absence:
Angus Fish External Audit (Senior Manager – Deloitte)
David Kenealy Local Counter Fraud Specialist (‘LCFS’ – TIAA)

NOTES
- The AC Chair decides on the appropriate order in which to take agenda items at AC meetings, and this is not necessarily the order shown below.
- The minutes focus on recording the information and assurances provided in the meeting, in response to questions and otherwise, rather than on the questions themselves.
- ‘MAPS CAG’ denotes the Mood Anxiety and Personality Services (‘MAPS’) Clinical Academic Group (‘CAG’)
- ‘PMed CAG’ denotes the Psychological Medicines CAG

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<td>1.</td>
<td>Non-minuted session. No such session was held, as no such session had been requested by any party.</td>
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<td>2.</td>
<td>Apologies for absence 2.1 All present introduced themselves. Apologies for absence were received as above. After due discussion the AC noted this and noted that the AC meeting was quorate.</td>
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<td>3.</td>
<td>Declarations of interest 3.1 JM 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</td>
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<td>Board of Lundbeck Co and Roche Co. SK advises and consults with pharmaceutical companies periodically. MH and JMUr confirmed that there were no issues around independence or conflicts of interest as regards: (a) external audit work; and (b) the consultancy work being performed by Deloitte, which JMUr briefly outlined. After due discussion the AC noted this agenda item.</td>
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<td>4.</td>
<td>Minutes of previous AC meetings</td>
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<td>4.1 All present considered, page by page, the final draft minutes of the AC meeting held on Tuesday 26 May 2015 and Tuesday 24 March 2015. MH advised that external audit would, as in prior years, report to the September meeting of the Council of Governors, so the appropriate deadline for Action Point 442 was Sep.2015. After due discussion and with that amendment the AC approved the minutes.</td>
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<td>5.</td>
<td>Action points from previous AC meetings</td>
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<td>5.1 All present considered the list of action points, and advised updates as appropriate. After due discussion the AC noted the list of action points and the AC Chair approved deletion of action points agreed as resolved. Post meeting note: the action point list attached to the present minutes reflects updates received at the meeting and afterwards.</td>
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<td>6.</td>
<td>Matters arising</td>
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<td>6.1 All present advised, and after due discussion the AC noted, that there were no matters arising that would not be appropriately dealt with in the agenda.</td>
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<td>7.</td>
<td>Quality Committee (‘QC’) and Business Development and Investment Committee (‘BDIC’): key issues from meetings</td>
<td>All AC agenda contributors</td>
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<td>7.1 The meeting considered:</td>
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<td>(a) the report of key points from the most recent BDIC meeting, in particular the work streams noted as being under consideration with BUPA. GH confirmed that these involved potential profit sharing, but that it had been decided not to pursue these further;</td>
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<td>(b) the report of key points from the most recent QC meeting. JM advised that she and the QC Chair had met recently and continued to work on how best to coordinate and prioritise risk issues between the AC and QC. JM invited all present to come forward with any advice on this outside of the AC meeting; and</td>
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<td>(c) after due discussion the AC noted the agenda item. 7.2 Action. The agenda front sheets for all agenda items should clarify specific implications for risk and assurance of the particular report/agenda item, not simply state generic risk factors covered by the body producing the report/agenda item (this action point was prompted initially by the AC’s consideration of agenda front sheets for the BDIC and QC items, but applies to almost all AC agenda items received).</td>
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<td>8.</td>
<td>AC-RELATED MATTERS</td>
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<td>8.1</td>
<td>AC workplan for the year ahead</td>
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<td>8.1.1 ST presented the workplan. JM noted that the workplan should include consideration of matters relating to the Maudsley Charity. RC noted that the July 2015 meeting of the Charity Committee would review its processes and relationships with SLaM. After due discussion the AC approved the workplan, subject to any updating required to reflect points</td>
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<td>raised in the meeting. Post meeting note: ST has updated the AC workplan accordingly.</td>
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<td>8.2</td>
<td><strong>AC Annual Report to the Board of Directors</strong></td>
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<td>8.2.1 ST presented the report. The meeting commented that the report was comprehensive and made several detailed comments on amendments required. In particular, responding to IC’s query, RC and JM expanded on the process by which the AC had been assessed in 2014/15, taking account of the fact that this was a year of transition for SLaM in many areas. After due discussion the AC approved the report in principle, subject to an amended final draft being circulated for comment and final ratification.</td>
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<td><strong>8.2.2 Action.</strong> The AC Secretary will circulate to all attendees a final draft AC Annual Report 2014/15 for final comment and the AC’s ratification, and will include the final version in the Board’s July 2015 agenda papers.</td>
<td>ST</td>
<td>Jul.15</td>
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<td>8.3</td>
<td><strong>AC terms of reference</strong></td>
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<td>8.3.1 ST presented the agenda item. The meeting made several detailed comments on amendments required, in particular as regards the attendance of a Governor Observer and the interaction of the AC and the Charity Committee. After due discussion the AC agreed that the terms of reference should be put to the Board’s July 2015 meeting for approval, subject to an amended final draft being circulated for the AC’s final comment before this.</td>
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<td><strong>8.3.2 Action.</strong> The AC Secretary will circulate a final draft of the AC’s terms of reference for final comment and for the AC’s agreement that it be included in the Board’s July 2015 agenda papers for the Board’s approval.</td>
<td>ST</td>
<td>Jul.15</td>
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<tr>
<td>9.</td>
<td><strong>REPORTS FROM/DISCUSSIONS WITH SLaM MANAGEMENT</strong></td>
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<td>9.1</td>
<td><strong>MAPS CAG and CIPs</strong></td>
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<td></td>
<td>9.1.1 (Note: JK is Deputy Director of the MAPS CAG, and hence discussion covered this CAG not PMed.) JK and CC gave a verbal report, outlining factors contributing to the success of the MAPS CAG as regards CIPs performance, reducing agency costs etc, and:</td>
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<td></td>
<td>(a) JK commented that the CAG had a mature working ethos focusing on trust, collaboration, financial balance and sharing of problems, which enabled difficult decisions to be made and followed through. For example the CAG had shut services/wards where necessary;</td>
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<td>(b) JK commented that one key factor to MAPS CAG success is its use of ‘Borough leads’ – clinicians who manage and coordinate services/specialisms provided to Boroughs, focusing on evidence-based treatments and interactions with primary care. GH explained that each CAG had its own approach for managing services at different locations/CCGs;</td>
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<td>(c) JK and CC considered that the financial models in place were acceptable, and CAG management sought to play a full part in the decision-making process, appreciating that services may well need to be curtailed in order to maintain overall financial balance. SK considered this to be an optimal attitude;</td>
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<td>(d) JK saw the key future challenge as being issues arising from fuller integration, and considered it vital that CAG management continued</td>
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</table>
to be part of the planning process;

(e) JK advised that the main frustration experienced was Estates, and the lack of space for IAPT services (‘Improving Access to Psychological Therapies’ services). JK commented that IAPT services in general performed well, but because they were ‘off the main radar’ and did not involve beds, space allocation for this service was not seen by general management as a priority, leading to issues with achieving one of the two key targets used by CCGs as performance metrics. JK considered the Maudsley building to be dysfunctional as regards the provision of efficient and effective services;

(f) JK advised that the other main frustration experienced was IT, in particular that the IAPT services used a different IT system that did not link well systems in use elsewhere. JK and CC advised some recent minor improvements in IT department’s response to solution of issues; and

(g) the AC thanked JK and CC for their attendance which had provided valuable insights and, after due discussion, the AC noted the agenda item.

9.2 Monitoring Monitor’s requirements
9.2.1 GH tabled a report summarising reports required by Monitor from SLaM over the period since January 2015 (advising that the report on page 48 of the main AC agenda papers was incomplete) and:

(a) GH advised that he was not aware of any discussions with Monitor prior to Monitor issuing any of the requirements for these reports;

(b) GH believed that in certain cases the requirement was the Department of Health’s, and Monitor was simply acting as a ‘post box’;

(c) RC noted that the number and content of the reports required by Monitor seemed at odds with the ‘light touch’ promised by Monitor;

(d) RC noted that the report requirements presumably indicated a view that Monitor is taking about risk at SLaM, and RC considered that the Board should form a judgment as to what that view may be;

(e) JM noted that Monitor should have a justification for each and every report request (in the same way as the Pensions Regulator did when she worked there) as production of such reports diverts SLaM’s resources from its central operations; and

(f) after due discussion the AC noted the agenda item and the AC noted that GH should continue to maintain the tabled report, which would provide the Board and the Trust Chair with useful information.

