Board of Directors Meeting

To be held 31st October 2017
3:00pm Learning Centre, Maudsley Hospital

AGENDA: Part 1

Opening Matters (1 of 1)
1. Welcome, apologies for absence, declarations of interest

Presentation
2. Quality Improvement – update and work plan with IHI 2017/2018
3:00pm Page 2
3. Patient Story - Safeguarding
3:20pm Page 12
4. Progress Update on Joint Initiatives with KHP - Professor Sir Robert Lechler
3:35pm

Opening Matters (1 of 2)
5. Minutes, Action log review
3:50pm Page 16
6. Chief Executive’s Report
3:55pm Page 32

Strategy
7. Development of SLaM Digital Strategy
4:00pm Page 34
8. Venturing Principles
4:15pm Page 40

Governance
9. CQC Re-Inspection Report – Adult Community Pathway (paper to be circulated when the embargo is lifted)
4:25pm

10. Council of Governors September Update
4:30pm Page 45
11. Quality Sub Committee September Update
Page 47
12. Audit Committee September Update
Page 49
13. Finance & Performance Committee October Update
Page 51
14. Business Development & Investment Update
Page 53

Performance
15. Performance Report
4:40pm Page 54
Page 82

For Noting
17. Conflicts of Interest Policy & Gifts and Hospitality Policy
Page 95
Page 127
19. Report from previous Month’s Part II
Page 135
20. Wrap-up, Next Meeting and Meeting dates for 2018
Page 137

The next Board of Directors Meeting will be held on 28th November 2017
at 3:00pm, in the Learning Centre, Maudsley Hospital

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
Purpose of the paper

1. To provide an update of the progress of QI work in the Trust and priorities for the next six months
2. Present the work plan with the Institute for health Improvement (IHI) for year two (October 2017-September 2018)

The board is requested to discuss and agree the priorities and work plan with the IHI.

Executive summary

The purpose of paper is to provide an update on progress of the QI work plan and the priorities for the QI team for the next 12 months. The paper provides a summary of the IHI first annual review and presents the recommended work plan for the next 12 months with the IHI.

QI team work progress
The QI team have delivered against the agreed work plan. Key points to note are:

QI communications. There have been some improvements, however there continue to be a number of problems with improving visibility. This is being addressed and the new QI communication manager who commenced work on 11/09/17 is making quick progress.

Building capacity and capability
The improvement advisors (IAs) are successfully delivering the improvement science in action training (ISIA) and leadership training and this has significantly reduced the cost of delivery. The feedback and subsequent team QI projects demonstrate the high standard of training. One GP federation in Southwark have taken up the offer of places on the leadership and ISIA training. As demand is expected to increase, a plan will need to put in place to balance the needs of SLaM and partners.

Progress on trust wide QI initiatives
The Large-scale initiative for adult acute care has increased in pace and will be supported by the IHI in 17/18. The 4 steps to safety sustainability plan for inpatient services and the development and implementation of safety improvements in the community work has commenced. The staff engagement QI plan which was approved by the board in September has commenced with the testing out of change ideas. This work will be linked with the wider Trust engagement work.
Work Plan with IHI
The IHI will be co-presenting the proposed work plan to enable the Trust to progress the work in the following areas:

- QI team support and additional QI capacity building
- Support for SLaM QI Programmes and Value-Based Health Care- (care process models, large scale initiatives,
- Data Training and Senior Level Mentoring on Use of High Level Data
- Leadership Support

Recommendation
The board is asked to approve the work plan with IHI
Section One: Progress against work plan reviewed at the board in June 2017

Since the last board update in June 2017, the QI team have continued to work at pace to progress the work plan. Outlined below is an update of progress against the work plan followed by priorities for the QI team for the next 6 months.

QI team recruitment: We have successfully recruited to three new QI leads and a Communications manager, staff commenced in these new posts at the start of September 2017. We have also recently recruited a team administrator who will be starting soon. Secondment opportunities have been offered for internal staff to work as QI facilitators for 12 months. Two people have been successfully recruited and will commence work with the team in November 2107.

Building capacity and capability

The investment in the IHI improvement advisor training has resulted in the QI team being able to successfully run both leadership training and Improvement science in action training for staff internally. The internal training has been very positively evaluated. It has reduced the cost and the evaluations and QI projects run following the training demonstrates that people are applying their learning in practice. To date 280 staff have attended the Improvement science in action (ISIA)training and 80 leaders/managers have completed “My role as a leader in QI”. The Trust has also trained its first cohort of QI mentors (12). In addition to this, CAMHs clinical QI lead has successfully tested QI awareness sessions (150 staff attended) and 90% of staff said that because of this they would be more likely to sign up for further QI training. The method and findings will be shared with other CAGs over the next two months. A co-produced introduction to QI course starts at the Recovery college this autumn.

The central QI team needs to agree with the CAGs/corporate teams how best to maintain the enthusiasm and engagement, ensuring that there is sufficient time and resource to enable people to put their improvement skills into practice.

Engagement, participation and Involvement in QI

The principle of co-production is being used in the design and development of all quality improvement projects. The Recovery College has been running sessions within the Quality Improvement training days on understanding co-production and some Quality Improvement projects have involved service users and carers in their inception. Gabrielle Richards has now started working with the Quality Improvement team, the EPI central team and the PPI leads in CAGs to develop a clear plan for coproduction in QI. They will be working with service users and carers to develop the draft driver diagram, which outlines the way forward to embed co-production into Quality Improvement Trust wide.

Communication and engagement plan

The QI communication and engagement plan presented in the last board paper (June 2017) is in place and progress has been slow. The QI team has started its first QI campaign “ask me about QI”. This will run for the month of October, and our learning from this one will inform future campaigns. The new communications manager is now in post and the QI team will now take the lead role in QI communication. The staff diagnostic work reported to the board in September as part of the work to develop the aim and driver diagram to improve staff engagement has also helped to raise the profile of QI. Do follow us on Twitter, @SLAM_QI.

QI Engagement with Partners

We have offered places on the QI training for primary care and CCGs and have had attendance from Southwark GPs. Southwark GPs have requested further places in the coming year and we are working with Lambeth CCG to open up places for their practices. As part of the SLP, places have been offered to Oxleas mental health trust. We regularly meet with QI counterparts within the South London Partnership and are starting to develop joined up QI programmes across the partnership as well as sharing learning.
Senior leadership quality and safety walk round review

Following the tests of change completed over the summer and in discussion with board, executive members and staff, there is a new plan in place which will be tested over the next 3 months and will be circulated to NEDs for their involvement in next 2 weeks. The aim is to develop a more consistent approach to the walk rounds, improve the administration, increase the number of teams who have visits and test a more robust and reporting and measurement method.

Large scale QI initiatives

1. 4 Steps to safety – The final report to the health Foundation for the work completed with inpatient wards has been submitted and the Institute for health Improvement (IHI) are working with the QI team to agree how best to embed and sustain improvements. The diagnostic work to support improvements for safety in community services has commenced.

2. Improving adult mental health acute care: the second collaborative event, led by the Trust and supported by the IHI took place in September. The day was very well attended (120 people) and was positively received. There was a focus on practical work to develop further ideas for improvement that are now being tested. This work also forms the basis of more detailed work with the IHI to progress the development and implementation of care process models for the adult inpatient service (see section two) and data presentation within the teams.

3. Progressing improvements in staff engagement: The QI plan for this work has started and will be incorporated into the wider staff engagement work in the Trust.

Developing as a data intelligence driven organisation

The QI team are working in conjunction with contracts and performance and the programme management office (PMO) and services (clinical and non-clinical) to develop and improve the consistency and accuracy of data so that teams can use the data to inform their decision making and improvement work. The third test of change for the QI dashboard was developed in September and this will be tested again at the Quality matters meeting on 24.10.17. This work will increase in pace in year two with the support of the IHI (section two)

Priorities for the next 12 months for the QI team

1. Complete QI recruitment
2. Ensure work plan proposed with IHI is executed so that the agreed objectives are achieved in the next 12 months (section two)
3. Maintain the progress to build the capacity and capability in the Trust in QI methodology including new training with the Recovery College and governors
4. Support people to more explicitly align QI activity to the Trust’s overall quality improvement plan
5. Develop and implement plan for coproduction for QI
6. Agree a framework with CAGs to report progress on QI
7. Support corporate departments to become more actively involved in QI in their services as well as with clinical services

Section Two: Institute for Health Improvement (IHI) review September 2017- and Work plan October 2017- end of September 2018

The IHI have been supporting SLaM with our quality improvement journey and conducted a visit to review our progress in September 2017, with the following aims:

1. To explore progress since the diagnostic visit in May 2016, including successes and opportunities for improvement
2. To gather views from throughout SLaM on the lived experience of quality improvement in the organisation
3. To shape the next 2 years of work together in service of accelerating the pace and scale of improvement.

During their visit, they met with many different groups across all boroughs and CAGs within the trust including the senior management team, service directors, non-executive directors, governors, Improvement Science in Action (ISIA) teams, teams involved with the large-scale initiative in adult mental health, and service users, carers and governors. Invitations were also extended to partners, who were unable to attend sessions.

The IHI were impressed by what they saw and what they heard. At one year into our work we are still early in this journey, they reported that we had made good progress at this stage. Figures 1 & 2 show a summary of the identified assets in SLaM and the areas for future improvement.

Figure 1: Current assets for building a culture of continuous improvement
Next steps and moving forward

As well as evaluating our current position the IHI considered how we might progress our achievements in the coming year. They emphasised the importance of maintaining and increasing the pace and momentum of the work.

To maximise the impact of our effort they suggested:

1. Sustained executive attention from a coalition of executive directors and senior/middle leaders and managers
2. Constancy of purpose and shared leadership. (Pursuing a single agenda around quality, being disciplined with the methodologies and being clear that we need leaders explicitly working together across the system to achieve the overall Trust QI goals)
3. Creating time and space for the work
4. Building an agile, fast-moving central QI team that can operate without seeking permission
5. Building a locally accessible QI support infrastructure
6. Capability building within the trust at pace and scale
7. Data for improvement used across the trust in all areas
8. A new communications approach that is innovative, optimistic, and persistent
There was some specific advice for the senior management team:

1. Consistency of data visualisation within the board report and a focus on data over time
2. Leadership visibility is important, including structured leadership walkarounds, opening and closing the QI programmes and increased communications with clarity of message
3. Corporate improvement projects which are linked to the strategic priorities for the trust
4. Developing fluency in improvement language and the improvement programme at SLaM

It was noted that governors would benefit from being kept more informed of the work, with stories shared with them and a standing item on the council meeting regarding QI. It was also suggested that they may wish to be involved in their own improvement project.

Although the IHI noted the asset at SLaM of having a motivated and involved service user and carer group they also recommended that:

1. Training for service users and carers in quality improvement methods be expanded and more easily available
2. Service users and carers should be encouraged and supported to lead projects, not just to be involved in them
3. Involvement of Slam Staff service users and carers in QI campaigns.

**Our response to the IHI recommendations**

1. A revised work plan with the IHI to be presented to the board on 31st October 2017.
2. The development of a clear plan for service user and carer involvement and co-production is in progress. An introduction to QI has been co-produced with the Recovery College.
3. QI training dates to continue to build capacity and capability have been set until end of March 2018. Dates from April onwards will be available in December.
4. The QI team are in discussion with corporate departments about how to become more actively involved in QI.
5. Work continues at pace to develop a more robust data system so that teams can have access to their data.
Section Two: Outcome of IHI review- Work plan October 2017- end of September 2018

As a consequence of the IHI review, the following revised work plan has been proposed with the IHI and the QI team on behalf of SlaM. This requires discussion and agreement with the on 31st October and the IHI will be part of that discussion.

Proposed work plan with IHI

<table>
<thead>
<tr>
<th>Element</th>
<th>Activity</th>
<th>Output</th>
<th>Outcomes October 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element 1: QI Team Support and Additional QI Capacity Building</td>
<td>Sessions will be a combination of learning events by IHI team and presentation of successes/challenges by SLaM QI Team with discussion and mentorship Working with the SLaM QI Team to create specific learning sessions for Trust staff to enhance skills to execute Trust-wide initiatives</td>
<td>Support of SLaM QI team in the Science of Improvement and QI project management including building additional skills, providing support and mentorship, and facilitating learning among team members.</td>
<td>The QI team demonstrate their skill and knowledge in enabling successful delivery of Trust wide QI programmes of work</td>
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<td>Element 2: Data Training and Senior Level Mentoring on Use of High Level Data</td>
<td>Measurement Workshop for 20 people, 2 days on-site, any materials needed for training. Development of SLaM Executive Measurement Strategy with senior leaders and managers (November 2017)</td>
<td>Business managers are better able to use and understand data for improvement and measure progress over time SLaM Leadership Team is aligned on SPC. The system of measurement contributes to the overall strategy of improvement at SLaM. Selection of high level measures to gauge overall performance of SLaM</td>
<td>Visible evidence that data is reported and used at team level using run charts and SPC charts to inform clinical decisions and improvements Visible evidence that newly agreed upon Executive Measurement Strategy (that is being developed) is being used to guide decision making at the Executive Level and the informatics system is reliable</td>
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<td>Element 3: Leadership Support</td>
<td>SMT bi-monthly coaching calls Virtual coaching on leadership topics (including Walk Around Support to start) Leadership’s use of Data for improvement - 1/2 day workshop on-site with wider Executive Team (about 25-30 people)</td>
<td>Leadership at SLaM understand and support the work of the QI team and partnership with IHI. Leaders continue to conduct Walk Rounds systematically and the information gathered during Walk Rounds is shared with point of care staff and SMT. Leaders understand their role in the use of practical data for improvement.</td>
<td>Evidence from team meeting minutes, conversations and feedback from staff and others that the senior team are modelling QI leadership behaviours</td>
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<td>Annual deep dive - final one in Autumn 2018: 1 day of site visits, 1 day of joint planning and design</td>
<td>IHI team has a deep understanding of ongoing work and progress. IHI and SLaM teams have dedicated time to co-design future work together</td>
<td>Demonstrable improvement in QI projects demonstrating improvements in quality and cost, leadership modelling QI Tipping point achieved (20%)</td>
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<tr>
<td>Weekly review and planning/challenging/support calls</td>
<td>Shared understanding of the current state of the overall IHI/SLaM body of work including all 5 elements' progress to date</td>
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**Element 4: Support for SLaM QI Programmes and Value-Based Health Care**

**Large Scale Initiative Adult Mental Health:**
- Quarterly in-person learning sessions, monthly virtual calls with teams, every other month in-person support and ongoing virtual support
- Creation of Care Process model for Adult Mental Health: design, prototype, large pilot in multiple wards across all four Boroughs

**Large Scale Initiative 4 Steps of Safety:**
- Inpatient: Adult Mental Health (will be reviewed as part of the Adult Mental Health Acute Care) - focus on spread to all wards and sustainability within wards

**Initial wards are moving towards achieving results in outcome measures, and have demonstrated improvement in process measures for work already underway from year 1.**

**Creation of care process model for adult mental health, outcomes in prototype wards, initiation of pilot testing in wards across all Boroughs with data collection and process measure improvement beginning.**

**Spread process has started of successful change.**

**For Care Process Model (CPM) for acute inpatient care and a Segment of Schizophrenia Care:**
**Months 0-4:**
- Development of CPM based on strong evidence, fully articulated with operational definitions and rationale noted
- Measurement strategy in place to know the changes are leading to improvement

**Months 4-7:**
- Initial prototype testing and modification of CPM if appropriate

**Months 8-12:**
- Pilot Testing in wards across all four Boroughs with early results in process measures leading towards results in outcome measures.

