A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
WILL BE HELD ON 26TH JULY 2016 AT
3:00PM, LEARNING CENTRE, MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence: Louise Hall, Anna Walker

2 Declarations of Interest

3 Patient Story - Addictions

4 Minutes of the Board Meeting held on 28th June 2016

5 MATTERS ARISING/ACTION POINTS REVIEW

QUALITY
6 Approve – Quality Improvement Programme Plan

7 Discuss – CQC Actions Update

8 Discuss – Safer Staffing Report

PERFORMANCE AND ACTIVITY
9 Approve – Finance Report Month 3

10 Approve – Performance Report

GOVERNANCE
11 Approve – Risk Management Strategy & Risk Management Update

12 Approve – Audit Committee Terms of Reference – Information – Audit Committee Update & Signed/Sealed report

13 Information – Pathology Contract Performance Update

14 Information – QSC Update

15 Information – BDIC June Meeting Update

16 Information - Report from the Chief Executive

17 Information - Update from the Council of Governors

INFORMATION
18 Directors Reports

19 Actions summary from today’s meeting

20 Reflections on today’s meeting

21 Forward Planner and Draft Agenda for September Meeting

22 Report from previous Month’s Part II

23 Any other business

3:00pm
3:10pm Attached
3:15pm Page 12 App A
3:20pm Page 15 App B
3:30pm Page 29 App C
3:40PM Page 36 App D
3:50pm Page 47 App E
4:00pm Page 59 App F
4:10pm Page 80 App G
4:20PM Page 83 App H
4:30pm Page 92 App I
4:35PM Verbal
4:40pm Page 97 App J
4:45pm Page 100 App K
4:50pm Page 105 App L
5:00pm Page 110 App M
5:05PM Page 116 App N

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.
Date of Next Meeting: Tuesday 13th September 2016 – 12:30pm. Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ

Please send apologies to Alison Baker 0203 228 4763 alison.baker@slam.nhs.uk
PRESENT

Roger Paffard Chair
Dr Martin Baggaley Medical Director
Dr Neil Brimblecombe Director of Nursing
Robert Coomber SID and Deputy Chair
Kristin Dominy Chief Operating Officer
Alan Downey Non-Executive Director
Mike Franklin Non-Executive Director
Duncan Hames 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

Chris Anderson Lead Governor
Dr Alison Beck Head of Psychology and Psychotherapy
Adam Black Council of Governors
Lucy Canning Service Director, Psychosis CAG
Jenny Cobley Deputy Lead Governor
Mark Ganderton Council of Governors
Cath Gormally Director of Social Care
Louise Hall Director of Human Resources
David James Business Manager Trust Secretariat (Minutes)
Altaf Kara Director of Strategy and Commerce
Michael Kelly Deputy Director of Human Resources
Paul Mitchell Trust Board Secretary
Zoe Reed Director of Organisation and Community

APOLOGIES

Stephen Docherty Chief Information Officer
Jo Fletcher Service Director, CAMHS
David Norman Director of Estates and Facilities
Anna Walker Non-Executive Director

DECLARATIONS OF INTEREST

Routine declarations were made:

- Dr Martin Baggaley declared that he occasionally chairs meetings for Johnson and Johnson.
- Prof Shitij Kapur declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. Prof Kapur advised and consulted with pharmaceutical companies periodically.
FAREWELL

Roger Paffard reported that this will be the last meeting for Robert Coomber who was coming to the end of his final term as a NED. He offered his thanks on behalf of the Board for his sterling hard work, wisdom and tenacity. A farewell celebration in conjunction with Shitij Kapur will be held after the July Board meeting.

MINUTES

The minutes of the Board held on the 24 May 2016 were agreed, as an accurate record of the meeting.

BOD 108/16 MATTERS ARISING/ACTION POINTS REVIEW

Julie Hollyman advised the Board that the Francis Report discussion had not taken place at the Council of Governors in June as suggested at the May Board. It was hoped there would be a discussion at the Quality Committee in early July. If that is not possible it will go to the September meeting.

The progress made on action points was noted.

Action: Roger Paffard/Paul Mitchell.

BOD 109/16 PATIENT STORY

Due the presenter being unable to attend the Board it was agreed that the presentation be deferred and not read out in their absence.

The Board agreed the presentation be deferred.

BOD 110/16 STRATEGY PRIORITY - Partnerships with people who use our services

Julie Hollyman introduced the paper clarifying the need for the Trust to develop an overarching Public and Patient Involvement policy.

The report suggested there was considerable fragmentation of effort within the Trust in relation to this area of PPI. It would be the purpose of the policy to encourage a coherent approach to the work already underway.

It was reported that the process of standardisation has been started with the Board’s ratification of the 4Pi National Involvement Standards which could be extended and supported through the development of this policy.

It was suggested that that both EPIC groups would progress the policy development through existing mechanisms including the Council of Governors (ISR group). There would also be input from the new stakeholder non-Executive Director; the Strategy and Commercial Director and the current board lead, Julie Hollyman.
It is recommended that the Board approves the development of the Patient and Public Involvement (PPI) Policy and asks that this be presented to the Board in December 2016.

Duncan Hames asked if the local Healthwatch would be involved and he was informed they would be part of the development process.

Roger Paffard asked if the new policy would sit with or would supersede present Carers and User Trust policies. Julie Hollyman responded that those polices would sit under the new PPI policy once completed and approved.

The Board of Directors approved the development of a Patient and Public Involvement (PPI) Policy and it will be presented at the December 2016 Board.

BOD 111/16 HEALTH and SAFETY REPORT – DEEP DIVE

Kristin Dominy introduced the report. The Paper detailed the current Trust approach to Health and Safety (H&S) and defined the roles within the organisation to ensure compliance with the H&S Policy and made recommendations to strengthen these arrangements.

The process described was one that offered assurance to the Board but it was recognised that there was more work required to ensure the processes and systems were embedded within the organisation.

Mike Franklin asked why there was no reference to the avoidance of violence towards staff within the document. Kristin Dominy advised him that issue was seen as clinical and therefore fell under the remit of the Director of Nursing and the Safer Services Committee. Dr Neil Brimblecombe informed the Board that the Safer Services Committee reported into the Quality Committee and they were in the process of developing a strategy for the Trust on this matter.

Mike Franklin noted the detail but felt that the work being done by the Safer Services Committee should be referenced with the Health and Safety strategy. This was agreed by the Board.

Action: Safer Services Committee work on Staff Safety to be referenced in Health and Safety Strategy.

Robert Coomber asked if the estates function would be a good test to discover if the processes and systems described within the paper were embedded within the organisation. It was agreed that the embedding process should commence and this would include the estates function. A report would return to the Board in six months.

The Board of Directors noted the paper and agreed to include a reference to the avoidance of violence towards staff in the H&S policy and for the embedding process to commence, which will report back in six months.

BOD 112/16 FINANCE REPORT MONTH 2

Gus Heatfield, Chief Financial Officer, introduced the paper. At Month 2 of the new financial year the Trust was on plan, with the Trust reporting a deficit of £2.7m which was a favourable variance of £0.1m against the planned position.
The phasing of the plan leads to the majority of the deficit being accrued in the first six months. The drivers for this profile are reducing trajectory for acute/PICU overspill bed usage; delivering on Cost Improvement Programmes and addressing infrastructure costs.

Julie Hollyman asked when the new structure of the Trust in relation to acute care changes will be reflected in future financial reporting. Gus Heafield replied this data would be available from month 4 of the financial year.

Alan Downey and Shitij Kapur expressed concern that the CIP programme was £0.5m behind target this early in the year. Gus Heafield responded that the slippage reflected the overspill issue referred to in the paper. A recovery plan was in place and the process was being overseen by the PMO.

Dr Matthew Patrick asked if the Trust needed to resubmit its operating plan as suggested in the paper. Gus Heafield responded as part of the review of the Trust’s Operating Plan NHSL confirmed that the Trust’s financial control total remains appropriate. However, they have developed an approach of allocating a proportion of the targeted element of the Sustainability and Transformation Fund; this has resulted in an offer to the Trust of an additional £2.28m, reducing the deficit control total to £4.05m. This helps to reduce both the Trust’s deficit and support it with additional cash. The offer was made on the basis that organisations sign up to the new control total by 1st June which the Trust did. Because of this a resubmission of the operating plan may be required to reflect these changes. One consequence of this will be a change in the CoS risk rating of the Trust from a 2 to a 3.

Shitij Kapur also asked about the projected sudden appearance of liquidity in months 9 and 10 of the financial year. Gus Heafield clarified that this was an artefact of payment runs and income from assumed property disposals. Concern was expressed that the values assumed from the property disposals may not be fulfilled. The Board were informed that the values were supported by an external review, although recent political events may have had some affect. It was agreed that a report should come to the Board in July to assure them that the value of the proposed properties for disposal had been maintained.

The Board of Directors noted the report and agreed an update on the value of property proposed for disposal come to the July Board.

BOD 113/16 PERFORMANCE REPORT

Kristin Dominy presented the paper which was taken as read. The Board noted that the new dashboards for Quality and Performance were within the report. It was also noted and agreed that from next month the data in Appendix C (Transformation) would be displayed in the Performance dashboard and not as a separate item. Dr Neil Brimblecombe added that the dashboards were first iterations and further work would be required.

Dr Neil Brimblecombe highlighted the new QUEST data within the report that set a series of scores that if high reflected cause for concern. Presently 39 of the Trusts 52 wards had been assessed using this process and all would eventually report via this methodology. Information on prone restraint had not been included in this month’s report but would be available from July. Dr Matthew Patrick added that this issue had been raised by the CQC in their report as well as supine restraint. Dr Neil
Brimblecombe confirmed this data was being collected and would be reported next month.

Julie Hollyman asked how the QUEST data assured the Board, Dr Neil Brimblecombe replied it showed that the Trust was assessing risk and therefore was more able to respond to areas of concern. Julie Hollyman suggested change over time would also assist with assurance. It was agreed that the Quality Committee should see the data at quarterly intervals to assess change over time.

The Board noted that in regard to first episode psychosis the Trust allocated, accepted, and engaged only 19% of new referrals for FEP within 14 days in May 2016. But this needed to be seen in the context of a 40% increase in numbers of referrals.

Shitij Kapur referred to the data regarding delayed discharges and asked what the causes were. Dr Martin Baggaley stated these were often very complex cases and Kristin Dominy advised that there were on-going discussions with local authorities to address and understand this issue.

It was agreed by the Board that the Trust needed to be aware of the costs to the organisation. It was agreed that the cost of these delays should be compiled and reported to the Board.

**ACTION:** Cost of Delayed discharges to the Trust to be assessed and reported to the Board.

The Trust has communicated to Croydon CCG the risk to the IAPT access standards for Croydon patients as a result of the bridging work to meet the Croydon affordability gap. This has a degree of risk to the Trust overall performance as well as Croydon CCG performance. The CCG has acknowledged that the decisions it has made in selecting the bridge components will impact on meeting some national standards for the CCG’s patients, and the IAPT access targets were a significant risk.

Roger Paffard was pleased to see the improved sickness numbers and Louise Hall responded that this reflected positive human resource activity.

The Board commended the dashboard development which was seen as a continuing major improvement.

The Board of Directors noted the report.

**BOD 114/16 FINANCE AND PERFORMANCE COMMITTEE: UPDATE APRIL**

June Mulroy introduced the paper. She reported that reference costs activity was developing and progress had been made with the longer term plans for the management of the Ortus building. Infrastructure management was improving and the Douglas Bennett programme review was in process.

The Board of Directors noted the report.

**BOD 115/16 AUDIT COMMITTEE - UPDATE**
June Mulroy introduced the report. She stated after the June Board the Chair of the Audit Committee would be Duncan Hames although she would remain as a member.

The Board noted her concern at the level of pressure on the executive from internal requirements and external demands.

The Board of Directors noted the report.

**BOD 116/16 REPORT FROM THE CHIEF EXECUTIVE**

Dr Matthew Patrick introduced his report and stated that he would not comment on recent political developments but confirmed that he had sent out a Trust wide communication to all staff that celebrated all the work, effort and contributions made by overseas staff.

Dr Matthew Patrick also referred to the number of Trust staff who had been honoured in the Queen’s Birthday Honours. This year four scientists and doctors from King’s College London’s Institute of Psychiatry Psychology & Neuroscience (IoPPN) and South London and Maudsley (SLaM) NHS Foundation Trust were recognised, reflecting the importance of mental health research and treatment in the UK.

It was noted that the Trust ended last year with a financial deficit of £8.3m. The present overall agreed target for 2016/17 is a deficit of £6.3m, but the plan is to be in balance by the middle of the year. In order to achieve this, the Trust needs to deliver savings of approximately £20m across the year.

It is important that the Trust delivers savings as financial allocations to the NHS will be tougher in future years. It will be critical for the Trust to be in balance going into 2017/18.

To give this activity a focus it has been agreed that the programme to achieve change and progress will be known as ‘Our Sustainable Future’ and will include support for the re-modelling of the acute care pathway with the aim of reducing bed occupancy down to manageable levels; reduce the use of agency staff; put in place more efficient rosters and more efficient shift crossover and reduce the organisation’s spend on management and administrative costs as part of an infrastructure review.

The Board of Directors noted the report.

**BOD 117/16 UPDATE FROM THE COUNCIL OF GOVERNORS**

Jenny Cobley commented that the Governors recognised the work put in by staff to produce Board information but they would appreciate a more detailed financial briefing to assist with their understanding. Roger Paffard agreed to investigate the most productive way of doing this.

Concern was being expressed by governors over staffing issues and the subsequent affect this has on patients. Issues the Governors identified were accommodation; access to overtime work and support for staff in post. Dr Neil Brimblecombe replied that the staffing situation was monitored and recruitment initiatives were in process. But it should be noted that staffing issues were prevalent across London. Louise Hall added that the Trust was focussed on reducing turnover and increasing overtime as
an option for staff will be looked at. Options to bring accommodation in house were being considered by the Trust.

There followed a debate on the reported rise in hate crime since the referendum in the context of the BME bullying issue within the Trust that had been discussed at the May Board. Dr Matthew Patrick stated the Trust has and will reject all forms of intolerance. It was agreed that the Chief Executive and Chair should jointly produce a letter to staff that highlighted the focus on tolerance within the Trust but also inform staff of the systems and methods whereby those who suffer from abuse can report the incident.

**ACTION:** Joint letter from CEO and Chairman to Staff supporting tolerance in the Trust and informing staff how to report any abuse they suffered.

The Board of Directors noted the report.

**BOD 118/16 CHANNEL 4 PROGRAMME**

Sarah Crack confirmed that the Trust had spent the past year working with Rare Day Production Company who are making a two part observational documentary series for Channel 4 about the Trust’s forensic mental health services.

The filming took place between November 2015 and May 2016. The producers were able to film with patients across a number of wards at River House at all stages of care and treatment. The series will include two programmes of an hour each.

Issues relating to patients’ involvement in the filming have been reviewed and managed on an ongoing basis by the individual patient’s consultant and by the Trust’s Medical Director Dr Martin Baggaley and the Caldicott Guardian.

As agreed with Rare Day and Channel 4, Dr Matthew Patrick, Dr Martin Baggaley, members of the communications team and relevant clinicians will have a chance to see the films when complete. At this point feedback will be given as to the suitability of the inclusion of some patients in the broadcast.

Mike Franklin asked what would be the situation if there was a problem with the programme. Sarah Crack replied that the interaction with the production company had implied that the product would be sensitive. Also the process to ensure consent had been robust.

The Board of Directors noted the report.

**BOD 119/16 STAFF AWARDS/AMM**

Zoe Reed and Chris Anderson introduced the paper, which was taken as read.

The purpose of the report was to provide an opportunity for the Board of Directors to consider the arrangements for the Annual Members Meeting which were proposed by the Partnership Working Group.

The proposal was that the main focus for the event will be the Staff Recognition Awards Ceremony and associated Stalls. It will be a daytime event with lunch provided and the whole event will have a festive feel. It is proposed that the formal
part of the event will feel different from previous years and that in addition to the statutory requirements there is a report from the Governors on the Council of Governors’ Year. Governors will also be involved in voting for the Governors Special Award Category. As part of the judging panel’s task for each category, they are each identifying a nomination to pass to the Governors Special Award Category and all Governors will be invited to vote – with the winner being kept secret to be announced, along with all the other winners, on 20th September at the event.

The Board of Directors endorsed the proposal that the Annual Members Meeting 2016 be augmented by the production and presentation of a report of the Council of Governors’ Year and noted that all Governors will be invited to vote for the Special Governors Staff Recognition Award Category.

BOD 120/16 DIRECTOR’S REPORTS

No Directors reports were received.

BOD 121/16 ACTIONS SUMMARY FROM THE MEETING

Paul Mitchell would circulate the actions from the meeting.

BOD 123/16 REFLECTIONS ON THE MEETING

Comments included:

- Short Board in terms of papers may affect other sessions in terms of extra content
- Good discussion of issues and concerns
- New dashboards appreciated
- Questions were challenging and thoughtful
- Need to clarify what is meant and expected in terms of assurance
- Performance report improving
- Amount of external pressure is worrying
- Good Health and Safety paper
- Constancy of Finance dashboard allows for better analysis.
- A lack of clinical material in this month’s papers

BOD 105/16 FORWARD PLANNERS & DRAFT AGENDA – APRIL MEETING

The following additions were requested:

- External review of property due for disposal - July Board
- PPi Policy - December Board
- Prone restraint data – July Board
- Health and Safety update - December Board

BOD 106/16 REPORT FROM PREVIOUS MONTH’S PART II

The report from the previous month’s Part II was noted.
BOD 107/16 ANY OTHER BUSINESS

No other business was discussed.

The date of the next meeting will be: Tuesday 26 July 2016 – 3:00pm
Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ

Representatives of the press and members of the public were asked to withdraw 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).
<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></td>
<td>January 2016 meeting</td>
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<tr>
<td>1</td>
<td>CQC action plan.</td>
<td>Bring back the CQC action plan in 6 months.</td>
<td>NB</td>
<td>July 16</td>
<td>On agenda.</td>
<td>Green</td>
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<tr>
<td></td>
<td>February 2016 meeting</td>
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<td>2</td>
<td>Scheme of Delegation.</td>
<td>Include with Risk update and BAF and bring back to July meeting.</td>
<td>GH</td>
<td>July 16</td>
<td>BAF and risk to board development session. Scheme of delegation to Sept meeting.</td>
<td>Yellow</td>
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<tr>
<td></td>
<td>March 16 meeting</td>
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<td>3</td>
<td>Analysis of natural causes of death.</td>
<td>Review by mortality committee.</td>
<td>MB</td>
<td>July 16</td>
<td>Discussed at meeting 5 July.</td>
<td>Green</td>
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<tr>
<td></td>
<td>April 16 meeting</td>
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<td>4</td>
<td>Carers Story.</td>
<td>Bring back a paper reporting on the quality of the Trust’s engagement with carers when an individual experiences their first episode.</td>
<td>HG</td>
<td>Sept 16</td>
<td>On schedule.</td>
<td></td>
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<tr>
<td>5</td>
<td>Deloitte Report.</td>
<td>Independent assurance to be sought before the Action Plan is signed off by the Board.</td>
<td>PM</td>
<td>Sept 16</td>
<td>Link to action on scheme of delegation. On schedule.</td>
<td></td>
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<td>6</td>
<td>Research and Development Committee.</td>
<td>Committee to be re-established and reports from the R&amp;D Director to come to the Board every 6 months.</td>
<td>PM</td>
<td>July 16</td>
<td>On schedule.</td>
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<td></td>
<td><strong>June 16 meeting</strong></td>
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<td>7</td>
<td>Value of property proposed for disposal.</td>
<td>Bring external review to the July Board.</td>
<td>GH</td>
<td>July 16</td>
<td>On agenda.</td>
<td></td>
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<tr>
<td>8</td>
<td>Cost of Delayed discharges.</td>
<td>To be assessed and reported to the Board.</td>
<td>KD/GH</td>
<td>July 16</td>
<td>On schedule.</td>
<td></td>
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<tr>
<td>9</td>
<td>Prone and restraint data.</td>
<td>To be included as part of the performance report.</td>
<td>NB/KD</td>
<td>Sep 16</td>
<td>On schedule.</td>
<td></td>
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<tr>
<td>10</td>
<td>Patient and Public Involvement (PPI) Policy.</td>
<td>To be presented at the December 2016 Board.</td>
<td>NB/AK</td>
<td>Dec 16</td>
<td>On schedule.</td>
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<td>11</td>
<td>Health and Safety Strategy.</td>
<td>Safer Services Committee work on Staff Safety to be referenced.</td>
<td>KD</td>
<td>July 16</td>
<td>Underway.</td>
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<tr>
<td>12</td>
<td>Health and Safety policy.</td>
<td>To include a reference to the avoidance of violence towards staff.</td>
<td>KD</td>
<td>July 16</td>
<td>Underway.</td>
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<td>13</td>
<td>Supporting tolerance in the Trust.</td>
<td>Joint letter from CEO and Chairman to go to all staff and informing them of how to report any abuse suffered.</td>
<td>LH</td>
<td>June 16</td>
<td>To be drafted and sent by end July.</td>
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<tr>
<td>14</td>
<td>CAG structures</td>
<td>Provide a diagram of the new CAG structure which made the geographical linkages clear.</td>
<td>KD</td>
<td>July 16</td>
<td>On schedule</td>
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<td>15</td>
<td>Overtime</td>
<td>Look at the use of overtime as an incentive for filling nursing shifts.</td>
<td>LH</td>
<td>July 16</td>
<td>On schedule</td>
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Code:

**Green** – completed

**Amber** – on schedule

**Red** – not on schedule

PNJM/June 2016
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 26th July 2016

Name of Report: Quality Improvement Programme Plan

Heading: - Quality

Author: Helen O’ Kelly, Quality Improvement Programme Manager

Approved by: Neil Brimblecombe

Presented by: Neil Brimblecombe

Purpose of the report:
This paper updates the Board on the proposed plan of work for the quality improvement programme, led by the internal quality improvement team, and includes the contribution from our strategic partners Institute for Healthcare Improvement and Intermountain.