9.3 Procurement’s contribution to CIPs: update
9.3.1 GH presented this agenda item, tabling for context a further report analysing SLaM’s total spend for the year ended 31 December 2014, and:

(a) GH advised that SLaM was working with an expert to improve Procurement’s contribution to CIPs. A thorough review of the Procurement function at SLaM is currently being undertaken by the London Procurement Partnership (‘LPP’), and a final report from LPP is due in July/August 2015;

(b) GH advised that SLaM’s Procurement function performed well as regards dealing with transactions, but Procurement strategy was in a period of transition and needed further improvement;
<table>
<thead>
<tr>
<th>Item no.</th>
<th>Business Item</th>
<th>Action by</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>(c)</td>
<td>GH advised that if SLaM opts to outsource certain aspects of the Procurement service, this would be subject to tender, the terms of which would allow other KHP partners to use it;</td>
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<td>(d)</td>
<td>JM agreed to talk further with GH outside of the AC meeting; and</td>
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<tr>
<td>(e)</td>
<td>after due discussion the AC noted the agenda item.</td>
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<tr>
<td>10</td>
<td>RISK MANAGEMENT AND FINANCE</td>
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<tr>
<td>10.1</td>
<td>CFO’s report on ‘GH’ items in this agenda</td>
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<tr>
<td>10.1.1</td>
<td>GH reported as appropriate within agenda items 10.2 to 10.4 below. After due discussion the AC noted this.</td>
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<tr>
<td>10.2</td>
<td>Assurance Framework</td>
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<tr>
<td>10.2.1</td>
<td>GH presented this report, and:</td>
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<tr>
<td>(a)</td>
<td>GH advised that work to improve the format/content of the report continued, and in particular recent improvements included the links with SLaM’s strategy and with reviews of risk registers in CAGs. Key risks dealt with included CIP delivery and the commissioning landscape, which was changing rapidly;</td>
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<td>(b)</td>
<td>SK advised that experience in the US with ‘Accountable Care Organisations (ACOs)’ had indicated that the only way to achieve significant lasting savings was to shut services. Introducing ACOs had required major efforts and even after significant incentives ACOs had achieved only 1% ongoing savings, not the 20% levels sought;</td>
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<tr>
<td>(c)</td>
<td>GH advised that reviews of the commissioner landscape had identified that CCGs needed to carry an appropriate proportion of risk;</td>
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<td>(d)</td>
<td>IC advised that the report should show accountable individuals, and should be RAG-rated;</td>
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<tr>
<td>(e)</td>
<td>responding to IC’s query, GH confirmed that detailed action plans underlay the assurance framework; and</td>
<td></td>
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<td>(f)</td>
<td>after due discussion the AC noted the agenda item.</td>
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<tr>
<td>10.3</td>
<td>Update on policies</td>
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<tr>
<td>10.3.1</td>
<td>GH presented a verbal report, confirming that the Anti-Bribery Policy had been issued in June 2015 (agenda item 11.2) and that SLaM was working on a revised draft Scheme of Delegation. GH agreed to circulate this in due course. After due discussion the AC noted the agenda item.</td>
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<tr>
<td>10.4</td>
<td>Signed and sealed documents, SFI breaches and STAs</td>
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<tr>
<td>10.4.1</td>
<td>GH presented the agenda item, and</td>
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<tr>
<td>(a)</td>
<td>the AC noted GH’s explanation about SFI breaches 5 and 6 (£7k total re scanning of patient files – this referred to minor archiving of certain old files);</td>
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<td>(b)</td>
<td>the AC noted GH’s explanation about STA 138 (£51k) and STA 142 (£73k) which resulted from delays in contract renewal/tendering. GH confirmed that SLaM is now using a tender warning system to address this, to help ensure that contracts are renewed/tendered on a timely basis thus avoiding ‘gaps’ and hence STAs and SFI breaches; and</td>
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<td>(c)</td>
<td>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.</td>
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<tr>
<td>Item no.</td>
<td>Business Item</td>
<td>Action by</td>
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<tr>
<td>11.1</td>
<td><strong>LOCAL COUNTER FRAUD SPECIALIST ('LCFS')</strong></td>
<td>DK</td>
<td>Sep.15</td>
</tr>
<tr>
<td>11.1.1</td>
<td><strong>Progress/annual report (with summary cover sheet)</strong></td>
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<td></td>
<td><strong>(a)</strong> In DK's absence, KL presented this agenda item, and in particular:</td>
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<td></td>
<td>(a) KL confirmed that LCFS used a cost/benefit analysis to support decisions on whether to proceed via the Police or via SLaM’s Human Resources function;</td>
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<td>(b) RC asked for more details about PAA 6369 (false overtime claims investigation); and</td>
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<td>(c) after due discussion the AC noted the agenda item.</td>
<td>DK</td>
<td>Sep.15</td>
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<tr>
<td>11.1.2</td>
<td><strong>Action.</strong> LCFS will provide the next AC meeting with further details about case PAA 6369.</td>
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<tr>
<td>11.2</td>
<td><strong>Presentation on Bribery Act 2010 (SLaM policy issued June 2015)</strong></td>
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<tr>
<td>11.2.1</td>
<td><strong>GH introduced this agenda item, noting that ST had been involved in producing the final version of the Anti-Bribery Policy as issued, subject to ‘sign off’ by DK and relevant SLaM management. KL agreed that in DK’s absence the planned presentation would be dealt with at the Sep.2015 AC meeting. GH confirmed that SLaM would seek to cover the new Anti-Bribery Policy in Board training. After due discussion the AC noted the foregoing.</strong></td>
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<td>11.3</td>
<td><strong>Report on declaration, monitoring and definition of interests</strong></td>
<td>GH</td>
<td>Sep.15</td>
</tr>
<tr>
<td>11.3.1</td>
<td><strong>In DK’s absence, KL presented this agenda item, and in particular:</strong></td>
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<td>(a) SK noted that, unless some judgment is applied, declarations can become excessively long with standard ‘boiler plate’ text being used rendering the declarations made effectively meaningless;</td>
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<td>(b) the AC considered that it was vital that attention was also focused on management of declarations made, not simply the making of the declarations, and to this end declarations should be covered as part of annual appraisals;</td>
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<td>(c) the meeting discussed a particular declaration made by a SLaM consultant; and</td>
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<td>(d) after due discussion the AC noted the agenda item.</td>
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<tr>
<td>11.3.2</td>
<td><strong>Action.</strong> The CFO will provide the AC with further details about a declaration of interest made by a SLaM consultant as regards an interest in working on a project with external consultants engaged by SLaM, in particular: how the declaration was managed; and how the declared work interacted with the SLaM consultant’s work for SLaM.</td>
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<td>12</td>
<td><strong>INTERNAL AUDIT (INCLUDING ICT AUDIT AND CLINICAL AUDIT IF RELEVANT)</strong></td>
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<td>12.1</td>
<td><strong>Progress report</strong></td>
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<td>12.1.1</td>
<td><strong>KL presented the agenda item, and:</strong></td>
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<td>(a) AC members agreed to forward to internal audit (via the CFO) a recent report on governance at the Maudsley Charity on the basis that any and all information therein would be kept strictly confidential and not disclosed to any other party;</td>
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<td>(b) the meeting discussed the ‘mock CQC reports’ prepared by TIAA based on one-day visits to each of five SLaM units by ex-CQC inspectors who were now working with TIAA (Appendix B refers). RC noted that the reports identified many examples of good practice, but there were also a number of major issues, for example involving lack</td>
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of a legionella risk assessment and ligature risks. KL advised that these types of finding were fairly typical based on experience at other Trusts. The meeting agreed that this exercise was extremely useful and the AC and QC shared an interest in the findings; and (c) after due discussion the AC noted the agenda item.

12.1.2 Action. The AC Chair will recommend to the Board that the Board considers the performance of ‘mock CQC visits’ on a cyclical basis, perhaps focusing more on remote units. Post meeting note: a verbal recommendation was made to the 23.Jun.2015 Board meeting.

12.2 Report on estates management
12.2.1 KL and TK gave a verbal update on the position, advising that the review was underway and would be reported to the Sep.2015 AC meeting. After due discussion the AC noted the agenda item.

13 EXTERNAL AUDIT
13.1 Matters (if any) arising from the 2014/15 audit
13.1.1 MH gave a verbal report, advising that there were no significant matters to report and that external audit would meet shortly with the CFO and his team members to deal with any detailed matters arising from the 2014/15 audit. After due discussion the AC noted the agenda item.

14. CPD needs identified, matters for escalation to the Board, and any other business
14.1 After due discussion the AC concluded that:
(a) all agenda items and supporting agenda papers had received due consideration, or had been deferred to a future AC meeting;
(b) no significant training (Continued Professional Development – ‘CPD’) needs had been identified for AC members;
(c) no matters required escalation for the attention of the Board;
(d) the AC Chair would report verbally to the Board at its meeting later on 23.Jun.2015 as regards: (i) discussions with management from the PMed CAG and MAPS CAG (agenda item 9.1 refers); and (ii) findings from the ‘mock CQC’ visits (agenda item 11.1 refers). Post meeting note: this was done; and
(e) there being no further AC business, JM closed the meeting.