**For Inpatient: Demonstrates reduction in violence and aggression in inpatient wards by 50% from baseline from 2016**
<table>
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<tr>
<th>Already embedded; Inpatient: Older Adults, Child and Adolescent Mental Health, Forensic Services, Other Psych Medicines Services - continued support for those who have initiated, spread to new wards, creation of a sustainability plan, modification of approach to be appropriate for local wards (in particular CAMHS) - Community: Creation of content, prototype and pilot testing across all services in SLaM</th>
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<tr>
<td>Inpatient Older Adults, CAMS, Forensic, Other Psych Medicines: modification of change package to be appropriate for local change, initiation of changes in prototype and pilot wards, improvement in process and outcome measures Community: creation of solid change package for community changes. Process level changes in pilot units. Beginning of spread plan.</td>
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<td>Continued support for SLaM to become a data-intelligent driven organization focused on data for monitoring, improvement, and value-driven care</td>
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<td>Decisions at SLaM are guided by the use of data for improvement. Ongoing monitoring for data for quality assurance, quality improvement and quality planning is routine. Outcomes data is linked to cost data with the intent to deliver value-based care for all service users.</td>
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<td>- At the end of 12 Months - Full completion of QI training - Modification of interventions to be appropriate for CAMHS, Forensic, Other Psych Medicines - Overall 50% reduction in violence from baseline data. Demonstrates consistent use of interventions to sustain best practice. For community safety intervention (CSI). There will be evidence that staff and service users and carers have been engaged, content of interventions developed and tested in all areas For Inpatient: Quality and cost data will be linked routinely to be able to demonstrate not just improvement in patient and staff outcomes but also delivery of value-based care - tying financial data to the outcomes achieved.</td>
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The Service User story

This story is about a 45-year-old black British man of Nigerian decent who was found dead at his accommodation within one month of being discharged from hospital. At the time of his untimely death he was diagnosed with schizo-affective disorder and type II diabetes. Mr A had a long mental health history with numerous formal admissions to hospital often preceded by criminal activity and involvement with the police. Between admissions Mr A was under the care of community teams, although he had some more stable periods it was in general difficult to offer treatment with any consistency since Mr A had a history of disengaging from services, stopping his medication, and going missing from his address for weeks or months at a time. He was described as typical of service users who required an assertive outreach model of care and prior to the re-organisation of Southwark services he was under the care of the Assertive Outreach Team. Although he was diagnosed with type II diabetes in 2008 he was noted to be non-concordant with medication and often failed to comply with his diabetes care.

In May 2012 Mr A was formally admitted on section 2 of MHA, following being arrested by the police for trying to break into a house. On admission he was very unwell showing signs of relapse of his mental health condition. He was restarted on medication and progressed fairly well on the ward. An OT assessment undertaken during his admission found that he had the functional skills required to live independently as long as he maintained stable mental state and engaged in community services. His mental state continued to improve and at a ward round on 12th July 2012 he was thought to be ready for discharge but accommodation was required.

On the 4th August 2012 he was found collapsed on the ward and was admitted via ambulance to Kings College Hospital, being initially nursed in intensive care. Whilst in Kings Hospital he was found to have unstable diabetes and started on insulin treatment. A diabetic nurse met with Mr A to explain how he could manage his diabetes better, it is unclear how much of this he understood or whether he had the capacity to understand what was being discussed. On return to the ward he was referred to the dietician and a care plan was developed around his physical health and monitoring of diabetes and insulin. A discharge CPA was held on 9th August 2012 and his care co-ordinator attended. It was agreed at this meeting that he was ready for discharge but that accommodation and Community Treatment Order (CTO) needed to be agreed.

On 14th August 2012 Mr A was found to have a high blood glucose level and was advised to go to King’s Hospital but he declined. The duty doctor was again called on 18th August 2012 and Mr A was found to have a high blood glucose level due to poorly controlled diet. He refused to attend King’s Hospital and the nursing team monitored him for signs of deterioration and completed two hourly blood glucose monitoring. During his admission he was seen by the dietician on several occasions and they provided advice on diet and how to manage his insulin and diabetes. Their advice was that he would benefit from further education and that this should be done via his GP practice.

A final discharge ward round was held on 23rd August 2012 but not attended by any of the community team. A discharge date was set for 28th August 2012 as accommodation had been found. The community
Consultant met with Mr A on 24th August 2012 and completed his Community Treatment Order (CTO). A final discharge ward round was held on 24th August 2012 but there were no members of the community team present. He was discharged from hospital on 29th August 2012 to temporary accommodation out of borough in Streatham. He was discharged on anti-psychotic medication and insulin and given a two-week supply.

His care co-ordinator was on annual leave at the time of discharge but he was offered a seven day follow up appointment with the community team duty worker on 3rd September 2012. He did not attend this appointment and following discussion in their MDT meeting on 7th September 2012 he was offered a second appointment by letter to see his care co-ordinator on 12th September 2012. He was also sent a letter inviting him to see his community consultant on 18th September 2012.

Mr A did not attend for his depot medication on 10th September 2012 or his planned appointments on 12th or 18th September 2012. On 12th September 2012 the care co-ordinator documented a plan to do a home visit the following week. This home visit did not take place and another letter was sent inviting him to attend the team base on 24th September 2012. Mr A did not attend this appointment and a home visit was carried out by his care co-ordinator on 25th September 2012 but there was no response. A further plan was made to send a letter inviting Mr A to attend for an appointment. On 27th September 2012 the community team.

What we did well

Inpatients:

- Attempts were made by the team to educate Mr A about his diabetes and management of it with insulin.
- The dietician was actively involved and provided education about management of diabetes.
- An assessment of Mr A’s capacity to accept treatment was made and clearly documented.
- There was a care plan about how to manage his physical health whilst an in-patient.
- EPJs records clearly documented the issues Mr A had in managing his diabetes effectively.
- A discharge CPA did take place on 9th August 2012.
- The consultant psychiatrist knew Mr A well as he had previously been his consultant in the community.

Community:

- There was consistency in care co-ordination as the current allocated person had known Mr A for several years.
- The care co-ordinator did attend a Care Programme Approach (CPA) meeting held on the ward on 9th August 2012.
- The risk assessment and CPA document were updated after this meeting (but did not contain information about his change in management of diabetes)
- The team did liaise with other community services once Mr A did not attend for 7 day follow up.

When Mr A did not attend his 7 day follow up an initial plan to follow up was made and documented.

What we did not do well

Inpatient:

- There was clear evidence of a breakdown in communication between the in-patient and community team.
- There was no discharge summary completed.
• There was no clear documented evidence that the community team were informed about the change in his diabetes management.
• The dietician clearly stated that he would need on-going support with his diabetes from his GP once discharged. However, there is no clear documented evidence of a plan about how his physical health would be managed in the community at the point of discharge or if this was communicated to the community team or GP.
• The CPA meeting was completed several weeks prior to his actual discharge date.
• There was not a member of the community team present at the final ward round before discharge.
• There was no clear documentation that the community team were informed of his discharge or what the discharge plan was for managing his on-going mental or physical health needs
• Mr A did not have a GP and was placed in accommodation out of the borough
• The inpatient team felt that there was a lack of involvement by the care co-ordinator once Mr A was admitted to hospital.
• Delays in finding accommodation affected his discharge date

Community:

• The CPA document and risk assessment written by the care co-ordinator following his attendance at the CPA meeting did no mention any change in his diabetic control or his recent emergency admission to Kings College Hospital.
• A home visit was not carried out on date agreed and no rational as to why was evident within the notes. Therefore the suitability of the accommodation was not assessed.
• A home visit was not attempted until 25 days after discharge.
• There is no documented evidence of the MDT discussions and agreed action plan or the outcome of agreed interventions.
• There was a breakdown of communication within the team as both Consultant and Team manager believed a home visit had been attempted prior to 25th September 2012.
• Mr A had a long history of poor engagement, it was not seen as unusual that he had not attended appointments. This may have influenced the community team’s clinical decision making not to escalate their concerns and increase the number of attempts to contact him after he failed to attend his 7 day follow up and planned depot.
• The care co-ordinator expressed that his capacity to manage his caseload effectively was compromised by his caseload size and amount of work he was required to do.
• Mr A was placed in temporary accommodation outside of the borough which did not meet his support needs.
• Consultant psychiatrist, care co-ordinator and team manager all clearly stated at the time that they were not aware of the change in management of his diabetes.

What we will do now

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<tr>
<th>No.</th>
<th>Action Plan</th>
<th>Owner</th>
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<tbody>
<tr>
<td>1</td>
<td>Pre-discharge Planning - Wards and community teams have access to the GP database to check who patients are registered with. Patients are supported to access / register with GPs. All patients will be assessed for their suitability for HTT prior to discharge. The CC is invited to the pre-discharge meeting. A discharge checklist is in operation on inpatient wards. The ward undertakes a 7/7 day follow-up audit. The North West Southwark community team have</td>
<td>WM, TL</td>
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<tr>
<td>1</td>
<td><strong>Minimum standards for community contact</strong> – The Team monitors Care Coordinator visits to the ward, this is discussed in MDT meeting weekly and recorded in minutes. The ward is given the dates and who will be attending the meetings. The team can check who attended WR if required. There is also more pro-active liaison between the inpatient and community consultants, for example emailing issues and having informal discussions about patients.</td>
<td>TL/ Team CONs</td>
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<td>2</td>
<td><strong>Seven Day follow up</strong> - Monitored via MDT weekly meetings and recorded on the MDT template, dates of pending seven day follow ups circulated to team. The team prefers to see patients face to face. Although if patient is discharged to stay with family out of the area, they will undertake follow up via telephone. If they are unable to locate patient they will contact other professionals, carers or family etc until the patient is located.</td>
<td>WM, TL</td>
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<td><strong>Managing Complex patients</strong> - The wards use MEWS protocol, there is access to tissue viability and other professionals. There are OTs on all the wards providing input and support. The Community team has zoning in place, supervision, and have developed a <strong>Clinical Formulation</strong> meeting, this meeting is available to all staff to discuss complex and challenging patients, devise a clear plan and provide a weekly update. In terms of managing Did Not Attend (DNAs) – home visit undertaken, if no contact, telephone call to patient, relatives, other professionals for example housing. Letters will be sent offering another appointment and further home visits undertaken. Improved management of patients on Community Treatment Orders</td>
<td>WM /TL / Ward / Team CONs</td>
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<td>4</td>
<td><strong>Managing Caseloads</strong> - Caseload audit undertaken monthly by Business Managers / Team Leaders. Caseloads managed within supervision, using My Team Dashboard. Assertive discharge planning has improved caseload management. There are additional opportunities for patients to be seen in other venues post discharge from the team, for example clinic at Guys Hospital and or transfer to other teams, Staying Well Team. If caseload exceeds a specific number it will trigger a number of interventions which include meeting with the Consultant and TL, focussed supervision and support to discharge or explore other interventions for the patient.</td>
<td>TL / Team CONs</td>
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<tr>
<td>5</td>
<td><strong>Managing Physical Health</strong> - Inpatients – A Physical healthcare strategy is in operation and a MEWS protocol. There is well established physical health care (PHC) training for all staff. The new Modern Matron roles are taking a lead role on the management of PHC. In the community on-going discussions are taking place regarding roles and responsibilities between secondary and primary care re PHC. New IT developments, for example My Team Dashboard, -New physical health screen on EPJS have enabled improved review of physical health care monitoring and supportive interventions. Supervision, CQUIN target, -CPA reviews have also focussed teams. Southwark Teams have access to Southwark portal which enables them to review patient notes in a number of GP surgeries, Kings Health Care and Guys and St Thomas’ this information is monitored at monthly pathway performance meeting. All CPA letters to GPs ask about monitoring of PH conditions documented, and identify those patients who do not engage. Some physical health care conditions noted as an alert on EPJS. The team undertake a monthly physical health clinic. This is well attended and the team piloted the use of a Physical Health POD which was very popular with patients. The assessing of capacity is systematic including discussion about best interests.</td>
<td>WM / TL</td>
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</table>
MINUTES OF THE HUNDRED AND TENTH MEETING OF THE BOARD OF DIRECTORS
OF
THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 19 SEPTEMBER 2017

PRESENT

Roger Paffard Chair
Kristin Dominy Chief Operating Officer
Alan Downey Non-Executive Director
Rachel Evans Director of Corporate Affairs
Professor Ian Everall Non-Executive Director
Mike Franklin Non-Executive Director
Duncan Hames Non-Executive Director
Gus Heafield Chief Financial Officer
Dr Michael Holland Medical Director
Dr Julie Hollyman Non-Executive Director
Altaf Kara Director of Strategy and Commercial
June Mulroy Non-Executive Director
Beverley Murphy Director of Nursing
Dr Matthew Patrick Chief Executive
Sally Storey Interim Director of Human Resources
Anna Walker Non-Executive Director

IN ATTENDANCE

Barbara Barter Clinical Psychologist Item BOD 116/17
Andy Bell Director of Finance
Lucy Canning Interim Associate Director of Strategy and Commerce
Jenny Coble Interim Associate Director of Strategy and Commerce
Catherine Collins Involvement and Engagement Lead Item BOD 116/17
Sarah Crack Head of Communications
Arleen Elson Chair BME Staff Network;
Angela Flood Governor
Marnie Hayward Governor
Charlotte Hudson Deputy Director of Corporate Affairs
David James Business Manager Trust Secretariat (Minutes)
Michael Kelly Deputy Director of Human Resources
Brian Lumsden Deputy Lead Governor
Anne Parris Senior Behavioural Support Practitioner
Zoe Reed Freedom to Speak Up Guardian

APOLOGIES

None

DECLARATIONS OF INTEREST

None
MINUTES

The minutes of the Board held on the 25 July 2017 were agreed, as an accurate record of the meeting. The Chair was content for the minutes to be regarded as signed by him on this date

BOD 115/17 MATTERS ARISING/ACTION POINTS REVIEW

The progress made on action points was noted.

Action: Roger Paffard/Rachel Evans

BOD 116/17 PATIENT STORY

The presentation was by Barbara Barter, Clinical Psychologist; Anne Parris, Senior Behavioural Support Practitioner and Catherine Collins Involvement and Engagement Lead

The Board were informed that the individual described in the presentation was now deceased but family permission had been sought and granted for this presentation.

Abi was a lady with a significant learning disability who did not communicate verbally. She lived at home with her parents and had close family network who regularly visited the family home. Abi attended a local day centre in South London five days per week and had been there for 15 years.

A physiotherapist during a visit to the day centre had questioned why she was wearing arm splints, which restrained her arm movement. This triggered a review by colleagues and from records, observations and discussions with staff and family members it became evident that Abi had a history of sucking her hands.

This had resulted in harm to Abi as her skin had broken down. Ten years previously there was a recommendation by the learning disability team to put arm splints in place as a means of reducing harm. At the time it was recommended that she wear the splints for no longer than 15 minutes in every hour.

When the team met Abi she was wearing these splints throughout the day with no break however her family removed these as soon as she got home. They never felt able to challenge the day centre on this matter.

The team supported the day service to remove the arm splints and through positive behavioural support supported the staff to engage with Abi and find more creative, less restive ways to prevent her from sucking her hand for example, taking her splints off at mealtimes when she was engaged, increasing meaningful activity and using gloves to prevent her skin breaking down.

Roger Paffard on behalf of the Board thanked the team for their presentation.
Mike Franklin expressed the shock he believed the whole Board felt that this situation had occurred and carried on for so long. He asked how this could have happened. Barbara Barter replied that the original recommendation was not for continuous application of the splints and no record of why the practice had been changed could be found, but it was suspected that the application and removal had slipped over time to a point where they were not taken off at all while at the day centre. Systems to prevent this situation reoccurring were now in place with regular reviews of physical restraints by the Trust.

Anna Walker observed that one positive aspect of the story was that the situation was spotted and addressed. Her view was that in the area of Learning Disability there is a need for constant review as the approaches to care and treatment are constantly changing.

Beverley Murphy thought the presentation very thoughtful and the Board should note that restrictive practices need not just involve physical restraint. Standards and a Strategy are in place but there is a need to have a Trust culture whereby actions and behaviours can be challenged in an open and non-threatening manner. She added the team should feel proud of their achievements with this patient.

The Board

Noted the Report

BOD 117/17 CHIEF EXECUTIVES REPORT

The paper was taken as read.

Matthew Patrick began by welcoming Professor Ian Everall and Sally Storey to the Board as this was the first Board for both of them. A welcome was also made to the members of the Black, Minority and Ethnic Staff Network who were attending the Board as they had been involved in developing a paper on race equality that was on the agenda.

The Board was informed that the Directors of Nursing across Oxleas, South West London and St George’s and the Trust are leading a Nursing Development Programme, which will improve career opportunities across the three trusts to address the challenges in attracting and recruiting nurses.

This new programme is being rolled-out with funding support from Health Education England. The three Trusts are working to design nursing roles that support high-quality care and are as positive and fulfilling for the job-holder as possible. The programme was launched in July 2017. Mention was also made of work to develop physician associate programmes as new ways to recruit staff are, and will be needed.