Recommendations to the Board:
The Board is asked to:
• Approve the plan, noting there may be some flexibility required to respond to the needs of the organisation.
• Note request for support with high level messages about quality improvement and the longevity of the programme.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
Whilst this paper does not cover directly, it is expected that the programme will support the Assurance Framework.

Summary of Financial and Legal Implications:
No new implications

Equality & Diversity and Public & Patient Involvement Implications:
Consideration of equality and diversity will be considered as part of projects taken forward as part of the quality improvement programme.

The programme will encourage use of the principles of coproduction to engage service users, carers and families.

Service Quality Implications:
The intended impact of the programme is to improve outcomes for people using our services, and to improve the quality of our services.
Executive Summary

This paper updates the Board on the proposed plan of work for the quality improvement programme, led by the internal quality improvement team, and includes the contribution from our strategic partners Institute for Healthcare Improvement and Intermountain.

The Board is asked to:
- Approve the plan, noting there may be some flexibility required to respond to the needs of the organisation.
- Note request for support with high level messages about quality improvement and the longevity of the programme.

Introduction

Our vision is to create and sustain a culture with continuous quality improvement.

We aim to become an organisation with a culture of improvement that is based on service users, carers, staff and key partners working together to improve the delivery of care to deliver the outcomes that matter to people using our services, and carers and families.

We have undertaken a procurement to contract a partner to help us deliver a trust wide quality improvement programme to achieve this vision over the next three years, embedding this culture in our organisation permanently and ensuring value for money in everything we do. The partner will support us to deliver a programme that will be service user focused, flexible in delivery and provide economies through standardisation of our methods and continuous efficiency improvement.

The overall aim of the programme is to deliver the right care at the right time in the right place. We will be looking to design a way of measuring that patients are receiving evidence based care that is safe, with no delays, treatment is close to home, with outcomes that matter to them. The leadership workshop in July will be used to refine this aim and design the measurement framework that underpins this.
Summary of plan

This is a high level summary of the plan prepared in conjunction with the IHI and Intermountain.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
<th>High level actions</th>
<th>Dates for delivery</th>
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</table>
| Building a culture of continuous improvement | • Using the model for improvement – which will involve training at all levels in one improvement methodology  
• Modeled by leadership at all levels of the organisation and across boundaries to achieve constancy of purpose  
• Confident staff, who feel they have permission to act to improve outcomes, working with people who use our services | • Leadership workshop  
• Improvement Science in Action (ISIA) – aimed at frontline staff leading QI projects  
• Improvement coach - a cadre of staff able to support others in their improvement projects  
• Sustainability – QI team takeover ISIA, SLAM partners will support improvement coaches and develop further training for all staff and people who use services (for example we are looking at an option to work with the Recovery College) | • July 2016  
• September 2016 (first wave)  
• January 2017 (first wave)  
• From September 2016 |
| Making space for improvement by: | | • ‘Fix It’ – IT and estates to create new escalation process so that problems are resolved quickly  
• ‘Your time matters’ – a campaign for staff to come up with ideas of things that they could stop doing. Senior management team to take action to take the best ideas forward | • July 2016  
• August – November 2016 |
| Being transparent to enable the organisation and improve | • Development of data to drive clinical decisions, relevant to clinicians and people who use our services, at team level and scalable to enable Trustwide accountability | • Data dashboards that are used by staff to monitor impact and drive improvements in direct patient care | • From October 2016 |
| Improving and reducing variation in care and treatment | • Reduce variations between team and clinicians and their practices, into a single best practice  
• Developing a Trust way to do things – underpinned by value methodology | • Large scale improvement project -looking at acute care pathway, coached by IHI  
• Team level QI projects from the ISIA courses  
• QI team Improvement Advisor projects | • July 2017 – February 2018  
• From September 2016  
• June 2016 -March 2017 |
| Building a culture of inclusion and engagement for staff and people using services | • Build will and belief through early engagement of staff  
• Use principles of coproduction to engage service users, carers and families  
• Use stories of improvements to encourage and inspire others | • Comprehensive communications activity – website, newsletter, pop up sessions, QI visits…  
• Campaigns for ‘fix it’ and ‘your time matters’ and introduction to QI  
• Co-production with service users and carers built into all QI projects | • Throughout  
• See above  
• Throughout |
This plan is being led by the Trust’s quality improvement team who will provide support to staff and people using our services who are involved in improvement work. They will manage the IHI contract and ensure that by the end of the three year contract the system of quality improvement in the Trust is fully developed and can be managed by the team alone. For example, the team will be taking over the quality improvement training from year two.

In Appendix A there is a Quality Improvement Driver Diagram – a representation of the aim and actions with more detail than the high level plan. Appendix B shows the timeline for the overall programme. Appendix C demonstrates the contribution being made by the IHI and their timeline. Appendix D gives a brief outline of the projects the quality improvement team are taking on whilst learning with IHI.

**Risks**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing the systems to support quality improvement, particularly to enable data for learning.</td>
<td>A statistician and data analyst are being recruited to the team</td>
</tr>
<tr>
<td></td>
<td>Close working with Business and Intelligence and Biomedical Research Centre</td>
</tr>
<tr>
<td>Context of the organisation – multiple change programmes with different objectives</td>
<td>Communications strategy for both QI programme and transformation programmes to reflect nuance.</td>
</tr>
<tr>
<td>Ability of staff to engage – affected by morale, turnover, staffing levels and wariness of new initiatives</td>
<td>Work with the willing in the first instance</td>
</tr>
<tr>
<td></td>
<td>Consistent messages from senior leaders re longevity of programme</td>
</tr>
</tbody>
</table>

**Conclusion**

The Board is asked to:

- Approve the plan, noting there may be some flexibility required to respond to the needs of the organisation.
- Note request for support with high level messages about quality improvement and longevity of the programme.

**Appendices:**

Appendix A: Quality Improvement Programme Driver Diagram
Appendix B: Quality Improvement Programme Timeline
Appendix C: IHI Deliverables Timeline
Appendix D: IA projects
Appendix A: Quality Improvement Programme Driver Diagram

Building a culture of continuous improvement
- Practical improvement capability at all levels and all teams including service users
- Leadership that supports improvement as a way of life
- Trust systems to support QI
- Integrated into staff job expectations

Being transparent to enable the organisation to improve
- Using real time data to know how we are doing at all times
- Transparency and openness with data and simple visualisation

Improving and reducing variation in care and treatment
- Protocolisation of care where appropriate
- Large scale improvement initiative
- CAG level projects
- Make time for improvement

Building a culture of inclusion and engagement for staff & people using services
- Involve and engage staff
- Provide ‘joy in work’
- Partnering and co-production with people using services and carers

Right Care, Right Time, Right Place
- e-learning
- ISIA
- Improvement coaches
- Leadership courses
- Fix It
- Your time matters
- Develop job roles

Dashboard development
- IA projects
- Large scale project
- Care process models

Newsletter
Website
Visits
Focus group
Appendix B: Quality Improvement Programme Timeline

<table>
<thead>
<tr>
<th>Change Ideas</th>
<th>JUL-16</th>
<th>AUG-16</th>
<th>OCT-16</th>
<th>NOV-16</th>
<th>DEC-16</th>
<th>JAN-17</th>
<th>FEB-17</th>
<th>MAR-17</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q1</th>
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<td>ISIA</td>
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<td>wave 2</td>
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<td>wave 4</td>
<td>wave 5</td>
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<td>Develop job roles</td>
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<td>Dashboard development</td>
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<td>Leaflets and Posters</td>
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</table>
Appendix C: IHI Deliverables Timeline (see attachment)
## Appendix D: IA projects

<table>
<thead>
<tr>
<th>Project</th>
<th>Clinical Advisory Group</th>
<th>QI team lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with promoting recovery teams in Lewisham, to look at reducing relapse and readmission to hospital.</td>
<td>Psychosis</td>
<td>Helen O’Kelly</td>
</tr>
<tr>
<td>Working with inpatient wards to reduce self harm – with a particular focus on the use of ligatures.</td>
<td>CAMHS</td>
<td>Iyonis Ranasinghe</td>
</tr>
<tr>
<td>Working with Hayworth ward to improve recovery through co-production of care plans with patients and family.</td>
<td>Mental Health of Older Adults</td>
<td>Polly Ragoobar</td>
</tr>
<tr>
<td>Working with Norbury ward and learning disability community teams to improve physical health outcomes for people using services and reduce health inequalities.</td>
<td>Behaviour and Development</td>
<td>Rachael Leaton</td>
</tr>
<tr>
<td>Working with the Wandsworth team to improve use and quality of care planning to help increase numbers of patients successfully completing their recovery care programme.</td>
<td>Addictions</td>
<td>Sian Martin</td>
</tr>
</tbody>
</table>
Appendix C:
**IHI Deliverables Timeline**

**Work Packages:**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Deliverables</th>
<th>Date</th>
<th>Assigned Faculty*</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Diagnostic Pre-Work</td>
<td></td>
<td></td>
<td>Virtual planning meetings and data collection</td>
</tr>
<tr>
<td></td>
<td>On-Site Diagnostic</td>
<td></td>
<td></td>
<td>• Workstreams: general improvement, leadership, innovation &amp; value</td>
</tr>
<tr>
<td></td>
<td>Diagnostic Report Out</td>
<td></td>
<td></td>
<td>• Delivered May 20, 2016</td>
</tr>
<tr>
<td></td>
<td>Board Development Session</td>
<td>May 24, 2016</td>
<td>Pedro Delgado, Amelia Brooks</td>
<td>• Two hour session to cover the model for improvement, rapid cycle change testing and the SLaM Improvement Programme</td>
</tr>
<tr>
<td></td>
<td>Leadership Workshop</td>
<td>July 21-22, 2016</td>
<td>Kathy Luther, Michael Pugh</td>
<td>• Targets senior leaders of organisation to build on key system priorities and aims</td>
</tr>
<tr>
<td></td>
<td>Improvement Advisor (IA) Programme</td>
<td>May 2016 - Feb 2017</td>
<td>Bob Lloyd, Jane Taylor, Richard Scoville, and Rebecca Steinfeld</td>
<td>• A 12 month professional development programme for 6 SLaM QI Team members;</td>
</tr>
<tr>
<td></td>
<td>Wave 42</td>
<td></td>
<td></td>
<td>• Prework call held May 16, with three 4 day workshops and monthly Webex calls.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• The IA programme provides an in-depth learning path in the science of</td>
</tr>
</tbody>
</table>
| Improvement Science in Action (ISIA) Programme Wave 1 | Workshop 2 October 10-13, 2016  
Workshop 3 Jan 30 – Feb 2, 2017 | Richard Scoville, Christina Southey | Improvement (SOI). It builds a foundation on the concepts, tool and methods of the SOI and allows the participants to apply this knowledge and the skills to an improvement project relevant to their organisation. The workshops create a collaborative learning environment where participants not only learn but engage in teaching each other. Developing and testing actionable ideas that will help each participant achieve maximum results for their defined project serve as a central design principle for the IA Programme. Approximately 100 participants will be in this first wave of the ISIA. As a result of participation in the ISIA participants will be able to:  
- Understand the system you are trying to improve and the population you wish to serve.  
- Use the three questions of the Model for Improvement to shape and frame an improvement project to increase the probability of success including: aims, a measurement system, change ideas to test, and execution plan.  
- Develop a project plans to enable successful testing and team work.  
- Utilize small scale, iterative Plan, Do, Study, Act (PDSA) cycles of testing to rigorously develop tests and build deep and immediate learning and improvement.  
- Learn how to manage an improvement project and to communicate progress and results to leaders  
- Build skills in understanding and applying QI tools and methods |

| IHI Open School Subscription | Oct 2016 – Sep 2017 | N/A | - 250 subscriptions per year  
- A network of students and educators like you. Connect with students and faculty from other professions, states, and countries through our face-to-face campus Chapters.  
- The IHI Open School Basic Certificate in Quality & Safety – Complete a set of required online courses and earn a certificate that shows employers you’re serious about improving care.  
- Case studies, videos, featured articles — and a bounty of other online activities.  
- Experiential learning opportunities. Complete the IHI Open School Quality Improvement Practicum by conducting a quality improvement project with your local institution, or join the IHI Open School Change Agent Network (I-CAN) and build leadership and community organizing skills to |
## Improvement Science in Action (ISIA) Programme

**Wave 2**

**March 2017**

Robert Lloyd and SLaM Faculty (TBD)

100 participants held at SLaM

As a result of participation in the ISIA participants will be able to:

- Understand the system you are trying to improve and the population you wish to serve.
- Use the three questions of the Model for Improvement to shape and frame an improvement project to increase the probability of success including: aims, a measurement system, change ideas to test, and execution plan.
- Develop a project plan to enable successful testing and team work.
- Utilize small scale, iterative Plan, Do, Study, Act (PDSA) cycles of testing to rigorously develop tests and build deep and immediate learning and improvement.
- Learn how to manage an improvement project and to communicate progress and results to leaders.
- Build skills in understanding and applying QI tools and methods.

## Improvement Coach Professional Development

**April-September 2017**

Robert Lloyd & IHI Faculty (TBD)

This 7 day program will be combined with Webex calls interspersed between the workshops.

- The program can be designed as 3 workshops or 2 depending on how SLaM wishes to organize the programme.
- 30 participants trained on-site.
- Skills focus more on the human side of change than with measurement and statistical analysis.
- Participants must have knowledge of and experience with QI concepts, tools and methods in order to be invited to join this program.
- Team meeting skills, communication styles, application of QI team tools, the Model for Improvement and the quality measurement journey provide the foundation for this programme.

## IA Programme

**Wave 45**

**Jun 2017 - Dec 2018 (specific dates TBD)**

Robert Lloyd, Richard Scoville, Rebecca Steinfield, Dave Williams

A 12 month professional development programme for 5-6 SLaM QI Team members;

- Prework call held in May followed by three 4 day workshops and monthly Webex calls.
- The IA programme provides an in-depth learning path in the science of...
improvement (SOI). It builds a foundation on the concepts, tool and methods of the SOI and allows the participants to apply this knowledge and the skills to an improvement project relevant to their organisation. The workshops create a collaborative learning environment where participants not only learn but engage in teaching each other. Developing and testing actionable ideas that will help each participant achieve maximum results for their defined project serve as a central design principle for the IA Programme.

<table>
<thead>
<tr>
<th>Large Scale Improvement Initiative (LSII) identification and set up</th>
<th><strong>Jun 2016 – Jul 2017</strong></th>
<th>Kathy Luther, Pedro Delgado, Amelia Brooks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breakthrough Series (BTS) Design &amp; Implementation</strong></td>
<td><strong>Aug 2016 – Feb 2018</strong></td>
<td>Kathy Luther</td>
</tr>
</tbody>
</table>

- Select and scope a results-oriented initiative as per work package 5
- Planning call with core faculty
- Board approval of plan
- Purpose of work package: Select, scope, design and execute a results-oriented improvement initiative from prototype to spread; this work package will build from the outcomes defined during the innovation phase
- Begin Breakthrough Series (BTS) Collaborative planning (Jan 2017) after first innovation cycle (Nov 2016) produces initial success
- BTS consists of periodic virtual and in-person learning sessions focused around SLaM’s LSSI coupled with action periods where teams conduct plan-do-study-act (PDSA) cycles to carry out tests of change and collect data, ultimately building scale change for improvement. BTS is focused around a 5 step framework: aim statement, content theory, execution theory, measurement plan, and dissemination.
- Short term goals to understand current state and identify quick wins
- Medium term goals to develop detailed understanding, content theory, measurement plan and improvement plan
- Long term goals to engage staff and create ownership in service of sustainably achieving improvement plan
- Direct support for implementation will involve coaching from faculty and improvement experts using the methods of prototyping, collaborative movement, spread and scale; also includes a leadership track to support strategic initiative
- LSSI Monthly Workstream Calls: Aug 2016-Feb 2018
- LSII Quarterly Milestone Calls: Nov 2016-Nov 2018
- Annual Deep Dive: Feb 2017-Feb 2019
- 3 Learning sessions: April 2017-Dec 2017
  - Learning sessions to further improvement activity of results
| Innovation Cycle 1 | Oct 2016 – Dec 2016 | Lindsay Martin, Kedar Mate | - 90 day innovation process: (i) Scan, (ii) Focus and Test, and (iii) Refine, Summarise and Action Planning  
- Focus on developing theory that applies to value-based mental health care in support of the large scale improvement initiative to ensure cost reduction is driven by improvements in clinical quality  
- Creating a value based framework that applies specifically to mental health and is adapted from other value methodologies using a methodology that we have modified and are testing now. The first phase of the innovation would be development of the theory with them that would specifically apply to mental health ending in a validated theory. |
| Innovation Cycle 2 | Feb 2017 | Lindsay Martin | - 90 day innovation process: (i) Scan, (ii) Focus and Test, and (iii) Refine, Summarise and Action Planning  
- Test theory from first cycle within SlaM clinical and operational setting  
- The second phase of innovation would be alpha and beta testing to prep the theory for moving into prototype and pilot testing. As the planning for the large scale project gets underway we can more specifically highlight where the current gaps are that would need to addressed through innovation. |
| Measurement System Set Up | Oct-Dec 2016 | Lucy Savitz | - Identify small work-group for engaged planning and exploration with SlaM  
- Inventory available SlaM data  
- Develop scalable design and template protocol  
- Test for set up |
| Measurement System Launch | Jan 2017 | Lucy Savitz | - Webinar to describe measurement system “ready” for full scale deployment in preparation for ISIA Programme (including playbook with data dictionary, measure definitions, etc.)  
- Facilitated discussion with Set Up Work Group and others TBD  
- Identify needed refinements/modifications  
- Leverage existing SlaM data systems to identify key areas for improvement and develop measurement systems to monitor continuous improvement  
- Use financial performance data and clinical capacity information to build systems that achieve value-based care and high quality operations |
<p>| Data Monthly Coaching Calls | Feb 2017 - Feb 2019 | Lucy Savitz | - |</p>
<table>
<thead>
<tr>
<th>Activity</th>
<th>Dates</th>
<th>Lead</th>
<th>Key Actions</th>
</tr>
</thead>
</table>
| Identify high cost/high risk areas and apply three-pronged approach: standardising care models, optimising efficiency and optimising capacity | | | - In-depth check ins to:  
  - address identified challenges and opportunities (e.g., benchmarking);  
  - review/interpret progress and results; and  
  - present new, relevant tools/techniques. |
| Data Site Visits | Feb 2017, Sept 2017, June 2018 | Lucy Savitz |  |
| Weekly calls with SLaM QI team – programme review | Apr 2016 – Cont | Amelia Brooks, Catherine Mather, Amber Watson | - Logistics and planning review  
- Review of all outstanding actions  
- Agree next steps |
| Weekly calls with SLaM QI team – leadership workshop | Jun 2016 – Jul 2016 | Kathy Luther, Michael Pugh, Amelia Brooks | - Logistics and planning review  
- Develop bespoke agenda and content |
| Quarterly gateway progress review with IHI faculty and SLaM QI team | Aug 2016 - Cont | Pedro Delgado, Amelia Brooks, Kathy Luther, Kedar Mate, Bob Lloyd | - Review progress and next steps against full programme  
- Review budget  
- Coaching for QI team  
- Identification of topic  
- Understanding of current state  
- Clarify roles and responsibilities  
- Agree short, medium and long term goals |
| Fortnightly prep calls – Large scale improvement initiative | Jul 2016 – Dec 2016 | Kathy Luther, Amelia Brooks, Angela Zambeaux, Amber Watson |  |
| Fortnightly prep calls – innovation cycle | Aug 2016 – Oct 2016 | Lindsay Martin, Amelia Brooks, Angela Zambeaux, Amber Watson | - 90 day innovation process: (i) Scan, (ii) Focus and Test, and (iii) Refine, Summarise and Action Planning |
Date of Board meeting: 26th July 2016

Name of Report: CQC Actions Update

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

Author: Mary O’Donovan, Head of Quality

Approved by: Dr Neil Brimblecombe, Director of Nursing

Presented by: Dr Neil Brimblecombe, Director of Nursing

Purpose of the report:

To present a summary of CQC Action plan implementation progress and assurance.