15. Date of next meeting
15.1 The next meeting is set for Tuesday 15th September 2015 at 09:00 to 11:00 in the ORTUS Learning Centre

**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. Progress in closing items will be checked at the next AC meeting in the usual way.

<table>
<thead>
<tr>
<th>Date arising</th>
<th>AC action point</th>
<th>Action lead</th>
<th>Date to complete</th>
<th>Notes/evidence that completed (or ref to relevant agenda item)</th>
<th>AC Chair sign off</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.10.14</td>
<td>12.5. ND and GH will obtain internal audit’s independent assessment of the Estates Department, including benchmarking it with other departments, and will report back to the AC and Board.</td>
<td>ND, GH</td>
<td>Jun.15</td>
<td>Internal audit confirmed at the 23.Jun.2015 AC meeting that Work on this was underway</td>
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<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>
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<tr>
<td>16.12.14 423</td>
<td>10.1.3. RC will flag to the Chief Executive the AC’s recommendations: (1) that the Chief Executive should coordinate production of a strategy or other means of prioritising competing demands on time and resources when dealing with strategic partners; and (2) that the Board should consider the internal audit report on quality governance arrangements as a means of improving the efficiency and effectiveness of Board and committee operations generally.</td>
<td>RC, GH</td>
<td>Jan.15</td>
<td>RC confirmed he had flagged these matters, and awaits an appropriate response. Update at 27.May.15 AC meeting: GH will check and report the position on this. At the 23.Jun.2015 AC meeting the CFO confirmed responsibilities had been allocated across the Board</td>
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<tr>
<td>27.05.15 442</td>
<td>0.2.3 External audit will feedback to the September 2015 Council of Governors meeting the inherent difficulties in an independent review of the performance indicator for 2014/15 (patient service responses) selected by the Council for such review.</td>
<td>MH, AF</td>
<td>Sep.15</td>
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<tr>
<td>23.06.15 444</td>
<td>7.2 The agenda front sheets for all agenda items should clarify specific implications for risk and assurance of the particular report/agenda item, not simply generic factors covered by the body producing the report/agenda item (this action point was prompted initially by the AC’s consideration of agenda front sheets for the BDIC and QC items, but applies to almost all AC agenda items received).</td>
<td>All AC agenda contributors</td>
<td>Now on</td>
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<tr>
<td>23.06.15 445</td>
<td>8.2.2 The AC Secretary will circulate to all attendees a final draft AC Annual Report 2014/15 for final comment and the AC’s ratification, and will include the final version in the Board’s July 2015 agenda papers.</td>
<td>ST</td>
<td>Jul.15</td>
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<tr>
<td>23.06.15 446</td>
<td>8.3.2 The AC Secretary will circulate a final draft of the AC’s terms of reference for final comment and for the AC’s agreement that it be included in the Board’s July 2015 agenda papers for the Board’s approval.</td>
<td>ST</td>
<td>Jul.15</td>
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<tr>
<td>23.06.15 447</td>
<td>11.1.2 LCFS will provide the next AC meeting with further details about case PAA 6369.</td>
<td>DK</td>
<td>Sep.15</td>
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<tr>
<td>23.06.15 448</td>
<td>11.3.2 The CFO will provide the AC with further details about a declaration of interest made by a SLaM consultant as regards an interest in working on a project with external consultants engaged by SLaM, in particular: how the declaration was managed; and how the declared work interacted with the SLaM consultant’s work for SLaM.</td>
<td>GH</td>
<td>Sep.15</td>
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<tr>
<td>23.06.15 449</td>
<td>12.1.2 The AC Chair will recommend to the Board that the Board considers the performance of mock CQC visits on a cyclical basis, perhaps focusing more on remote units. Post meeting note: a verbal recommendation was made to the 23 Jun.2015 Board meeting.</td>
<td>JM</td>
<td>Jun.15</td>
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<tr>
<td>Number</td>
<td>Date</td>
<td>Description</td>
<td>Between</td>
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<td>Signature</td>
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<tr>
<td>126</td>
<td>13/04/2015</td>
<td>Lambeth Integrated Personalised Services Agreement for the period of 2015/2016-2016/2017</td>
<td>SLaM</td>
<td>Alliance</td>
<td>Matthew Patrick</td>
</tr>
<tr>
<td>127</td>
<td>19/05/2015</td>
<td>Lease renewal in respect of Masters House and Gatehouse at Lambeth Hospital site (1 copy)</td>
<td>SLaM</td>
<td>Cinema Museum</td>
<td>Zoe Reed</td>
</tr>
<tr>
<td>128</td>
<td>19/05/2015</td>
<td>Lease renewal in respect of Carolyn House Croydon (1 copy)</td>
<td>SLaM</td>
<td>HSBC Pension Trust (UK) Ltd</td>
<td>Gus Heafield</td>
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</tbody>
</table>
## Summary of Documents signed on behalf of the South London & Maudsley NHSFT where sealing is required

<table>
<thead>
<tr>
<th>Number</th>
<th>Date</th>
<th>Description</th>
<th>Between</th>
<th>And</th>
<th>Signature</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>444</td>
<td>31/03/2015</td>
<td>Learning and Development Agreement 2015/16 (1 copy)</td>
<td>SLaM</td>
<td>Health Education England</td>
<td>Matthew Patrick</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>445</td>
<td>31/03/2015</td>
<td>Revised Clinical Trials Agreement REF: 2013 - U025094-25 (3 copies) (see previous entry no: 440 only one signature)</td>
<td>SLaM</td>
<td>King's College London Piramal Healthcare UK Ltd</td>
<td>Matthew Patrick</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>446</td>
<td>31/03/2015</td>
<td>Contract in respect of Medical Devices Maintenance (2 copies) (One signature required)</td>
<td>SLaM</td>
<td>Key Health Solutions Ltd</td>
<td>Matthew Patrick</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>447</td>
<td>31/03/2015</td>
<td>Tender contract in respect of refurbishment works at Larkbarrow House, Bethlem Royal Hospital (2 copies)</td>
<td>SLaM</td>
<td>Cooper Clarke Construction Ltd</td>
<td>Matthew Patrick</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>448</td>
<td>31/03/2015</td>
<td>Rental schedule supplied by Cycle scheme Ltd in respect of the Cycle to Work Scheme under the contract</td>
<td>SLaM</td>
<td>AM Solutions</td>
<td>Matthew Patrick</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>449</td>
<td>31/03/2015</td>
<td>Amendment No.2 in respect of the Clinical Trials Agreement led by Professor Clive Ballard (4 copies)</td>
<td>SLaM</td>
<td>King's College Hospital King's College London Takeda Development Centre Quintiles Ltd</td>
<td>Matthew Patrick</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>450</td>
<td>13/04/2015</td>
<td>Agreement in respect of the HV Switch Upgrade at Bethlem Royal Hospital (2 copies)</td>
<td>SLaM</td>
<td>UK Power Services</td>
<td>Martin Baggaley</td>
<td>Emily Buttrum</td>
</tr>
<tr>
<td>451</td>
<td>19/05/2015</td>
<td>NHS Standard Contract 2015/2016 (2 copies) (Alliance Contract)</td>
<td>SLaM</td>
<td>Lambeth CCG</td>
<td>Gus Heafield</td>
<td>Zoe Reed</td>
</tr>
<tr>
<td>452</td>
<td>19/05/2015</td>
<td>Amendment in respect of the Luther King Dormitory Reconfiguration Works and Nelson Bathroom Refurbishment works (2 copies)</td>
<td>SLaM</td>
<td>ITC Concepts Ltd</td>
<td>Gus Heafield</td>
<td>Zoe Reed</td>
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<tr>
<td>No.</td>
<td>Date</td>
<td>Description</td>
<td>Parties</td>
<td>Signatories</td>
<td>Approver</td>
<td></td>
</tr>
<tr>
<td>-----</td>
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<td></td>
</tr>
<tr>
<td>458</td>
<td>26/05/2015</td>
<td>Agreement in respect of the Genomics Network Alliance (1 copy)</td>
<td>SLaM Genomics Network Alliance (1 copy)</td>
<td>Matthew Patrick</td>
<td>Zoe Reed</td>
<td></td>
</tr>
<tr>
<td>459</td>
<td>27/05/2015</td>
<td>Engagement Contract in respect of assistance to undertake an Independent Review of SLaM's Governance Arrangements (1 copy)</td>
<td>Deloitte Genomics Network Alliance (1 copy)</td>
<td>Matthew Patrick</td>
<td>Gus Heafield</td>
<td></td>
</tr>
<tr>
<td>460</td>
<td>01/06/2015</td>
<td>NHS Standard Contract 2015/2016</td>
<td>Southwark CCG (1 copy)</td>
<td>Martin Baggaley</td>
<td>Gus Heafield</td>
<td></td>
</tr>
<tr>
<td>461</td>
<td>01/06/2015</td>
<td>NHS Standard Contract 2015/2016</td>
<td>Southwark CCG (1 copy)</td>
<td>Martin Baggaley</td>
<td>Gus Heafield</td>
<td></td>
</tr>
<tr>
<td>462</td>
<td>01/06/2015</td>
<td>Technical Agreement for Physiological Study in respect of the trial &quot;Effect of N-Acetyl cysteine on brain Glutamate in Schizophrenia Study&quot; (1 copy) CANCELLED Agreement collected by Lauren Moul for Gill Dale to sign off</td>
<td>AFM Solutions (1 copy)</td>
<td>Gus Heafield</td>
<td>Gus Heafield</td>
<td></td>
</tr>
<tr>
<td>463</td>
<td>03/06/2015</td>
<td>Agreement in respect of the Cycle to Work Scheme (2 copies)</td>
<td>SLaM (2 copies)</td>
<td>Gus Heafield</td>
<td>Gus Heafield</td>
<td></td>
</tr>
</tbody>
</table>
Date of Board meeting: 28 July 2015