Lambeth Clinical Commissioning Group (CCG) and Lambeth Local Authority (LA) are working on the commissioning of a “Living Well Network Alliance contract” (LWN Alliance) to lead, co-ordinate and manage support and services for those experiencing mental health issues in Lambeth. The contract will include community support, crisis, beds, vocational services, and voluntary sector offers such as supported accommodation, housing, welfare advice and peer support.
The CCG and Local Authority launched their procurement process in early March 2017 by inviting interested Alliances to submit an Expression of Interest. The Trust, Local Authority, Thames Reach and Certitude formed an Alliance to bid for the contract, and submitted a joint response. Over the summer the Commissioners chose our Alliance to move onto next stage of negotiation.

This form of population based contract is seen as the way forward and discussions are under way with other borough to see if the model can be expanded beyond the boundaries of Lambeth.

The Board

Noted the Report

**BOD 118/17 WORKPLACE RACE EQUALITY**

The paper was presented by Zoe Reed.

At its meeting in May 2017, the Board received a report setting out the foundations to secure equality and inclusion within the Trust; especially for Black Minority and Ethnic (BME) staff. That report also included the Trust’s Workforce Race Equality Standard metrics for 2016/17. From these figures it was clear that in a number of areas BME staff had less favourable access, experience and outcomes.

The Trust Board and Senior Management Team, led by the Chair and Chief Executive, have identified improving the experience of BME staff within the workforce as a key organisational priority. Three clear targets were set by the Board for achievement by 2021. The Board asked the Tackling Snowy White Peaks working party to develop proposals to achieve the target aspirations and bring them back to the Board in September 2017.

The purpose of the report was to set out the first year of a 4-year Implementation Plan to achieve three targets. These are: Band 8c and above – proportionate representation; Disciplinary Proceedings, proportionate referral and Career Opportunities, reported proportionate access.

Roger Paffard commended the commitment of the BME Staff Network toward the delivery of the proposals. It was noted this was the start of a process and gaining trust and confidence will be a long term aim that will require a ‘leap of faith’. But good progress had been made.

Mike Franklin gave thanks to Zoe Reed, Arleen Elson and Michael Kelly for all their efforts and congratulated the Board on its commitment to this programme shown by the involvement of the Chief Executive and Chairman. There was still work to be done, as there was a need to balance openness with the requirement for confidentiality. But this work was a positive first step.
Julie Hollyman asked if there was an effective feedback system to those candidates who applied for jobs but were not short listed or appointed as this could assist with future applications. Sally Storey noted the observation and would ensure feedback was available.

Duncan Hames referenced his observations at a previous Board about agencies being aware of the Trust’s commitment to a diverse workforce. With this in mind he was surprised that an agency used recently by the Trust to recruit to a high level post had been engaged again even though its recent work for the Trust had seen BME applications fall away very early in the recruitment process. Sally Storey responded that the need for the Trust to attract applicants from a diverse range of candidates would be communicated to the agency in question.

**Action: Sally Storey to contact recruitment agency to ensure focus on having a diverse pool of talent being sought for appointment**

Anna Walker requested that staff survey results be used to record how well the Trust is doing in this area of work. This was agreed. Matthew Patrick thought the Trust should be aware of the Board’s commitment to equality and it was agreed that the communication function would ensure the detail of the paper was made known to staff.

**Action: Communications to inform Trust staff of Board’s commitment to Race Equality**

The Board

**Noted** the report

**BOD 119/17 MORTALITY REPORT**

Michael Holland introduced the paper and a brief background was given to the Board.

All deaths, both of those under our care and discharged within 6 months from service, now receive a mortality review which is carried out by senior doctor. This involves a case note review to determine whether there was any quality of care problems that may have resulted in death. Deaths are identified from the ONS feed and reported to the CAGs for review.

The most common cause of death, (74%) had physical health causes as the underlying cause. Within these the highest number were categorised as: circulatory system; neoplasms/cancer; or diseases of respiratory system.

To ensure consistency in the review process the Trust has adapted two frameworks to use for the Mortality Review. Permission was given to use the Mazars framework used to review deaths are part of the independent review into deaths at Southern Health NHS Foundation Trust with an adapted version of the grading system for case reviewers from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Alan Downey observed that the report had clearly highlighted the predominant causes of death were physical and the strategy for the Trust regarding this issue had previously come to the Board on two occasions and found to be unsatisfactory. He asked when the third version would be produced and he was assured that an updated strategy would be with the Board before the end of November 2017.

**Action: Updated Physical Health Strategy to Board by November 2017**

The Board noted that guidance for the compilation of mortality data for mental health trusts was limited but the Trust was working with colleagues in Nottingham and Sheffield to develop the best system for future use.

Anna Walker asked where the detail from serious incidents that did not result in death were located and used. Beverley Murphy observed that such events are learning tools for the Trust and it was agreed further work would be required and is on-going on how to use the data from such reports.

**The Board**

**Noted** the Report

**BOD 120/17 PUBLIC INVOLVEMENT - UPDATE**

A verbal report was given by Beverley Murphy.

In December 2016 the Board approved a Public and Patient Involvement (PPI) policy which would focus on CAG delivery of involvement activities. An outcomes framework was requested by the Board and this is due to come to the Board in December 2017.

There were reported to be good examples of PPI work within some CAGs but there is a lack of consistency across the Trust. The need to improve consistency and to move on from involvement towards co-production is recognised as a necessary development. Work is also progressing with the assistance of Altaf Kara and Lucy Canning linking staff and patient involvement strands within the Trust.

A ‘deep dive’ into PPI across the Trust has been arranged for November 2017 and a report to the Board is planned for January 2018.

Julie Hollyman observed that a PPI oversight group had been established but it was still developing and more work was required to make that group less bureaucratic and more meaningful for service users, especially with the planned move towards co-production.

**The Board**

**Noted** the Report
BOD 121/17 LESSONS LEARNED QUARTER 1 2017/18

The paper was presented by Beverley Murphy.

All NHS provided services have a responsibility to meet the Duty of Candour. The Trust meets this duty in a number of ways, one method being the sharing of lessons learned in public with the Board on a quarterly basis.

The report provided information about themes of lessons learned and performance data regarding adverse incidents including complaints, incidents, serious incidents, safeguarding activity, claims, Central Alerting System (CAS alerts) and Inquests. The report also noted internal safety bulletins.

Lessons emphasised in the report included the need to care for people closer to their home and the need to work effectively across boundaries with other NHS trusts. The lessons learned have been aligned to the Trust’s large scale QI initiative with the aim of improving care in adult mental health.

Roger Paffard asked if the report had previously been seen by the Quality subcommittee and he was assured it had, but due to time constraints not all the comments at the subcommittee were within the Board report.

Roger Paffard asked if the intention was for future reports to go first to the Quality subcommittee before the Board. Beverley Murphy replied that was the intention, but if the timings of meetings did not allow for this the report would come directly to the Board. This was agreed.

The Board

Noted the Report

BOD 122/17 UPDATE on the QUALITY IMPROVEMENT INITIATIVE to IMPROVE STAFF ENGAGEMENT

The paper was presented by Michael Holland.

Improving staff engagement is a core component of the aim to have a Trust workforce that is well engaged characterised by staff having consistently excellent experiences of working in the Trust. A programme of work was established in May 2017.

The paper provided a list of the ideas for improvement generated by: staff conversations; through the staff survey and at a staff feedback and engagement event in September 2017. It recommended the development of a detailed measurable QI plan with a structure and process to ensure a consistent approach to staff engagement. These will be in place by early October 2017. A follow up report will come to the Board in December 2017.

Mike Franklin observed the paper did not refer to Trade Unions and Staff Associations who had networks within the Trust that could be valuable sources of
information regarding staff views and perceptions. This observation was noted by the Board and Michael Holland agreed he would address the issue.

The Board

Noted the report

BOD 123/17 BOARD ASSURANCE FRAMEWORK (BAF)

In June 2017 members of the Board considered the potential risks that may impede the delivery of the Trust’s strategic objectives.

The Director of Nursing was asked to revise the BAF in line with the risk identification exercise and present the revised BAF to the Board for consideration and approval. The BAF has undergone a complete review in line with the revised strategic objectives discussed at Board development sessions and formal Board of Director meetings.

Each BAF risk has an Executive Director responsible for that element of the framework and subcommittees have oversight of each risk and its controls. The Audit committee will have oversight of the full BAF and the process on behalf of the Board.

The revised BAF has been presented in full to the Audit committee and the relevant risks to the quality committee. A plan is in place for each committee to review relevant risks, each one will determine if its current terms of reference address the matters that are material to the risks listed. The Board was asked to approve the BAF and the process of review.

Duncan Hames was assured that a Risk Manager will soon been in post as that position had been hard to fill, but had now been achieved. He was of the view more work was required to support risk oversight by the Board, a major part of this was for the Board to discuss and agree it’s risk appetite.

It was agreed by the Board that once in post the Risk Manager would be tasked to facilitate and confirm the risk appetite of the Board.

Julie Hollyman observed a number of typological errors in the paper and agreed to liaise with Beverley Murphy to ensure they were addressed. Anna Walker asked that references to the Care Quality Commission regulation risk be expanded to include all regulators such as the Health and Safety Executive. These amendments were agreed by the Board.

The Board

Approved the BAF and the process of review

BOD 124/17 COUNCIL OF GOVERNORS’ REPORT
Jenny Cobley introduced the paper which was taken as read.

It was accepted that as the Board was to be followed by the Trust’s Council of Governors quarterly meeting that further discussions and comment would take place at that event.

**The Board**

**Noted** the report

**BOD 125/17 BRIEFING from QUALITY SUBCOMMITTEE**

The Report was taken as read. Although not in the report Anna Walker stated the September meeting looked a wide variety of issues such as trying to ensure key elements of the CAG dashboards are extracted and presented to the Committee to give it an overview of Trust issues.

**The Board**

**Noted** the report

**BOD 126/17 FINANCE AND PERFORMANCE SUBCOMMITTEE REPORT**

The Report was taken as read.

June Mulroy reported

Work was on-going with the Maudsley Charity which will in the near future become independent of the Trust and bearing in mind future building work and maintenance, issues account was being taken of the experience of other Trusts in a similar position.

The Board noted a recent increase in demand for beds, and that housing-related issues are a key reason for service users using beds for over long periods

Analysis of the position on Cost Improvement Programmes (‘CIPs’) showed a ‘true’ CIP gap for 2017/18 (beyond month 2) of £9m. This issue was being looked at by the Committee.

Discussions on the Capped Expenditure Process (CEP) now seem to have ceased with a focus now on the Sustainability and Transformation Programme delivering long term savings.

**The Board**
Noted the report

BOD 127/17 BUSINESS DEVELOPMENT INVESTMENT COMMITTEE REPORT

The Report was taken as read.

The Board

Noted the report

BOD 128/17 MENTAL HEALTH LAW MANAGEMENT ANNUAL REPORT – APRIL 2016 - MARCH 2017

Beverley Murphy introduced the paper and it was taken as read, but a number of issues were highlighted.

The report gave a detailed account of Mental Health Law activity for the Trust, both Mental Health Act (MHA) and Mental Capacity Act (MCA). It also included operational developments, information about incidents which have resulted from breaches in the use of the Mental Health Act, a summary of findings for action by the Care Quality Commission following Mental Health Act monitoring visits, data and information about Mental Health Tribunals and Associate Hospital Managers activity for the year and data on the use of the MHA and MCA in 2016-17. The report also listed the proposed MHA developments for 2017/18.

Both the Quality committee and the Mental Health Law committee had seen the report prior to it coming to the Board. The Mental Health Law committee had endorsed the report.

Mike Franklin requested to see more detail as to the ethnic breakdown of the numbers arrested by the police; the numbers restrained; numbers detained under section 136 and forcible restraint. Matthew Patrick suggested that the data in the report did seems to suggest use of section 136 by the police was aligned with the overall demography of the areas served but there was some disparity in regard to section 2 and 3 of the Mental Health Act.

Mike Franklin expressed some concern over the potential use of Mental Health Act powers to stop and search certain individuals. It was agreed that a report with increased data analysis should return to the Board in January 2018.

Action: A report to the Board in January 2018 with increased data analysis of the Annual Report material

The Board

Approved the report
Kris Dominy introduced the paper and it was taken as read, but a number of issues were highlighted.

NHS Improvement has just announced proposals for the Single Oversight Framework which will see two Mental Health Services Data Set (MHSDS) data quality indicators being replaced with the Data Quality Maturity Index (DQMI) score. This change will be effective from October 2017. The Trust is already meeting the target required evidenced in the most recent NHS Digital publication (May 2017), reviewing the data for October-December 2016. The indicator considers recording and validity of Ethnic Category, GP Practice, NHS Number, Commissioner, Gender and postcode of usual address. Existing reports will be updated to reflect these changes to ensure appropriate monitoring and action is taking place.

NHSI have requested in regard to Emergency Preparedness, Resilience and Response (EPRR) that the Trust identifies an active Non-Executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation. After discussion by the Board it was agreed that Mike Franklin would take on this role.

The Board were informed that the old triage ward in Lambeth has requested to be rename itself, due to its change in role. The name suggested was the Rosa Parks Ward. The Board had no objection but Beverley Murphy asked that no formal change be made for a short period to allow of the CQC to be informed as there is a need for registration. This was agreed.

The Board were informed that the Memorandum of Understanding between the Metropolitan Police and the Trust regarding joint working is nearing completion.

Roger Paffard asked about the QUESTT scores reported in regard to the adolescent service. Kris Dominy was able to explain that long term illness and the need to back fill that post had caused some issues, but the situation was now being addressed. Beverley Hughes further highlighted learning from recruiting a significant batch of newly qualified nurses at the same time required additional support to avoid high turnover.

This learning highlighted the value of the QUESTT scores in providing live “Board to Ward” visibility and accountability. Kris Dominy proposed the need to develop a similar “Board to Community” scorecard for Community Teams and stated this would be presented at a future Board before the end of 2017.

The Board

Approved the Report and Noted the performance data

Agreed Mike Franklin NED to be portfolio holder for EPRR
**BOD 130/17 OVERVIEW of WORKING AGE COMMUNITY MENTAL HEALTH SERVICES in CROYDON**

Kris Dominy provided an overview to the challenges currently faced by Croydon Community Adult Mental Health Services.

Croydon is a diverse Borough with high levels of deprivation in a number of localities. Its characteristics are similar to many inner London Boroughs. It has experienced a chronic shortage of funding for mental health for many years and the whole health economy is currently challenged. A reduced level of Adult Mental Health model funding was invested in 2015, to include additional resources for Croydon IAPT.

However, due to Croydon CCG’s funding gap and being placed in special measure in 2016, a significant amount of the original investment was withdrawn. The current working age community mental health offer consists of multiple teams across four adult CAG’s.

The system is challenged across the patch but particularly in core community teams operated by the Psychosis and PMIC CAG’s. Mitigations are in place to manage these challenges, but a medium to long term solution is required to ensure safe and sustainable service delivery. The Trust is working with commissioners about the problems but it appears unlikely that there is sufficient resource in the health economy to address these challenges.

Reference was made to a report prepared by McKinsey management consultants that is not in the public domain assessing the needs of the Croydon health economy. It was agreed that the Board should see the report in confidence.

**Action: McKinsey Report on Croydon Health Economy to go to be circulated to Board**

Kris Dominy reported that more resource had been put into the Croydon services by the Trust and staff have done their utmost to maintain service delivery. Roger Paffard requested that the thanks and appreciation of the Board be passed on to those staff Gus Heafield added that it is likely that the Croydon contracts held by the Trust will require a refresh and preparation for that would be discussed via the Senior Management Team.

**Action: Update on Croydon Contract refresh to come to November 2017 Board**

The Board noted the deteriorating final position of 3 of the 4 CCGs in the local area and it is feared the five year forward view funding is under threat. Mike Franklin was of the view that the position was so serious that it required the Board to be explicit in expressing concern over the challenges developing that could eventually affect delivery of healthcare by the Trust.

Matthew Patrick responded that secure and innovative contractual arrangements such as the Lambeth Alliance would allow for savings to be made and service delivery to be improved as the fragmentation that affects the health economy could be addressed by such developments.

Duncan Hames added that the Board would need to consider the most effective time and place to highlight the challenges it faces. In 2017/18 the situation is difficult but targets are being met, although some of the financial savings are non-recurrent. Therefore the financial year 2018/19 is where the challenge lies and nearer the time
discussions by the Board on the ability of the Trust to meet its control total may be required if innovative commissioning does not address the problems faced by the Trust.

Roger Paffard concluded the discussion by stating that developing systems whereby budgets are delegated to the local area based on population need, offered a possible method of maintaining quality services during a period of financial stress.