Recommendations to the Board:

The Board of Directors is asked to note this report and decide whether any further action or briefing is required.

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 Assurance Framework risk 3 - Failure to provide the quality of service that is contracted and that service users deserve. The level of assurance provided by this report is moderate.

Summary of Financial and Legal Implications:

Statutory enforcement action from CQC, if the Trust does not complete ‘Must do’s’ from the Inspection.

Equality & Diversity and Public & Patient Involvement Implications:

The CQC Action plans assist the Trust in delivering high quality, safe effective care which incorporates a commitment to ensure effective patient/public involvement and equality and diversity issues.

Service Quality Implications:

Improving quality and safety of care provision has a significant impact on service delivery
1. Care Quality Commission (CQC); Compliance Inspection September 2015 Results

Following the comprehensive compliance inspection carried out by the CQC last September, the CQC published its final report and ratings on their website on the 8th January 2016. Following which there was a Trust Quality Summit on the 20th January 2016 with stakeholders and the CQC outlining the final feedback and results. The CQC’s report provided the Trust with an agenda and action plan for making necessary improvements for issues that was raised. The final trust ratings are outlined below:

<table>
<thead>
<tr>
<th>Name of provider</th>
<th>SLAM</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult wards for adults of working age and psychiatric intensive care units (PICUs)</td>
<td>Adequate</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td></td>
</tr>
<tr>
<td>Long stay/rehabilitation mental health wards for working age adults</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic inpatient / secure wards</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td></td>
</tr>
<tr>
<td>Child and adolescent mental health wards</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>Wards for older people with mental health problems</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td></td>
</tr>
<tr>
<td>Wards for people with a learning disability or autism</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td></td>
</tr>
<tr>
<td>Community-based mental health services for adults of working age</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>Mental health crisis services and health based places of safety</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>Specialist community mental health services for children and young people</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>Community-based mental health services for older people</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>Community mental health services for people with a learning disability or autism</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td></td>
</tr>
</tbody>
</table>
2. Care Quality Commission compliance Inspection Benchmarking results

The current national benchmarking data available demonstrates that of the 45 MH Trusts currently rated by the CQC, 29% of Trusts received a rating of Good and nationally and 20% in London. To date no MH Trusts have received a rating of Outstanding. The domain ‘safety’ proved to be a challenge for the vast majority of Mental Health Trusts nationally and London the latter region all requiring improvement.

![Overall CQC rating by %](image1)

![CQC Safety Domain rating by %](image2)

3. Future CQC Inspection processes

Recent feedback from the CQC indicates that future CQC compliance visits will not take the same format of the recent in-depth compliance CQC inspection carried out in September 2015. The CQC are currently evaluating and discussing future CQC inspection methodology, style and format. However, initial feedback would appear to suggest that future inspections will be more focused in style with smaller number of inspectors visiting a specific service area/type. Service areas visited will most likely be areas that have been highlighted as requiring improvement in the September 2015 visit or other sources of intelligence such as Incident reporting and whistleblowing.
4. Summary of main issues raised by CQC

Whilst the inspection highlighted much to be proud of there were also areas that both the CQC and the Trust recognised needed improvement. Below is a summary of the quality improvement work currently being undertaken in the main areas of concern raised by the CQC.

<table>
<thead>
<tr>
<th>Area of Improvement</th>
<th>Issues</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Risk Assessments    | Consistent completion, sufficiently detailed, responsively up dated, recorded in right place, linked to actions | • Redesign of ePJS  
• EObs project  
• Revising and strengthening training  
• Ongoing audit |
| (Safety)            |                                                                        |                                                                                                                   |
| Food                | Responding better to individual and cultural need ( Particularly Forensic and Older Adult Wards) | • New menu developed  
• Improve menu booking  
• Retendering of catering contract  
• Tighter monitoring and feedback  
• Regular patient feedback, centrally collated |
| Reducing Restraint  | Reducing incidence of restraint, particularly prone, and improving recording | • Improve detail/process of reporting (complete)  
• Complete Trust Violence Reduction Strategy (including NICE guidance)  
• Roll out 4 Steps to Safety on all inpatient wards  
• Review training to ensure best practice and emphasis on accurate recording |
| (Safety)            |                                                                        |                                                                                                                   |
| Environmental       | Ensuring specific risks are managed including fire precautions and ligature risks | • Specific actions for PoS, ES1, Heather Close  
• Completion of ligature reduction programme  
• Visual management - audit of environmental risks |
| Safety              | Consistent access to ligature cutters and timely checks on all equipment | • Review of emergency equipment standards  
• Improved audit processes re: equipment  
• Centralised online equipment audits to improve governance |
| Equipment Safety     |                                                                        |                                                                                                                   |
| (Safety)            | Sufficient staff available on acute wards, staff fully confident to work with people with dementia on Older People’s Wards | • Continue current focus on recruitment, including focused reward schemes  
• Continue to develop new and innovative workforce models  
• Improved vacancy adverts and social media campaigns  
• Outdoor recruitment campaign (e.g. escalators at Waterloo Underground)  
• Process improvements in recruitment system – speedier and more efficient to reduce delays  
• Increase in notice periods  
• Review of training needs in Older Adults services |
| Staffing            |                                                                        |                                                                                                                   |
| (Safety)            |                                                                        |                                                                                                                   |
| Ensuring Inpatient’s | Ensuring that privacy and dignity needs are sensitively met, that informal patients are fully aware of their rights and that blanket restrictions do not prevent individual needs being met. | Standards to be developed and audited re: observation windows on bedrooms  
• Development of standardised information re: informal patient rights which will be made fully visible and available in different forms on relevant wards  
• Review of restrictive practices on Rehabilitation Wards to ensure individual needs can be met |
5. Current status of Action plans and process for delivery and assurance of implementation

There are 33 ‘Must Do’s’ and 76 ‘Should Dos’ actions that have been highlighted by the CQC. The weekly updates to the CAGS regarding the ‘MUST Dos’ are outlined below.

![Table with Action plans and process for delivery and assurance of implementation](image)

The CQC action plans, for both the ‘Must Dos’ and ‘Should Dos’ were submitted to the CQC in January and February this year. These have been uploaded to the Datix system and are monitored for implementation monthly at the Quality Delivery Committee where senior managers from the Clinical Academic Groups (CAGs) provide an update on their progress against the actions. The Datix system produces a dashboard for both Trustwide and CAG leads which shows at a glance when action updates are overdue.

6. Risks

There have been delays in some of the Action plan implementation dates against the original due date submission. In these instances the rationale for delays and the subsequent mitigation plans have been communicated to the CQC by Director of Nursing on the 10th June 2016. These are outlined below:
**Central Place of Safety (PoS)**

Improving Place of Safety environments: Plan remains to open a central place of safety to improve both staffing arrangements and environmental issues. This will lead to the closing down of the existing 4 PoS. Southwark Health Scrutiny Committee has requested additional time for consultation prior to opening the new unit, primarily because of potential concerns regarding the Borough’s responsibility for AMHPs. This has delayed this process by approximately 3 months. In the meanwhile, local POS environmental risk assessments are being carried out as per action plan.

**Risk assessments actions- action date due- 30/6/16**

Eight of the Must and Should do actions related to improved risk assessments, with most of the due dates being 30/06/16. Short term actions have been on going and there was a Trust wide audit recently which showed improvement around risk assessments being completed. The CQC actions centred around the quality of risk assessments and how they translate into the Care plan. Changes to the Trust’s electronic patient journey system are an important part of the action plan, that will make it easier for front line staff to deliver good recording of both risk assessments and linking that to care planning. However, the ICT changes needed to change the system are taking longer than anticipated and the Trust is looking at a new end of September date for completion of these structural changes to the care planning format. Other planned actions will continue regardless. New due date 30/09/16.

7. **Internal Assurance and Inspection process**

The Quality Delivery Committee (QDC) is held monthly and chaired by the Director of Nursing with representatives from all the CAGs and Central Services. The QDC challenges evidence and performance manages Action plan delivery.

The Best Practice Inspection tool used last year, pre CQC inspection has been reviewed and subsequently revised to include questions and assurance in issues raised by the CQC. The ‘safety’ domain in the questionnaire has therefore been extended which is reflective of the CQC results.

Ten service areas which cross CAG and geographical areas) have been visited throughout June which are highlighted below. The visits have been undertaken by a team of three staff led by the Nursing Directorate and service users. Data entry is currently underway and analysis will be carried out over the next month with results reported via both the Quality Delivery Committee and Quality Sub Committee.

<table>
<thead>
<tr>
<th>Service Area</th>
<th>CQC Clinical Care Pathway</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL3</td>
<td>Acute</td>
<td>Maudsley</td>
</tr>
<tr>
<td>Norbury</td>
<td>Forensic</td>
<td>Bethlem</td>
</tr>
<tr>
<td>Clare Ward</td>
<td>Acute</td>
<td>Ladywell</td>
</tr>
<tr>
<td>Eden Ward (PoS)</td>
<td>Crisis</td>
<td>Lambeth</td>
</tr>
<tr>
<td>Fitzmary 2</td>
<td>Specialist/National</td>
<td>Bethlem</td>
</tr>
<tr>
<td>Gresham 1</td>
<td>Acute</td>
<td>Bethlem</td>
</tr>
<tr>
<td>Heather Close (3-5)</td>
<td>Complex care</td>
<td>Lewisham</td>
</tr>
<tr>
<td>Lambeth triage</td>
<td>Acute</td>
<td>Lambeth</td>
</tr>
<tr>
<td>Chelsham Ward</td>
<td>MHOA</td>
<td>Bethlem</td>
</tr>
<tr>
<td>Westways- Alex 1</td>
<td>Complex Care</td>
<td>Bethlem</td>
</tr>
</tbody>
</table>
Internal Audit TIAA are due to carry out an audit in July regarding evidence uploaded by the CAGS in demonstrating Action plan implementation, again these results will be reported via the Quality Sub Committee and trust Board in due course.
Date of Board meeting: 26th July 2016

Name of Report: Safe Staffing Report

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

Author: Neil Brimblecombe – Director of Nursing

Approved by: Neil Brimblecombe

Presented by: Neil Brimblecombe

Purpose of the report:
This paper summarises the national requirements regarding Safe Staffing in inpatient care settings, the actions taken within SLaM to support Safe Staffing and future plans to monitor and review staffing arrangements.

Recommendations to the Board:
The Board is asked to:
Note actions taken by the Trust to date and future plans to implement processes to ensure safe staffing in inpatient services.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
Risk 2 – ‘The Trust’s workforce lacks the correct skills in the correct numbers to ensure services are provided in line with best practice’

Summary of Financial and Legal Implications:
Additional investment has been outlined to increase staffing in some wards. This is within planned CAG budgets.

Equality & Diversity and Public & Patient Involvement Implications:
Ensuring that staffing levels are appropriate to demand and clinical requirements help ensure appropriate services for service users with all protected characteristics.

Service Quality Implications:
To enable inpatient areas to provide safe and therapeutic care, appropriate staffing levels and processes for monitoring and reviewing these are essential.
1. **Introduction**

This paper aims to provide assurance to the Trust Board and the public that issues relating to ward staffing are continuously monitored and reviewed at local and organisational level as outlined in the most recent guidance issued by the National Quality Board (2016) ‘Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time, safe, sustainable and productive staffing’.

2. **Context**

In 2013, the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about staffing that put service users first. In July 2016 NQB published an updated version of the guidance building on the expectations outlined in the 2013 document and taking into account both the Five Year Forward View and the Carter report.

The Five Year Forward View and the Carter productivity and efficiency report make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. The reports emphasise that improving workforce efficiency can benefit service user care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to service user need, and reduced dependency on agency staff. Lord Carter’s report also recommended a new metric, care hours per patient day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments.

The development of new service models means building teams across traditional boundaries and ensuring they have the full range of skills and expertise to respond to patient need across different settings. As provider and commissioner organisations work together to develop Sustainability and Transformation Plans, staffing decisions must support these new models of care.

3. **Aims**

The aim of the Safer Staffing review is to:

- Provide an overview of updated NQB safer staffing guidance.
- Report against actions identified in the previous safer staffing board report.
- Review elements of the QUESTT in relation to safe staffing.
- Report on the engagement with the national work regarding the development of tools to support safe staffing establishments in community and in-patient services.
- Review of planned work in how best to utilise other professional groups and levels of banding to address the Band 5 recruitment challenges.
- Highlight plans for the SafeCare rollout to inpatient services.
- Plan actions for the next six months.

4. **Updated NQB guidance and expectations 2016**

The NQB Guidance (2016) is the first step in developing resources to support safe, sustainable staffing within the NHS. NHS Improvement is also coordinating work to develop
safe staffing improvement resources for a range of care settings including: mental health, learning disability, acute adult inpatients, urgent and emergency care, children’s services, maternity services, and community services.

The core principles underpinning this work are:

- To identify and review the best available evidence on safe, sustainable staffing.
- To be multi-disciplinary in approach to staffing.
- To be outcomes focused.
- To complete an economic impact assessment on any proposed safe staffing improvement resource.
- To develop these staffing resources with the appropriate experts, focus groups and other key stakeholder groups, including patients, families and carers.

NHS Improvement will begin to release these improvement resources later in 2016/17, with approval from the NQB.

There are three expectations outlined in the refreshed NQB guidance in July 2016:

4.1 *Expectation 1: Right Staff*

Boards should ensure:

- Workforce planning is evidence-based.
- Professional judgement and knowledge is used to inform decision making on staffing requirements.
- Comparisons on staffing levels are made with peers.
- The organisation reviews comparative data in a dashboard on actual staffing alongside data that provides context, such as, length of stay, occupancy rates, admissions, discharges and transfers, and patient acuity and dependency.

4.2 *Expectation 2: Right Skills*

Boards should ensure:

- Staff receive mandatory training, development and education and staffing establishments take this into account.
- That staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.
- There is an analysis of training needs and this analysis helps identify, build and maximise the skills of staff.
- Staff are allocated time to discharge their supervisory and management responsibilities.
- There is a commitment to investing in new roles and skill mix that will enable staff to spend more time focusing on clinical duties.
- The organisation works collaboratively with others in the local health and care system to support the development of future care models.
- The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves.
- The organisation has effective strategies to recruitment and retention of staff.
4.3 **Expectation 3: Right Place**

Boards should ensure:

- Productive working and eliminating waste by using lean principles.
- Pathways are designed to optimise patient flow and improve outcomes and efficiency.
- Systems are in place for managing and deploying staff across a range of care settings.
- Clinical capacity and skill mix are aligned to the needs of patients.
- Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action.
- Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed.
- Meaningful application of effective e-rostering is evident.
- An annual strategic staffing assessment takes place and provides the board with a clear medium-term view of the likely temporary staffing requirements.
- The use of agency staff is reduced in line with NHS Improvement’s nursing agency rules, supplementary guidance and timescales.
- The workforce plan is based on the local Sustainability and Transformation Plan.

5. **Actions identified Nov 2015**

This report highlights progress made since the last safer staffing review in November 2015 and reports against the actions identified as outlined below:

- Monitor and report back number of monthly breaches.
- Impact review of Safer Staffing changes to date.
- Review the impact of the use of Allied Health Professionals and Band 4 Senior Health Care Assistants within the minimum safe staffing numbers on inpatient teams.
- Review outcomes of new tools on Safe Staffing levels in both inpatient and community settings.
- To review CAG plans as to how they will ensure weekend inpatient services do not provide a ‘lesser’ service.
- Detailed analysis of community caseloads between team by type, area, expected and actual caseloads.
- Detailed review of enhanced observations and their impact on minimum safer staffing levels.
- Review of the implementation SafeCare and NHSP platform and impact to date.

6. **Monthly safer staffing breaches**

The inpatient wards provide monthly staffing returns outlining actual staffing numbers against planned. These figures are reported to NHS England and are available to the public on the Trust website and NHS Choices.

Future reporting will change with the introduction of reporting care hours per patient day (CHPPD). This is currently an expectation set out in the NQB guidance for Acute Trusts and
work has begun to consider appropriate application of this metric in other care settings and will include other allied healthcare professionals.

Breaches of planned staffing levels are highlighted monthly to the Board if over 20% of shifts do not have the stated minimum staffing levels.

The graph below shows the number of wards per month within the Trust that have breached minimum staffing levels over the past 12 months.

The main reasons cited for breaches are NHSP being unable to fill vacant shifts often due to short notice bookings however in many cases the shift was covered by an experienced support worker or allied health professional.

An audit will be undertaken to look at the timeliness of staffing requests and explore other factors, which may contribute, to NHSP being unable to fill vacant shifts.

A number of wards are running exceptionally high vacancy rates. There are currently 209 Band 5 WTE vacancies across inpatient services. However, it is difficult to measure the exact figure at ward level as the WTE budgets currently do not link with the e-roster system.

Work is progressing to ensure this is addressed and therefore in the future all wards will have their WTE budgets on e-roster which will enable wards and CAGs to have a clear understanding of their vacancy rates.

7. **Quality Effectiveness Safety Trigger Tool (QUESTT)**

To provide a consistent approach in measuring quality issues at team level across inpatient services the Trust is rolling out the Quality, Effectiveness, Safety Trigger Tool (QUESTT) across all wards. Thirty-seven wards and three Home Treatment Teams are currently using the tool and scores are reviewed centrally alongside safer staffing figures to provide an overview of staffing and quality issues. It is envisaged that over the next 6 months all remaining wards will be using QUESTT. The tool looks at a number of quality indicators which when aligned may impact on staff/patient experience and/or safety, triggering the need for action at local and organisational level before any negative impact occurs.

The quality indicators focus on leadership, team working, environment and issues that impact on staffing, such as, vacancy rates and bank usage.
The tables below show the percentage of teams within each CAG that answered ‘yes’ to three quality indicators, from the April 2016 figures.

<table>
<thead>
<tr>
<th>CAMHS – 5 wards</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 7% posts vacant</td>
<td>60%</td>
</tr>
<tr>
<td>Over 6% of shifts filled with bank staff</td>
<td>100%</td>
</tr>
<tr>
<td>New or no ward manager in post</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychosis/Acute Pathway – 11 wards</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 7% posts vacant</td>
<td>50%</td>
</tr>
<tr>
<td>Over 6% of shifts filled with bank staff</td>
<td>90%</td>
</tr>
<tr>
<td>New or no ward manager in post</td>
<td>30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BND – 10 wards</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 7% posts vacant</td>
<td>60%</td>
</tr>
<tr>
<td>Over 6% of shifts filled with bank staff</td>
<td>80%</td>
</tr>
<tr>
<td>New or no ward manager in post</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MHOA – 5 wards</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 7% posts vacant</td>
<td>0%</td>
</tr>
<tr>
<td>Over 6% of shifts filled with bank staff</td>
<td>80%</td>
</tr>
<tr>
<td>New or no ward manager in post</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Medicine – 6 wards</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 7% posts vacant</td>
<td>100%</td>
</tr>
<tr>
<td>Over 6% of shifts filled with bank staff</td>
<td>89%</td>
</tr>
<tr>
<td>New or no ward manager in post</td>
<td>44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall (All CAG’s)</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 7% post vacant</td>
<td>54%</td>
</tr>
<tr>
<td>Over 6% of shifts filled with bank staff</td>
<td>88%</td>
</tr>
<tr>
<td>New or no ward manager in post</td>
<td>32%</td>
</tr>
</tbody>
</table>
Stable and effective leadership is an important influencing factor on quality outcomes, team collaboration, staff morale, team effectiveness and service user experience. The results in April show that 32% of wards participating had either a new Ward Manager or no Ward Manager in post. Therefore, a third of wards worked with staff acting up which in turn affects frontline staffing and direct patient care.

Over half of the wards are exceeding 7% vacancy rates and this impacts on the number of shifts requiring bank staff to be booked. None of the wards in MHOA CAG are exceeding 7% vacancy rates and all have stable Ward Management in place although most wards exceed the 6% of shifts being covered by bank staff. This is due to increased dependency and physical health needs requiring increases in the staff required per shift.

There is an agreed escalation process for all CAG’s to develop MDT action plans if their teams report a high level of quality indicators.

8. **Introduction of new workforce models**

A programme to recruit Band 4 posts through a competency based assessment process is underway in a number of CAGs. The purpose of this is to ensure that those services struggling to recruit to Band 5 nursing posts continue to provide high quality care and teams have the right level of skills to deliver the right care. These roles also support wards where three or more qualified nurses are required to meet minimum staffing levels. In some CAGs these roles undertake some of the crucial tasks of a Band 5 nurse with clear exceptions outlined.