Name of Report: BDIC Summary Report

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

Author: Emily Buttrum

Approved by: Matthew Patrick

Presented by: Emily Buttrum

Purpose of the report:

To inform the board of the key issues discussed at the Business Development Investment Committee

Action required:

None

Recommendations to the Board:

To note the report
To note the pathology services recommended supplier will require board sign off in September.

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

The Business Development Investment Committee provides support and challenge to the development and implementation of the Trust’s commercial strategy. It is responsible for approving major investment decisions including proposals for new business and for scrutinising the strategy for the improvement of efficiency and productivity in order to enable delivery of the Trust’s strategic and operational objectives.

The three key items discussed in this meeting were two large tenders and a commercial partnership. These were of significant value and complexity to require a committee discussion and have been subject to the appropriate level of due diligence.

Summary of Financial and Legal Implications:

Pathology

There are significant cost savings to be made through the procurement of a new provider by consolidating our current contracts with multiple providers. We are following the appropriate legal OJEU process.

Substance misuse tender
A financially sound proposal was signed off by the BDIC Chair, CEO and CFO following discussion at the meeting and prior to the bid being submitted. All bids aim to make a contribution to the Trust overhead.

**Bupa**
The partnership made a good financial contribution to the trust over its lifetime, and no further cost implication will be incurred during the wind down phase.

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

**Pathology**
Through the procurement of a new provider the trust will meet the needs of patients by offering a more streamlined, high quality service. With the new option to view data trends this will support good patient care and equality across multiple sites.

**Substance misuse tender**
The partnership is aiming for more of its services to be provided in community settings to improve accessibility for our service users and non-staff costs. There will be a clear emphasis on PPI and the service will build on the strengths of our partners in this area.

**Bupa**
The Trust is working to only developing with organisations that have similar values and commitments with E&D, as such the work undertaken with Bupa was related to improving patient experience through pathway improvement.

**Service Quality Implications:**

**Pathology**
There will be significant improvements to service quality under a new pathology service, such as timely electronic results on blood tests, set times for the collection of samples and 24hr access to pathology advice and support.

**Substance Misuse Tender**
Through joint pathways and teams the partnership has drawn upon best practice in each area to improve service quality.

**Bupa**
We have compiled an extensive lessons learned template related which will be translated back into BDIC governance when considering future partnerships.

---

**Report from the Business Development Investment Committee (BDIC)**

1. **Pathology Services Tender**

   The aim of this paper was for BDIC was to provide an update regarding the progress of the pathology services OJEU tender which is now fully underway, and to sign off the tender timetable.

   This is a significant procurement for the Trust. It will bring together all our pathology services to a single provider, meaning a large transformation from our current system. In order to execute the
delivery as efficiently and seamlessly as possible, a strongly governed project group has been set up with the support of an independent pathology expert.

Agreed

- The committee approved the tender timetable
- The appropriate staff members were engaged and included in the process and would continue to be.
- Assurance on the relationship with KCH regarding IT system would be sought. Consideration would be given to for the appropriate support for ongoing contract management.
- A report to the Board would be prepared for September to recommend the new pathology provider.

2. Substance Misuse Tender

One of the Trust’s drug and alcohol service is out for tender. We have formed a strong partnership with two other organisations, with the trust being the lead provider. It was agreed that the final finances would be signed off by BDIC electronically through the Chair, the CEO and CFO. Discussion at the committee was around the importance of finding the right balance between cost and quality.

*Update:* Since the June BDIC meeting we have finalised the bid which was signed off by the Chair, CEO and CFO prior to submission.

Next steps
Bids will be evaluated over the summer and we will be informed of the result around October.

3. The Bupa Partnership

The committee was informed that the parties in the partnership have agreed to wind down the current work and withdraw the resources, while keeping the commercial framework in place for any future potential work that could arise.

Lessons learnt from our experience of working within this partnership were discussed and a set of principles that would support future relationships were agreed.

Actions

- Keep the commercial framework with Bupa in place and withdraw the resources.
- To note the partnership principles and create a ‘check list’ to be considered when entering a similar type of relationship in the future.
- It was also suggested to inform staff more widely of the purpose of the BDIC and engage communications to follow this up.

4. A Prison Tender

The committee were informed that a prison Tender will be released soon and will be discussed at an extra meeting of the committee in July.
# Business Development Investment Committee – 2014/15 action tracker

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue</th>
<th>Action</th>
<th>By</th>
<th>When</th>
<th>Status</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>June 2015</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/15</td>
<td>Pathology Tender</td>
<td>Bring the recommended supplier to the Board for sign off in September.</td>
<td>EB</td>
<td>Sept</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td>7/15</td>
<td>Substance Misuse Tender</td>
<td>AD/MP to sign off the bid before final submission.</td>
<td>AD/MP</td>
<td>June</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td>8/15</td>
<td>Bupa Partnership</td>
<td>Keep the commercial framework with Bupa in place and withdraw the resources.</td>
<td>AP</td>
<td>June</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td>9/15</td>
<td></td>
<td>Note the partnership principles and create a 'check list' to be considered when entering a similar type of relationship in the future.</td>
<td>OH</td>
<td>Aug</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td>10/15</td>
<td></td>
<td>Inform staff more widely of the purpose of the BDIC</td>
<td>OH</td>
<td>Aug</td>
<td>In prog</td>
<td></td>
</tr>
<tr>
<td>11/15</td>
<td>AOB</td>
<td>A prison tender – to be discussed at an extra meeting of the committee on 27 July.</td>
<td>BDIC</td>
<td>Aug</td>
<td>n/a</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>April 2015</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/15</td>
<td>Bupa Partnership</td>
<td>We await feedback from Bupa on the potential work-streams and bring back to BDIC.</td>
<td>BDIC</td>
<td>May 15</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td>5/15</td>
<td>Digital Strategy</td>
<td>Board to sign off strategy and governance structure and, in due course, the implementation and communication plans.</td>
<td>Board</td>
<td>May</td>
<td>Ongoing</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>February 2015</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/15</td>
<td>International opportunity – Abu Dhabi</td>
<td>Update would be welcome at the meeting of the BDIC in June, with the financial models</td>
<td>JF</td>
<td>June 15</td>
<td>Schedule</td>
<td></td>
</tr>
</tbody>
</table>
would be circulated in the interim.

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
<th>Description</th>
<th>Responsible Person</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/15</td>
<td>International opportunity - China</td>
<td>Agreed to schedule update for the Oct BDIC after further visit and decision on whether and how work will progress.</td>
<td>ZR</td>
<td>Oct 15</td>
<td></td>
</tr>
<tr>
<td>3/15</td>
<td>International opportunity – Qatar</td>
<td>Sign off letter to Qatar</td>
<td>All</td>
<td>Feb 15</td>
<td>Done</td>
</tr>
</tbody>
</table>

**December 2014**

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
<th>Description</th>
<th>Responsible Person</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/14</td>
<td>Commercial strategy</td>
<td>After minor amends from BDIC, circulate to the Board and executive group. Schedule a SMT discussion to help shape the workshop direction.</td>
<td>EB</td>
<td>Dec 14</td>
<td>Done</td>
</tr>
</tbody>
</table>

**October 2014**

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
<th>Description</th>
<th>Responsible Person</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/14</td>
<td>International opportunity - Abu Dhabi</td>
<td>Update report to be provided in February, with the note the financials need to be reviewed beforehand.</td>
<td>JF</td>
<td>Oct 14</td>
<td>Done</td>
</tr>
<tr>
<td>2/14</td>
<td>International opportunity - China</td>
<td>Develop the business model and financial analysis.</td>
<td>ZR</td>
<td>Oct 14</td>
<td>Done</td>
</tr>
<tr>
<td>3/14</td>
<td>International strategy</td>
<td>Development of due diligence template out of the meeting.</td>
<td>EB, GH</td>
<td>Oct 14</td>
<td>Done</td>
</tr>
</tbody>
</table>

OH/July 2015
 Date of Board meeting: 28th July 2015

Name of Report: Fit and Proper Persons Test

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

Author: Michael Kelly

Approved by: Louise Hall

Presented by: Louise Hall

Purpose of the report:

To provide an update to the Board on the approach for the Fit and Proper Persons Test requirements.