The Board

Noted the Report

BOD 131/17 FINANCE REPORT

Gus Heafield took the paper as read. At Month 5 year to date, the Trust had made a deficit of £2.1m, a favourable variance of £0.04m against its surplus control total.

Considerable debate on the financial position of the Trust’s and the local health economy had taken place during the previous papers. Therefore, Gus Heafield in the time available restated that non-recurrent savings were being used by the Trust, which was not sustainable in the long term. Therefore the transformation of services offered the best way forward to maintain services and hit financial targets.

The Board

Approved the Report

BOD 132/17 QUARTERLY REPORT ON DAFE WORKING HOURS FOR DOCTORS in POSTGRADUATE TRAINING at SOUTH LONDON and MAUDSLEY NHS FT

The Report was taken as read

The Board

Noted the Report

BOD 112/17 REPORT FROM PREVIOUS MONTHS’S PART II

The Report was taken as read

The Board
Noted the Report

BOD 113/17 WRAP UP

No other business was discussed.

BOD 114/17 FORWARD PLANNERS & DRAFT AGENDA –

This was noted by the Board.

The date of the next meeting will be:
Tuesday 31 October 2017 – 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)
## Public Board meeting 31 October – Action points

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue/Board Paper</th>
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<th>By</th>
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<td><strong>July 2017 Meeting</strong></td>
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<td>1</td>
<td>Retention and Recruitment</td>
<td>Workforce subcommittee from October 2017 to oversee the Recruitment and Retention data and develop KPIs for insertion into the Performance Report.</td>
<td>SS/JH</td>
<td>Oct 2017</td>
<td>On track</td>
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<td><strong>September 2017 Meeting</strong></td>
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<td>2</td>
<td>Matters Arising</td>
<td>Chair to arrange meeting with the new Chair Croydon CCG to express concern over access to MH services in that Borough.</td>
<td>RP</td>
<td>Oct 2017</td>
<td>In Process</td>
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<td>3</td>
<td>Workforce Race Equality Standard Metrics for 2016-2017</td>
<td>Recruitment Agency assisting with senior appointments to be advised of Trust’s commitment to diversity</td>
<td>SS</td>
<td>Oct 2017</td>
<td>Action Completed</td>
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<td>5</td>
<td>Mortality Report</td>
<td>Updated Physical Health Strategy to come to the Board by November 2017</td>
<td>BM</td>
<td>Nov 2017</td>
<td>On track</td>
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Page 1 of 2
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<th>Ref</th>
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<td>6</td>
<td>Mental Health Law Management Annual Report. April 2016 - March 2017</td>
<td>Increased data analysis requested in regard to the data over the use of Sections 2, 3 and 136 Mental Health Act powers</td>
<td>BM</td>
<td>Jan 2018</td>
<td>On track</td>
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<td>7</td>
<td>Overview of working age community mental health services in Croydon</td>
<td>McKinsey Report on Croydon Health Economy to be circulated to the Board – In confidence</td>
<td>RE</td>
<td>Oct 2017</td>
<td>Completed</td>
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<tr>
<td>8</td>
<td>Overview of Working Age Community Mental Health Services in Croydon</td>
<td>Update on Croydon Contract refresh to come to the Board after SMT discussion</td>
<td>GH</td>
<td>Nov 2017</td>
<td>On track</td>
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Code:

- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule
Title | CHIEF EXECUTIVE’S REPORT
---|---
Author | Dr. Matthew Patrick

**Purpose of the paper**

To inform the Board about significant issues affecting the Trust.

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**A – Annual Members Meeting and Staff Recognition Awards**

1. My highlight of the last month was the staff recognition awards which took place on 25 September. This was a wonderful opportunity to celebrate colleagues from across the trust and the amazing effect they often have on people’s lives. Large numbers of staff, governors and members of the Trust gathered at the Oval for an inspirational and uplifting event.

2. During the ceremony, we heard from service users, carers and colleagues who had nominated people for awards – there were more than 160 nominations in total. There were many uplifting stories and I came away inspired and proud to work with a talented group of people who make such a difference to people’s lives, often in challenging circumstances. My warm thanks to the nominees, the judges and all those who organised such a fantastic event and my congratulations to all those who were nominated.

**B - CAMHS Tier IV**

3. On October 2nd our South London Mental Health and Community Partnership CAMHS Tier 4 New Model of Care went live in shadow form. As has been highlighted recently in the media, the context is challenging. There is a national shortage of CAMHS inpatient beds and many children and adolescents end up in facilities that are away from their families and friends. Our new care model will invest in both community crisis teams and community dialectical behaviour therapy services, as well as strengthening the community eating disorder pathway and the autism and learning disability support packages. We are confident that this will result in more treatment being delivered much closer to home resulting in better and more appropriate care being provided to local children and adolescents.
C - Maudsley Health Annual Conference in Abu Dhabi

4. On 13 October, I opened the excellent Maudsley Health second Annual Conference in Yas Island, Abu Dhabi. Key topics being addressed included cognitive impairment in mood disorders, perinatal mental health and the treatment of non-suicidal self-injury in adolescents. Maudsley Health, is a joint venture between the Trust and Macani Medical Centre in Abu Dhabi. Professors, consultants and experts in mental health, including from SLaM, met to share new research and developments in the field. It was an interesting and enriching event.

D - Cinema Museum

5. The Trust owns part of a former hospital site in central London, which is now vacant. The site is nearly two acres in size. This asset presents a substantial opportunity for the Trust to realise proceeds that are desperately needed to enable us to invest in frontline services and the refurbishment of our clinically active estates at a time of considerable ongoing financial pressure.

6. Unfortunately, there is opposition from the Cinema Museum, which is housed in one of the site’s many listed buildings. The Cinema Museum has been engaged throughout but is opposed to the trust’s plans. It is seeking to canvass public support to pressurise the Trust into selling the property to them at below market value. The Museum appear to be making deliberately inaccurate statements to the effect that the Trust promised to sell the property to the Museum at undervalue. There is currently an online petition protesting against the Trust’s plans on this basis.

7. The Trust’s position is that it absolutely recognises and values the Cinema Museum, which has a rich heritage and makes an important contribution to the local community. However, we are clear that we are required, both legally and morally, to ensure that full value from the public estate is secured for the NHS and for the benefit of front-line mental health services. To this end, we are encouraging the Museum to engage with developers to secure the future of the Museum or to submit a bid that is consistent with the market valuation. We are convinced that there is a solution that preserves the Museum whilst also providing the Trust with the vital additional funding that it needs for mental health services.

E – Finances

8. Finally, I wanted to recognise the substantial work that is going on across the Trust to deliver cost improvement plans and enable the Trust to operate within significant financial constraints this financial year. It is extremely challenging to deliver savings year on year, whilst retaining a quality service to our users, and I want to thank every member of staff for their continued efforts.
Purpose of the paper

The purpose of this paper is to inform the board of the proposal for developing the new digital strategy for SLaM.

Specifically, we are seeking direction and comment from the board on the approach to developing the new digital strategy with the aim of bringing the draft strategy proposal to the board at a subsequent meeting.

Additionally, we are asking the board to provide direction and comment on the governance of the overall strategy, programme and reporting mechanisms. It has been proposed by SMT that both the QI programme and Digital Strategy (and GDE deliverables) should be a joint governance structure.

Executive summary

In March 2015, the Trust board approved the IT Strategy which was for a period of 2 years. In March this year, NHS England announced that SLaM has been awarded Global Digital Exemplar (GDE) status which is a 3 year programme, with a funding agreement of £5m (matched by SLaM) over the 3 year period.

Over the last few months there has been a lot of detailed work and planning due to setting out the agreement and deliverables of the GDE programme. This is timely, as we anticipated that this would also form part of the new digital strategy, and would include many other factors which are set out below.

Once developed and approved by the board, this new digital strategy will cover the period of 3 years from November/December 2017 onwards.

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>9th October 2017</td>
<td>Trust SMT have had an initial presentation on the proposed contents of the new digital strategy</td>
</tr>
</tbody>
</table>
Background:
In October 2014 the Five Year Forward View (FYFV) was published by NHSE and set out, in broad terms, the aims to exploit the information revolution to improve the delivery of care. This publication recognised the slow progress attributed to the previous two approaches of centralised national programmes, and the extreme opposite approach of letting local providers decide on technology and system implementation, resulting in a mosaic of systems that do not talk to each other (lack of interoperability).

In November 2014, the newly established National Information Board (NIB) set out the Personalised Health and Care 2020 Framework which builds upon the FYFV, the Government Digital Strategy (2013) and the Department of Health’s Digital Strategy (2012).

This framework set out milestones up to 2020 including (but not limited to) the following:

- Standards for accessing systems (interoperability)
- 100k Genome Project (sequencing 100,000 individual genomes)
- Information Governance Toolkit
- Digital Maturity Index
- Individuals will be able to access and comment on their care record online
- By 2020 – all care records will be digital and interoperable
- Knowledge and skills frameworks to enable the NHS workforce to embrace information and technology

In late 2015 the Secretary of State for Health and NHSE leadership created the National Advisory Group on Health Information Technology to advise the NHS on its efforts to digitise the NHS secondary care sector.

In September 2016 the US clinician and academic Professor Robert Wachter (who led the Advisory group) published the following report:

Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England

Otherwise known as the Wachter Review, there were 10 recommendations summarised below:

- Carry out a long term national engagement strategy
- Appoint national CCIO (Keith McNeil)
- Develop & train clinician informaticians at Trusts
- Allocate new funding to help Trusts go digital (Global Digital Exemplar Programme)
- Link national funding to viable local implementation plans
- All trusts to be digital by 2023 (paperless by 2020 deemed to be unrealistic)
- Interoperability across health systems and to promote innovation and research
- Organise digital learning networks
- Develop & grow CCIOs, Informatics and IT Professionals more generally (NHS Digital Academy)
- A robust evaluation of the programme should be in place

As a result – the GDE programme was established and across England there are 16 acute trusts which received £10m in matched funding, whilst there are 7 mental health trusts that have been allocated £5m in matched funding.

SLaM is the only MH trust in London to become a GDE.

What does being a GDE mean?

The Wachter Review recognised that the NHS can’t digitise the whole sector at the same time and at the same pace, therefore the aim is for GDEs (with the appropriate funding) to share learning and experiences with other trusts. GDEs are expected to create the ‘digital blueprints’ for services that other trusts can adopt. The programme is planned to deliver its milestones over 3 years, with benefits realisation extending beyond that period.

Those trusts that show a level of digital maturity and leadership can potentially become a ‘fast follower’ (FF) by working closely with GDEs. Acute FFs are being given £5m matched funding and MH FFs are going to
be allocated £3m matched funding. Note: MH FFs have still to be decided and the process will be made public in November.

**SLaM Strategy:**
The diagram below shows the recently created strategic primary drivers for the trust. The bullet points on the right have been collated from the details within the trust strategy that refers to how information technology needs to directly or indirectly support those objectives and will also form part of the new digital strategy.

**Listening to staff – getting the basics right:**
Whilst the GDE programme will form a significant part of what we have to deliver in terms of the new digital strategy, and additionally what we need to achieve in support of the strategic objectives for the trust, there are a number of other factors that need to be considered – specifically from the user experience (UX) perspective to ensure we get the basics right for the people who provide our services. We also recognise that we are on a digital transformation journey and need to bring our staff with us on that journey.

**IT Survey:**
Between December 2014 and December 2016 there was a significant improvement in the overall satisfaction of staff using digital services, as shown in the board paper (IT Survey Brief to Board) in February 2017. As part of the December 2016 survey we asked respondents to answer the following three questions:

*Are there any areas in your opinion where Digital Services (IT) could improve the services that they provide? (please comment)*

We received 272 responses with comments and suggestions

*Can you suggest any areas where Digital Services / Technology can help you in your daily duties (please comment)*

We received 240 responses with comments and suggestions

*Do you use the Trust Intranet? What improvements would you suggest for the Intranet?*
We received 459 responses with comments and suggestions

Whilst there may be many of the comments/suggestions that would have been actioned since December 2016, we will analyse the detail and ensure we capture any outstanding issues and suggestions to incorporate within the new digital strategy.

**Device Replacement & Desktop Services**

The replacement of devices has slowed due to reduced resources, the extension by one year of device lifecycle (replacement), and the introduction of the ‘one device’ policy. This policy aligns profiles to job roles, which sees allocation of devices suited to job roles and their working environment. From a total of 360 aged devices requiring replacement in 2017/18, to date only 139 have been replaced, whilst at the same time several hundred devices have been reallocated as part of the one device policy. We need to concentrate efforts and apply the necessary resource to device replacement activity.

We also recognise that we need to improve our desktop services and will engage with a third party to conduct a review. This review will aim to provide recommendations around how we optimise the experience for our staff, how the desktop team are structured, and the methods used to carry out their services. This is also an opportunity to work with our partners Oxleas and South West London & St.Georges (SWLSTG) to standardise and optimise desktop services across the three partner estates, including agile working which will help to reduce dependencies upon so many locations, allowing staff to move freely between sites.

**CAGs & Digital Services:**

Since July this year, Sharon Wright (Head of Service Management) and Emma Lane (Service delivery Manager) have implemented a quarterly review process with CAG leadership. Five out of six CAGs have had reviews where outstanding tickets (requests/faults) are discussed, printing and mobile usage stats are presented, mobilisation of staff, where devices need to be replaced and any other areas where Digital Services can assist. This is a great forum and helps the communication between Digital Services & CAGs from a business relationship management perspective, and will also ensure engagement around how we deliver future services.

**Digital Services Operations:**

Since 2015 we have implemented and evolved our balanced scorecard which captures all Digital Services statistics and KPIs, as well as usage for Office365 as we drive adoption across the Trust. We receive around 4,000 calls to the Service Desk which results in an average of 1,400 tickets per month. As part of the new strategy, we need to go after the root cause of the number of tickets which are a mix between incidents (issues, faults) and requests (new accounts, access permissions, new devices). Our service desk platform is not fit-for-purpose and we have started the process for procuring a new cloud-based platform in partnership with SWLSTG with a view to implementation in March 2018.

With a new platform in place we will be able to automate processes such as password resets and requests, which will significantly reduce the number of calls/tickets to the Service Desk. The new platform will also allow for more granular detail to allow for root cause analysis and problem management.

**ePJS:**

Whilst we look at the options we are still working towards making improvements (less costly) to the performance, functionality and look and feel of ePJS where we can. The Clinical System team (led by Jane Stewart), have also started to benchmark performance of ePJS across sites, looking for any areas where access or performance is slower than necessary, allowing Digital Services to target those areas for improvement with internet bandwidth upgrades or new PCs.

We will work with our GDE colleagues (Oxford & Worcestershire) to look at how we can make improvements to the platform and deliver a much better experience for our staff. SL@M Connect forum (see below) will allow staff to come forward with ideas on improvements.

**Staff Engagement:**

We are establishing **SL@M Connect** as our main vehicle for staff engagement. Since spring 2017, SL@M Connect has been running as a weekly Wednesday morning forum, involving the following: CCIO; head of
digital clinical systems; head of digital programme management; Trust comms digital lead and a member of the Trust QI team.

The forum is open to any staff to register to attend with any digital frustrations or ideas to discuss. We want to bring people with digital ideas together with the people who can realise them. In doing so, we aim to strengthen our overview of who is doing what across the Trust, promoting collaboration between CAGs, bringing people working on similar projects together and to encourage cross-fertilisation of ideas. The forum is linked to the Centre for Translational Informatics (CTI), with the CTI now referring people who approach them with ideas (e.g. to develop an app for clinical use) to SL@M Connect first to discuss its clinical utility and potential resource requirements before inception.

We have also established a connection with the Maudsley Charity, inputting into their review of grant applications for digital tool developments. We hope therefore to connect people, existing work, potential sources of funding and research opportunities. To date we’ve hosted 88 members of staff from SLaM & the IoPPN, discussing 43 topics, which often extend into related - or previously seemingly unrelated - areas, generating new ideas and connections.

Beyond the weekly forum, the next stage of engagement is to develop SL@M Connect as a platform for digital discussions and dissemination of ‘the new’ across the Trust, via SLaM communications and the use of Yammer, a group discussion tool on our Microsoft Office 365 suite of software that has the potential to improve how we communicate and collaborate across the Trust. Over 1,000 staff have now gone onto Yammer, and promoting its use as an alternative to email will be one aspect of how Digital Services will be contributing to the communications work that will be underpinning the Trust strategy going forward.