In the Behavioural and Neurodevelopmental CAG, the Band 4 role has been established for approximately two years and is fully embedded into the service. The CAG reports that there is a high turnover of staff in the Band 4 posts due to them attracting psychology students aiming to gain work experience. These roles have added value as they provide psychotherapeutic interventions to service users which extend to evenings and weekends.

It is intended that new workforce models and roles will be evaluated by CAGs in order to share learning and agree the competency framework for this new workforce.

9. **Acuity and Dependency Tools**

In order to ensure we have the right staff with the right skills in the right place, the NQB emphasises the importance of using a triangulated approach (outlined below) to determine staffing levels based on service user need, risk and acuity with the recommendation that this is monitored and measured from the ward to the board.
Right place           Right skills           Risks           Acuity

Unlike that for general acute care and midwifery there is very little or no evidence base relating to the use of acuity and dependency tools to determine safer staffing levels in mental health settings.

When attempting to measure dependency levels, it is important to recognise the differences between mental health settings and other areas of care delivery:

- Mental Health services require a higher proportion of interventions.
- Interventions are often reactive and unplanned.
- Higher proportion of service users are ambulatory rather than bed based.
- Length of stay in hospital tends to be longer for Mental Health service users.
- Higher percentage of service users are detained rather than there by choice.
- Around half of service users require a higher degree of security.

Clearly the focus for Mental Health is more on psychological than physical care, with behavioural risks being key considerations, rather than environmental risks such as surgery errors or infection control.

Keith Hurst has developed a mental health inpatient tool and a community mental health team dependency tool. Both tools are being tested as part of a national piece of work.

9.1 *Inpatient acuity and dependency tool*

SLaM has participated in developing and testing the inpatient Hurst tool in collaboration with a number of West Midlands Mental Health Trusts. This tool is currently being rolled out as part of the SafeCare module on e-roster to all wards in the Trust. Training on the use of the tool and the dependency descriptors will be provided to teams and feedback will be sought to inform further work on the national development of mental health dependency tools.

9.2 *Community acuity and dependency tool*

Three community teams in the Addictions CAG participated in the pilot. A detailed analysis of findings was provided by the national lead.

The five data sets collated were:

- Data and accuracy
- Caseload (daily contacts)
- Staff activity by grade
- Service quality
- Funded, actual, temporary and recommended staffing

The community teams who participated were found to be efficient with their time due to travel time being minimised significantly by facilitating a number of clinics. It was recognised that although it is challenging for staff, teams are working with high dependency and acuity levels and therefore keeping patients out of hospital.
Detailed analysis has been provided to the CAG for further consideration. The Trust awaits the outcome of the national pilot, to inform decisions regarding further use and spread of the tool in the future.

10. **Ensuring weekend inpatient services do not provide a 'lesser' service**

A substantial body of evidence exists which indicates significant variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, length of stay and re-admission rates. Additionally, medical, nursing, other health professional and managerial staffing levels, also vary by day of the week.

In February 2016 NHS England produced 10 seven-day service clinical standards for NHS Trusts to consider. Four of these clinical standards have been highlighted as priority areas:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review

As healthcare systems produce their Sustainability and Transformation Plans, seven-day hospital services should be an integral part of these plans and local areas should set out how they intend to deliver on the four priority clinical standards.

All CAGs continue to consider ways in which they can provide an equitable service across a 7-day period. Examples include, the introduction of the Band 4 role providing activities in the evening and at weekends and some CAGs have introduced Occupational Therapists into the 7-day shift pattern. On Triage wards, Consultant Psychiatrist cover is also extended to the weekends.

11. **Enhanced observations and their impact on minimum safer staffing levels**

In order to gain a clear understanding of safe staffing levels it is important to look at patient acuity and dependency. This includes having a clear understanding of the levels of enhanced observations at ward level and Trust wide. Enhanced levels of observation places increased demand on staffing time and therefore understanding this demand will allow us to deploy staff where and when required to meet patient need. The introduction of the SafeCare module will allow the Trust to capture this data consistently across wards in the future.

12. **Implementation of SafeCare**

SafeCare is an effective management tool within e-rostering which enables the clinical team and other senior leaders to measure acuity and dependency levels of service users within wards and provides information on the following: -

- WTE metrics
- Staffing skill mix
- Effective deployment of staff within and across wards
The SafeCare application will be available to use on desktops and mobile devices and therefore will enable staff efficiency. The SafeCare module will be rolled out for use across all inpatient wards over the next 12 months. Training for staff will be provided as part of the roll out plan commencing in September 2016.

13. Changes made in current staffing review

The BND CAG have recruited Clinical Nurse Specialists who will carry a caseload and provide senior clinical leadership visibility. They have also introduced a Band 6 development programme to support the CAG with succession planning and help retain and develop the workforce.

MHOA CAG has created Band 4 roles with a specific skill set to provide therapeutic care to service users. The effectiveness of this role will be evaluated and the learning shared with other CAGs.

CAMHs have introduced Occupational Therapists who work within rostered numbers which broadens the skill mix on shifts. Clinical Service Leads have now implemented a clinical day into their working pattern to provide senior leadership to teams once a week.

The Psychological Medicine CAG has increased minimum staffing levels on the Mother and Baby Unit by introducing Occupational Therapists into minimum staffing levels in order to enhance skill mix and meet service user need. This has been achieved within the current budget.

The Psychosis CAG/ Acute Pathway are supporting the provision of additional staffing by utilising a float staff system in two boroughs – Lewisham and Southwark. Lewisham provides three float staff per shift, one staff member based on each of the acute wards (Powell, Clare and Wharton). These staff can be utilised flexibly across the wards in response to areas of high acuity and highest staffing demand.

In Southwark, additional float staff are booked in accordance to the needs of the four acute wards on site and the decision to book float staff and the number of staff required per shift is based on clinical judgement of service acuity.

A float staff budget is provided for both borough acute services therefore the provision of these staff does not impact on individual ward budgets.

In addition, the CAG in-patient services have recruited Band 4 staff to support the role of qualified nursing staff.


Over the next six months, recruitment will continue to be a priority for the Trust in order to reduce vacancy rates. Going forward Trust Band 5 assessment days will include interviews on the same day to improve efficiency and reduce delays in the process.

There will be a focus on ensuring teams are effective in the use of e-rostering and further work will be required with NHSP to ensure that when shifts are required they are able to be filled.
<table>
<thead>
<tr>
<th>Number</th>
<th>Action</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review progress against NQB expectations</td>
<td>Ongoing</td>
</tr>
<tr>
<td>2</td>
<td>Continue to monitor and report monthly breaches.</td>
<td>Monthly</td>
</tr>
<tr>
<td>3</td>
<td>Review the impact of new workforce models and report findings</td>
<td>Jan 17</td>
</tr>
<tr>
<td>4</td>
<td>Gain a clear measurement of enhanced levels of observations per ward</td>
<td>Sep 16</td>
</tr>
<tr>
<td>5</td>
<td>Commence roll out SafeCare module and the use of the Hurst acuity and dependency tool.</td>
<td>Sep 16</td>
</tr>
<tr>
<td>6</td>
<td>Monitor and review vacancy rates by ward/CAG</td>
<td>Nov 16</td>
</tr>
<tr>
<td>7</td>
<td>Roll out the use of the QUESTT to all inpatient wards, monitor and report results</td>
<td>Oct 16</td>
</tr>
<tr>
<td>8</td>
<td>To review progress made to ensure equity of service 7 days per week</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

14. **Recommendations**

The Board is asked to:

- Consider the issues arising from the Safer Staffing Review process
- Agree to the proposed actions in the next 6-month period
Date of Board meeting: 26th July 2016

Name of Report: Finance Report (Month 3 FY16/17)

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 2016 (month 3 FY 16/17).

Recommendations to the Board:
That the Trust Board approves the report on the financial position for June 2016

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, meet regulatory requirements and deliver to plan. The Operational Plan for the Trust is in line with its agreed NHSI target that allows a deficit of up to £4.05m to be made at Q4. A Risk Assessment Framework (RAF) is in operation with NHSI. This is being used to assess the Trust financial performance during the year and includes the requirement to submit monthly financial returns and an annual financial forecast.

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 FY16/17 plan may have implications on the Trust’s ability to deliver its equality, diversity and patient involvement commitments as set out in the Operational 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 Operational Plan
Section A – Headlines & Key Issues

- At Month 3 the Trust remains on plan, reporting a deficit of £2.6m (after application of the Sustainability Fund – see point 3 below), a favourable variance of £1.3m against our deficit control total. The favourable variance is largely due to –
  - The release of a provision which covered the costs of the Mutually Agreed Resignation Scheme. The provision did not form part of the Plan as submitted to NHSI as it was still subject to audit approval at this time.
  - The Sustainability Fund being paid ahead of Plan. This will correct itself from month 4 when both Plan and actual income will be aligned. Excluding these 2 items, the Trust was on Plan at Q1.

- Following our agreement to a new £4m deficit control total last month, the Trust resubmitted its operating plan to NHSI to reflect the necessary changes.

- Further details regarding the principles of and access to the Sustainability and Transformation Fund (STF) have been issued. Last month the Trust signed up to a new control total which included the offer of an additional £2.28m from the STF. Payment will be made via a lead CCG, in arrears and subject to a quarterly review process. The review process will cover delivery against the STF conditions. For SLaM, these conditions appear to be solely related to achievement of the quarterly financial control total, a total that excludes any STF funding to avoid a situation where a provider is penalised twice for a single issue. The STF will operate on a cumulative basis so that if the year to date total is missed in one quarter but the control total is achieved in a subsequent quarter then full payment for both quarters would be made. However there is no claw back mechanism should a provider achieve in one quarter but then go off plan in subsequent quarters. Given our performance at Q1, the Trust would expect to receive its first quarterly payment of £0.57m in full.

- Although the Trust is currently on Plan, it is important to remember that the phasing of the Plan is such that the majority of the deficit is planned for the first six months. This is largely due to the expectation that acute/PICU overspill bed usage would fall during Q1 and remain at a low level thereon, whilst a number of savings programmes would only deliver in the second half of the year. It is therefore important, after 3 months of running with the Plan, that a forecast position is undertaken to ensure we are still on track to deliver and to highlight areas of risk. To that end, each of service positions have now been reviewed by the CAGs, senior Finance team and the Chief Operating Officer to build an agreed forecast position as at Q1. This is set out in Table 1.

- Table 1 highlights both the ytd and forecast position by service including a brief narrative regarding their main financial issues and assumptions underpinning their forecast. As part of the plan to ensure discretionary expenditure is minimised, a number of CAGs and infrastructure services had year to date underspends ‘locked in’
this month, by transferring the appropriate budget and holding it as a central non recurring saving. This has distorted the in month variance positions across a number of directorates. However the underlying position remains as before with the majority of services operating within budget at month 3 and expecting to continue to do so. However, the forecast helps to emphasise what existing and future pressures will need to be addressed if we are to meet the control total.

- The overall forecast is for the Trust to meet its deficit control total. However within this there are number of risks and assumptions that need to be addressed or met. The main ones are highlighted below –
  - The use of adult acute/PICU beds is considerably higher than plan. With the planned trajectory of overspill beds rapidly reducing in Q2, the Trust is exposed should bed numbers not reduce. Although risk shares are in place, they mitigate the impact but do not eliminate it. A revised plan is taking shape under the new Director of Acute Care Pathway with the aim of eliminating overspill (bar 7 PICU beds) by the end of December. If this can be achieved, it would still leave the Trust c£3m off plan, of which £1m has already been incurred in Q1 with a further £1.4m estimated in Q2. To substantially improve on the £3m estimate would require a significant reduction in overspill from now onwards.
  - £10.1m of CIPs are planned to be delivered as part of a Trustwide set of schemes. The majority of these schemes were not due to deliver until the second half of the year but it is clear that some schemes have slipped or are not expected to deliver the value of saving originally envisaged. The MARs scheme is currently expected to contribute c£1m with the remaining amount to come from areas such as the infrastructure review, improved rostering of staff, mobile working and reductions in use of agency. In order to meet the deficit control total as set out in this forecast, we have built in some scope to mitigate against the risks of not achieving the full saving. The Portfolio Board has recently approved the engagement of a full time transformation consultant to complete the final stage of infrastructure design work and produce an implementation, consultation and engagement plan for sign off in August.
  - The Trust needs to agree the share of risk on the savings proposal to reduce NHS England’s use of external forensic placements. Currently £1m has been removed from the SLaM contract. The expectation in the forecast is that this £1m will either be saved or be returned by NHSE under the risk share agreement.
  - Other Commissioner issues are assumed to be resolved with no detrimental impact to the Trust. In particular, the savings required to bridge the funding shortfall on the Croydon CCG contract are expected to be made in full or recovered under the risk arrangements in place.

- Given the significant pressures/risks emerging in the Q1 financial position, it is important that wherever possible additional measures are taken to give ourselves some headroom and build in additional contingency. The Trust is therefore –
  - Locking in underspends by removing Q1 budgets where possible
  - Stopping further discretionary expenditure by requiring more senior level scrutiny and authorisation
  - Undertaking a review of purchase cards with a view to reducing their use where appropriate
  - Introducing further non pay controls by, for example, lowering authorisation limits
  - Seeking opportunities to slow down investment where appropriate
  - Running functional design groups in June/July to identify efficiency opportunities across all corporate functions and management support functions within CAGS
• Considering setting further savings targets to be addressed at a local level
• Reviewing the balance sheet for possible provision releases where that is prudent to do so

Progress on savings schemes and the actions being taken to reduce expenditure are being tracked through the Programme Management Office, Senior Management Team and Financial and Performance Committee of the Board.

Gus Heafield
Chief Financial Officer
July 2016
Section B - Finance Analysis

1) Financial Summary

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Year Live Budgets (£)</td>
<td>Monthly Figures</td>
<td>Year to Date Figures</td>
</tr>
<tr>
<td></td>
<td>Current Month Actual (£)</td>
<td>Variance From Live Budget (£)</td>
<td>Year To Date Actual (£)</td>
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<td>01. Psychosis</td>
<td>102,877,400</td>
<td>9,652,000</td>
<td>872,700</td>
</tr>
<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>1,930,900</td>
<td>195,600</td>
<td>57,700</td>
</tr>
<tr>
<td>03. Mood, Anxiety, Personality</td>
<td>(1,870,300)</td>
<td>(123,300)</td>
<td>238,200</td>
</tr>
<tr>
<td>04. Psychological Medicine</td>
<td>815,400</td>
<td>(173,700)</td>
<td>203,100</td>
</tr>
<tr>
<td>05. Child &amp; Adolescent Service</td>
<td>485,300</td>
<td>0</td>
<td>5,400</td>
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<td>06. MHOA And Dementia</td>
<td>2,178,300</td>
<td>192,300</td>
<td>8,100</td>
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<td>07. Addictions</td>
<td>54,376,700</td>
<td>0</td>
<td>(1,614,133)</td>
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<tr>
<td>08. Clinical Support Services</td>
<td>815,400</td>
<td>(173,700)</td>
<td>203,100</td>
</tr>
<tr>
<td>09. Infrastructure Directorates</td>
<td>485,300</td>
<td>0</td>
<td>5,400</td>
</tr>
<tr>
<td>10. Corporate Income</td>
<td>(1,870,300)</td>
<td>(123,300)</td>
<td>238,200</td>
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<tr>
<td>Operational Deficit</td>
<td>58,367,800</td>
<td>5,443,700</td>
<td>1,178,800</td>
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<td>11. Corporate Other</td>
<td>(63,320,100)</td>
<td>(6,147,600)</td>
<td>65,600</td>
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<td>12. Contingency - planned</td>
<td>2,000,000</td>
<td>0</td>
<td>(1,614,133)</td>
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<td>13. Other reserves/provisions</td>
<td>9,956,400</td>
<td>0</td>
<td>(1,614,133)</td>
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<tr>
<td>Corporate Other</td>
<td>(71,363,700)</td>
<td>(6,147,600)</td>
<td>(1,715,200)</td>
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<td>EBITDA</td>
<td>(12,995,900)</td>
<td>(703,900)</td>
<td>(536,400)</td>
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<td>Trust Financial Position</td>
<td>6,642,100</td>
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<td>(2,493,500)</td>
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<td>Items Not Included In NHSI Target</td>
<td>(2,511,000)</td>
<td>(43,000)</td>
<td>1,300,000</td>
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<td>NHSI Target</td>
<td>4,131,100</td>
<td>(135,000)</td>
<td>(1,193,500)</td>
</tr>
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</table>

2) Key Cost Drivers (unmitigated by alternative income, risk shares etc.)

Area

<table>
<thead>
<tr>
<th>Area</th>
<th>2015/16 Mth 11 Variance £000</th>
<th>2015/16 Mth 12 Variance £000</th>
<th>2015/16 Total Variance £000</th>
<th>2016/17 Mth 1 Variance £000</th>
<th>2016/17 Mth 2 Variance £000</th>
<th>2016/17 Mth 3 Variance £000</th>
<th>2016/17 Total Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Nursing*</td>
<td>(288)</td>
<td>(326)</td>
<td>(2,695)</td>
<td>(80)</td>
<td>(112)</td>
<td>(141)</td>
<td>(333)</td>
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<tr>
<td>Agency Premium @ 20%**</td>
<td>(321)</td>
<td>(355)</td>
<td>(4,272)</td>
<td>(288)</td>
<td>(330)</td>
<td>(303)</td>
<td>(921)</td>
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<td>Acute Overspill***</td>
<td>(424)</td>
<td>(722)</td>
<td>(5,742)</td>
<td>(479)</td>
<td>(184)</td>
<td>(638)</td>
<td>(1,301)</td>
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<tr>
<td>Unmet CIPs***</td>
<td>(233)</td>
<td>(481)</td>
<td>(4,350)</td>
<td>(280)</td>
<td>(283)</td>
<td>(284)</td>
<td>(827)</td>
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<tr>
<td>CPC/C&amp;V Income</td>
<td>354</td>
<td>298</td>
<td>1,140</td>
<td>(103)</td>
<td>157</td>
<td>154</td>
<td>208</td>
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<tr>
<td>Placements****</td>
<td>(275)</td>
<td>(124)</td>
<td>(2,041)</td>
<td>(79)</td>
<td>(176)</td>
<td>(217)</td>
<td>(472)</td>
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<tr>
<td>Total</td>
<td>(1,277)</td>
<td>(1,710)</td>
<td>(17,681)</td>
<td>(1,279)</td>
<td>(938)</td>
<td>(1,429)</td>
<td>(3,646)</td>
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</table>

* includes safer staffing funding ** Costs built into the plan *** see Section 3 **** before application of risk shares
Performance against the main cost drivers is detailed below –

- **Acute/PICU Overspill**

The 2016/17 Operational Plan is reliant upon previous levels of overspill falling rapidly over the first quarter. Planned acute activity trajectories have been agreed with all 4 local CCGs based on 2015/16 activity levels adjusted for a series of mitigations around length of stay and impact of our Home Treatment Teams. The graph below shows the planned overspill trajectory in 2016/17 that required a period of sustained reduction through to July 2016.

However, as can be seen, the decrease in overspill seen since March has not been maintained going into June. Early figures for July show no improvement on this with a gap opening up between plan and actual. Overall 36 beds were used outside the Trust in June, an increase of 8 compared to the previous month. This rise was exacerbated by an increase in the use of unfunded internal beds of 2 leaving a net increase of 10 beds in the month. Including internal beds, this is 25 beds above plan resulting in a £0.6m overspend in the month. In total acute/PICU overspill are now £1.3m ytd off plan excluding the impact of any risk shares. Structural changes took place to the management of adult acute beds in July with the formation of the Acute Care Pathway CAG. With its sole focus on the provision of acute care across inpatient and home treatment teams, further changes are expected over the coming months to ensure our bedstock is being managed as effectively as possible.

- **Use of Agency Staff**

Plans to reduce agency expenditure are one of the conditions attached to accessing the NHSI Sustainability and Transformation Fund. For SLam, NHSI have set a target to spend no more than £17.4m on all agency staff. Based on this target the Trust spent £5.7m ytd against all agency staff (after release of provisions in month 1) compared to a target of £6.0m. However this target is set to reduce over the remaining 9 months such that by March 2017 it will be 63% less than April 2016. The Trust continues to focus its attention on reducing reliance upon agency staff through enhanced control procedures and supporting recruitment of permanent staff.

- **Ward/Unit Nursing Costs**

At month 3 ward nursing costs overspent by £141k (£333k ytd), a decrease on the 2015/16 average but still above budgets that have been set at both safer staffing levels and adjusted to take account of additional costs of providing place of safety. Most wards/units continue to operate within plan. The main exceptions are the adult acute and PICU wards which together are £365k overspent after 3 months (£142k in the month). Out of 21 wards/units, 4 are +20% above budget, a decrease of 3 in the month.
**Complex Placements (£472k overspend excluding risk shares)**

SLaM are currently responsible for expenditure on 4 main complex placement budgets:

- **Lambeth Alliance (IPSA)** – a budget of £1.38m. Currently underspending by £58k with this forecast to continue despite having a £304k QIPP applied to it in 2016/17.