Recommendations to the Board:

To agree the approach.

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

This is a new requirement and will form part of the assessment and inspection by the CQC.

Summary of Financial and Legal Implications:

A requirement by the CQC and Monitor.

Equality & Diversity and Public & Patient Involvement Implications:

Provides assurance that the Leadership of the Trust meets the new requirements.

Service Quality Implications:

As above.
Fit and Proper Persons Regulations.

Introduction

This paper provides an update on the Fit and Proper Persons Regulations (FPPR) which have recently been integrated into the CQC’s regulation requirements. The FPPR outlined that from 27 November 2014 all NHS Providers must ensure that all director level appointments meet the “fit and proper persons test”.

To meet this requirement NHS Providers must not appoint a person to a director level post (including associate directors) or to a non-executive director post unless they are;

- Of good character;
- Have the necessary qualifications, skills and experience;
- Are able to perform the work they are employed for after reasonable adjustments are made;
- Can supply information set out in the Regulation.

Roles covered by the Regulation

For the purposes of the fit and proper persons test, it is suggested the following roles fall within the description of director, associate director and non-executive director:

Trust Chair
Non-executive Directors and Senior Independent Director (where applicable).
Chief Executive Officer
Chief Operating Officer
Chief Financial Officer
Medical Director
Director of Nursing
Director of HR, OD & ET
Director of Organisation and Community
Commercial Director

CQC Requirements and Expectations

As part of the inspection process, the CQC will assess evidence that the NHS Provider has ensured that all director roles above meet the “fit and proper persons test” criteria, and/or whether the following has been considered, and assurance obtained:

- Whether the person has been convicted in the UK of any offence or convicted elsewhere, which if in the UK would constitute an offence;
- Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals;

For the previous two criteria Boards have some discretion, as it is recognised that people can and do change over time and this is not regarded as an exclusively objective test. For
The next criteria, the Regulation stipulates there should be no discretion and persons should be prevented from holding the office, if:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it that has not been discharged;
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order, or equivalent in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period under a debt relief order applies under the Insolvency Act 1986;
- The person has made a composition or arrangement with, or granted a Trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children’s barred list or adults’ barred list maintained under the Safeguarding Vulnerable Groups Act 2006 or under an equivalent enactment in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on a regulated activity, by or under any enactment;
- The person has been responsible for, privy to, contributed to or facilitated and serious misconduct or mismanagement in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

Our Approach

In order to meet these requirements under the Regulation which will also be subject to inspection by the CQC, individuals holding the director roles outlined previously will be asked to complete a Self-Declaration Form (attached). The questions within the form are matters included within the Regulation.

In addition, to ensure we can provide further assurance files will be audited to evidence that postholders have the required qualifications for the post they hold including registration with a professional body where required and outlined as an essential requirement in the person specification for the role.

Where now required, individuals with no current DBS check will be required to have a DBS check completed. As there is a requirement to ensure an individual is not included in a barred list under the Safeguarding Vulnerable Groups, this check will be at an enhanced level with checks made against the respective barred lists. For those with current DBS checks, this will be undertaken on the rolling 3 years anniversary of their current check.

The Regulation places an emphasis of ensuring that individuals are not prohibited from holding an office as a director through disqualification or have been subject to bankruptcy or insolvency. For this purpose, a check of Companies House Disqualified Directors’ List will be undertaken as will a check of the UK Insolvency Register.

8th July 2015
# SELF-DECLARATION FORM

**Name:** …………………………………………………………………………………………………

**Position:** ………………………………………………………………………………………………

As part of the Trust’s overall Governance standards, all members of the Trust Board, Trust Executive and Senior Management Team are required to complete this self-declaration questionnaire which also incorporates the new standards for the fit and proper person requirements (FPPR) for directors and the duty of candour which came into force for all NHS bodies.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you consider yourself to be fit, both physically and in good mental health for the position you hold in the Trust, with reasonable adjustments if required?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If No, please provide details:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2. Have you previously at any time in your career or previous employment(s) been responsible for, privy to, contributed to, or facilitated any serious misconduct or mismanagement in the course of carrying on of a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If Yes, please provide details:</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
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<tr>
<td>3. Have you ever declared or been declared bankrupt or are subject to an undischarged bankruptcy?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If Yes, please provide details:</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>4. Are you, or have you been subject of a bankruptcy restrictions order or interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If Yes, please provide details:</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>
5. Are you, or have you been subject to a moratorium period under a debt relief order of the Insolvency Act 1986?

- No
- Yes

If Yes, please provide details:

6. Have you previously made a composition or arrangement with, or granted a trust deed for, creditors and then not been discharged in respect of it?

- No
- Yes

If Yes, please provide details:

7. Are you, or have you been included in the Children’s Barred List or the Adults’ Barred List maintained under Section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland?

- No
- Yes

If Yes, please provide details:

8. Have you ever been convicted of an offence in the United Kingdom, or been convicted elsewhere of any offence which, if committed in the UK, would constitute an offence?

- No
- Yes

If Yes, please provide details:

9. Do you have any unspent convictions, cautions, bind-overs, reprimands or warnings?

- No
- Yes

If Yes, please provide details:

10. Are you or have you ever been prohibited from holding the relevant office or position, or in the case of an individual, from carrying on the regulated activity, by or under any enactment?

- No
- Yes

If Yes, please provide details:
11. Have you, or presently subject to an investigation where you have or could be erased, removed or struck off a register of professionals maintained by a regulator of healthcare or social care

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

If Yes, please provide details:

……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………

12. Are you able to account for your full working career?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If No, please provide details:

……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………

13. Has your full working career been included on your CV or application form when you applied for your position?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If No, please provide details:

……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………

14. Are there any gaps in your career that are unaccounted for?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

If Yes, please provide details:

……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………

15. Do you feel you have the required skills, qualifications knowledge, integrity and experience for the position you hold?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If No, please provide details:

……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………

16. Do you feel you have the capacity, capability and experience for the position you hold?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If No, please provide details:

……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………
17. Do you feel you perform your role and discharge your responsibilities with openness, transparency and candour?

Yes ☐ No ☐

If No, please provide details:

……………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………

You are required to immediately notify the Trust Director of HR, OD and Education & Training if any circumstances change from those upon which you have made a self-declaration.

By signing this form you are confirming that the statements made are true and accurate.

Please sign below to confirm that you are aware of your responsibilities to advise the Trust of any changes as failure to do so may result in disciplinary action.

I, the undersigned, confirm that the information provided by me on this form is true and accurate.

Full Name: ……………………………………………………………………………………………

Signature: ……………………………………………………………………………………………

Date: ……………………………………………………………………………………………

Please return this completed form confidentially to: Michael Kelly, Deputy HR Director, Maudsley Hospital, Denmark Hill, London SE5 8AZ.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 28 July 2015
Name of Report: Workforce Update
Heading: - Governance
Author: Louise Hall
Approved by: Matthew Patrick
(name of Exec Member)
Presented by: Louise Hall

Purpose of the report:
To inform the Board of progress made on the workforce workstream over the past six months since the January Board presentation and to advise on next steps.

Recommendations to the Board:
To note the report and to support the activity and direction of travel.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
There is a moderate risk that if we fail to recruit the numbers of Band 5/6 staff needed that this will sustain our bank and agency use and in turn our financial situation.

Summary of Financial and Legal Implications:
Positive activity around recruitment and absence management in particular will positively affect our financial position.

Equality & Diversity and Public & Patient Involvement Implications:
An equalities impact assessment has been undertaken as part of this workstream.

Service Quality Implications:
A more stable and consistently trained workforce will in turn have a positive effect on service quality.

1 BACKGROUND

With current levels of services, SlaM is facing unprecedented financial pressure until we feel the benefits of our developing 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.

At the 29th June 2014 Board we proposed a three phase approach to workforce planning:

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.