With the development of new software, we will routinely involve a range of frontline staff from different contexts at a project’s inception to help shape how the project develops. This has proved readily achievable where a project addresses a well-recognised ‘pain point’ for staff e.g. improving the user experience of ePJS. Staff engagement needs to occur not only through the prism of committees however, but crucially within the clinical context in which any software will be deployed. This has been the key lesson we’ve learnt from the slow progress of the electronic observations pilot. This will mean developing a new approach that incorporates IT business analysis to inform software development, ensuring clinical processes and potential clinical risks are comprehensively mapped out in situ through frontline observation and engagement with staff.

We anticipate that the introduction and spread of initiatives introducing new and different ways of working (e.g. Skype; Healthlocker) will prove more challenging. These will represent cultural shifts in very established behaviours and staff will need to be convinced of the potential benefits and then motivated to learn and trying something new. As such, engagement with new ways of working will need a more strategic and multi-layered approach, informed by improvement methodology. Such initiatives will require more than comms dissemination; we will need to think more about how ideas flow, or ‘diffuse’, across different networks of people within this Trust. This will include addressing how we engage opinion leaders and change champions to attract early adopters, then consideration of what different approaches might be needed for adoption to cross over into the early and late(r) majorities. Finally, the ‘laggards’ may need different incentives, reassurance or nudges.

**Innovation, R&D**

To date we have struggled to respond to requests from the BRC/CTI as we have not had the resource to dedicate towards those projects. We have met with F.Gaughran who has agreed to work with us in the development of the new digital strategy, and in speaking with M.Hotopf, he has provided the quote below:

“It is essential that SLaM Digital Services have the capacity to respond to requests arising from our research and development team based in the BRC, and to date pressures on the team have made this difficult. We have examples of projects which have been long-delayed because hard-pressed colleagues in IT have not had the capacity to respond to such requests as their main “business as usual” commitments have swamped them. This means that engagement, though often well-meaning and collegiate, has been insufficient to progress studies at the pace required. There is an urgent need to establish a small team based within IT to respond to these requests which I believe could be supported by the considerable financial contribution the BRC makes in indirect and research support costs to SLaM”.
We have the opportunity with the GDE funding to organise and add to our resource (dedicated to CTI projects) which will allow us to pick up the pace and move forward with innovation, otherwise we risk falling behind.

**Sustainability Transformation Plans (Partnerships):**
SLaM Digital Services staff have been heavily involved in both influencing and developing the Local Digital Roadmaps (LDRs) which underpin the objectives of the STPs. We will continue to align our digital plans with those of both the SE & SW London footprints. At the same time, SLaM CIO is the Chair of the London CIO Council and is involved in pan-London and national initiatives which will also help to inform our digital services strategy; such as population health management, data sharing agreements, patient record sharing, interoperability and innovation.

**Cyber Security:**
With the recent Wannacry outbreak that affected parts of the NHS and other sectors, it is imperative that we continue to invest in cyber security measures to mitigate against attacks. We will ensure that this is part of our digital strategy and will seek to keep our staff at all levels up to date with awareness campaigns and the introduction of passphrases (instead of passwords).

**Alignment:**
We will work with our colleagues across other corporate departments and gather input as we form the new digital strategy including (but not limited to):

- Communications (new Intranet, GDE communications)
- Estates (mobile / agile working)
- HR (develop digital training for existing staff and ‘digital induction’ for new staff)
- Finance & Procurement (develop business cases and supplier management)
- Corporate Affairs (understand needs and develop digital solutions)
- Central PMO (change management)

In summary, we aim to engage across and beyond the Trust as we develop our new digital strategy. We have a great opportunity to build upon the foundations of the previous strategy and to develop SLaM into one of the most digitally mature MH Trusts in the country.

We seek comment and direction from the board on the above, and to give direction on the governance of the new digital strategy, coupled with the QI programme governance.
Purpose of the paper

The purpose of this paper is to set out The Trust’s principles for venturing in commercial ‘non-core’ areas such as international expansion, private care or commercialisation of property.

It is recommended that the Board discuss this set of principles and provide input that can be added to the next draft of the document.

Executive summary

As part of the ongoing Board-level discussions regarding our international ambitions, it was agreed that the Trust would establish a set of principles for venturing in ‘non-core’ areas such as international expansion, private care or commercialisation of property.

The paper aims to comprehensively capture all of the components that need to be considered when venturing and clearly sets out the ‘red lines’ under each:

Impact on Business as Usual and Strategic Fit

Principle: The venture directly or indirectly supports or enhances existing service provision, does not impede/compete with current contracts/NHS patient access and fits with the Trust’s strategy.

Red lines: The venture does not support/enhance existing service provision or impedes/competes with existing contracts/obstructs NHS patient access or does not fit with Trust strategy.

Quality

Principle: The venture is high quality, underpinned by QI principles, supports the population it serves and we are proud to be associated with it.
Red lines: We are not able to safeguard a level of quality that is acceptable to the Trust.

Ethics and Political Landscape
Principle: The venture has been scrutinised from an ethical perspective and is deemed acceptable. Importantly, we can clearly delineate the benefit that the venture will bring to SLaM’s local patients and communities. The political landscape is deemed to be sound and the relevant UK authorities endorse doing business there.

Red lines: The venture is ethically unacceptable, benefit to SLaM’s local population is not clear or political landscape is not fit for venture.

Legislation / Regulation
Principle: We only pursue ventures where we fully understand and meet legislative and regulatory requirements (domestic and in-country), and are aligned with regulating bodies in the UK such as NHS Improvement and NHS England.

Red lines: We do not fully understand and/or meet the legislative/regulatory requirements (domestic or in-country), or the venture is not endorsed by regulators.

People
Principle: The people that pay us, that work in partnership with us, and those employed by us are fit and proper and of good moral standing.

Red lines: We have serious concerns about the ethics, motivations, capability or capacity of the people that pay us, work in partnership with us or are employed by us.

Financials and Risk
Principle: The venture is financially attractive, underpinned by a rigorous financial model that is acceptable to the Trust, with an acceptable risk profile where applicable.

Red lines: Financials are not attractive, have not been modelled thoroughly or gone through an appropriate level of scrutiny or the risk profile is unacceptable.

Exit Strategy
Principle: We always have a clearly defined exit strategy (where appropriate e.g. a fixed term arrangement) or we have clear options for exit/venture wind down that are acceptable to the Trust.
Red lines: There is no exit strategy or clearly defined options for exit/winddown are not defined.

It is recommended that these components are thoroughly interrogated as part of the sign off process for future ‘non-core’ ventures.

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/09/17</td>
<td>Trust Board</td>
</tr>
<tr>
<td>09/10/17</td>
<td>Business Development Investment Committee</td>
</tr>
</tbody>
</table>

1. INTRODUCTION

Conversations with Trust Leaders, both executive and non-executive, regarding non-core commercial activity have raised numerous issues including:

- The morality of an NHS organisation doing private work
- The ethical considerations that an NHS organisation should consider when operating in GCC markets (the Gulf – noting that there are significant differences amongst individual country markets)
- Fit with personal or corporate value systems as they relate to geography, social attitudes etc

Prior to Trust Board on 19th September, SMT proposed that a set of principles is required to govern The Trust’s non-core activities and that the development of such principles is done between now and 15th December and is overseen by BDIC and presented to the Board for agreement in December with drafts being shared for input prior.

This proposal was discussed in more detail at BDIC on the 9th of October and it was subsequently agreed that a paper would be produced for October Board to explore first thoughts and possible red lines.

2. WHY WE NEED TO AGREE PRINCIPLES FOR VENTURING

It was highlighted in the September Board part II paper on commercial considerations for international expansion that there is motivation to pursue selected commercial opportunities enabling us to:

- invest in core infrastructure such as estates
- invest in transformation of our capability (e.g. QI programme) or local services (e.g. NMoC or Lambeth Alliance, and,
- invest in assets that make us unique and able to innovate in mental health for the benefit of patients and populations we serve (e.g. CTI, CRIS, Healthlocker moving forward)
- help support, temporarily, local services that would otherwise be at threat of closure (e.g. addictions)

Our core services offer very limited opportunity to enable investment in the four areas described above, and we therefore need to venture in non-core commercial areas to do so. Venturing activity, payers and partners will not be the same as our core services and it is therefore necessary to investigate all considerations carefully to ensure that these activities are ethically and strategically aligned to our core purpose of improving the lives of the people and the communities we serve.

3. PRINCIPLES FOR VENTURING AND RED LINES
This section aims to clearly set out a) the principles under which The Trust will pursue non-core commercial ventures and b) the conditions under which the Trust would ‘walk away’ from an opportunity or venture.

**Impact on Business as Usual and Strategic Fit**

Principle: The venture directly or indirectly supports or enhances existing service provision, does not impede/compete with current contracts/NHS patient access and fits with the Trust’s strategy.

Red lines: The venture does not support/enhance existing service provision or impedes/competes with existing contracts/obstructs NHS patient access or does not fit with Trust strategy.

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Principle: The venture has been scrutinised from an ethical perspective and is deemed acceptable. Importantly, we can clearly delineate the benefit that the venture will bring to SLaM’s local patients and communities. The political landscape is deemed to be sound and the relevant UK authorities endorse doing business there.

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**Legislation / Regulation**

Principle: We only pursue ventures where we fully understand and meet legislative and regulatory requirements (domestic and in-country), and are aligned with regulating bodies in the UK such as NHS Improvement and NHS England.

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Red lines: There is no exit strategy or clearly defined options for exit/winddown are not defined.

4. ASK OF THE BOARD
It is recommended that the Board discuss this set of principles and provide input that can be added to the next draft of the document.
REPORT TO THE TRUST BOARD:  PUBLIC
31st October 2017

Title  CQC re-inspection report – Adult Community Pathway

Author  Mary O’Donovan, Head of Quality

Accountable Director  Beverley Murphy, Director of Nursing and Quality

Purpose of the paper

1. To report the findings of the re-inspection by the CQC in July 2017 of the Adult Community services.

2. To note the key issues raised and the highlighted risks.

Executive summary

In September 2015, the Trust was subject to a comprehensive CQC inspection and was rated overall as ‘good’. The rating for the Adult Community Pathway was ‘Good, with an improvement plan agreed, implemented and monitored for the areas identified by the CQC for improvement’. The adult community pathway was re-inspected in July 2017. The final report will be published on 30 October 2017.

The report notes areas of good practice and improvements, but it is disappointing that the overall quality rating for the Adult Community Pathway has dropped to ‘requires improvement ’. Both the Trust and the Adult Community pathway recognise the areas identified in the report for improvement and the actions provide a useful baseline on which the Trust can learn and improve services.
CQC re-inspection report – Adult Community Services

1.0 Introduction

As a part of the Chief Inspector of Hospitals (CIH) inspection regime the Trust was subject to a comprehensive Care Quality Inspection (CQC) during the week commencing 21st September 2015. The overall Trust rating was ‘good’, this included the rating for Adult Community services which was also rated ‘Good’, with the individual domain ratings outlined below in table one. Three community teams were inspected.

<table>
<thead>
<tr>
<th>Overall rating for the service</th>
<th>Good</th>
<th>Requires improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are services effective?</td>
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<td>Are services caring?</td>
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<tr>
<td>Are services responsive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are services well-led?</td>
<td></td>
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</tbody>
</table>

Table one: CQC Community-based mental health services for adults of working age: Rating; Jan 2016

The Adult Community services were re-inspected in July 2017. The paper sets out why the re-inspection took place, the findings and the subsequent quality rating.

2.0 Re-Inspection Rating

Following the re-inspection of the Acute services in January 2017, the Trust was advised that the Adult Community pathway would be re-inspected in the near future due to some of the interface issues that arose during the Acute re-inspection.

The re-inspection in July 2017 involved 19 community teams and assessed if the Adult Community pathway had made the required improvements, following the previous comprehensive inspection of the trust in September 2015. The inspection team judged the ‘must do’ actions as delivered.

Following the re-inspection, the overall rating for the Trust remains at ‘Good’. The overall rating for the Adult Community Pathway was assessed as ‘requires improvement’ whilst the specific domains of caring and Well Led were assessed as ‘Good’. The table below outlines the revised quality rating for the pathway.

<table>
<thead>
<tr>
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</tr>
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<tr>
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<tr>
<td>Are services caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services responsive?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Good</td>
</tr>
</tbody>
</table>
### 3.0 CQC identified immediate actions to be taken

Post the CQC visit the Trust was advised of recommended immediate actions to be taken which were carried out and outlined below:

<table>
<thead>
<tr>
<th>Action identified by CQC</th>
<th>Service Area</th>
<th>Action Update</th>
<th>Current mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinic Room temperatures</strong></td>
<td>Southwark NE Recovery team</td>
<td>Air Con units ordered and installed week ending 25/08/17.</td>
<td>Team have been informed and are aware of the reduced expiry dates and there is a sticker on each medicine to indicate a reduced expiry date. Pharmacy to be advised by Team of temperature ‘migrations’ &gt; 25 degrees C resulting in a calculated reduced expiry date, with stickers for the medication.</td>
</tr>
<tr>
<td></td>
<td>Brixton Central and NE teams (shared clinic room)</td>
<td>Air Con units ordered and installed week ending 25/08/17.</td>
<td>Pharmacy to be advised by Team of temperature ‘migrations’ &gt; 25 degrees C resulting in a calculated reduced expiry date, with stickers for the medication.</td>
</tr>
<tr>
<td><strong>Alarm system</strong></td>
<td>Brixton Central Team, 332 Brixton Rd</td>
<td>ASCOM installation is programmed to be completed on the 10/11/17. There had been an initial delay due to the requirement of supporting IT infrastructure works which are now complete.</td>
<td>Blick system – which is still operational and fulfils the role of a networked alarm system for the building. In addition, staff have a stock of ‘screech’ alarms similar to those available on the high street available to all staff that let out a loud shrill burst to ward off attackers and notify those in the local vicinity. Trust security lead has subsequently visited 332 and ascertained some of the personal alarms required new batteries which were replaced within the day- there are enough working personal alarms for staff. This has been communicated to the CQC.</td>
</tr>
<tr>
<td><strong>Emergency medicines for anaphylaxis</strong></td>
<td>Brixton Central Team and NE Team, 332 Brixton Rd. Lewisham neighbourh ood teams 3&amp;4</td>
<td>1. Kits have been provided to relevant teams. 2. Trust Policy being reviewed for minimum standards</td>
<td>As per Action update</td>
</tr>
</tbody>
</table>
Stocks of FP10s were not recorded, only the scripts going out.

<table>
<thead>
<tr>
<th>Brixton Central and NE teams (shared clinic room)</th>
<th>Resolved- now in place</th>
<th>As per Action update</th>
</tr>
</thead>
</table>

There was no checklist for the defibrillator to ensure it was always available and in working order.

<table>
<thead>
<tr>
<th>Lewisham neighbourhood teams 3&amp;4</th>
<th>Resolved- now in place</th>
<th>As per Action update</th>
</tr>
</thead>
</table>

Table three: CQC identified immediate actions to be taken by Trust.

### 4.0 Improvements since 2015 and Good practice identified

The CQC highlighted the improvements made in each of the five domains; Safety, Effective, Caring, Responsive and Well led since 2015. These improvements are highlighted below.

<table>
<thead>
<tr>
<th>Domain</th>
<th>CQC Identified Improvements</th>
</tr>
</thead>
</table>
| **Safe** | • An improvement in the safe systems for transporting medicines, medical waste and sharps, with new bags and arrangements in place.  
• Trust had put in place a recruitment and retention strategy, there was a marked improvement in numbers of permanent staff recruited to these teams, although this continued to be a challenge.  
• Changes in care co-ordinators were now being monitored in the recovery teams.  
• Regular checks in place to ensure that most equipment was serviced, potable appliance tested, and calibrated as needed.  
• Improvement in compliance with the Lone working Policy and procedures to ensure staff safety.  
• The Team managers and senior managers within the clinical academic groups (CAGs) were aware of the main issues that we found during the inspection, and had plans in place to address some of them. |
| **Effective** | • Staff made information available to patients on local advocacy groups.  
• Examples of good practice across the teams, including the Lambeth living well network hub which provided a single point of access for the public and professionals to all mental health referrals. Lewisham, neighbourhood 1 promoting recovery team provided support for a group of patients with diabetes.  
• Staff used case discussion and formulation meetings to improve the quality of care and treatment for patients.  
• Staff feedback to their teams about successful interventions with patients. Staff received regular supervision and appraisal and had access to opportunities for further learning and development.  
• The trust offered patients the opportunity to participate in innovative treatments.  
• Patients were able to access a number of groups held within the community including a ‘Hearing Voices Group’ that was co-facilitated by patients. |
| **Caring** | • Accessible, caring and respectful staff.  
• Patient and carer forums were available.  
• An involvement register which enabled patient participation in various tasks including recruitment. |
Patient experience data collected and used to improve the service.