- **Lambeth Forensic** – a budget of £0.91m. Following an underspend in 2015/16, the CCG reduced their funding by £200k in 2016/17. Currently underspending and supported by a small risk share (up to £200k).

- **Southwark Complex Placements** – a budget of £5.25m jointly funded by the CCG and Local Authority. Overspent by £1.5m (before risk shares) in 2015/16 but no net increase in funding in 2016/17. There is a £0.25m risk share on the CCG element of the budget and a 100% risk share agreement remains in place on the Local Authority element via the CCG pooled funding arrangement. There is a current overspend of £532k (of which £350k is expected to be covered by the risk share arrangements) with a further £0.43m of QIPP due to be taken from October. Work is taking place with the CCG/LA to develop cost reduction measures and improve monitoring/reporting of placements but activity has been increasing in part due to an increase in forensic patients stepping down from NHS England funded secure facilities.

- **Lewisham Complex Placements** – overspent by £0.2m in 2015/16 but brought under control during second half of the year. It is currently recording a small overspend. Monthly monitoring meetings take place with the CCG following their investment in Placement Coordinators and expectation that this budget will now remain in balance.

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

After a poor start to the year, the position has continued to improve particularly in CAMHS services where both inpatient and outpatient activity is above plan and in Psychosis where activity on the rehab units has improved (partly through their use as overspill wards). The main areas of concern are in –

- Psychosis – Heather Close is £96k below target levels and a recovery plan is being drawn up.
- Psychological Medicine – not meeting activity/income targets in several outpatient services particularly neuro psychiatry and chronic fatigue.
- MAP – 25% shortfall on Cawley Day Service (personality disorder)
- B&D – lower activity in ADHD and Behavioural Genetics Clinic than plan
The Chief Operating Officer has requested recovery plans from those CAGs where income levels are significantly off target.

<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(-) At Year End £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>1,997</td>
<td>2,015</td>
<td>17</td>
<td>(54)</td>
</tr>
<tr>
<td>Behavioural &amp; Dev</td>
<td>5,361</td>
<td>5,338</td>
<td>(23)</td>
<td>41</td>
</tr>
<tr>
<td>Psychological Med</td>
<td>4,721</td>
<td>4,683</td>
<td>(38)</td>
<td>5</td>
</tr>
<tr>
<td>Mood and Anxiety</td>
<td>2,695</td>
<td>2,575</td>
<td>(120)</td>
<td>(93)</td>
</tr>
<tr>
<td>CAMHS</td>
<td>6,139</td>
<td>6,436</td>
<td>297</td>
<td>107</td>
</tr>
<tr>
<td>MHOA</td>
<td>131</td>
<td>198</td>
<td>67</td>
<td>44</td>
</tr>
<tr>
<td>Addictions</td>
<td>315</td>
<td>324</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>21,359</strong></td>
<td><strong>21,568</strong></td>
<td><strong>209</strong></td>
<td><strong>54</strong></td>
</tr>
</tbody>
</table>

3) Cost Improvement Programme (CIP)

In order to achieve its Financial Plan for the year, the Trust has set itself a challenging target of delivering savings and cost reductions of £29.2m. This target is split as to CAG schemes £14.9m, Infrastructure schemes £4.2m and trust wide schemes £10.1m. The phasing of these savings is as follows: Q1 £3.5m, Q2 £5.6m, Q3 £10m and Q4 £10.1m.

At the end of Q1, the Trust has recorded savings of £2.7m against a target of £3.5m. The shortfall has been significantly impacted by the Trust’s ongoing overspill challenges with the anticipated levels of reduction in overspill costs yet to be achieved. The ytd shortfall breaks down as follows: Psychosis £0.6m (overspill, NCA income and Heather Close), BDP £0.2m (a number of schemes delayed), Psychological Medicine £0.1m (overspill and Eating Disorders Day care), Corporate departments £0.2m (principally CEO and Nursing) net of favourable variances of £0.2m from lock in underspends principally due to vacancies.

However, the impact of continuing high levels of overspill and delays and downgrades to schemes means a forecast shortfall for the year of £2.3m (net of underspend lock ins of £1.6m). The forecast adverse variance on activity and overspill related schemes alone is £2.9m against which £0.5m of centrally held contingency has been allocated. The forecast assumes savings of £9.6m against planned Trust and CAG wide schemes of £10.1m. Within this the principal infrastructure review scheme is assumed to deliver £5.5m pending finalisation of the development of these schemes.

4) Local CCG/NHSE Contract Positions

Although contracts with all our main purchasers have now been signed off, discussions are continuing with -

- Southwark CCG – to input into various task and finish groups that are focussing on the development and delivery of savings plans and to review the on going management of placements
- Lewisham CCG – to agree an obd rate for MHOA continuing care
- Croydon CCG – to agree the detailed savings required to deliver services within the agreed financial envelope
- NHS England – to agree the share of risk on the savings proposal to reduce NHS England’s use of external forensic placements

Tim Greenwood & Mark Nelson
Finance Department, July 2016
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMH</td>
<td>Adult Mental Health</td>
<td>used in this report to cover a programme of investment in community schemes that aim to reduce the usage of acute/atriage beds in the Trust</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group</td>
<td>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</td>
<td>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>
<td></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>
<td></td>
</tr>
<tr>
<td>CPC/C&amp;V</td>
<td>Cost per Case and Cost and Volume</td>
<td>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</td>
<td>is an accounting measure used as a proxy for an organisations current operating profitability</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
<td></td>
</tr>
<tr>
<td>MHOA</td>
<td>Mental Health of Older Adults</td>
<td></td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
<td>the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day</td>
<td>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</td>
<td>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</td>
<td>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 &quot;place of safety&quot; where they may be assessed by a doctor</td>
</tr>
<tr>
<td>QIPP</td>
<td>The Quality, Innovation, Productivity and Prevention programme</td>
<td>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>STF</td>
<td>Sustainability &amp; Transformation Fund</td>
<td>that is intended to support providers to move to a sustainable financial footing</td>
</tr>
<tr>
<td>Triage</td>
<td>Triage ward</td>
<td>- 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>
<td></td>
</tr>
</tbody>
</table>
## The South London and Maudsley NHS Foundation Trust - Operating Budgets

### Corporate Analysis

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>As At Mth 3</th>
<th>Notes Re Mth 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Year Live (())</td>
<td>Current Actual (())</td>
<td>Variance From Live Budgets (())</td>
<td>Year to Date Actual (())</td>
</tr>
<tr>
<td><strong>A1) Estates &amp; Facilities</strong></td>
<td>15,879,500</td>
<td>1,332,800</td>
<td>(45,700)</td>
<td>4,235,700</td>
</tr>
<tr>
<td>Unfunded strategic capital costs, increase in Sunshine Hse costs, hire of vehicles, potential increase in cost of new transport contract and unmet CIPs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A2) Hotel Services</strong></td>
<td>10,329,500</td>
<td>882,500</td>
<td>22,700</td>
<td>2,572,600</td>
</tr>
<tr>
<td><strong>A3) Nursing &amp; Quality</strong></td>
<td>2,666,700</td>
<td>286,300</td>
<td>35,900</td>
<td>665,400</td>
</tr>
<tr>
<td><strong>A4) Finance &amp; Audit</strong></td>
<td>4,420,500</td>
<td>328,400</td>
<td>6,400</td>
<td>1,050,100</td>
</tr>
<tr>
<td><strong>A5) Human Resources</strong></td>
<td>3,548,000</td>
<td>249,100</td>
<td>43,700</td>
<td>721,500</td>
</tr>
<tr>
<td><strong>A6) Information &amp; IT</strong></td>
<td>8,610,000</td>
<td>716,500</td>
<td>44,000</td>
<td>2,130,600</td>
</tr>
<tr>
<td><strong>A7) Procurement &amp; Supply</strong></td>
<td>9,059,000</td>
<td>833,000</td>
<td>26,400</td>
<td>1,175,900</td>
</tr>
<tr>
<td><strong>A8) Medical &amp; Clinical Governance</strong></td>
<td>3,103,100</td>
<td>339,800</td>
<td>90,500</td>
<td>918,500</td>
</tr>
<tr>
<td><strong>A9) Legal &amp; Regulatory</strong></td>
<td>1,604,000</td>
<td>124,600</td>
<td>80,900</td>
<td>467,500</td>
</tr>
<tr>
<td><strong>A10) Operational Support</strong></td>
<td>2,495,000</td>
<td>286,100</td>
<td>24,400</td>
<td>1,179,900</td>
</tr>
<tr>
<td><strong>A11) Infrastructure Services</strong></td>
<td>54,376,700</td>
<td>4,572,700</td>
<td>247,300</td>
<td>13,867,700</td>
</tr>
</tbody>
</table>

### Monthly Figures

<table>
<thead>
<tr>
<th>Corporate Analysis</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>As At Mth 3</th>
<th>Notes Re Mth 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B) Corporate Services</strong></td>
<td>15,879,500</td>
<td>1,332,800</td>
<td>(45,700)</td>
<td>4,235,700</td>
</tr>
<tr>
<td>Unfunded strategic capital costs, increase in Sunshine Hse costs, hire of vehicles, potential increase in cost of new transport contract and unmet CIPs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C) Trust Services</strong></td>
<td>10,329,500</td>
<td>882,500</td>
<td>22,700</td>
<td>2,572,600</td>
</tr>
<tr>
<td><strong>D) Procurement &amp; Supply</strong></td>
<td>9,059,000</td>
<td>833,000</td>
<td>26,400</td>
<td>1,175,900</td>
</tr>
<tr>
<td><strong>E) Infrastructure Services</strong></td>
<td>54,376,700</td>
<td>4,572,700</td>
<td>247,300</td>
<td>13,867,700</td>
</tr>
</tbody>
</table>

### Notes

- Adverse acute overspill variance of £1.3m ytd comprising average of 17 beds over plan (£0.97m), payment for unused block beds (£0.18m) and shortfall on overseas/NCA income target (£0.15m). Swk placements were £235k overspent ytd (Local Authority & CCGs) offset by £248k. Under the risk share arrangements. Income targets not being met in Heather Close Rehab Unit (£26k ytd). Adverse nurse pay overspends on P6U units (£68k - ES1 - ES9k - Johnson - £107k) after excluding place of safety costs. Assumes monthly overspill numbers recover to Plan by 31/12/16.
- Behavioural Genetics & ADHD not meeting income targets & CIP targets not being achieved (£0.16m) - recovery plan requested. Community forensic costs higher than plan.
- Community vacancies & outpatient income above target. Reduction in Kent beds will start to adversely impact on income targets.
- Items Not Included In NHSI Target: £2,511,000 (43,000) (2,493,500) 2,629,700 (2,562,100) (68,400) 0
- Trust Financial Position: £57 of 117
- Operational Deficit: £58,367,800 (1,178,800) (2,493,500) 1,268,700 (5,795,000)
- Current Year To Date: £1,268,700 (5,795,000)
- Full Year Live: £58,367,800 (1,178,800)
### Table 2 - SLAM summary CIP status report

**Jun-16**

<table>
<thead>
<tr>
<th>£000s</th>
<th>Plan</th>
<th>YTD Actual</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>2,597</td>
<td>1,698</td>
<td>(899)</td>
<td>-</td>
<td>14,918</td>
<td>12,119</td>
<td>(2,799)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Corporate schemes:</strong></td>
<td>800</td>
<td>642</td>
<td>(157)</td>
<td>-</td>
<td>4,210</td>
<td>3,529</td>
<td>(680)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Trust wide schemes:</strong></td>
<td>164</td>
<td>393</td>
<td>230</td>
<td>161</td>
<td>10,105</td>
<td>11,241</td>
<td>1,136</td>
<td>1,610</td>
</tr>
<tr>
<td><strong>Trust Total</strong></td>
<td>3,560</td>
<td>2,734</td>
<td>(827)</td>
<td>161</td>
<td>29,233</td>
<td>26,889</td>
<td>(2,344)</td>
<td>1,610</td>
</tr>
</tbody>
</table>

#### CIPs / Cost Reduction

<table>
<thead>
<tr>
<th></th>
<th>Plan/Forecast by RAG per month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Red</td>
</tr>
<tr>
<td><strong>M01</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M02</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M03</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M04</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M05</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M06</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M07</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M08</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M09</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M10</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M11</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M12</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Overview comment

Forecast shortfalls in all CAGs apart from CAMHS. Principal adverse variances arise in Psychosis (Activity/Overspill/Heather Close), B&D (delayed start to schemes) and MHOA (delay re specialist care).

Significant anticipated shortfalls in CEO, Medical (proposed savings not materialised) and Nursing (complaints scheme delay).

MARs will deliver in year savings of £1m, although the remainder of the Infrastructure review scheme is not expected to deliver until later in the year. The forecast has been held at the planned figure pending further development. Delays (mobile working & rostering schemes) and downgrades (Medicines Management & New Business schemes) has generated the forecast shortfall. In mitigation, budget savings of £1.6m have been made to reflect identified underspends (principally vacancies).
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 26th July 2016

Name of Report: Performance Report

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

Author: Martin Black, Performance & Contracts

Approved by: Kristin Dominy, Chief Operating Officer

Presented by: Kristin Dominy, Chief Operating Officer

Purpose of the report:

To report the Trusts’ performance against a range of key indicators, identify any major areas of learning and success, identify and analyse under-performance and provide action plans to address such under-performance, and take due account of benchmarking information as applicable.

Recommendations to the Board:

To approve the report and note the key performance issues and the ongoing development of the performance report.

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

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

Summary of Financial and Legal Implications:

These are specified where relevant in the report.

Equality & Diversity and Public & Patient Involvement Implications:

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.

Service Quality Implications:

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.
PERFORMANCE REPORT: July 2016

Executive Summary

This month’s report summarises Quarter 1 performance against the key indicators contained within NHS Improvement (formerly Monitor) Risk assessment Framework. The Trust has achieved the majority of the indicators with two exceptions.

The report also summarises Trust performance identifying key issues and actions arising from the CAG Performance reviews in Month 2.

The report continues to be developed and this is an iterative version reflecting key Trust, regulator and commissioner priorities. Progress of key programmes including Adult Mental Health Programme, Workforce, IT, and Estates previously reported via the Transformation Dashboard are now incorporated within this report.

The former transformation dashboard content has now been incorporated into the body of this report, as per the agreement from the last board meeting.

Contents:

1. Performance against NHSI (Monitor) indicators: Quarter 1
2. CAG Performance Review Summary (Month 2)
3. Safer Staffing (May)
4. Key Corporate Programmes
5. Programme Management Office
6. Commissioning and Contracts (including CQUIN)
7. Social Care
8. Conclusion

The following Appendices are included:

Appendix A: PMF Trust Summary Month 1
Appendix B: Quality Sub-Committee Quality Dashboard (abbreviated)
Appendix C: Safer Staffing: Ward Level Detail (May)
1. NHSI (formerly Monitor) indicators: Quarter 1 Performance

The Trust has met the quarterly NHSI indicator thresholds with the exception of Early Intervention (First Episode Psychosis) and Access to Crisis Resolution / Home Treatment Team gatekeeping for admissions.

Quarter 1 performance has been completed in preparation for submission to NHSI (formerly Monitor) and is presented to Board for notification.

Table 1: NHSI Indicators – Quarter 1

<table>
<thead>
<tr>
<th>Summary Table</th>
<th>Target</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
<th>Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IAPT Waiting Times 6 Week Standard</td>
<td>75%</td>
<td>90.7%</td>
<td>91.3%</td>
<td>90.2%</td>
</tr>
<tr>
<td>2</td>
<td>IAPT Waiting Times 18 Week Standard</td>
<td>95%</td>
<td>99.4%</td>
<td>99.6%</td>
<td>99.2%</td>
</tr>
<tr>
<td>3</td>
<td>Early Intervention in Psychosis</td>
<td>50%</td>
<td>58%</td>
<td>19%</td>
<td>46.4%</td>
</tr>
<tr>
<td>4</td>
<td>Admissions had access to crisis resolution / home treatment teams</td>
<td>95%</td>
<td>95.1%</td>
<td>94.2%</td>
<td>92.4%</td>
</tr>
<tr>
<td>5</td>
<td>CPA formal review within 12 months</td>
<td>95%</td>
<td>85.1%</td>
<td>90.8%</td>
<td>95.4%</td>
</tr>
<tr>
<td>6</td>
<td>CPA follow up within 7 days of discharge</td>
<td>95%</td>
<td>98.4%</td>
<td>98.4%</td>
<td>96.0%</td>
</tr>
<tr>
<td>7</td>
<td>Minimising MH delayed transfers of care</td>
<td>7.5%</td>
<td>4.3%</td>
<td>3.9%</td>
<td>4.0%*</td>
</tr>
</tbody>
</table>

The following indicators are measured on a quarterly basis:

<table>
<thead>
<tr>
<th>Summary Table</th>
<th>Target</th>
<th>Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Requirements for access to healthcare for people with a learning disability</td>
<td>Yes/No</td>
</tr>
<tr>
<td>9</td>
<td>MH Identifiers (data completeness)</td>
<td>97%</td>
</tr>
<tr>
<td>10</td>
<td>MH Outcomes (data completeness)</td>
<td>50%</td>
</tr>
</tbody>
</table>

* Due to retrospective HSCIC reporting and production timescales the results provided for data completeness indicators have been generated by the Trust. The final HSCIC figures will be published in future.

Exception Reporting

Early Intervention (First Episode Psychosis)

The Trust has not met the quarterly target for EI due to an issue in the way in which results were reported in May which underestimated the Trust’s actual performance. Therefore, while the official Q1 position is 43.59% achievement, if the Trust had reported correctly the Q1 position would be 53.85%.

Performance in June was slightly under the target at 46.43%, in part due to the 40% increase in referrals to EI teams following the start of the target in April. Work continues with teams to improve performance and look at mitigations around the very significant increase in referrals and increasing caseloads within teams. The risk of non-achievement was indicated to NHSI in the annual operating plan, with a planned achievement of 38% in June.

Therefore, although the Trust underperformed in June its performance was higher than the original trajectory submitted to NHSI.
Home Treatment Team Gatekeeping:

The Trust has not met the 95% threshold for Access to Crisis Resolution / Home Treatment Team Gatekeeping in Quarter 1. This is primarily the result of a higher number of misses in the month of June outlined in table 2.

Table 2: Patients without access to Home Treatment Gatekeeping

<table>
<thead>
<tr>
<th>Overall Performance</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Q 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients not gate kept</td>
<td>10</td>
<td>13</td>
<td>19</td>
<td>42</td>
</tr>
</tbody>
</table>

There has been an increase of approximately 10% per month in the number of applicable admissions since April. A clinically led review and analysis of the circumstances of the patients who were not gate-kept in June has been undertaken. There was a significant proportion (42%) of a specific cohort of patients who were not gate-kept. Work with teams not making HTT referrals is being addressed at Service Director level. Of the remainder there three instances the misses were outside of the Trust’s direct control due to the patient’s being sectioned out of area or sectioned by non-SLAM doctors.

At CCG level the Trust achieved the quarterly target for Lewisham, Southwark and Croydon but was narrowly below target in Lambeth.

Table 3: Home Treatment Gatekeeping Performance by LSLC CCG’s

<table>
<thead>
<tr>
<th>CCG Performance</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Q 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon CCG</td>
<td>96%</td>
<td>92%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Lambeth CCG</td>
<td>96%</td>
<td>94%</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td>Lewisham CCG</td>
<td>98%</td>
<td>95%</td>
<td>91%</td>
<td>95%</td>
</tr>
<tr>
<td>Southwark CCG</td>
<td>93%</td>
<td>98%</td>
<td>94%</td>
<td>95%</td>
</tr>
</tbody>
</table>

The HTT developments are being undertaken. Of note HTT will be expanding coverage by strengthening the PLN out of hours coverage with effect from October. A proposal is under development for the centralisation of the triage gatekeeping proposal which will ensure patients are offered the least restrictive option of treatment. These developments are targeted at improving the quality and consistency of the gatekeeping process.

Risks

The following NHSI indicators continue to have associated risks:

IAPT Waiting Time standards:

The Trust has communicated to Croydon CCG the risk to the IAPT access standards for Croydon patients as a result of the bridging work to meet the Croydon affordability gap. This also has a degree of risk to the Trust overall performance.
MH Identifiers and Outcomes:
Mental Health Services Dataset (MHSDS) submissions continue however due to the continuing supplier delaying the availability of the AHC extraction tool the returns continue to be completed by Business Intelligence. The Trust has continued to liaise closely with Health and Social Care Information Centre (HSCIC) over these issues as this impacts on published HSCIC results in relation to completeness of data, published KPIs and accuracy.