Specifically we agreed that HR would focus on the following activities in phase 1:

1. Nursing: effective E-Rostering and Safer Staffing – led by Neil Brimblecombe and Michael Kelly
2. 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
3. Focus more strongly on performance and sickness absence – led by Louise Hall
4. Increase the challenge on backfilling vacant roles, remove any roles that have been open for longer than 6 months - led by Louise Hall
5. 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

This report is provides an update to the Board on progress on those workstreams for which HR is accountable.

1.1 FOCUS MORE STRONGLY ON PERFORMANCE AND ABSENCE

What we said we would do

Absence costs us £5.3 million annually in terms of staff costs. 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 and 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

What we have achieved to date.

1. Clear view of sickness by CAG/ Directorate levels across the Trust.
2. Benchmarked Trust sickness performance against all other 56 English MH Trusts. As of April 2014 SLaM had the seventh best sickness levels. Calculated the additional cost to the Trust of Bank and Agency cost to cover staff on sick leave.

3. Identified two CAGs with significant sickness issues and gained agreement to address sickness in a systematic way.

4. Agreed case conferences with Occupational Health to accelerate returns to work and supporting managers in helping staff return to work.

5. Reviewed the sickness policy, making it clearer and easier to implement.

6. Identified every member of staff Trust who has triggered the sickness warning level.

7. Moved from a reactive Employee Relation sickness support model to a proactive model where ER advisors contact line managers where sickness levels have triggered a warning but managers had not taken any formal action.

8. Activity is being tracked through:
   a. Trust wide and local sickness rates
   b. Number of formal Return to Work Notices
   c. Number of sickness cases on Track it; Number of Formal Attendance Notices; and Number of dismissals as a result of non-attendance

9. HR Business Partners have reinforced the message in all CAGs and Directorates that Return To Work interviews must be completed and recorded on eRoster.
   a. Cost of sickness in 2013/14 the total sickness cost to the Trust was calculated as c£6,525,000 PA.

10. Trust sickness levels reduced from a peak of 6.72% in Jan 13, to 5.78% in Jan 14, to 5.63% in April 14. Currently standing at 5.07% in June 15.

11. Sickness all but one of the CAGs has fallen to a ‘normal’ level.

12. In the 12 month period starting ending June 2015 sickness has fallen from 5.62% to 5.07% - a reduction of 0.42% saving the Trust an estimated £700,000 over a full year.

13. We will continue to focus on managing sickness, however we are not expecting to see significant further reductions from our current levels.

1.2 FOCUS ON PERFORMANCE AND RECOGNITION

What we said we would do
We need 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. 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 need to look at financial and non-financial ways of recognising staff for their contribution, ideas and exceptional performance.

What we have achieved to date

1. Emphasized the importance of the Performance Development process to managers and staff alike.
2. Identified that in 2014 not all reviews have taken place or they had taken place and not been captured. Based on completion data provided, we estimate appraisal completion rates at c75%. Feedback tells us that there is great variability in the capability of the managers conducting appraisals. This is reinforced in the 2013 staff survey where only 42% of staff reported having a “well-structured appraisal”.
3. Initial indications from the 2014 Staff Survey show that the Trust has made significant improvements in the question “Clear work objectives not agreed during appraisal” down from 22% to 16%. SlAM was also significantly above the ‘Picker Average’ of 14 MH trusts in other appraisal questions, with no questions significantly below the Picker Average.
4. With the exception of one CAG, we do not appear to be challenging poor performers via the Performance Appraisal process. Additionally, based an analysis since January 2013, we have only had 26 formal performance related ER cases of which four employees have either directly or indirectly left the Trust as a result.
5. We have identified that the bulk of our staff will not be adversely impacted by the increment deferral. Based on 2014 data, a ball park figure may be c100 people receiving a “0” rating, with 48.3% of them at the top of their grade, which equates to circa 50 individuals (c 1% of staff).
6. We drafted revised and simplified performance development policy for publication which was published in January 2015. We have developed a four point evaluation scale to help managers further differentiate performance, which we ratified with the JSC in January 2015.
7. We have developed extensive range of resources (training, documents, video etc.) and processes to support effective and fair appraisals.
8. Built a Performance Development Recording System, which is simple to use and to date we have experienced few problems.
9. Performance Development 2015 -16 was launched as planned to managers and staff in March ahead of the April – June appraisal season. To date feedback and results have been positive.

Completion rates for staff, excluding medical staff, to date (14/7/15) are as follows:

<table>
<thead>
<tr>
<th>CAG / Function</th>
<th>Employee Number</th>
<th>Recorded Appraisals</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>160</td>
<td>136</td>
<td>85%</td>
</tr>
<tr>
<td>Behavioural and Development Psychiatry</td>
<td>388</td>
<td>382</td>
<td>98%</td>
</tr>
<tr>
<td>Child &amp; Adolescent Services</td>
<td>501</td>
<td>464</td>
<td>93%</td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>706</td>
<td>564</td>
<td>80%</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>352</td>
<td>304</td>
<td>86%</td>
</tr>
<tr>
<td>Mood, Anxiety and Personality</td>
<td>515</td>
<td>451</td>
<td>88%</td>
</tr>
<tr>
<td>Psychological Medical</td>
<td>449</td>
<td>378</td>
<td>84%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1024</td>
<td>937</td>
<td>92%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4095</td>
<td>3616</td>
<td>88%</td>
</tr>
</tbody>
</table>

10. The Trust wide uncalibrated performance distributions are shown below:
11. Between now and the end of July we are working through calibration at a CAG/Function/Trust level to ensure that appraisals are fair and equitable and ensuring we achieve our goal of 100% employee participation in the appraisal process.

12. 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. Recruitment, bank agency and open positions

**What we said we would do**

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.

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.

We will also need to analyse regretted attrition in order to minimise 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. Bank and agency use will need to be limited to an agreed flexible/contingency level.

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.

**What we have achieved to date**
Recruited a Resourcing Manager who has responsibility for working with CAGs and Directorates to enhance SLaM’s employer brand and implement targeted recruitment campaigns based on the analysis of priority vacancies. Additionally, we have resourced the recruitment team to meet the increased demand placed on them by the current recruitment surge.

**Branding:**

SLaM has a good grounding as a brand within the mental health space but lacked a recruitment brand. Part of the on-going work is to help the trust promote itself in the recruitment market and ensure that candidates are aware that we have constant recruitment needs and that we are perceived as an employer of choice.

- Updated profile on NHS Jobs - https://www.jobs.nhs.uk/agency_info/1c6a0f46d710b56026b42a220559315b/?agency_id=123472
- Use of social media to promote the trust and specific roles. The aim is to drive more candidates through to our website and engage with our content. Since the campaign went live in June:

<table>
<thead>
<tr>
<th>Publishers</th>
<th>Spend</th>
<th>Overall Clicks</th>
<th>Cost per Click</th>
<th>Work for us</th>
<th>Homepage</th>
<th>About Us</th>
<th>Contact Us</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNAP</td>
<td>£890.63</td>
<td>436</td>
<td>£2.04</td>
<td>251</td>
<td>5</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Google Display Network</td>
<td>£578.77</td>
<td>2,953</td>
<td>£0.20</td>
<td>2,035</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Google Paid Search</td>
<td>£2,359.63</td>
<td>2,461</td>
<td>£0.96</td>
<td>2,788</td>
<td>29</td>
<td>12</td>
<td>71</td>
</tr>
<tr>
<td>Totals</td>
<td>£3,829.03</td>
<td>5,850</td>
<td>£0.65</td>
<td>5,074</td>
<td>40</td>
<td>22</td>
<td>73</td>
</tr>
</tbody>
</table>

- Large spike in activity for people visiting the website for job related activity – much is related to Psychosis (see below but benefits the whole Trust).
- Attracting ‘new’ candidates – although it has only run for a short time we can see that it is not the same people visiting the site repeatedly.

- New designs/branding for the trust to be linked with recruitment – in design stage at the moment (to be approved by communications)
- Updated job descriptions and adverts – managers given access to guides to ensure a better quality advert and more consistency of language
- Advertising plans in place for branding across new channels (social media, editorials – print/online etc., radio, trade media, banners)
- Internal and external promotion of accommodation and staff offer
- Updated website – under construction. This includes identification of brand advocates. Part of the branding strategy is to use success stories to encourage applications. Candidates will need to understand the potential for progression within the Trust.
- We have reviewed our involvement in events such as the large RCN fairs and other recruitment fairs at universities and cannot see a positive return on investment.