Responsive

- Most patients knew how to make a complaint and staff responded to complaints appropriately. Shared learning was identified.
- Flexible working with patients.
- Information available in different formats.
- Lambeth were aware of the over-representation of black people amongst their patient group and were seeking to promote better prevention, improved access to appropriate services and improved experience for black people.

Well Led

- Domain rated good because although the service had three domains that were rated as requires improvement, the team managers and senior managers within the clinical academic groups (CAGs) were aware of the issues that were found during the inspection. There were proactive plans in place to address them.
- The CAG risk registers reflected the concerns identified during this inspection.
- There were clear governance structures in place for each CAG overseeing community mental health services, and a wide range of quality improvement projects recently put in place encouraging staff to take a central role in improving services.
- Despite high caseloads, staff morale was generally good, and staff felt well supported by their line managers and colleagues.
- There was a strong emphasis on multi-disciplinary working leading to innovative projects between team members bringing different skills.
- The trust was working closely with other agencies, including the police and social services, to address delays in Mental Health Act assessments.

Table four: CQC Adult Community Pathway: Improvements since, 2015

5.0 Areas for Improvement

The Adult Community Pathway received four ‘MUST’ dos and eight ‘SHOULD’ do actions to improve on.

5.1 MUST

<table>
<thead>
<tr>
<th>Number</th>
<th>Must</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Risk Assessments</td>
<td>The trust must ensure that risk assessments and risk management plans are always completed and reviewed after changes in patients’ circumstances and risk events, and stored where other staff can find them easily.</td>
</tr>
<tr>
<td>2</td>
<td>Care Plan</td>
<td>The trust must ensure that each patient has a care plan, which is person-centred and includes information about how staff will support them.</td>
</tr>
<tr>
<td>3</td>
<td>MHA Assessments</td>
<td>The trust must ensure that patients who require a Mental Health Act assessment are assessed without undue delay to ensure their safety and that of others.</td>
</tr>
<tr>
<td>4</td>
<td>Croydon A&amp;L assessment target</td>
<td>The trust must ensure that patients referred to the Croydon assessment and liaison team, receive an assessment within trust target timescales.</td>
</tr>
</tbody>
</table>

Table five: CQC Adult Community Pathway, Must Dos; October 2017

5.2 SHOULD
<table>
<thead>
<tr>
<th>Number</th>
<th>Should</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>EI caseloads</td>
<td>The trust should continue to take action to reduce the caseloads of care coordinators in the early intervention teams, so that they can consistently provide effective support to patients experiencing a first episode of psychosis.</td>
</tr>
<tr>
<td>2</td>
<td>Mandatory training</td>
<td>The trust should ensure that staff complete all mandatory training including annual basic life support, infection control and fire safety training.</td>
</tr>
<tr>
<td>3</td>
<td>Care plan- patient involvement</td>
<td>The trust should ensure that staff clearly record patient involvement in their care records, and offer each patient a copy of their care plan.</td>
</tr>
<tr>
<td>4</td>
<td>CTO patient rights</td>
<td>The trust should ensure that staff explain patients’ rights in respect of community treatment orders consistently in accordance with the Mental Health Act (MHA) Code of Practice, and keep accurate records of consent to treatment in line with the MHA and when patients’ rights have been explained.</td>
</tr>
<tr>
<td>5</td>
<td>Psychological therapy access</td>
<td>The trust should ensure that patients have access to psychological therapies without undue delay in line with best practice guidance.</td>
</tr>
<tr>
<td>6</td>
<td>Interface with HTT and Acute</td>
<td>The trust should continue to develop more effective working relationships between the community teams, home treatment teams and inpatient wards; and improve the quality and frequency of contact between community staff, ward staff and patients admitted to the wards.</td>
</tr>
<tr>
<td>7</td>
<td>Pathway barriers</td>
<td>The trust should continue to address barriers to effective patient movement along the care pathway. The trust should ensure that staff clearly understand their roles and responsibilities, clarify referral criteria and thresholds, ensure specialist teams can accept referrals, and support community staff to make more effective placement funding applications.</td>
</tr>
<tr>
<td>8</td>
<td>Quality management-risk assessments/care plans</td>
<td>The trust should ensure that quality management systems are further improved to ensure that significant gaps in the quality of risk assessments and care plans, and unreasonable waiting times for patients are addressed swiftly.</td>
</tr>
</tbody>
</table>

Table six: CQC Adult Community Pathway, Should Dos; October 2017

6.0 Governance and Assurance

The Director of Nursing has met with the Service Directors to consider the ‘MUST’ and ‘SHOULD’ do actions, they will lead the process of developing an action plan at CAG level.

The Director of Nursing and Chief Operating Officer will jointly scrutinise the plan and once approved it will be provided to the CQC within requested deadline and be implemented across the CAG.

The CAG leaders will take operational responsibility for the delivery of the improvement plan, the governance of the plan is via the Quality Governance Compliance Meeting (QGCM) and the progress or issues for escalation reported to the Senior Management Team meeting or the Quality Sub Committee accordingly.
The QGMC will also consider the utility of the learning from the report across the CAGs trust wide.

6.0 Conclusion

Whilst it was positive to note the good practice and improvements highlighted by the CQC, it is disappointing that the overall quality rating for the Adult Community Pathway dropped to 'requires improvement'. The Adult Community pathway recognises the areas identified in the report for improvement and the actions provide a useful baseline on which the Trust can learn and improve services.

Mary O’ Donovan
Head of Quality
24th October 17
Purpose of the paper

To update the Board on the recent activity of the Council of Governors

Governor Elections

1. All constituencies for which there are vacancies in the 2017 elections are being contested. Voting closes on 9th November and all eligible members are reminded to vote online before that date. Five governors are standing down (two of them having served their full allowed terms) and three are standing for re-election. The results will be announced on November 10th. This will enable new governors to undergo induction training before they take up their role on December 1st. We are very grateful to the departing Governors for their contribution to the Trust and wish them all the best for the future.

Council of Governors’ meeting

2. The Council of Governors met on 19th September for a packed agenda. There was a detailed focus on Finance and Audit, with the Council considering a redesigned finance paper and hearing directly from the External Auditors. There were updates from each of the Committees, including from the Governance Committee which the Council agreed should now be dissolved, having fulfilled its original purposes. A new travel expenses policy was agreed that will be incorporated in the Governors’ Handbook.

3. The Council approved the appointment of Grant Thornton UK LLP as the Trust’s external auditors.
4. On 12th October, SLaM hosted a joint meeting for governors and NEDs of the SLMHC partners. A film was shown introducing the Partnership and governors were given presentations by clinicians across the three trusts on Forensics, CAMHS Tier IV and the Nursing Development Programme. All three presentations were well-received and the Governors were pleased to hear about the excellent progress being made.

5. The governors present expressed an interest in further joint meetings. Oxleas will be offered the opportunity to host another meeting in the new year.

**Governor Awayday**

6. The Autumn Governors awayday was held on 10th October at Prospero House, Borough. Presentations were given by Altaf Kara on the direction of the Trust and by Cath Gormally on Social Care. Each presentation generated extensive discussion and reflection. Attendees also considered the emerging proposals for engaging with communities and piloting visits to local community events and venues, such as the Dragon Café to hear the views of the membership. Turnout to the Away Day was lower than usual, but this could be attributed to the large number of Governor events that had been requested and organised during September and October.

**Governor Training**

7. SLaM hosted a ‘Governwell’ Finance training course on 17th October with seven SLaM, four Oxleas and two Guys and St Thomas’s governors attending. Guys and St Thomas are hosting a Governwell Effective Questioning and Challenge course today which has been offered to our governors. SLaM Governors have been funded to attend Governwell courses on Member and Public Engagement course (one governor) and Accountability course (two governors). The Accountability and the Finance courses are particularly valuable and the Trust will explore hosting these within SLaM or with our partners to ensure that maximum numbers of Governors are able to attend.

8. Governwell core training and SLaM induction will be offered to all new governors during November. The core training is being hosted by Kings College Hospital. This will be supplemented by induction training for new Governors which is specific to SLaM. This will explain to them how the Council of Governors operates in SLaM as well as introducing them to the Chair, to key members of the support team in the Corporate Affairs directorate and to fellow members of the Council.

**Nominations Committee**

9. All members of the Nominations Committee have been actively involved in the processes for appointing a new Non-Executive Director to join the Trust when Julie Hollyman reaches the end of her term. The recruitment attracted an outstanding field.
REPORT TO THE TRUST BOARD:
PUBLIC
31st October 2017

Title | Briefing from Quality Sub Committee
---|---
Author | Amanda Pithouse, Director of Patient Experience and Quality/Deputy Director of Nursing
Accountable Director | Beverley Murphy, Director of Nursing

Purpose of the paper

To present a brief summary of the key points discussed at the meeting of the Quality Sub Committee of the Board held on 12th September 2017 drawing the Board’s attention to these for consideration.

Executive summary

Key issues were discussed at the committee and actions identified relating to:

- Reducing restrictive practice
- Quality priorities 2017/18
- Safeguarding children and adults
- Physical healthcare

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>12th September 2017</td>
<td>Quality Sub Committee</td>
</tr>
</tbody>
</table>
Key points

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

Meeting of the Quality Sub Committee – 12th September 2017

1. Reducing restrictive practice

A paper on reducing restrictive practice was presented to the committee. The paper outlined future plans to improve Trust governance structures to monitor progress on the reduction of restrictive practices. Suggestions were made by committee members to update the terms of reference.

Action:

- The terms of reference to include more robust detail on preventative strategies.

2. Quality Priorities 2017/18

A progress summary of 2017/18 quality priorities was presented to the committee which also outlined the process for setting the 2018/19 quality priorities. The process for approval of the 2018/19 quality priorities was discussed. Limited progress with the implementation of the inpatient electronic observations programme was highlighted. The committee agreed that this should be considered under the Board Assurance Framework (BAF). It was agreed that regular progress updates would be provided to the committee in the future.

Action:

- The 2018/19 quality priorities will be approved by the QSC
- Electronic observations to be included in the BAF
- In the future progress updates on quality priorities will be presented to the QSC three times per annum with a much more intensive piece of work towards the end of the year.

3. Safeguarding children and adults

The annual report for safeguarding adults and children was presented which will also be presented to the Trust Board. The report highlighted:

- Approved assurance systems which have been put in place over the last year in relation to Safeguarding
- Improvement on data has been made with changes to EPJS
- A consistent presence at the LSCBs over the last year.
- Newly appointed substantive named Safeguarding Lead on 30th October.
- Croydon had been issued with an Ofsted Judgement in relation to their Safeguarding work. The local authority and CCG would be looking for a strong executive presence in Croydon safeguarding committees to support them in their improvement efforts.

Action:

- A standardised set of safeguarding quality indicators developed with CCG partners will be created. A further update will be provided to the QSC on this once agreed.

4. Physical healthcare

The Physical Healthcare update was presented and agreed that this paper be returned to the Board. Areas of discussion included:

- Acknowledgement of progress to date.
- Recognition of further work required with Primary Care
- Methodology around data and triangulation
- Proposal of joining the Physical healthcare Committee with the Mortality Review Group to ensure wider strategy aims are achieved.

Action:

Review of the Committee structure as outlined above and Physical healthcare update paper to be returned to the Board.

Next meeting: 21st November 2017
REPORT TO THE TRUST BOARD: PUBLIC
31 October 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Audit Committee – update comprising (a) Key issues from September 2017 Audit Committee meeting (b) ‘Signed and sealed’ report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Steven Thomas (Audit Committee Secretary)</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Duncan Hames (Audit Committee – Non Executive Director)</td>
</tr>
</tbody>
</table>

**Purpose of the paper**

The following are regular reports to the Board following Audit Committee meetings, and are presented for the Board’s information/discussion. The Board is requested to note the reports:

(a) **key issues summary.** This paper informs the Board about key issues noted at the Audit Committee meeting held on 18 September 2017. At this meeting the Audit Committee concluded that (minutes 13.2.1(c) refers) no matters required escalation for the attention of the Board; and

(b) **signed and sealed report.** SLaM management is required to report to Audit Committee meetings on documents signed and sealed on behalf of the Trust, and the Audit Committee is required subsequently to present that report to the Board. The Audit Committee considered the attached signed and sealed report at its meeting on 18 September 2017.

**Executive summary**

**Key issues summary.** This report is itself a summary, and so is not further summarised.

**Signed and sealed report.** The CFO expanded on entries in the report.

**Committees where this item has been considered**

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 September 2017</td>
<td><strong>Audit Committee.</strong> The <strong>key issues report</strong> shows key issues arising from the Audit Committee’s meeting, and has been approved by the Audit Committee Chair. The Audit Committee considered the ‘<strong>signed and sealed</strong>’ report at this meeting.</td>
</tr>
</tbody>
</table>

Available upon request are the Audit Committee minutes on which this key issues summary is based.
AUDIT COMMITTEE MEETING: 18 SEPTEMBER 2017
KEY ISSUES SUMMARY

Board involvement recommended
(1). Declaration of interests policy (Committee agenda item 7.1)
The Committee reviewed and supported submission of the draft policy to the Board for approval subject to amendment for points raised at the Committee meeting including in particular:
- the scope of the policy should be broadened to cover: (a) non-medic decision makers who are not directly employed by SLaM, but who may appear to be; and (b) researchers working within complex funding arrangements; and
- after expiry, an interest should be required to remain on registers for a minimum of 18 months, rather than 6 months as currently stated in the policy (given that those reviewing older documents, such as past years’ accounts, may wish to be aware of relevant entries on the register).

(2). Assurance framework/proposals paper (Committee agenda item 8.2)
The Committee reviewed and supported submission of the proposals paper to the Board for approval subject to amendment for points raised at the Committee meeting including in particular:
- the proposals paper currently does not show the Board’s risk appetite. The Committee recommends that the Risk Manager prepares a paper to support Board consideration and decision as to the Board’s risk appetite;
- the Committee recommends that the Risk Manager clarifies how the assurance framework records mitigation of risks in a way that facilitates review; and
- the Committee supported further consideration of allocation of risk areas to committees for review, and supported quarterly overall review of the assurance framework by the Audit Committee.

For Board information
(3). External audit procurement (Committee agenda item 9.2)
The CFO advised the Committee that a panel would shortly review the tenders received from the 3 firms (Mazars LLP, Grant Thornton UK LLP, Deloitte & Touche LLP) with a view to making a recommendation to the Council of Governors. The panel includes representatives from the governing bodies and senior management teams of both SLaM and Oxleas NHS Foundation Trust, the Committee Chair, the CFO and SLaM’s procurement team.

(4). Estates Repairs and Maintenance (Committee agenda item 11.1)
The Committee supported internal audit’s comments arising from internal audit’s review of Estates Repairs and Maintenance, in particular as regards Estates Strategy on which internal audit commented: ‘There is no clear strategy that assesses, defines and communicates the way in which planned and reactive maintenance/repair work is to be delivered, organised and managed across the Trust. The Estates department has delivered its service based on historic working practices and with the development of an Estate’s Strategy there is a need to review the Trust’s Estates reactive and maintenance requirements and how this is aligned to the Estate’s Strategy. Management should undertake a review of the Estates department function with a view to developing a strategic approach which is aligned to the Estate’s Strategy. The review should consider the future scope of the Trust’s estate and what resources (both internal and external) are needed to deliver effective maintenance (for implementation by Capital Estates and Facilities Executive Board, Dec 2017)’.

Key points of assurance
Points (1), (2), and (3) above provide assurance.
The Committee received assurance reports from the internal audit and counter fraud service provider.
The current external audit provider (Deloitte) had no significant matters to raise, their audit of the 2016/17 annual accounts and related reports having been completed and reported at previous Audit Committee meetings.

Key risks to flag – for Board attention
As discussed more fully above, issues around: declaration of interests policy; assurance framework and related proposals paper; and Estates Strategy/repairs and maintenance.