- DQ Identifiers (Projected):

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number</td>
<td>99.20%</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>99.85%</td>
</tr>
<tr>
<td>Postcode</td>
<td>95.51%</td>
</tr>
<tr>
<td>Gender</td>
<td>99.91%</td>
</tr>
<tr>
<td>GP Practice</td>
<td>97.72%</td>
</tr>
<tr>
<td>Commissioner</td>
<td>98.89%</td>
</tr>
<tr>
<td><strong>Overall (97% Target)</strong></td>
<td><strong>98.51%</strong></td>
</tr>
</tbody>
</table>

- DQ Outcomes for CPA (Projected):

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HoNOS</td>
<td>39.60%</td>
</tr>
<tr>
<td>Accommodation Status recorded</td>
<td>88.25%</td>
</tr>
<tr>
<td>Employment Status recorded</td>
<td>45.85%</td>
</tr>
<tr>
<td><strong>Overall (50% Target)</strong></td>
<td><strong>57.90%</strong></td>
</tr>
</tbody>
</table>

Early Intervention (First Episode Psychosis):
The risk associated with this standard is if there is continuation of the increased referrals trend over the first 3 months and the potential impact on the standard.

2. CAG Performance Reviews Summary: Month 2
This section summarises the main issues and remedial actions arising from the Operational Performance Reviews occurring in June.
The Performance Management framework comprises of key performance metrics across

- Finance (including cost improvements and cost reductions)
- Operations (workforce and key activity and quality indicators)
- Patient and commissioner measures
- Learning and growth

The metrics are designed to track progress towards the Trust’s strategic direction and priorities. The Trust submitted an interim KPI Board dashboard to NHS Improvement (NHSI) as part of the Trust’s Annual Operating Plan. These metrics are included within the PMF Trust Summary attached as Appendix A. The PMF will be developed and refined further over the coming months to adapt to new priorities and learning from the performance reviews.
**Key issues**

The main themes arising from the performance reviews were:

- Review of Acute CAG transition planning and progress
- Delivery of CIP Programmes

**3. Safer Staffing (May)**

In May the Trust had 20 wards breaching over 20% of shifts consistent a slight reduction from April and May. June results are currently being finalised but indicate similar performance.

Vacancies continue to be an issue on many wards. Annual leave planning is incorporated within Operational Performance reviews to identify potential improvements in leave planning and provide assurance.

The ongoing actions in tackling safer staffing levels continue to be:

- Ongoing recruitment campaigns, both Trust wide and service specific
- Work and regular meetings with NHSP to recruiting flexible staff to improve the filling of available shifts.

The ward level report for April is included as Appendix C.

**4. Key Corporate Programmes**

**Adult Mental Health (AMH) Programme:**

The 18 month review of the impact of the AMH programme in Lambeth and Lewisham is currently underway and will be shared with the AMH Programme Board in due course. Following completion of the review there will be new metrics developed to chart impact in the next stage of the programme. The programme was initiated as a 3 year programme in Lambeth and Lewisham.

Development of the programme in Croydon and Southwark will require adaptation to reflect the circumstances of each area. The detail of which is being worked through.

**Workforce:**

- CPN Usage - There is a slight reduction in CPN usage based on the baseline measure, 98.8 WTE in compared to 103.2 WTE in May. This might be an early indication CPN agency use falling again as additionally Psychosis have a number of new starters scheduled for July. The data is based on Billing and Accruals from the Ledger.
- Appraisal - The initial figures for Appraisal indicate 92% of staff in post at the beginning of April have had their appraisal completed. HR Business Partners are following up instances of staff without a recorded appraisal to identify the reasons for this. Calibration of scoring to ensure consistency in rating is underway.

**Estates:**

*Reduce number of community properties and related operating costs*
The intention is to achieve £20m of capital planned through asset disposal in 2016/17. The impact of the Referendum may have an impact on the property market and therefore each planned disposal is being reviewed with agents to assess the market.

**Capital projects achievement against plan**
- Work Hubs – Maudsley: Programme completed.
- Trust Wide Staff Attack Alarms: Programme completed.

**Capital projects achievement against plan- Progress report**
- The suspension of the DBH programme is impacting on other minor schemes for example the ward refresh programme and some planned clinical moves. The revised estates strategy will be presented to the Senior Management team in July.

  Adamson Centre- the project team is in discussion with the clinical teams to move into 151 Blackfriars Road the target date for the move is October2016, the space for utilisation in Blackfriars and the Adamson Centre is being finalised and it is likely that some residual space in the Adamson centre will be required.

- JWH – the exchange of contracts is scheduled at the end of July’16 and completion in September’16.
- Centralised Place of Safety: This is scheduled to open in September’16

**Hotel Services:**
The results of the Patient–led Assessments of the Care Environment (PLACE) audits are due in August 2016.

The Hotel Services and Procurement team are working on the specifications for the Catering and Domestic tender. The Procurement Team is formally requesting Aramark to extend the present contract to 01st April 2017 to allow the retendering to take place.

**IT Transformation Update:**
The IT Service Desk closed 96% of incoming 303 incidents and 100% of incoming 1000 requests in June. The PC Replacement Programme is completing the roll-out for 2015/16 with a final validation exercise as additional devices had to be purchased. 2016/17 roll-out will commence once the steering groups have completed the profiling of device allocations based on staff roles. The Business Intelligence Team completed all 11 national data submission on time. The NHS number completeness rate is 99.1%. There are 613 reporting requests to the BI Team. 304 have been assessed, 20 of these were prioritised for production and 142 were identified as not requiring BI involvement.

**5. Programme Management Office**
The two highest value savings programmes, Infrastructure Review (£5.5m) and Acute Care Pathway Transformation (£5.4m) remain at risk although good progress is being made to progress plans at pace. The infrastructure design work has identified a number of savings opportunities and work is underway to produce a final design blueprint and implementation plan for sign-off. Work remains on track to begin a staff consultation process from August.
Achievement of these key milestones is expected to improve confidence around the level of savings that the programme is tasked with delivering. Additional programme management resources have been engaged to manage delivery of this work and are now in place to ensure this is achieved on time.

The new Acute CAG has been established and work is underway to develop the plans to implement the proposed changes to operational structures and services that will address the current overspill pressure and achieve a cost reduction. There is still a degree of uncertainty about the level of cost reduction that will be achieved through this programme in 2016-17 and contingency arrangements are being considered to cover any potential plan shortfall.

An emerging issue regarding the achievement of the NHS Improvement (Monitor) agency spend cap has been escalated and a programme has been initiated to address this compliance requirement. The intention is to bring together the other resource management and planning programmes (on-call rotas; rostering; shift cross over; agency staff review) and deliver this as an integrated programme because of the high level of inter-dependency and overlap. A PMO resource has been assigned to manage this.

An internal audit is underway to review and provide assurance on the portfolio management governance and management processes.

Additional PMO resources are now in place to provide more direct support to the other 20 savings schemes which are being managed as large scale projects. A review of plans and recovery actions is underway to ensure any delays and savings risk is minimised or there are plans to manage this down. The following is a summary of progress during this reporting period:

- Initial infrastructure design workshops held and outline proposal document produced
- Infrastructure design proposal challenge and assurance panel meeting held
- QIA panel meeting held
- New Acute CAG established and transformation plans defined
- PMO Senior Project Manager application process complete and interviews scheduled in July
- Programme resourcing issues resolved

The main focus for the next reporting period will be:

- Produce Infrastructure transformation blueprint document, plan and consultation principles for sign-off
- Hold infrastructure SMT Portfolio Board gateway meeting to provide assurance for the proposed changes and implementation plans
- Hold Acute Care design workshop
- Roll out new specification recruitment of Band 4 psychology assistants
- Run a short tender process to engage a digital transformation consultancy to support the initial engagement and scoping work for the mobile working programme
- Conduct forensic review of non-pay costs
- Align on-call; rostering; shift-crossover and agency cap projects into a single delivery programme
- Provide the necessary input for the PMO audit
6. Commissioning and Contracts Update (including CQUIN)

Contract monitoring meetings across LSLC are being enhanced by the clearer contract data sets based on the single source. Inpatient activity has been prioritised. The service directory is being updated to reflect new CAG structures over July and August and the Performance Management Framework has identified changes required to reflect changes in teams and structures. The progress report for the Data Quality Improvement Plan (DQIP) has confirmed that the Trust is meeting the requirements of the CCG’s agreed in the DQIP contract schedule.

The key contractual challenges are:

1. Croydon Affordability Bridge (£2.781 million): Whilst the bridge has been agreed, implementation delays have been identified in a number of areas. This has been escalated to the Croydon CFO and a recovery plan is being defined to meet the bridge. Risk shares were agreed for each bridge initiative although this is constrained by the fact that there is no additional finance if the bridge is not achieved. The independent diagnostic review of Croydon acute pathways and provision is commencing in July with an initial report in September and the potential for a more detailed second phase immediately thereafter.

2. MHOA review: The plan for reconfiguring MHOA services is not progressing to the timetable agreed in the contract negotiations and the financial impact is being assessed alongside confirmation of recovery plans. Commissioners are aware that delays will require additional funding although no formal risk share exists for this. This affects all four CCGs, primarily Southwark and Lewisham for the immediate financial impact.

3. Delivery of the Lambeth Alliance £1.9m savings plan and activity substitution on the Tony Hillis Unit.

4. An external review of Lewisham CCG plans has highlighted a £350k gap in their QIIPP reporting. There has been an initial suggestion from commissioners that this will have an impact to the SLaM contract in the current year even despite the contract being finalised. A final position to address this new problem is being sought.

5. NHSE: £220k is still under dispute these are outstanding from 15/16 (CQUIN final payments and a technical value adjustment). The main area of concern is the 16/17 contract plan to repatriate forensic placement activity to deliver a £1 million QIIPP through the value of the repatriated work being transferred to South London providers. The risk is that the repatriation will not happen and that the £1 million would be removed from the contract. NHSE has confirmed in writing that it will review the actual delivery of the programme before removing money from the contract. A detailed memorandum of understanding to confirm the process is now overdue.

Commissioning for Quality and Innovation:

CQUIN sign-off has been delayed against the original target of 30 June. LSL CCG’s CQUINS are now at a stage where the CQUINs can commence the Trust internal approval process. The Trust has proposed to commissioners that all Q1 activities and deliverables will be rolled into Q2.

Croydon CCG is still finalising the national CQUIN they are leading on (Physical Health) and the SLaM team is working to the agreed plan for this CQUIN to mitigate the impact of delay. Croydon have not produced their second local CQUIN (BME Engagement) but have provided assurance that the delay will be factored in to the anticipated outcomes.
7. Social Care

Social care performance:

A social care dashboard has been agreed with the key performance indicators from the Adult Social Care Outcomes Framework and other local measures, including AMHP data. However, development work within ePJS has been delayed and reports have not yet been finalised. A project plan will be produced by BI in liaison with Performance and Contracts in order to prioritise the delivery of the dashboard with achievable timescales for delivery. Local improvement targets will be agreed operationally within CAGs to ensure real improvement in social care outcomes is achieved in all areas.

Section 75 agreements:

The agreements are still under negotiation with SLaM and the local boroughs it serves, with the exception of Southwark which is pending the implementation of the Southwark review of social care.

Professional Social Work:

Social Work for Better Mental Health programme:

‘Social Work for Better Mental Health’ is an initiative, commissioned by the Chief Social Worker, Lyn Romeo and the Department of Health to follow up the work that was done by Dr Ruth Allen on the role of mental health social workers, for the College of Social Work. Meetings have been held with the national team leading on this work and provisional dates set for a start in September 2016.

The Director of Social Care has established a SLaM Social Work Governance group with a small group of social workers employed by SLaM and HR. The purpose of the group is to establish robust governance for the profession of social workers employed by SLaM which is clear on regulatory and professional requirements including: Continuing Professional Development (CPD) for social workers and registration with the Health Care Professional Council.

Central Place of Safety Engagement Plan:

The Central Place of Safety proposal was presented to the four boroughs Health Overview and Scrutiny Committee on the 26th April 2016. The recommendation of the committee was that a further period of engagement should take place over three months with Healthwatch, key stakeholders and partners with a particular focus on homelessness, people with no recourse to public funds and children and families; the agreement of formal arrangements with local authorities and the financial rationale for a central place of safety. A comprehensive engagement plan has since been agreed with the chair of the Health
Overview and Scrutiny Committee and progress is being monitored through the Place of Safety Clinic Project Board on a fortnightly basis. An open day has been planned, in partnership with local Healthwatch, on the 9th August to allow people the opportunity to visit the proposed site, meet the staff, hear about the proposals and contribute their ideas. The Director of Social Care has engaged with the Heads of Social Care, Directors of Children’s Social Care and Housing in each borough to discuss statutory responsibilities and formal agreements to avoid boundary disputes across the four boroughs serving a central place of safety. A workshop has been held with AMHP managers and the emergency duty teams across the boroughs to work towards an agreed AMHP service model. These discussions will form the basis of a formal protocol to be agreed across the four boroughs. SLaM is required to present the completed engagement plan to the Health Overview and Scrutiny Committee in early September and the outcome will be presented to Trust Board in September.

**Carers’ assessments:**
Carer’s assessments are a quality priority for the Trust and, following an audit of carer’s assessments, an action plan has been developed to ensure improvements are made and a target of 50% of identified carers are offered a carer’s assessment. The carer’s assessment documentation has been reviewed and the SLaM carer’s assessment form will be fully retired from ePJS on the 1st September. This will be replaced by an ‘Initial Carer’s Contact Form’ and staff guidance to signpost to local authority forms if a formal assessment under the Care Act is required.

**8. Report Conclusion**
The Trust met the key NHS Improvement indicators with the exceptions of Early Intervention (First Episode Psychosis) and Home Treatment Team Gatekeeping in Quarter 1.

Safer staffing and the associated recruitment issues continue to be a key priority for the Trust.

The Month 2 CAG Performance Reviews have been undertaken the key issues being focused on are:

- Review of Acute CAG transition planning and progress
- Delivery of CIP Programmes

There continue to be significant challenges relating to the mitigation of Croydon CCG’s affordability gap and maintaining performance standards.
Appendix A
Refer to Board Finance Report

Bank & Agency Expenditure: Nursing and Admin

Nursing Vacancies, Bank & Agency WTE Usage (YTD)

Safer Staffing: Wards Breaching 20% of shifts (YTD) Quality Priority to reduce to 10 wards

Nursing Vacancies, Bank & Agency WTE Usage (YTD)

Admin Vacancies, Bank & Agency WTE Usage

Sickness

OBD Variance Against Monitor Plan (Latest)

Delayed Discharges Days Lost

Activity

Private Overispill Summary

Adult OBD Against Monitor Plan (excl. Private Overspill)
Appendix B
QUALITY SUB COMMITTEE
SUMMARY REPORT

Date of meeting: Tuesday 19 July 2016

Name of Report: Quality and Performance Dashboard

Author: Martin Black, Tess Al-Kabi, Performance

Presented by: Neil Brimblecombe

Purpose of the report – Please indicate if the report directly relates to any of the Francis recommendations, highlighting which of the four key areas your paper covers from the list below:-

The report directly relates to the following recommendations:
1. Creating the right culture for positive challenge and positive action
2. Working with service users in a spirit of co-creation and co-production
3. Looking after staff, each other and ourselves
4. Assuring the quality of patient care in every corner of the trust

Action required:
The Quality sub-committee is asked to review the quality and performance issues within this report and identify any areas of concern and appropriate action. This may include additions to the Board Assurance Framework of Corporate Risk log (Operational risks).

Recommendations to the Quality Sub Committee:
That the report is accepted and the Sub-Committee give consideration as to how the report could be improved for 2016/17 and how we might enhance monitoring of future quality and performance issues.

Trust-wide risk(s) affected by this report and the level of assurance provided (none, low, moderate, high):
The review of service quality and performance issues supports the first principle objective of the Trust: The service user is the centre of all we do.

Equality & Diversity and Public & Patient Involvement Implications:
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.

Service Quality Implications:
There are clear implications for the safety and care of patients within these quality and performance issues

Summary of Financial and Legal Implications:
There are undetermined financial and legal (regulatory) implications.
Introduction

The QSC Dashboard has been reviewed and updated for 2016/17. It is presented for views and feedback from Quality Sub-Committee members as to further developments. This is an iterative model and further changes and functionality are planned. The key changes in 2016/17 are:

- Business Intelligence development on the new Power BI tool to allow drill down to CAG and Borough.
- Incorporation of development and learning arising from the QI programme.
- Benchmarking data will be drawn upon in line with publication and as indicated.

The report continues to be organised by the CQC Key Lines of Enquiry: Safe, Effective, Caring, Responsive and Well Led. The report will provide analysis and exception reporting as indicated.

The report will also provide written updates on:

- The delivery of Commissioning Quality and Innovation (CQUINS) throughout the year.
- There will be regular updates on progress in meeting Quality Priorities and supporting activities (for instance Patient-led assessments of the care environment (PLACE) and the roll out of E-Observations across the wards).
- At present work is being undertaken in the development of interim monitoring reports for the following Quality Priorities: Carers Assessments and Full Risk Assessments (CPA patients) completed within policy timescales. The final measurement for these priorities will be by audit but the interim monitoring alongside CAG audits will support and identify potential for improvements throughout the year.

Exception reporting:

- Private Patient overspill - there was a reduction in May but this has since reverted in June and continues to be closely monitored as there continues to high demand for Acute and PICU.
- Safer Staffing - there has been a reduction of 2 wards breaching in May. June results are currently being finalised.
- Home Treatment Team Gatekeeping was below the 95% threshold for May and performance for the Quarter to date was discussed at Performance Review with the CAG.
Safe

- Safer Staffing (Number of Wards Breaching 20% of Shifts)
- Patients in Private Overspill

- 7 Day Follow Up (Target 95%)
- Brief or Full Risk Screen (CPA Patients)
- Child Need Risk Screen (CPA Patients)

- New Serious Incidents
- Use of Prone Restraints 2016/17

- 98.0% followed up within 7 days of discharge
- 95% of patients had a brief or full risk screen
- 92% of patients had a child need risk screen

- 76 of 117
QUESTT addresses the following Metrics:

- New or no Ward Manager in post (within last 6 months)
- Vacancy rate higher than 7%
- Bank shifts is higher than 6%
- Sickness absence rate higher than 3%
- No monthly MPT review of key quality indicators (e.g. peer review or governance team meetings)
- Planned annual appraisals not performed
- Planned clinical supervision sessions not performed
- No formal feedback obtained from patients during the month (e.g. questionnaires or surveys)
- 2 or more formal complaints in a month
- No evidence of resolution to recurring themes
- Unusual demands on service exceeding capacity to deliver
- Number of hours of enhanced levels of observation exceed 120
- Ward/department appears untidy/disrepair
- No evidence of effective multidisciplinary/multi-professional team working
- Ongoing investigation or disciplinary investigation

QUESTT Commentary:

There has been an increase of wards at Level 1 in comparison to April primarily from Level 0. Another ward is also now making returns.

Gresham 1

Last month Gresham 1 scored 17 (level 2) this month the score decreased to 14 (level 1). The action plan to make the drop in score is taking effect – the new ward manager was appointed in April. 2 new Band 6 nurses have started. 2 Band 5 agency nurses will be working until September when the new Band 5’s start. The ward currently has 6 band 5 nurses.
Caring

Do you Feel Involved in your Care? Quality Priority

Friends & Family

New Complaints - SPC Chart

CPA 12 Month review
(Target 95% by End of Quarter)

IAPT (6 weeks) Target 75%

IAPT (18 weeks) Target 95%
Early Intervention results were below target for May. Overall the Trust allocated, accepted, and engaged 19% of new referrals for FEP within 14 days in May 2016 in the context of a continued 40% increase in numbers of referrals. An important factor is the accumulation of work required by the team after 2 months of unprecedented levels of referrals. A Four Borough review occurred and June results are being finalised.

Caring (continued)

Well Led

For the core skills framework subjects a total of 24 tailored training courses are provided dependent on staff type and including skills refresh.

The updated RAG rating has been applied whereby below 70% = Red, 71-84% = Amber, above 85% = Green (except IG which is 95%).

Staff Sickness

Staff Sickness rate % (rolling year %)
Date of Board meeting: 26 July 2016

Name of Report: Risk Management Update

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

Author: J Hall

Approved by: Gus Heafield, Chief Finance Officer

Presented by: Gus Heafield, Chief Finance Officer

Purpose of the report:
This report provides the Board with an update on progress on the work being undertaken to address the recommendations from the Deloitte Well Led Review in terms of the development of a robust Board Assurance Framework and to approve the revised Risk Management Strategy.

Recommendations to the Board:
The Trust Board is requested to:
a. NOTE progress on the Board Assurance Framework
b. APPROVE the Risk Management Strategy previously circulated to the Trust Board.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
The deliverables associated with the policy are core to generating robust ward to Board intelligence to support Board understanding of risks within the organisation and to addressing the recommended actions with the Deloitte Well Led Assessment. This will ultimately give high level assurance over the operation of the risk management systems and processes. Over the coming weeks and months further work will be undertaken to continually improve the quality of assurance, however it is recognised that it will take a number of iterations of updates and Board reviews over to provide evidence that the system is maturing and as such assurance at this stage and for several months may be low to moderate.