**Band 5 Nurse Recruitment**

The nurse recruitment market is very competitive at the current time with all Trusts trying to attract candidates from a small pool. It is important that SLam improve our processes to ensure they are robust, candidates have a good impression of the Trust and our attraction methods are innovative whilst capturing the best candidates possible.
• Project plan completed for Band 5 – dates agreed for assessment centres/interviews up until May 2016. CAGs will be responsible for ensuring they are organised with staff to support the process
• Improved assessment centres - the aim is to provide a better experience for candidates
• Updated preference sheet – ensuring that candidates get a more refined choice of role and all CAGS get access to candidates
• Tracking candidates throughout process to ensure that they cannot sit the assessments more than once in a three month and a better understanding of where they are coming from etc.

Psychosis recruitment:

Psychosis is the largest specialism within the Trust with the largest number of vacancies. We are currently implementing a targeted recruitment strategy for Psychosis which will have additional benefits for the whole Trust.

• Specific project for Band 3, 5, 6 inpatient Nursing staff within the Psychosis CAG. The CAG had around 100 identified vacancies in May 2015.

<table>
<thead>
<tr>
<th>Band</th>
<th>Vacancies (May)</th>
<th>Psychosis Inpatient Offers</th>
<th>PoS Offers</th>
<th>% Filled (Provision.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/3</td>
<td>30</td>
<td>20</td>
<td>6</td>
<td>87%</td>
</tr>
<tr>
<td>5</td>
<td>55</td>
<td>18</td>
<td>2</td>
<td>36%</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
<td>3</td>
<td>4</td>
<td>54%</td>
</tr>
</tbody>
</table>

• 54% of roles have been filled Response has been very good with a good number of quality candidates applying for roles
• Successes to be rolled out across the Trust and talent pooling for candidates who are employable, but currently no vacancies exist

Recruitment Systems

Recruitment has a vital role to play in ensuring a pipeline of skills and staff in key areas. We currently have a very labour intensive model, which is perceived to be slow and cumbersome and which relies on a number of different systems and processes in order for it to be successfully managed. This will be key opportunity to review this and look at how technology can streamline what we do and how we interact more efficiently with other Directorates, for example with Finance.

We have carried out comprehensive market research into recruitment systems, created a business case and developed a detailed specification based on our requirements. We are currently working with Finance to procure a suitable system by October with a provisional implementation date of December / January. Once the recruitment system in live we will be looking to procure a Learning Management, Performance and Talent Management System to simplify, streamline and accelerate processes.

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

What we said we would do

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

What we have achieved to date
1. Identified accurately the cost premiums of using agency staff and cost savings of using bank staff. It has proved challenging to accurately identify vacancies from ESR / Finance systems; however we have identified long term bank and agency usage from a combination of NHSP and the Finance ledger.

2. Developed a clear and transparent view, Trust wide, by CAG, Directorate, and team and individual of bank and agency usage.

3. Developed a prioritised list of roles we should focus on to reduce agency usage, the top priority being CPN where bank and agency premiums are costing the Trust £1.1 million per annum.

4. Initiated a cross functional senior level project team in December to start to take a strategic approach to addressing the CPN vacancy issue. As the result of the CPN project we have commenced targeted recruitment particularly in the area of highest use (Psychosis) and ensuring the correct skills were being requisitioned from NHSP in other areas particularly Psych Med.

5. Based on action taken to reduce CPN bank and agency spend since May, monthly savings are provisionally estimated to be c £22K/month with further savings planned.

6. We are currently in the later stages of developing a robust agency and contractor review and control process in Corporate areas for roll out starting August 2015.

1.4 **Implementation of E-Rostering V10**

**What we said we would do**

Until December 2014, the Trust used e-Roster v9.5 which had a number of limitations. The system could only be used to roster and report on Trust employees and did 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 was 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.

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.

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.

**What we have achieved to date.**

1. Health Roster v10 which was successfully implemented on time, on budget on the 15th December.
2. Initial feedback of new system is seen to be favourable, with no significant post launch issues reported.
3. Over 100 rostering champions and key users have been trained on how to get the best out of the new system.
4. With the successful implementation of v10, we have now commenced the pilot phase of rolling out E-Rostering of NHSP bank staff in our inpatient wards. Currently we have successfully piloted the NHSP rollout in three wards in June and five Psych Med wards in July. The plan is on course to roll out the NHSP interface to all inpatient wards by the end of October.
5. As part of the roll out, together with Nursing we have been training ward managers to use the new functionality and supporting ward managers to review their rules and providing guidance on effective rostering e.g. leave management.
6. Once this is complete we will be able to implement the electronic setting of and reporting on Safer Staffing levels later in the year.
7. Cost savings and efficiency savings are likely to come from
   a. Better dynamic visibility of staff usage by all levels of management, enabling staffing level decisions to be made in virtually real time
   b. Reduction in time currently used to manually collate and analyse Safer Staffing levels, scheduled for the Spring of 2015
   c. Increased performance of auto roster facility which leads to more efficient rostering
   d. Review of local roster rules to ensure efficient rostering
8. Estimated cost savings currently not currently quantified

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

What we said we would do

Nearly all first level and second level managers in clinical areas have developed and promoted through professional excellence, often with little managerial development. Employees therefore experience differing qualities of management and a lack of consistency in the way it has been applied. 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>Staff</th>
<th>Work</th>
<th>Self</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Performance/recognition</td>
<td>• Commercial</td>
<td>• Role of the Manager</td>
</tr>
<tr>
<td></td>
<td>• Development</td>
<td>• Budgets</td>
<td>• Planning, Organising</td>
</tr>
<tr>
<td></td>
<td>• Coaching</td>
<td>• Rostering</td>
<td>• Directing, Evaluating</td>
</tr>
<tr>
<td></td>
<td>• Appraisal</td>
<td>• Effective meetings</td>
<td>• Delegating</td>
</tr>
<tr>
<td></td>
<td>• Absence</td>
<td>• Team management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disciplinary</td>
<td>• Keeping quality high in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Staff Engagement</td>
<td>• changing times</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Change</td>
<td>• Patient experience and safety</td>
<td></td>
</tr>
</tbody>
</table>
1. Undertaken background work to develop business case, project and engagement plan
2. Reviewed our existing portfolio of leadership and management development learning with the aim of rationalising and streamlining resources.
3. Consulted with CAG Education and Training Leads to validate need and identify draft content.
4. Validated that the programme is required and broadly our initial thoughts on content identified all known people managers in the Trust and analysed their formal learning since 2010
5. We have successfully developed the high level content of the programme, consulted with key stakeholders and agreed the business case for the programme subject to HESL reducing funds by 22%.
6. We have developed and implemented an application process for the programme to ensure appropriate employees attend the appropriate learning.

2. **Next Steps**

The project work has now been completed on the *sickness/absence workstream* and has been transferred to “Business as Usual”, however we will continue to monitor our performance to ensure the progress to date is sustained. Going forward our focus will be proactively looking to improve Health and Wellbeing, which complements the Trust’s clinical strategy of focusing on prevention before treatment and early intervention.

The 5 year Forward View recognises that we need to make the NHS a healthier workplace. There are recommendations within this to help our staff to stop smoking, eat more healthily, take more exercise, use the Trust’s facilities, make better use of Occupational Health and promote the Trust being part of the Workplace Wellbeing Charter. We will start to do all of these and additionally will develop guidance for managers to manage Mental Health within their own staff.

We will also leverage the tools that are being developed internally such as the Wheel of Wellbeing and build a more informative intranet site for those looking for help and information.

The next phase of the work on **Performance Development** is well in hand and will be rolled out over the 2015/16 appraisal year. Currently we are focused on ensuring that *all employees have a fair appraisal* and quality development conversation on their performance over 2014/15. Once this is complete we will look to implement Maximizing Potential – a Trust wide talent management programme.

We will pilot the Maximising Potential programme in 2015, with a view to roll this out in the 2016 Annual Appraisal process. Our succession planning has already started in order for us to identify key roles and potential succession plans and this will continue to be developed over the year and reviewed annually thereafter.

With the successful implementation of Health Roster v10 we are rolling out **E-Rostering** of NHSP bank staff together with the setting of and reporting on Safer Staffing levels. It is in these areas where we are likely to see productivity and efficiency savings, together with a greater level of reporting and monitoring of workforce activity.

Having agreed the proposal and business case we are in the process of developing the detailed content and approach for the **Strengthening Leadership and Development Programme** and will look to start the implementation towards the end of 2015.

There is no doubt that from a Trust perspective our biggest challenge, similar to the whole of the NHS, will be **addressing staff shortages and bank and agency use**. We have already identified a number of actions which will incrementally improve staffing levels, but it will not be an instant solution.