Issues to be brought to the attention of other Committees
Nothing significant from this Audit Committee meeting.
## 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>
<th>Between</th>
<th>And</th>
<th>Signature</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>161</td>
<td>21/06/2017</td>
<td>Engrossed form of transfer of 158 Foxley Lane, Purley CR8 3NF</td>
<td>£1,100,000</td>
<td></td>
<td>SLaM</td>
<td>Capsticks Solicitors</td>
<td>Altaf Kara</td>
<td>Beverley Murphy</td>
</tr>
<tr>
<td>162</td>
<td>21/06/2017</td>
<td>Engrossed form of transfer of 27 Inglemere Road, London SE23 2BB</td>
<td>£2,130,000</td>
<td></td>
<td>SLaM</td>
<td>Capsticks Solicitors</td>
<td>Altaf Kara</td>
<td>0</td>
</tr>
</tbody>
</table>

## Summary of Documents on behalf of the South London & Maudsley NHSFT where signing is required.

<table>
<thead>
<tr>
<th>Number</th>
<th>Date</th>
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<th>Value</th>
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<th>Between</th>
<th>And</th>
<th>Signature</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>536</td>
<td>12/07/2017</td>
<td>NHS Professionals contract extension until 31st July 2017 (1 month) (no amount specified)</td>
<td>No amount specified</td>
<td>1 month</td>
<td>SLaM</td>
<td>NHS Professionals</td>
<td>Gus Heafied</td>
<td>Kris Dominy</td>
</tr>
<tr>
<td>537</td>
<td>18/07/2017</td>
<td>Lambeth Consortium Lead Providers Contract (2 copies signed)</td>
<td>£253,177.00 per annum</td>
<td>Until 31st March 2020</td>
<td>SLaM</td>
<td>Addaction</td>
<td>Gus Heafied</td>
<td></td>
</tr>
<tr>
<td>538</td>
<td>18/07/2017</td>
<td>Lambeth Consortium Lead Providers Contract (2 copies signed)</td>
<td>£40,000 per annum</td>
<td>Until 31st March 2020</td>
<td>SLaM</td>
<td>Aurora</td>
<td>Gus Heafied</td>
<td></td>
</tr>
<tr>
<td>539</td>
<td>26/07/2017</td>
<td>Lambeth Consortium Lead Providers Contract (2 copies signed)</td>
<td>£228,383.00 per annum</td>
<td>Until 31st March 2020</td>
<td>SLaM</td>
<td>Foundation 66</td>
<td>Gus Heafied</td>
<td>Kris Dominy</td>
</tr>
<tr>
<td>560</td>
<td>26/07/2017</td>
<td>Contract for Cycle Scheme for staff</td>
<td>£1516.07 per month</td>
<td>1 year</td>
<td>SLaM</td>
<td>Asset Finance Management Ltd</td>
<td>Gus Heafied</td>
<td>Kris Dominy</td>
</tr>
<tr>
<td>561</td>
<td>26/07/2017</td>
<td>Lambeth Consortium Lead Providers Contract (2 copies signed)</td>
<td>£408,334.08 per annum</td>
<td>Until 31st March 2020</td>
<td>SLaM</td>
<td>Blenheim</td>
<td>Gus Heafied</td>
<td>Michael Holland</td>
</tr>
<tr>
<td>562</td>
<td>23/08/2017</td>
<td>Service Agreement for the provision of “BadgerNet” Neuro-Rehab data Management Service</td>
<td>£26,000</td>
<td>2 years</td>
<td>SLaM</td>
<td>CleverMed Ltd</td>
<td>Beverley Murphy</td>
<td>Matthew Patrick</td>
</tr>
<tr>
<td>563</td>
<td>23/08/2017</td>
<td>Extension of existing Contract, (no amount specified)</td>
<td>No amount specified</td>
<td>2 months</td>
<td>SLaM</td>
<td>NHS Professionals</td>
<td>Beverley Murphy</td>
<td>Matthew Patrick</td>
</tr>
<tr>
<td>564</td>
<td>23/08/2017</td>
<td>Addition of Healthcare Scientists Staff Group, (no amount specified)</td>
<td>No amount specified</td>
<td></td>
<td>SLaM</td>
<td>NHS Professionals</td>
<td>Beverley Murphy</td>
<td>Matthew Patrick</td>
</tr>
</tbody>
</table>
COMMITTEE REPORT TO THE TRUST BOARD: PUBLIC
31 OCTOBER 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>FINANCE AND PERFORMANCE COMMITTEE UPDATE TO BOARD From the October 2017 Committee meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Executive Director</td>
<td>JUNE MULROY</td>
</tr>
</tbody>
</table>

Purpose of the paper

This is a regular report to the Board which sets out:

A. the key issues discussed at the Committee meeting and the actions proposed;
B. the key points of assurance;
C. the key risks that the Chair or the Committee wish to flag to the Board and
D. any issues to flag to other Committees.

The Board is asked to note the report which is presented for information and discussion.

Note. Available upon request are the draft minutes upon which this key issues summary is based

(A). KEY ISSUES SUMMARY (section C below flags key risks for Board attention)

A1. 2017/18 Performance report and CIPs, QUIPP, CQUIN (Committee agenda items 6, 7)

The majority of the FPC meeting was used to discuss in detail the risks identified in the paper. The FPC noted excellent progress in developing the report. Key issues covered were:

- NHSI indicators: early intervention in psychosis 2-week standard; Improving Access to Psychological Therapies (‘IAPT’) standards; IAPT Payment by Results (‘PbR’); and Data set submissions;
- operational performance and activity: bed equivalents; Length of stay (‘LoS’); and Adult Assessment and Liaison (‘A&L’) caseloads etc;
- Commissioning: Quality Innovation Productivity and Prevention (‘QIPP’); and Commissioning for Quality and Innovation (‘CQUIN’); and
- Cost Improvement Programme.

There was considerable discussion about financial risks. The FPC noted that current plans for recovery in 2017/18 placed heavy reliance on non-recurrent (‘one-off’) items. This, and indications that some commissioners are looking for delivery of additional savings for 2018/19 (despite the 2-year contracts already agreed), puts delivery of 2018/19 financial targets at an increased risk. The FPC was advised that from October 2017 onwards assurance reviews led by the Chief Executive will seek to identify recurrent saving initiatives to address this.

Key actions agreed were:

- The Director of Performance, Contracts and Operational Assurance will provide FPC members with numerical information about the rising caseloads which SLaM has flagged to commissioners regarding the early intervention in psychosis 2-week standard (Oct.2017); and
- The Director of Performance, Contracts and Operational Assurance will: (a) ensure that the graphs of monthly actual and contracted bed equivalents include projections past August 2017; and (b) clarify the baseline occupancy rate assumed in the contracted figures (Dec.2017). (The FPC had noted that the general pattern was for actual to exceed contracted bed equivalents, albeit that the trend for actual bed equivalents was reducing).

(Contd)
A2. Board Assurance Framework (Committee agenda item 8)
The Director of Finance has produced a report that would support the Board Assurance Framework as regards financial risks, controls and mitigations. The CFO noted that the Board needed to consider and conclude on its risk appetite. The meeting discussed the position on risk 8 (timely access to safe and high quality services) and risk 12 (financial position). The CFO advised that for these risks the targets for likelihood and consequence shown in the Board Assurance Framework should be set at realistic levels. For example the target likelihood for risk 12 should be 4 not 2, and so the overall target risk should be at least 16, hence making this a red-rated target.

Key actions agreed were: The Director of Finance will provide the FPC Chair with a copy of the financial risk report, and will subsequently circulate it to FPC members for review and comment. The Board will receive a revised version, reflecting these comments, and a note about principal risks 8 and 12 (Nov.2017).

(B). Key points of assurance

- For bed equivalents, although the general pattern is for actual to exceed contracted bed equivalents, the trend for actual bed equivalents is reducing
- The Service Director, Acute Care Clinical Academic Group (‘CAG’) is carrying out a ‘barriers to discharge’ review
- The Director of Performance, Contracts and Operational Assurance advised that a report from external consultants McKinsey & Company on a recent study at Croydon CCG appeared to confirm that Mental Health funding is not an area where further cuts can be made.

(C). Key risks to flag to Board (key issues summary section A above gives more background)

- Key risks discussed in the FPC meeting arose during review of the Performance Report. The Board agenda includes a Performance Report which will flag such key risks as appropriate.
- The FPC noted that the Board needs to consider and conclude on the Board’s risk appetite for the purposes of the Board Assurance Report.
- The FPC discussed key risks 8 (timely access to safe high and quality services) and 12 (financial position) in the Board Assurance Framework. The CFO advised that for these risks the targets for likelihood and consequence shown in the Board Assurance Framework should be set at realistic levels. For example the target likelihood for risk 12 should be 4 not 2, and so the overall target risk should be at least 16, hence making this a red-rated target. The FPC agreed that the Board should receive a note about this

(D). Issues to be brought to the attention of other Committees

- The FPC noted that the Board needs to consider and conclude on the Board’s risk appetite for the purposes of the Board Assurance Report.
- The Audit Committee will receive a copy of this key issues report as a matter of course.
This is a regular report to the Board which sets out:
- the key issues discussed at the Committee meeting and the actions proposed;
- the key points of assurance;
- the key risks that the Chair or the Committee wish to flag; and
- any issues to flag to other Committees.

The Board is asked to note the report which is presented for information and discussion.

### KEY ISSUES SUMMARY

<table>
<thead>
<tr>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maudsley Health, Abu Dhabi performance and due diligence on a commercial opportunity</strong></td>
</tr>
<tr>
<td>A report of current performance on Maudsley Health CAMHS and Adult operations was presented along with revised projections for each. These will continue to be presented at BDIC</td>
</tr>
<tr>
<td>A due diligence process for an international commercial opportunity was also discussed and recommended to commence.</td>
</tr>
<tr>
<td><strong>Intellectual Property</strong></td>
</tr>
<tr>
<td>A revised Intellectual Property Policy was presented and it was agreed that further investigation would be conducted on IP ownership/royalty share for staff employed by SLaM and other parties.</td>
</tr>
<tr>
<td><strong>Genetic Labs Reconfiguration Tender</strong></td>
</tr>
<tr>
<td>The tender was discussed and it was agreed that The Trust’s stance is that it should not bear any bid costs in this exercise.</td>
</tr>
<tr>
<td><strong>Financial Reporting and Governance</strong></td>
</tr>
<tr>
<td>It was agreed that the Chief Financial Officer and Commercial would lead on pulling together and quantifying the value of Maudsley branded services and initiatives.</td>
</tr>
<tr>
<td><strong>Terms of Reference Update</strong></td>
</tr>
<tr>
<td>The committee discussed proposed changes which will be updated and agreed at the next meeting.</td>
</tr>
</tbody>
</table>

### Key points of assurance

**Due diligence**: the committee requested regular updates on the due diligence exercise at BDIC and Board.

### Key risks to flag

N/A
REPORT TO THE TRUST BOARD: PUBLIC

30 October 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Performance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Harold Bennison, Director of Performance, Contracts and Operational Assurance</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Kristin Dominy, Chief Operating Officer</td>
</tr>
</tbody>
</table>

**Purpose of the paper**

To report the Trust’s operational performance against a range of key national indicators and identify and analyse under-performance and report action plans.

The report summarises the Performance Management Framework review meetings and identifies any major areas of learning and success.

To report on current contractual matters arising and key areas of focus for the Project Management Office.

To report on emergency preparedness status and current actions.

**Executive Summary:**

The Trust continues to meet the performance-related NHS Improvement Single Oversight Framework indicators with the exception of IAPT recovery. There are a number of risks and associated actions set out in the report.

The pressure in the acute inpatient pathway remains significant with particular heat in Lambeth and Lewisham. Actions continue to be based on a whole system approach covering both inpatient and community services to achieve the necessary flow. Additional reporting work is required to present the areas of pressure in community services.

CIP delivery shows a forecast variance of £7.4 million behind plan. The PMO is working with all underperforming CAGs and departments to develop emerging schemes to close the gap, however much of the recovery is non-recurrent and while closing the gap this year, will require further recurrent savings next year, which currently stands at a forecast CIP target of £18.2M.

The contract refresh discussions to confirm 2018/19 are critical to ensure areas of pressure are addressed. If there is a significant gap between the contract values, QIPP plans and the finance available for services there will be rapid escalation in November (COO and CFO) and then to the Chief Executive in December. The Board is asked to support this streamlined approach and to confirm that the Trust process is for QIPP schemes to undertake Quality Impact Assessment prior to sign-off and the risk for QIPP plans remains with commissioners.
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Appendix A – August Performance Dashboard
Appendix B – August Quality Sub Committee Dashboard
1. NHS Improvement Indicators

NHSI Access and Effectiveness indicators for the Single Oversight Framework are reported to the Finance and Performance committee (including Waiting Times for IAPT, EI, and Home Treatment Team gatekeeping).

NHSI Quality related indicators (Seven Day Follow Up and IAPT Recovery rate) are reported to the Quality Sub-Committee.

Trust performance is detailed below. Performance for September is being validated at the time of writing.

![Fig. 1 Summary Table NHSI Indicators: Access and Effectiveness](image1)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Target</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>Q1</th>
<th>Jul</th>
<th>Aug</th>
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</thead>
<tbody>
<tr>
<td>Admissions had access to crisis resolution/home treatment</td>
<td>95</td>
<td>98</td>
<td>100</td>
<td>100</td>
<td>99</td>
<td>90</td>
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<td>50</td>
<td>72</td>
<td>69</td>
<td>61</td>
<td>68</td>
<td>53</td>
<td>50</td>
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<tr>
<td>IAPT waiting times 6 week standard</td>
<td>75</td>
<td>89</td>
<td>87</td>
<td>88</td>
<td>88</td>
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<td>IAPT waiting times 18 week standard</td>
<td>95</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

![Fig. 2 Summary Table NHSI Indicators: Quality](image2)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Target</th>
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<th>May</th>
<th>June</th>
<th>Jul</th>
<th>Aug</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA follow up within 7 days of discharge</td>
<td>95</td>
<td>96.7</td>
<td>95</td>
<td>99.2</td>
<td>97.7</td>
<td>98.4</td>
</tr>
<tr>
<td>IAPT Recovery Rate</td>
<td>50</td>
<td>49</td>
<td>47.4</td>
<td>49</td>
<td>48.2</td>
<td>49.7</td>
</tr>
</tbody>
</table>

1.1 Risks

1.1.1 Early Intervention in Psychosis 2 week standard

The standard continues to be met. There is a significant change in the reporting process which is being prepared for.

Throughout last year, the Trust has reported aggregated EI waiting times through the UNIFY2 online data reporting system which allows for manual validation of data before submission. During 2017, this system will be retired and data will be supplied by the more detailed, automated, Mental Health Services Data Set (MHSDS). The initial August submission, based on the MHSDS data, was 47%; subsequent validation by the CAG team confirmed actual performance was 50% as shown in Fig.1. Data validation processes within the Psychosis CAG, supported by Business Intelligence, are being adjusted to use the ‘live’ data which should eliminate the discrepancy. This will continue to be monitored in the coming months.

Conversations with commissioners continue, regarding concerns about delivery of part two of the standard based on existing CCG investment, the rising caseloads and the projected 70% total caseload increase over three years. Of particular concern is the ability of the Croydon team to move to expanding the service to those over 35 years old.

1.1.2 IAPT Standards – waiting times and access

Whilst the IAPT waiting time standards were met, Trust provision is affected by the reduced service commissioned by Croydon CCG targeting 12% access against the national CCG target of 16.8%
access for population with depression or anxiety disorders. The Lewisham IAPT service did not meet the 6 week target in July and August and this is being reviewed and addressed by the team.

1.1.3 IAPT Recovery

Since 2009 the IAPT model has been central to successive governments mental health policy. IAPT currently is one of the major national mental health standards and is central to commissioning agendas.

The IAPT model provides early intervention to people with common mental health problems, thus preventing these experiences from worsening. The prevalence of common mental health problems in a local population is calculated and it is the role of the service to now provide access for 16.8% of that defined population (although Croydon has commissioned reduced capacity). The Five Year Forward View has set very ambitious access targets for IAPT services and the access target will incrementally increase to 25% by 2021. People with long term physical health condition will be a central target population.

IAPT interventions were predominantly based on cognitive behaviour therapy (CBT) at the outset but this has since extended to person centred/solution focused counselling, couple therapy and brief psychodynamic therapies. Supporting meaningful occupation and employment is also now a key driver for IAPT services.