Summary of Financial and Legal Implications:
None within this paper per se but application of planned changes gives assurance on the mitigation of Financial and Legal risks

Equality & Diversity and Public & Patient Involvement Implications:
None within this paper

Service Quality Implications:
The implementation of the policy and operation of these systems will provide assurance to the Board that service quality risk will be identified and managed appropriately.
1. Introduction

Board members must understand the strategic objectives and be able to identify the principle risks which may threaten the achievement of these objectives. The board’s role therefore is to focus on those risks that may compromise the achievement of the strategic objectives.

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate strategic risks and also enables the board to gain assurance about the effectiveness of these controls.

The Trust has been focussing on reviewing and developing its BAF to ensure it meets best practice and is fit for purpose. The Board recently held a workshop with the primary aim to agree the content of the BAF. The outputs of this will now be incorporated into the final document and aligned to the 2016/17 business plan.

Underpinning the BAF is a revised Risk Management Strategy. There have been several iterations of the document the latest has been circulated to the Board for comment. These will be reviewed and included as appropriate.

Board Assurance Framework (BAF)

The BAF has been aligned to the 4PQ and Quality Improvement (QI) programmes as outlined in the business plan 2016/17:

**People** - to ensure safe staffing, real opportunities to develop new skills and career progression, and investing in staff well being

**Places** – To ensure we have buildings we can be proud of

**Platforms** – To develop IT that works for everyone; informatics to support data driven decision-making

**Partnerships** – To ensure we work closely together with people who use services, family friends and carers professionals and other stakeholders

**Quality** – That we equip everyone with the skills and support to improve quality across the organisation

**Clinical Transformation** – Working in partnership to transform clinical services, developing community based models of care, improving clinical quality and reducing unwanted variation and delivering these through new population based models of commissioning and delivery

**Maximising Value** – Manage our costs effectively while ensuring we deliver outcomes that are valued by people who use our services

As a Foundation Trust it is important that the BAF works as a tool to support the Board’s assurances in terms of self-certification on compliance with its Terms of Authorisation.

Scrutiny is important to the Assurance Framework process and the organisation’s strategic risks must be reviewed and challenged systematically.

Further work will continue over the coming weeks to strengthen the approach to robust assurance, the quality of controls and to strategically align the BAF to the Annual Governance Statement, so as to enable a focus on the board’s agenda linked to strategic risk imperatives

The BAF will now form part of the annual cycle of business of the Trust Board and be presented in its entirety at least four times a year and monthly by exception reporting:
The Boards Sub-Committees will review the BAF monthly by exception on those risks relating to its Terms of Reference.

**Risk Management Strategy**

The Risk Management Strategy has been reviewed and redrafted. The strategy was circulated to the Board for comments in May. All comments received were reviewed and where appropriate incorporated into the latest draft, this version has subsequently been circulated to members prior to the Board’s approval at this meeting. It should be noted that although the document has not been presented to Board it has been seen by the Board and will be placed on the Trusts internet as part of the public Board papers.

**Recommendation**

The Trust Board is requested to:

a. NOTE progress on the Board Assurance Framework
b. APPROVE the Risk Management Strategy previously circulated to the Trust Board.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: Tuesday 26th July 2016

Audit Committee (‘AC’)

Name of Report:
(a) AC key issues summary (overpage)
(b) Signed and sealed report
(c) AC terms of reference

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

Author: Steven Thomas (AC Secretary)

Approved by: June Mulroy (AC Chair)

Presented by: June Mulroy (AC Chair)

Purpose of the report:
The following reports are presented for the Board’s information/discussion
Item (a): key issues summary. To inform the Board about key issues noted at the Audit Committee meeting held on 28th June 2016; and
Item (b): signed and sealed report. To inform the Board about documents signed and sealed on behalf of the Trust.

The following report is presented for the Board’s approval
Item (c): AC terms of reference. This is presented in ‘track changes’ mode to flag the amendments proposed. Those amendments update the document include the Finance and Performance Committee (paras 5.6 and 5.7) and the Chief Operating Officer (para 15.1) as that committee and that role were created after the Board’s most recent approval of the terms of reference.

Recommendations to the Board:
Review and note the documents and approve the terms of reference

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
AC meetings typically cover a number of issues dealt with in the Assurance Framework. The most recent key issues discussed are those noted overpage.

Summary of Financial and Legal Implications:
AC meetings typically cover a number of financial and legal issues. The most recent key issues discussed are those noted overpage.

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

Note
To help ensure the Board papers are as concise as possible, the key issues paper (overpage) has been presented without the related AC minutes. These are available upon request.
KEY ISSUES SUMMARY (references are to the 28th June 2016 AC minutes)

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

At its meeting on 28th June 2016 the AC concluded that no matters required escalation for the attention of the Board (minutes 14.1 refer). 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.

<table>
<thead>
<tr>
<th>Key potential issues as at 28th June 2016</th>
<th>Mins ref</th>
<th>Actions proposed to address key issues as at 28th June 2016 (with timescales)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(1). Quality Committee (‘QC’) reports</strong></td>
<td>7.1</td>
<td>The AC recommends that the Board should consider its committees’ current arrangements for receiving and reviewing agenda items, and reporting thereon to the Board and to each other. The aim of such revisions should be to focus on judgments about risk (Sep.2016). Internal audit will provide SLaM management and the AC with contact details of Trusts exemplifying best practice as regards review and reporting of key risks between committees and to Boards (Jul.2016).</td>
</tr>
<tr>
<td>The meeting considered the reports from the QC to the Board. These reports are also used to inform the AC of key issues raised at QC meetings. The AC Chair noted that it was difficult for Board member readers to pick out key risks and proposed responses thereto. An AC member noted that it would assist if reports to the QC (upon which QC meetings and hence the QC’s reports to the Board were based) flagged key risks and proposed responses and/or if the QC’s agenda were based on some form of QC risk framework report. Broadening the discussion, the meeting discussed SLaM’s arrangements for reviewing and reporting risk generally, both between committees (eg QC to AC) and by committees to the Board. A key concern raised was that reporting needs to highlight key risks and judgments made about these.</td>
<td></td>
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<tr>
<td><strong>(2). Internal audit: AMH review</strong></td>
<td>12.1</td>
<td>Internal audit and the COO will further discuss reporting on the AMH Programme and the COO will report to the Board with a short implications paper. This should identify the changed circumstances affecting the AMH Programme, the key issues faced by the AMH Programme, and key options/actions proposed for addressing these (Sep.2016).</td>
</tr>
<tr>
<td>Internal audit flagged their ‘limited assurance’ opinion arising from the Adult Mental Health (‘AMH’) Programme internal audit review. The meeting discussed the recommendations and actions proposed (agenda pages 114 et seq) to address the weaknesses identified. The Chief Operating Officer (‘COO’) confirmed that these recommendations and actions appeared appropriate. The Chief Financial Officer (‘CFO’) and COO advised that the AMH Programme was effectively a prototype model which had been running for some 18 months, which was now due for review, and which would continue to be flexed to meet changing circumstances, in particular as regards the link with length of stay and the increase in volume of service users. The COO confirmed that the Programme Management Office (‘PMO’) was available to review and control this and other SLaM prototype programmes generally. The meeting discussed an AC member’s view that currently the reporting to the Board about the AMH Programme (which is a major project with high expectations) may not give the Board an appropriate impression either of the major issues that the AMH Programme is encountering, or of the options/actions for addressing these.</td>
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<tr>
<td><strong>(3). Internal audit: Information Governance review</strong></td>
<td>12.1</td>
<td>Internal audit will discuss Information Governance with the Head of Information Governance. The CFO and Head of Information Governance will present an appropriate briefing paper to the Board (Sep.2016).</td>
</tr>
<tr>
<td>Internal audit outlined the Information Governance Toolkit review and its purpose, advising that internal audit was to meet SLaM’s Head of Information Governance on 5 July 2016 to agree a plan going forward.</td>
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### 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>Value</th>
<th>Length of Time involved</th>
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<th>And</th>
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<th>Signature</th>
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<tr>
<td>140</td>
<td>12/05/2016</td>
<td>Lease renewal in respect for the Masters House and Gatehouse at Lambeth Hospital Site (1 copy)</td>
<td>SLaM Cinema Museum</td>
<td>Gus Heafield</td>
<td>Kris Dominy</td>
<td></td>
<td></td>
<td></td>
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CFO Report to Audit Committee Meeting 28th June 2016

Appendix 1

Page 85 of 117
<table>
<thead>
<tr>
<th>Number</th>
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<th>Description</th>
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<th>Between And</th>
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<td>480</td>
<td>29/02/2016</td>
<td>Agreement to support the delivery of the VBH &amp; GI Programme (1 copy)</td>
<td>SLaM</td>
<td></td>
<td>SLaM</td>
<td>Matthew Patrick</td>
<td>Emily Buttrum</td>
<td>Institute for Healthcare Improvement</td>
</tr>
<tr>
<td>481</td>
<td>19/04/2016</td>
<td>Clinical Trial Agreement led by Anthony Cleare</td>
<td>SLaM</td>
<td></td>
<td>SLaM</td>
<td>Matthew Patrick</td>
<td>Martin Baggaley</td>
<td></td>
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<tr>
<td></td>
<td>19/04/2016</td>
<td>Clinical Trial Agreement led by Prof John Strang</td>
<td>SLaM</td>
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<td>SLaM</td>
<td>Matthew Patrick</td>
<td>Martin Baggaley</td>
<td></td>
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<tr>
<td>482</td>
<td>26/04/2016</td>
<td>Agreement in respect of the Cycle to work scheme (2 copies)</td>
<td>SLaM</td>
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<td>SLaM</td>
<td>Asset Finance and Management Ltd</td>
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<td>Tender in respect of the Croydon IAPT Counselling Service from 01/04/2016 - 31/03/2017 (2 copies)</td>
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<td>26/04/2016</td>
<td>Contract in respect of the provision of Children and Young People's Emotional Wellbeing and Mental Health Early Intervention Services (2 copies)</td>
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<td>Variation to Contract in respect of the Agreement for the provision of the LCPRN (2 copies)</td>
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<td>486</td>
<td>12/05/2016</td>
<td>NHS Standard Contract 2016/17 (2 copies)</td>
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<td>Lambeth CCG</td>
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<td>Change Control Note in respect of the Agreement for the provision of Flexible Worker Services (REF: SLaM 0008) (1 copy)</td>
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<td>490</td>
<td>12/05/2016</td>
<td>Addendum to the Memorandum of Understanding in respect of the Data Sharing Agreement (2 copies)</td>
<td>SLaM</td>
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<td>491</td>
<td>12/05/2016</td>
<td>Change Control Note in respect of the Agreement for the provision of Managed Staff Bank Services (REF: SLaM 0004) (1 copy)</td>
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<td>492</td>
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<td>SLaM</td>
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<td>496</td>
<td>20/06/2016</td>
<td>Framework Agreement - rental agreement of laundry machines</td>
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<td>Solent Laundry Solutions</td>
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<td>497</td>
<td>20/06/2016</td>
<td>Change Control Note Agreement for the provision of a managed Staff Bank Service (1 copy)</td>
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<td>SLaM</td>
<td>NHS Professionals</td>
<td>Gus Heatfield</td>
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</tbody>
</table>
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 Finance and Performance 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, the Finance and Performance 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 Chief Operating 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)
<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>
<tr>
<td>September 2015</td>
<td>Audit Committee Secretary</td>
<td>Interim update to refer to the attendance of the Chief Operating Officer at Audit Committee meetings (paragraph 15.1 refers). The Board’s ratification of this change will be sought as part of the next substantive update of the terms of reference.</td>
</tr>
<tr>
<td>July 2016</td>
<td>Audit Committee Secretary</td>
<td>No changes are proposed other than ratifying inclusion of the Chief Operating Officer in para 15.1 (as noted above) and inclusion of the Finance and Performance Committee in paras 5.6 and 5.7, as that Committee was formed after the Board most recently approved the Audit Committee’s terms of reference.</td>
</tr>
</tbody>
</table>
Date of Board meeting: 26th July 2016

Name of Report: Pathology Summary Report

Heading: Governance

Author: Malcolm Goodwin & Prof. David Taylor

Approved by: (name of Exec Member)

Presented by: Prof David Taylor

Purpose of the report:
- Update the executive on Pathology matters and contract performance
- Remind Board re South London Genomic Medicine Centre – board and committee representation required for Consortium;

Recommendations to the Board:
- Maintain contract provision with Viapath
- Select commercial, clinical & scientific representatives for SL-GMC
- Review pilot Clozapine Clinic Improvement project at Tamworth Road to introduce POCHI testing in Clozapine Clinic with a view to roll out to other clinics. Review at next board.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
- Risks – Pathology Contract none/low
- Controls & Assurance: costs accrued monthly and corrected in quarter; low risk
- Lean Process training in line with QI’s IHI initiative

Summary of Financial and Legal Implications:
- Contract – Overall running to plan but with Drug Monitoring & Genetics under-performing & Clinical Other over-performing.
- Currently being invoice monthly with 1/12 contract value. True-up due in June figures later this week.
- More services to come on board e.g. Wandsworth which may improve Drug Monitoring
- Negotiated resolution of disputed “duplicates” brings further £6.5k favourable
### Equality & Diversity and Public & Patient Involvement Implications:

Pilot Clozapine Clinic Improvement has elements of improvement for patient experience including increased participation in obtaining vital signs data and improvement to clinical interview times/quality.

### Service Quality Implications:

Pilot Clozapine Clinic Improvement introduces same day testing of FBC while in clinic and facilitates reduction in call back and enables same day pharmacy dispensing. Data will be gathered to review hardware for vital signs equipment with a view to recommending a Managed service contract for equipment & maintenance.
Pathology Detailed report.

Outcomes since start of Viapath Pathology Contract commenced

1. Appointments
   a. Interim Pathology Services Manager Malcolm Goodwin started May 3rd 2016.
   b. Formerly SDM for Infection Sciences at Viapath (KSH Site.)
   c. Was part of the team writing the tender response for SLaM contract

2. Resolution of Duplicate prices
   a. Design of the group pricing into various categories resulted in same tests with variant names being allocated different prices depending on which category they were allotted to.
   b. This was successfully resolved in SLaM's favour by negotiation between initially Graeme Burgess and finally by Malcolm Goodwin & Viapath Contract team.

3. Implementation of Cyberlab
   a. Currently requests are made on paper forms and results are successfully returning back to ePJS directly.
   b. Quality of form completion is high including addition of cost centres used for cross charging to CAG’s
   c. Preparation for implementing Cyberlab electronic requesting underway
      i. Training materials have been created and will be trialled with early adopters next week
      ii. Testing of IT in test environments is scheduled for later this month and will include a restricted access post go live validation prior to complete roll out.
      iii. Complete roll out delayed due to Viapath/KCH problems affecting access to test environments and conflicts with Cyberlab. Rescheduled testing due to be complete by mid-October thus roll out at SLaM can’t start before then.

4. Implementation of PathTrak.
   a. Online manual tracking is being used by most of the larger units but several smaller units are still not implementing the new sample tracking software. These will be targeted for training by the PSM.
   b. Electronic scanners are due to arrive soon and will be installed in all areas to improve uptake of tracking.
   c. Lean process review is being used to facilitate process improvement and use of phlebotomy as well as facilitating cascade of tasks from trainee doctors to band 3 HCW’s/Admin staff and phlebotomy team.

5. Communications
   a. New pathology newsletter “PATHe-News” launched in June 2016
      i. currently targeted at trainee doctors and ward managers.
      ii. Includes articles pertinent to SLaM e.g. July edition had an article on Nutristasis & Eating disorders.
   b. PSM updated the Trainee Doctors handbook regarding Pathology and will be participating in the induction in August.
6. Liaison  
   a. PSM currently liaising with Dr Mary Doherty to review OOH pathology requesting with a view to writing a Hospital at Night Policy which includes appropriate urgent test requesting.
   b. PSM has joined Medical Devices Committee and is assisting with the review of devices for vital signs and clinical observations with a view to recommending a managed service contract for purchase and maintenance of equipment that is interfaced with ePJS and facilitates improved VAT return. Draft OBC soon to be written and reviewed by Medical Devices Committee before coming to the board in the future.
   c. PSM is facilitating a pilot process improvement workshop with Tamworth road Psychosis team next week.
      i. Aims include introduction of point of care testing for Full Blood Counts on a POCHI machine.
      ii. It is anticipated that these will be run mostly by the HCW/Phlebotomist (band 3 with some local oversite by Band 5/6 Pharmacy technicians.
      iii. Review of processes to enable same day “one stop shop” for clients with same day pharmacy dispensing
      iv. Design of new process will aim to bring improved patient participation in collecting vital signs and other clinical observations before seeing a nurse thus allowing for higher quality clinical interview.
      v. Reduces waste will be monitored and costed so that any costs for improving phlebotomy team that is required is partially offset from this improvement.

7. Pathology Contract & Finances  
   a. Currently the Viapath contract, overall, is running to plan
      i. Q1 Activity is 34,937 versus threshold of 34,885 (0.15% over performance)
      ii. The subcategories below that are operating variously (see table below:

<table>
<thead>
<tr>
<th>Total Test Volume</th>
<th>Total Contract Price</th>
<th>Monthly Invoice (95%)</th>
<th>Qtr Activity Threshold</th>
<th>Qtr 1 YTD Activity</th>
<th>Qtr 1 % Achieved</th>
<th>Qtr 2 Activity</th>
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<td>Threshold</td>
<td>£104,201</td>
<td>£529,301</td>
<td>£41,903</td>
<td>£26,050</td>
<td>12,244</td>
<td>£25,923</td>
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<td>Clinical Top 20</td>
<td></td>
<td></td>
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<tr>
<td>Drugs Monitoring</td>
<td>17,345</td>
<td>435,019</td>
<td>34,439</td>
<td>4,336</td>
<td>1,189</td>
<td>74%</td>
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<td>Clinical Top 21-100</td>
<td>16,889</td>
<td>127,496</td>
<td>10,093</td>
<td>4,222</td>
<td>4,542</td>
<td>108%</td>
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<tr>
<td>Genetics</td>
<td>125</td>
<td>23,422</td>
<td>1,854</td>
<td>31</td>
<td>15</td>
<td>48%</td>
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<tr>
<td>Clinical Other</td>
<td>978</td>
<td>29,445</td>
<td>2,331</td>
<td>245</td>
<td>1,268</td>
<td>159%</td>
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<tr>
<td>Total</td>
<td>139,538</td>
<td>1,144,682</td>
<td>90,621</td>
<td>34,885</td>
<td>34,937</td>
<td>12,244</td>
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   iii. Drug Monitoring & Genetics under-performing with & Clinical Other & Top-20 over-performing.
   iv. Clinical Other is being monitored to understand ordering patterns and over-performance.
   v. Invoices from Viapath are currently 1/12 of contract value and any under/over performance as well as corrections and amendments when errors our found by the PSM are noted each month, and trued-up in quarter.
b. **New Services to have a Pathology requirements review**
   
i. **Wandsworth Addictions**
   
   1. Currently sending pathology to St Georges (in breach of Viapath contract.
   
   2. PSM reviewing costs and services with Anthony Docherty (borough lead)

ii. **Central Place of Safety**

   1. Pathology services review to be conducted soon

iii. **Tamworth Road**

   1. Some community testing being sent to Croydon University Hospital; this will be reviewed and corrected during lean process sessions.

8. **South London Genomic Medicine Centre**

   a. Genetics UK conducting a review of service delivery of genetic and genomic medicine in UK and is working towards establishing 13 centres across the UK

   b. South London is designated as one catchment area which interested parties are being consulted with view to forming a central hub for this area.

   c. A consortium has been formed with the following groups:

      i. Guys & St Thomas’ NHS FT
      
      ii. Kings College Hospital NHS FT
      
      iii. South London & Maudsley NHS FT
      
      iv. St George’s University Hospital NHS FT
      
      v. Kings College University including IOPPN/SDGP

   d. PSM has joined the steering group and has been representing SLaM on that group.

   e. Steering group has charged its members with the task of escalating the requirements for next steps to their host Trust for agreement on representation on the consortium boards and the two sub-committees (Scientific & Clinical, and IT and Computing)

   f. **SLaM executive board needs to review the roadmap and minutes and agree who will be the representatives for these boards.**

   g. Particular reference was made on the steering committee that it was felt SLaM was under-represented on this strategically important project.

   h. PSM will take back recommendation to Steering group next month or before.