Much of the progress that has been made on the workforce project is as a result of utilising well established project management and change management methodologies, so we will continue to do so going forward. We will continue to engage with our stakeholders and ensure we have robust comms plans developed to inform and keep our staff engaged and appropriately aware of progress.
2.1 **APPENDIX — WORKFORCE DATA**

**Vacancies**

Vacancy levels across the Trust have remained relatively static for a long period of time. This demonstrates that recruitment occurs on a like-for-like basis when someone leaves, with services using vacancies to facilitate staffing flexibility in response to changes in demand. However, as previously outlined there has been an increasing demand for nursing staff, especially in inpatient areas through Safer Staffing requirements. Consequently, we are encouraging services to recruit staff on a substantive basis which should result in a reduction in vacancy levels.

**Turnover**

The highest proportion of leavers during the period occurred in March. This is consistently the case across most staff groups, with the largest number of leavers in the qualified nursing group. This is not uncommon being the largest professional group however focused work is underway to address the current gap in supply and demand for nursing staff, over and above just those leaving especially for inpatient nursing and Community Psychiatric Nurses (CPN’s).

**Bank and Agency Use**

The majority of temporary staffing fill has been through NHS Professionals (NHSP). The majority of agency fill for nursing has been for Community Psychiatric Nurses and plans are underway to reduce this through reviewing roles and recruiting to vacant posts. A large proportion of administrative bookings are through agencies and we are moving to converting a number of these to substantive appointments and/or transferring to NHSP. It is recognized that for other staff groups there will be an ongoing need for agency as they are not groups generically supplied through NHSP but rather through agencies historically. Work is planned to determine whether we should recruit to these posts on a substantive basis.
Sickness absence management has been a key area of focus and attention with positive results. Our current sickness levels in a rolling 12-month period is 5.07% falling from 5.63% in April 2014. This has resulted from improved monitoring, changes in policy, more proactive intervention through Employee Relations and increased management overview and confidence in dealing with sickness absence. We will continue to monitor sickness to ensure levels do not increase which increases our costs.

We have witnessed a very positive response to appraisal completions during the appraisal season – April to June 2015. We are presently calibrating appraisal ratings across the Trust to ensure consistency and fairness across CAGs and Directorates. We are also validating appraisal completions with services to identify reasons where an appraisal has not been conducted. As part of our Workforce Equality Objective we will be conducting an equality impact assessment (EIA) to identify any adverse trends for a particular ethnic group, once all appraisals have been validated and calibrated. Following on from this we will then use information from appraisals to inform our approach to talent management and our Maximising Potential programme.
<table>
<thead>
<tr>
<th>Month</th>
<th>Item</th>
<th>Lead</th>
<th>Section</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept</td>
<td>Francis Report – Review best practice to how Board involves patients (action from March)</td>
<td>Zoe Reed</td>
<td>Quality</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Speak up Guardian Proposal</td>
<td>Al Beck/Neil Brimblecombe</td>
<td>Quality</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Family and Carers Strategy</td>
<td>Zoe Reed</td>
<td>Strategy</td>
<td>Approval</td>
</tr>
<tr>
<td></td>
<td>Healthcare strategy (deep dive follow up)</td>
<td>Matthew Patrick</td>
<td>Strategy</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Arts Strategy</td>
<td>Matthew Patrick</td>
<td>Strategy</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>EPIC Annual Report</td>
<td>Zoe Reed/Matthew Patrick</td>
<td>Strategy</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Pathology Service Tender</td>
<td>Martin Baggaley/Emily Buttrum</td>
<td>Quality</td>
<td>Approval</td>
</tr>
<tr>
<td></td>
<td>Eliminating Mixed Sex Accommodation</td>
<td>Neil Brimblecombe/Matthew Patrick</td>
<td>Quality</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Social Care Strategy – Update (action from April)</td>
<td>Cath Gormally</td>
<td>Quality</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>IT equipment replacement – future proof inventory (action from May)</td>
<td>Stephen Docherty</td>
<td>Performance &amp; Activity</td>
<td>Approval</td>
</tr>
<tr>
<td></td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Roy Jaggon</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Check progress on IT delivery via Audit Committee (action from March)</td>
<td>Stephen Docherty</td>
<td>Performance &amp; Activity</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Revise Scheme of Delegation (action from March)</td>
<td>Gus Heafield</td>
<td>Governance</td>
<td>Approval</td>
</tr>
<tr>
<td></td>
<td>Assurance Framework Report</td>
<td>Gus Heafield/Roy Jaggon</td>
<td>Governance</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
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<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
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<td>Oct</td>
<td>Community Pharmacy Development (action from May)</td>
<td>Gus Heafield</td>
<td>Strategy</td>
<td>Discussion</td>
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<td>BDIC update</td>
<td>Alan Downey/Emily Buttrum</td>
<td>Strategy</td>
<td>Discussion</td>
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<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
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<td>Performance Report</td>
<td>Roy Jaggon</td>
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<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
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<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
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<td>KHP Update – Robert Lechler</td>
<td>Matthew Patrick</td>
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<td>Neil Brimblecombe/Lesley Calladine</td>
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<td>Assurance Framework Report</td>
<td>Gus Heafield/Roy Jaggon</td>
<td>Governance</td>
<td>Discussion</td>
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<td>Minutes from Audit Committee Meeting</td>
<td>Steven Thomas</td>
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<td>Information</td>
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<td>Risk Management Assurance Strategy (update)</td>
<td>Gus Heafield/Roy Jaggon</td>
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<td>Monitor return – Q2</td>
<td>Gus Heafield</td>
<td>P2</td>
<td>Approval</td>
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**Nov**

<table>
<thead>
<tr>
<th>R&amp;D Annual Report</th>
<th>Gill Dale/Tom Craig</th>
<th>Presentation</th>
<th>Discussion</th>
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<tbody>
<tr>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
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<td>Performance Report</td>
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**Dec**

<table>
<thead>
<tr>
<th>HR Dashboard/Workforce/Staff Survey (action from May)</th>
<th>Louise Hall/Michael Kelly</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
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<td>Roy Jaggon</td>
<td>Performance &amp; Activity</td>
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<td>Contracting update</td>
<td>COO</td>
<td>Performance &amp; Activity</td>
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<tr>
<td>Experiment on format of Board Meeting – Review after Board development Programme (action from March)</td>
<td>Roger Paffard/Paul Mitchell</td>
<td>Governance</td>
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<tr>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
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<td>Chief Executive Report</td>
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<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
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<tr>
<td>Biomedical Research Centre Renewal (action from June)</td>
<td>Shitij Kapur/Matthew Hotopf</td>
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**Jan 2016**

<table>
<thead>
<tr>
<th>HR Annual Plan</th>
<th>Louise Hall/Matthew Patrick</th>
<th>Strategy</th>
<th>Discussion</th>
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<td>BDIC Dec Meeting Update</td>
<td>Alan Downey/Emily Buttrum</td>
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| Monitor return – Q3 | Gus Heafield | P2 | Approval |

**Feb**

<table>
<thead>
<tr>
<th>Trust Quality Strategy (action from Feb 15)</th>
<th>Neil Brimblecombe/Matthew Patrick</th>
<th>Decision</th>
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<tbody>
<tr>
<td><strong>Date of Board meeting:</strong></td>
<td>28 July 2015</td>
<td></td>
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<tr>
<td><strong>Name of Report:</strong></td>
<td>Report from previous month’s Part 2 meeting</td>
<td></td>
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<tr>
<td><strong>Heading:</strong></td>
<td>Governance</td>
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</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Paul Mitchell, Trust Board Secretary</td>
<td></td>
</tr>
<tr>
<td><strong>Approved by:</strong></td>
<td>Matthew Patrick, Chief Executive</td>
<td></td>
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<tr>
<td><strong>Presented by:</strong></td>
<td>Roger Paffard, Chair</td>
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</table>

**Purpose of the report:**
To produce a summary report for consideration in the part of the Board meeting held in public which lists the items which were discussed in the P2 (private) meeting the previous month.

**Recommendations to the Board:**
To agree whether this report should be produced for future Board meetings.

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**
No direct link but the report increases the transparency of the Board’s governance arrangements.

**Summary of Financial and Legal Implications:**
N/A.

**Equality & Diversity and Public & Patient Involvement Implications:**
N/A

**Patient Quality Implications**
N/A
<table>
<thead>
<tr>
<th>Date of meeting</th>
<th>Ref</th>
<th>Item discussed</th>
<th>Summary of discussion</th>
<th>Lead Director</th>
<th>Reason for taking in P2</th>
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<tbody>
<tr>
<td>23 June</td>
<td>BOD PTII 33/15</td>
<td>SUI update.</td>
<td>Brief update.</td>
<td>Martin Baggaley</td>
<td>Patient confidentiality and subject to legal professional privilege.</td>
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<tr>
<td>23 June</td>
<td>BOD PTII 34/15</td>
<td>Re-appointment of the Chief Executive</td>
<td>NED discussion and approval.</td>
<td>SID/Deputy Chair</td>
<td>Staff confidentiality.</td>
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