9. **Review of Pilot project for Process improvement in Clozapine Clinics.**

   a. PSM hopes to have gathered some early information from the pilot which the board may be interested in.

   b. The use of lean process improvement and A3 problem solving is in line with QI’s IHI report and project; PSM collaborating with Helen O’Kelly in QI department.

   c. **Would the board find it helpful to have a progress report for the next or a subsequent board as an early project supporting the QI initiative?**
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 26 July 2016

Name of Report: Business Development Investment Committee update report

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

Author: Altaf Kara

Approved by: (name of Exec Member) Matthew Patrick

Presented by: Alan Downey

Purpose of the report:
To inform the board of the key issues discussed at the Business Development Investment Committee.

Recommendations to the Board:
To note the report.

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 key items discussed in this meeting relevant to the assurance framework was the CAMHS in Abu Dhabi, Addictions Commercial Strategy and the Croydon APA.

Summary of Financial and Legal Implications:
- **Abu Dhabi** – the committee welcomed further updates on the service with financial headlines.
- **Addictions Strategy** – a market analysis and CAG review was beneficial to understand the challenging financial setting which the CAG operates in.

Equality & Diversity and Public & Patient Involvement Implications:
All items of discussed in the meeting were required to provide assurance that the E&D and PPI implications had been considered.

Service Quality Implications:
The committee acknowledged the relationship between financial pressures and service quality when discussing the Addictions paper.
Business Development and Investment Committee
Sub Committee of the Board
18 April 2016, 12-2pm, Maudsley Boardroom

Attendees: Martin Baggaley (MB)
Graeme Burgess (GB)
Kristin Dominy (KD)
Alan Downey (Chair) (AD)
Angela Flood (AF)
Gus Heafield (GH)
Olivia Howarth (OH)
Altaf Kara (AK)
June Mulroy (JM)
Matthew Patrick (MP)
Adam Pryce (AP)

Guests: Jo Fletcher (JF)
Deborah Heron (DH)
Eleanor Bateman (EB)
Emily Finch (EF)
Siobhan Jackson (SJ)
Heather Gilmour (HG)

Apologies: Roger Paffard (RP)
Stephen Docherty (SD)
Kris Dominy (half meeting attendance)

Meeting administration
- The minutes of the last meeting were agreed as accurate.
- There were no new declarations of interest
- Altaf Kara was welcomed as the new Director of Strategy and Commercial.

Action Tracker

- **Ethics committee** – AK reported on a brief discussion with Al Beck. A paper will follow in due course.
- **Recovery and related services** – Further discussion is required – the Maudsley Charity needs to be involved, as it currently funds the Recovery College.
- **Genomics** - MP reported that he had met with Matthew Hotopf and Shitij Kapur. There is a nominated lead at the BRC but a conversation is needed to facilitate a handover from commercial to that person. In the longer term we need to recruit or train a clinical geneticist who can fully engage with this agenda.
- **E&T centre of excellence**. Louise Hall will take the discussion forward, involving the commercial team.
- **Intellectual Property** - Emily Buttrum is continuing to lead this piece of work and an update of the IP policy is scheduled for a future meeting of BDIC.
Abu Dhabi
Jo Fletcher, Deborah Heron

The committee was updated with the financial headlines and service update.

- In the absence of a comprehensive business case at the outset, we now need a clear financial and operational plan against which we can monitor performance. AK, JF and DH will work this up for a future BDIC.
- It will be important for BDIC to receive a further update of any other commercial opportunities in the region.

Summary

A focused paper on the base case and on monthly reporting will be prepared for the committee.

Action: AK, JF, DH, MB

Commercial Strategy for the Addictions CAG
Eleanor Bateman

The purpose of the report was to provide an overview of the addictions market and to endorse a commercial strategy for the Addictions CAG that supports its business plan.

An analysis and review of the current market was discussed.

Croydon APA
Graeme Burgess

There was an update on the current arrangements from the Commercial Finance Manager.

KHP Haematology and Cardiovascular Strategic Outline Cases
Heather Gilmour

A paper was presented to inform BDIC of progress on the Strategic Outline Cases for developing the KHP Haematology and Cardiovascular networks and institutes. These are Part of the KHP Institutes development programme, agreed by the partner organisations.

The committee noted the update and gained a better understanding of the issues at stake.

AOB - Tender pipeline

- Strategic Commercial Manager updated on the tender pipeline.
**TRUST BOARD - SUMMARY REPORT**

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<td>Name of Report:</td>
<td>Chief Executive’s report</td>
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<td>Heading: - (Strategy, Quality, Performance &amp; Activity, Governance, Information)</td>
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<td>Author(s):</td>
<td>Paul Mitchell, Trust Secretary</td>
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<td>Approved by (name of Executive member):</td>
<td>Dr Matthew Patrick, Chief Executive</td>
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<td>Presented by:</td>
<td>Dr Matthew Patrick, Chief Executive</td>
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**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:**

| No specific issues in this report although the report regularly highlights equality & diversity issues arising from the local health economy and nationally in the NHS and Social Care. |

**Service Quality Implications:**

| No specific issues in this report although a number of the national issues regularly listed in the report will have an impact on the quality of services provided by the Trust. |
Chief Executive’s Report
July 2016

1. The national and international backdrop

It is only a month since the last Board meeting but it is important to reflect on the amount of change that has taken place in such a short space of time.

I reported verbally at the June meeting on the outcome of the referendum which had decided that the country would leave the European Union. I subsequently sent a note round to all staff making it clear the value that I and all on the Board places on the contribution made by our staff who come from other parts of Europe and beyond.

The result of the referendum has led to a change in the government with Theresa May taking over from David Cameron as Prime Minister and making a large number of changes to Cabinet and other ministerial roles. One of the few people to remain in their original post is Jeremy Hunt, who continues Secretary of State for Health. I would like to pay particular thanks to Alistair Burt who resigned as a Minister prior to the reshuffle. He was a strong supporter of SLaM both in the provision of our local services and more recently abroad in Abu Dhabi.

I would also like to note the devastating loss of life in Nice and the deeply troubling coup attempt in Turkey.

2. Future NHS funding

A number of commentators have started to discuss the longer term impact of recent events on the NHS.

The King’s Fund have suggested that key targets must be relaxed if finance is to be the top priority. They have said that the government may have to review its key waiting time targets and the feasibility of a seven-day NHS as it comes to terms with the fact that the health system can no longer meet demand and deliver current standards of care whilst also staying within its allocated budget.

In a major report on the NHS deficit, the King’s Fund has called for realism and honesty with the public around the state of NHS finances and what it can achieve until 2020. According to the report, saving £22bn will not be one of these achievements.

Citing the massive £1.85bn deficit that providers and commissioners reported in 2015-16, the King’s Fund said that cuts in staffing and reductions in quality are inevitable if the government’s priority continues to be restoring financial balance.

This is especially true in a post-Brexit landscape, with the political and economic uncertainty left by last month’s vote to leave the EU meaning health and social care funding could face further cuts to offset financial shocks.
The report also recognised that new models of care focused on transforming services offer “significant opportunities” to improve care, but stressed these initiatives needed time and investment and would not deliver savings in the short term.

There are also real opportunities to deliver better value by improving clinical practice and reducing waste, as advocated by Lord Carter, but these are unlikely to be achieved at the pace or scale needed to save £22bn by 2020-21.

3. NHS Improvement framework

In the meantime NHS Improvement has published its new “Single Oversight Framework” for consultation. This aims to provide an integrated approach for both FTs and NHS Trusts, across regulation and performance management and to renew its offer of support.

Under the proposals, all Trusts will be placed in one of four segments depending on their performance. The five domains within the framework are:

- Quality of care (using ratings in 4 of the 5 CQC domains plus progress against standards for implementing 7 day services)
- Finance and use of resources (being developed with the CQC and including progress against control totals and efficiencies)
- Operational performance (largely reflecting existing national targets and based on a Trust’s agreed performance trajectory)
- Strategic change (a domain yet to be fleshed out in detail, this section will focus on progress on implementing STPs, and where applicable devo deals)
- Leadership and improvement capability (building on the existing well led framework to capture good governance and leadership and to introduce a focus on capacity for improvement)

4. Launch of the new Psychological Medicine and Integrated Care Clinical Academic Group

Following the reconfiguration of Adult Mental Health CAGs resulting in the creation of an Acute Care CAG, headed up by Hugh Jones and Jo Kent, services from Psychological Medicine and Mood, Anxiety and Personality Disorder (MAP) CAGs have been merged to form a new CAG called Psychological Medicine and Integrated Care. The name is intended to reflect the two foci of the new CAG, namely mind and body interfaces, and community and locality facing services and integration.

The leadership team is:

- Dr Ranga Rao – Clinical Director
- Neil Robertson – Acting Service Director
- Simon Darnley – Acting Deputy Director
- Professors Matthew Hotopf & Alan Young – Academic Directors

5. Forensic services
I am delighted to confirm the announcement by NHS England that a south London partnership including SLaM has been chosen as one of six sites for testing new approaches to mental health care. In our case the work focuses on the forensic care pathway.

We are all acutely aware that we have a shared responsibility to help prevent future south Londoners becoming the next generation of service users which is why we are working together to understand the wide-ranging needs of the population we serve and ensure that we do all we can to enhance their resilience and break the toxic cycle of ‘assumed inevitability’ linked with poor education, poverty, crime and mental ill health.

We will work together with patients to fundamentally reframe how secure mental health care services are commissioned and delivered across south London. We will do this by redesigning care to improve quality and experience, and increase the value for money of our services. To achieve our ambition we will:

- focus on bringing back into local care south Londoners who are being treated outside of south London;
- create a single point of referral for our services, linked to budgets;
- take a fresh look at how we can develop specialisms, such as women’s services, across our geography;
- invest in the transition from inpatient to care closer to home, shifting care towards a strong community offer;
- build on our approaches to improving the quality of the care we provide.

6. **New Medical Director**

I am delighted to report that after and very competitive process, Dr Michael Holland has been appointed as the new Medical Director of the Trust. He is currently the Trust’s Deputy Medical Director and Chief Clinical Information Officer. Prior to this he was Associate Medical Director and brings to the role very significant clinical leadership experience, most recently leading the Trust’s work on quality improvement and revalidation. Dr Holland was first appointed as a consultant psychiatrist at SLaM in 2003, having finished his specialist registrar training within the Trust.

Dr Holland is a Non-Executive Director at Recovery Focus and a visiting Senior Fellow at London School of Economics. He was a Fellow at the NHS Institute for Innovation and Improvement. He has also worked as an Improvement Advisor to the Improvement programmes delivered in NHS South West and NHS South.

Michael will take up his post in the autumn following a handover period with Dr Martin Baggaley.

7. **NIHR Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King’s College London - Competition 2016**
The Trust is tremendously proud of the fact that it hosts the only mental health Biomedical Research Centre (BRC) in the Country. The BRC is a partnership between the South London and Maudsley NHS Foundation Trust (SLaM), and King’s College London (KCL), which houses the Institute of Psychiatry, Psychology & Neuroscience (IoPPN), Europe’s leading academic centre for mental health research. This five year award is now coming to an end and the BRC team, led by Prof. Matthew Hotopf (BRC Director), has been working tremendously hard to fashion a strong application for renewal.

The proposal for renewal of our BRC was submitted in June. The proposal targets mental health, pain and dementia which include 13 of the 25 most “burdensome” health conditions.

Building on the successes of our BRC over the past five years, we will focus on four major aims:

- Precision Psychiatry
- Novel Therapies
- Translational Informatics
- Outcomes for people with both physical and mental illness

On July 19th I was part of a seven person team who presented to a large NIHR panel. We expect to hear about whether the Trust is successful in the autumn, but in the meantime I would like to pay tribute to the BRC team lead by Matthew who did an excellent job in creating a compelling plan for the future.

8. NHS Improvement Faculty conference

Finally, on Thursday 14th July I took part in an NHS Improvement Faculty conference last week. I represent mental health on Jim Mackey’s NHSI Faculty and was speaking about quality improvement, looking at both the opportunities and challenges presented. It would seem that there is now an increasing momentum around this approach to quality and productivity and it is very good that we are in the vanguard of developments.

Dr Matthew Patrick  
Chief Executive  
June 2016
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 26 July 2016

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

Presented by: Chris Anderson, 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 has an active role in the development of the quality of services via the CoG working group and the observer status on the Board’s QSC. The CoG bids programme specifically welcomes bids which “improve the patient experience”.

1. **Planning and Strategy Group** (Angela Flood)

**Background and Welcome**
The members of the Planning and Strategy Working Group represent the interests and views of different stakeholders - service users, carers, staff and appointed stakeholder organisations. The group is pleased to welcome Altaf Kara, Strategy and Commercial Director, and Alan Downey, Non-Executive Director (Planning and Strategy portfolio), who will be in attendance at future PSWG meetings. Their knowledge, skills and experience adds value to the group which looks forward to working with them on strategic and related developments.

**Links with other groups**
The PSWG values its link with other committees and working groups to inform and help shape its own remit going forward including: involvement in the forthcoming meeting with the external auditor regarding the recent Quality Report; the development of a Quality Improvement briefing for governors; BDIC emphasising the importance of clarity around key information to help determine both risk and reward, ready availability of good information for effective decision making, the need to clarify the Trust identity and to understand what our ‘brand’ means to our stakeholders; the work of the Governance Committee around risk and driving forward quality in different areas; the ISR group providing a link between the involvement of service users and carers in strategy development and consequent issues connected with service delivery.

**Data issues**
Data collection, analysis and reporting following the last three ‘Have Your Say’ meetings remain outstanding and the Governors hope that this will be addressed soon. It is essential that our constituents feel that their input is valued and contributes to the decision making process.

**PSWG meeting 5th July**
With regard to potential amendments to the ToR, members have requested a review of license conditions, the Board assurance framework and approach to risk management.

The Agenda included two key presentations which, although different in content, demonstrated shared issues connected to service delivery, patient care and new models of care:

1) **SLaM Strategy and Commercial Director**: early impressions of Trust strengths and opportunities alongside the challenges of medium term sustainability, adult overspill and nurse staffing, involvement, communication and engagement with our stakeholders, emerging priorities and the need for effective processes to underpin them.
2) Croydon CCG Chief Officer: Mental health in Croydon and the 2016/17 priorities: impact of high numbers of older people, looked after children, asylum seekers (children and adults), high prevalence of severe mental illness; higher spend on inpatient services; joint SLaM/CCG review has been commissioned to better understand the drivers behind increasing pressures; the STP presents both opportunities (prevention and early intervention), and challenges (improving access and care redesign).

DONM: Tuesday, 15th November 2016, 5:00-6:30 pm, Boardroom, Trust HQ.

2. Quality (Jenny Cobley and Marnie Hayward)

The Quality Working group usually meets quarterly, but this year we will probably have an additional meeting to learn more about quality issues. We are pleased that Anna Walker and Amanda Pithouse are now members of our working group. We are also grateful for active executive support from Amanda Pithouse and useful informal meetings with Mary O’Donovan, Cath Gormally and Edith Adejobi. Carol Stevenson continues to take the minutes of our meetings.

Our last meeting was held on 7 July when we discussed the Limited Assurance Quality Report from the External Auditors (Deloitte) and received an update on the CQC Action Plan from Amanda Pithouse. At our previous meetings we have had presentations on Complaints and the Quality Improvement Programme. In February we agreed that Carers’ Assessments should be the Local Indicator Quality Priority for 2016/17. We also reviewed the draft Quality Accounts and a reply was produced for inclusion in these Accounts. The group has invited Cath Gormally to give a presentation on the implications of the Care Act for SLaM. In future we are also due to look at complaints procedures and to undertake more scrutiny of data. We look forward to a training session on the Quality Dashboard and some involvement in internal audits.

Current concerns:

1. **PPI policy.** The Group fully supports the proposal for a PPI policy, to go to the next Board meeting. This has been produced as a result of the CoG’s review of the Trust’s response to the Francis Report.

2. **Facilities on some wards.** Governors were invited to join PLACE teams at the Maudsley and Ladywell and were concerned by the poor facilities on some wards and poor maintenance at Ladywell. We hope that the current estates programme will continue to improve facilities for patients.

3. **Staff recruitment and retention.** Governors are concerned that it is difficult to maintain safe staffing levels on some wards. We have suggested that it may help to offer more accommodation to staff, bearing in mind the high cost of housing in London. It has been suggested that KCL might be able to help with this.
4. **CQC report.** The Group welcomed the 'Good' report from the CQC and recognise the determined efforts of the Trust to provide safe, effective, caring, responsive and well led services. However, governors have had a number of questions about some of the findings in the CQC report. Many of these have been answered by the Action Plan and Amanda Pithouse’s presentation to our AwayDay in April. We are grateful to NEDs and others who have recently answered the remaining questions.

3. **Governance** (Chris Anderson)

The Governance Committee will be meeting on 21 July 2016, main items for consideration are:

- Governors Development Strategy and Programme.
- Governor to NED questions protocol.
- Engagement Policy.
- Combining of Membership and Communications working group and ISR.
- Service User Governor support policy.

4. **Membership and Communications** (Dele Olajide)

**Council of Governors elections**
The closure for nominations for the CoG elections is Monday, 25 July 2016. There are vacancies in the service user local, public carer and staff constituencies. At the time of writing, 14 candidates have expressed an interest in standing.

5. **Bids group** (David Blazey)

**Meetings**
The group usually meets at least quarterly, but more often if there is a need. There hasn’t been a meeting since the last report.

The next steering group meeting will be on **Monday 22nd August at 3.30pm.**

We would welcome any other Governors to subsequent meetings and events, and particularly to contribute to the assessment and scoring of bids in the new “Let’s Smile” scheme (see below).
“Let’s Smile” 2016-2018
As of 1 July (the deadline for applications) we have had 303 expressions of interest and (provisionally) 180 bids (60%) for Let’s Smile. This compares to 344 expressions of interest and 194 bids last year (56%).

Assessment and scoring sessions will take place on Thursday 4th, Tuesday 9th August and Wednesday 17th August, all from 1.00 to 4.30pm. Please contact Carol Stevenson if you’d like to be involved.

Paul Mitchell
Trust Secretary
July 2016

F: / cog update report July 16
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A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST WILL BE HELD ON 13TH SEPTEMBER 2016 AT 12:30PM, LEARNING CENTRE, MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence:

2 Declarations of Interest

3 Patient Story and Carers Story Update

4 Minutes of the Board Meeting held on 26th July 2016

5 MATTERS ARISING/ACTION POINTS REVIEW

6 Discuss – Engagement with Carers Update (action April)

7 Discuss – Q1 Incident & Complaints Report

8 Discuss – Engagement Policy Update (action April)

PERFORMANCE AND ACTIVITY

9 Approve – Finance Report Month 4

10 Approve – Performance Report

11 Discuss – Workforce Update

12 Discuss – Estates Update


GOVERNANCE

14 Information – Report from the FPC June Meeting

15 Information – QSC Update

16 Information – BDIC June Meeting Update

17 Information - Report from the Chief Executive

18 Information - Update from the Council of Governors

INFORMATION

19 Directors Reports

20 Actions summary from today’s meeting

21 Reflections on today’s meeting

22 Forward Planner and Draft Agenda for October Meeting

23 Report from previous Month’s Part II

24 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.

web site: www.slam.nhs.uk
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Date of Next Meeting: Tuesday 1st November 2016 – 3:00pm, Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ

Please send apologies to Alison Baker 0203 228 4763 alison.baker@slam.nhs.uk
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 26 July 2016

Name of Report: Report from previous month’s Part 2 meeting

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

Governance

Author: Paul Mitchell, Trust Board Secretary

Approved by: Matthew Patrick, Chief Executive

(name of Exec Member)

Presented by: Roger Paffard, Chair

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.

Action required:
To note.

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
# Date of meeting – 28 June (Part 2)

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<tr>
<th>Ref</th>
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<th>Summary of discussion</th>
<th>Lead Director</th>
<th>Reason for taking in P2</th>
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<tr>
<td>BOD PTII 37/16</td>
<td>SUI update.</td>
<td>Update for the Board on two SUIs.</td>
<td>Martin Baggaley</td>
<td>Patient confidentiality.</td>
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<tr>
<td>BOD PTII 38/16</td>
<td>Infrastructure review.</td>
<td>Update for the Board.</td>
<td>Gus Heafield</td>
<td>Commercial in confidence.</td>
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<td>BOD PTII 39/16</td>
<td>STPs update.</td>
<td>Update for the Board.</td>
<td>Altaf Kara</td>
<td>Commercial in confidence.</td>
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<td>BOD PTII 40/16</td>
<td>McKenzie ward closure.</td>
<td>Approval of the ward closure.</td>
<td>Kris Dominy</td>
<td>Staff and commercial confidentiality.</td>
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<td>BOD PTII 41/16</td>
<td>Croydon bridge.</td>
<td>Update on the current negotiations on the Croydon CCG contract.</td>
<td>Kris Dominy</td>
<td>Commercial in confidence.</td>
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<td>BOD PTII 42/16</td>
<td>Forensic services.</td>
<td>Update on the development of combined work across the three south London mental health Trusts on forensic services.</td>
<td>Matthew Patrick</td>
<td>Commercial in confidence.</td>
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PNJM/July 2016