Support Interventions are offered at step two or step three. Step two is guided self-help (group or individual) for people with low level needs and provided by a wellbeing practitioner for approximately six sessions. Step three is evidence based (mainly CBT) interventions, provided by a trained therapist and treatment should be 12-16 sessions. Group therapy at step two or three is efficacious but patient preference is often one to one.

The proportion of people receiving step two and three interventions is moving toward 70/30 respectively. Step two will be greater if resources are limited in a service. Digital offers are becoming increasingly available.

Including access, the main indicators are

- Access
- Waiting Times
- Recovery rates

Recovery rates are more readily achieved if a service user presents with a lone problem descriptor, such as depression or anxiety. Where a service user is experiencing co-morbid anxiety depression and/or a history of child trauma this can contribute to lowering the overall recovery rate. Although more complex cases may not in “IAPT model” terms have fully recovered, subjectively and clinically they will still have made significant improvement following an intervention. There are interventions that we can provide within the service, such as recovery focussed supervision that is a vehicle that focusses interventions to achieve recovery targets.

Clinical outcomes are measured thorough clinician and patient rated outcome measures, which is translated into overall recovery rates for each service. The expected recovery rate is 50%. NHS Digital continues to publish the official statistics for these measures. The most recent time period published at the time of writing is June 2017.

Southwark 41%
Lewisham 56%
Croydon 49%
Lambeth 52%

The Trust remains marginally below the 50% standard (see Fig. 2). The most recent data indicates Lewisham, Lambeth and Croydon are sustaining the improvement although Croydon performance
has been impacted by the significant cuts requested by commissioners as part of the implementation of the Croydon Affordability Bridge in June 2016 and Croydon CCG focus on access targets.

Southwark performance continues to be addressed in liaison with Southwark CCG. During August 2017, NHSI visited Southwark IAPT to review the clinical model and to review how corporate governance could be further improved regarding the data collection and assurance processes. The recommendations related to data coding, administration functions, engagement at referral, the use of other brief treatment modalities and the introduction of stepped interventions. Many of the recommendations are in train and there are internal actions alongside collaboration with the CCG to address outstanding issues. This includes a review of the service specification.

### 1.1.4 IAPT Payment by Results

There is a national initiative to change the mechanism by which IAPT services will receive income from April 2018. The new tariff system includes the measurement of clinical outcomes and the use of the mental health clustering tool. The Trust is liaising with NHSE and commissioners to understand the new model and guidance which is helping to shape an implementation plan. It is expected that future payment mechanisms across the four Borough’s will be agreed with the four CCG’s by the end of November 2017 in order to commence a shadow payment system for January 2018.

### 1.1.5 Seven Day Follow-Up

Whilst Seven Day follow-up no longer has a national target attached (this was 95%), it is recognised as an important measure and remained a mandated component of the 2016/17 Quality Account. Therefore, it is intended to continue to report it through the QSC. Performance for discharged patients remains above the 95% target for the financial year.

### 1.1.6 Data Quality for Mental Health Services Data Set submissions

The next version MHSDS, version 3, will be introduced in April 2018 and this change is required to meet the ambitions set out in Achieving Better Access to Mental Health Services by 2020 and The Five Year Forward View for Mental Health (MHFYFV). NHS Digital are working with the mental health access and waiting time standards programme to ensure that agreed methodologies can be reported from the MHSDS with respect to a number of care pathways: adult acute mental health, CYP mental health, CYP eating disorders, early intervention in psychosis (EIP), perinatal mental health and urgent and emergency mental health. This allows commissioners to monitor the defined care pathways, specifically access and waiting times (using pre-defined metrics).

Additionally, MHSDS version 3 has data developments to support the following clinical areas: children and young people’s mental health, learning disability case services, autism case services, specialist commissioning, referral activity, delayed transfers of care.

The Business Intelligence Team will perform a detailed gap analysis and will liaise with the Clinical Systems Team (Digital Services) to ensure clinicians can enter the data required by the national clinical standards and requirements.

The increasing use of information has highlighted the importance of the Trust Service Directory to ensure there is a clear and consistent structure for all teams with a consistent way to map information between the numerous data systems (eg Finance, Datix and ePJS). Agreement has been reached in August regarding the principles of the service directory and the mapping between different systems. A technical solution had been identified within Finance which was not compatible with the move towards cloud-based services (due to issues around database ‘hosting’). An alternative solution has now been scoped and an implementation plan will be developed in October.
1.1.7 Improving Physical Healthcare

Improving physical healthcare for people with serious mental illness indicators for screening and interventions were included in NHS Improvement’s single oversight framework and is also a national CQUIN. Monthly reporting on this is included in the quality priority summary within the new QI led quality dashboard.

2 Operational Performance and Activity

2.1 In-Patient Activity and Performance

In order to improve the tracking of performance against contract, the following run charts show the performance of the adult acute inpatient services for LSLC patients against the LSLC contract values. These figures include foreign patients for which a further accounting adjustment is made (usually reducing the activity by c. 2%).

The charts show performance on a monthly basis for 17 months from April 2016 to August 2017. In order to enable monthly comparison, the number of OBDs is divided by the number of days in the month and therefore also provides the equivalent to monitoring bed usage. Data excludes leave and the data combines Acute, Triage, PICU and Early Intervention wards (including all overspill).

Due to the 16/17 performance, contract negotiations agreed an increase in the contracted number of OBDs in April 2017 (ie month 13). However, Q4 performance meant that performance was already above the plan at the start of the 17/18 year and recovery plans are in place aligned with the QI Large Scale Initiative. The external overspill chart appears later in this report.

Of particular note is the excess in Lambeth (c. 25% excess in Q2) and Lewisham (c. 15% excess in Q2) and discussions are on-going to achieve an agreed forecast and risk share position when M6 is reported. As over performance has been up to 30%, Lambeth CCG is seeking mitigation regarding the risk share value from within the block contract.

Whilst starting from a relatively high base, the Croydon improvement is a highlight and can be seen to be the key driver in the overall Trust position. In fact, Q2 performance for Croydon was 9% ahead of plan for Q2. For all CCGs, Q3 and 4 plan for continued reductions in bed usage. Future versions of these charts will include the future trajectory.
Fig. 3 – LSLC Acute, Triage, PICU and EI performance against commissioned trajectory
In addition to the variance against contract, external overspill adds an additional cost pressure to the Trust. Eliminating external overspill aligns closely to the Mental Health Five Year Forward View target and the Crisp report recommendation to eliminate out of area placements.

The number of Out of Area Placements (OAPs) fell to zero briefly in August although September performance has shown a return to a low level of usage. Fig. 4 shows the position from April 2017 through to the first weeks in September, the colours represent the split between Acute and PICU beds.

**Fig. 4 – External Overspill, April 2017 through to mid September 2017**

The four boroughs have developed specific projects as part of the Large Scale Initiative (LSI) quality improvement. There are 15 projects working towards one of the four main drivers in addition to the mobile working initiative across all boroughs.

| Effective teamwork across boundaries | 9 |
| Patient and Staff experience | 2 |
| Patient experience | 3 |
| Recognition of and planning for possible deterioration | 1 |

**Large Scale Initiative project themes**

**2.1.1 Occupied Bed Days: Acute Care Pathway**

Patients with longer lengths of stay are reviewed weekly at clinical meetings. Longer lengths of stay can be attributable to delayed transfers of care, other reasons of social need and patient acuity. A
higher proportion of current patients in Croydon wards and private overspill have a length of stay over 6 months.

**Fig. 5 – Length of Stay Breakdown**

Figure 5 clusters the inpatient cohort within the acute care pathway (wk1, September) by their length of stay at that point. The first colour is 0-30 days, then 31-60 days and the final group is >180 days. The commissioners are in alphabetical order: Croydon, Lambeth, Lewisham, Southwark and “other”. Lambeth CCG can be seen to have the highest number of inpatients and also the highest number (13) whose length of stay already exceeds 180 days.

Regular interface meetings between Community and In-patient wards are occurring with a particular focus on strengthening the joint working and awareness between community teams and wards.
2.1.2 LSLC Admissions
The following charts show the admissions by CCG for each month Apr 16 – Aug 17. The planned level was based on historical performance in 2016. It can be seen that admission levels are broadly consistent although above the planned level which is contributing to the increased levels of inpatient activity.
2.1.3 Delayed Transfers of Care

The Trust makes a monthly submission to NHS England providing a snapshot of delays and lost bed days. The charts below provide a snapshot of patients with a delayed transfer of care and the corresponding number of bed days unavailable to new admissions or transfers. The reporting is by local authority as the reason for delay can be attributable to NHS or social care.

In August, the Trust recorded 871 bed days being lost to delayed transfers of care. At 5.4%, this has been at a consistent level over the last 6 months. A 3.5% target has been set from September by NHSE and an initial meeting with commissioners and Trust teams took place in August focusing on the reconciliation of DToC data and any necessary improvements to the current system wide processes. Initial actions were agreed and a follow up meeting with commissioners and local authorities is being arranged.
2.2 Community Activity & Performance

The reporting for community continues to be enhanced with recent developments supporting the reporting and analysis of which community teams are responsible for the current inpatient cohort. This supports the work to reduce length of stay already described.

Overall, the community picture remains one of increasing pressure in many areas of the system and this has been shared with commissioners. There is a 4 Borough workshop on 6th November where we aim to provide greater insight and clarity for commissioners into the scale of the problem. This will include trend analysis of areas of growth such as GP referrals as well as the existing focus on caseload size.
2.2.1 A&E Mental Health Liaison
The number of presentations to A&E Mental Health Liaison teams have increased in Croydon, Lewisham and Southwark since the beginning of this year and in these boroughs are up to 20% above indicative activity plans.

![A&E Liaison Services](image)

**Fig. 9 Mental Health Liaison Team Presentations**

2.2.2 Community Teams
The new community information has highlighted a continued growth in the caseload size of our community assessment and liaison teams. The updated information to August is shown in Fig. 10. The report is being refined to factor in the different model of care in Lambeth with the Living Well Hub. However, the overall trend in growth remains noteworthy.

![Community Teams](image)

**Fig. 10 Adult A&L caseload, referrals and discharges Apr 16 – Aug 17**
3. CAG Performance Reviews Summary

The Performance Management Framework is comprised of Key Performance Indicators across:

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

The key issues and associated actions at M6 are similar to M5:

- Adult inpatient pathway pressures; external overspill and Delayed Transfers of Care (DToC) – the full system approach to tackling this has now commenced although significant pressure remains in this area
- IAPT performance
- Early Intervention
- Delivery of CIP schemes for 17/18 and identifying additional opportunities given the on-going CIP gap.
- Implementation of QIPP plans and other commissioner cost reduction plans in response to commissioned schemes
- Agency expenditure and achieving the NHSI reduction trajectory

3.1 Training

3.1.1 Mandatory Training Compliance (August 2017)

Overall mandatory training compliance shows a small dip in August 2017. Tier 1 Level B (role-specific training requirements) compliance has increased over the period to the end of August but Tier 1 Level A has fallen by 0.55%.

The main concern to highlight is the on-going issue of LEAP account creation and expiry. LEAP is designed to interact with SLaM network accounts to create a single-sign on experience within the Trust network and to allow users to log on remotely using their Office 365 account details. This has overcome most of the issues that learners had with the previous array of platforms each of which required a separate account and access route.

LEAP accounts are created automatically from the Trust’s Active Directory records. They are then enhanced by role, position and infrastructure data taken from the Electronic Staff Record (ESR). The combination of this information drives the training audiences which direct learners to complete the correct training for their role and is the basis for compliance monitoring.

Unfortunately, despite many months of negotiations between various Trust departments, the process of creating and deleting accounts has still not been resolved satisfactorily. This is having an impact on compliance reporting, staff administration time and confidence in the system.

3.1.2 Physical Health Level 1 Awareness

In accordance with the Trust’s CQUIN targets, all staff are required to complete a level 1 awareness course on physical health. Since April, a session on physical health has been delivered to all new starters at Trust Values Day. Existing staff can now complete the training by watching a 15 minute interactive video either individually through LEAP or as a group in a team meeting. Compliance has been captured from April but reported for the first time in this month’s reports. Overall compliance stood at 49.96% on 11 September.
<table>
<thead>
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<th>Tier Level</th>
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<th>Renewal Period</th>
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<th>Tier 1 Level B</th>
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<td>A</td>
<td>Fire Safety Awareness</td>
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<tr>
<td></td>
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<tr>
<td></td>
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<td>29-Sep-16 - 28-Oct-16</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Fig. 11  Mandatory Training Tier 1 Levels A & B
4. Commissioning

There will be a concentrated contract refresh for 2018/19 with commissioners. This is the second year of the 2017/19 contracts already in place. Meetings commence towards the end of October with a 4 Borough workshop on 6th November.

Commissioners have been clear regarding the scale of QIPP expectations (in the order of £10 million) although there are very few detailed plans to achieve this. There is a gap of approximately £10 million between proposed contract values and the Mental Health Investment Standard. SLaM services have numerous areas of pressure, particularly in community services, which will need the engagement of commissioners to resolve through supporting system redesign or additional funding.

There will be continued engagement with commissioners to develop the QIPP programme and investment programme in the coming months. If there is a significant gap between the contract values, QIPP plans and the finance available for services, the plan is to escalate to the Chief Operating Officer and Chief Financial Officer in the second half of November and to the Chief Executive in early December. The Board is asked to support this streamlined approach and to confirm that the Trust process is for QIPP schemes to undertake Quality Impact Assessment prior to sign-off and the risk for QIPP plans remains with commissioners.

The adult inpatient performance continues to be a major area of focus for commissioners. The LSLC commissioners have expressed their desire to support our focus on tackling our inpatient demand. They have confirmed their willingness to expedite plans for overcoming blockages in the system.

Croydon CCG continues to face a significant financial challenge. A number of consultants are now supporting the CCG with a McKinsey report highlighting areas requiring focus. The conclusions appear to confirm that Mental Health funding is not an area where further cuts can be made. The CCG is seeking to extend the Older Adult Alliance principles across all adult ages. It will be important that there is specific focus on mental health within the overall programme. The status of the Mental Health Programme Board has been confirmed as the forum to approve mental health transformation changes.

The Trust is awaiting confirmation of the Croydon CCG proposals for Specialist Services in writing, although there has been clarification that decisions will be made based on clinical need as a priority over financial constraints except for the National Psychosis Unit where the plan is to terminate access and the plan for a “one in one out” system for the National Autism Unit. This has been highlighted again in September and resolution is expected in October before the next Mental Health Programme Board.

The BDP CAG has highlighted quality concerns for the ASD / ADHD service in Lewisham. Demand significantly exceeds capacity of this clinic, which has resulted in high waiting times for patients - approaching 2 years. An options paper will be reviewed with Lewisham CCG in October to address the current capacity and demand issues - each option includes a quality impact assessment.

Southwark CCG are developing plans to consider forming an Alliance for mental health services which could take a similar format to the Lambeth system.

Various initiatives under the Five Year Forward View (5YFV) are now proceeding and a system of oversight is being implemented with commissioners, using a simple template for each initiative referencing the national expectation and any local modifiers. The Psychological Medicine and Integrated Care CAG is leading on this given the current focus on IAPT, Core 24 liaison services and Perinatal services. This oversight of the implementation and results achieved will be particularly
important to assist our negotiations for making the new funding recurrent and part of our core contracts in the future. This will align with the STP reporting of the 5YFV.

There will be a review of NHS England CQUIN and QIPP schemes after Q2 to confirm the process for SLaM to invoice for the value of the QIPP to be returned to the baseline (NHS England remove the QIPP value from the contract at the start of the year). Commissioners have confirmed their belief that the CQUIN actions will realise sufficient repatriation to release the value of the QIPP back to SLaM. At the time of writing, the contractual position for the New Models of Care streams – both Forensic and CAMHS – remain outstanding within this financial year. Similarly, NHS England have confirmed no immediate plans to commence discussions around detailed planning for 2018/19.

### 4.1 Commissioner-related Quality Impact Assessments (QIAs)

The Programme Management Office has managed QIAs for CIP schemes and this is extending to include commissioner-related QIAs including the Quality, Innovation, Productivity, and Prevention (QIPP) programme. Timing of QIA panels has resulted in the expiry of many QIPP QIAs and in some cases the change has already occurred despite not having a quality impact assessment. The system is currently relying on the assurance of QIPP delivery leads that quality is not adversely affected. The PMO is introducing a governance RAG alongside the CSO delivery RAG to more readily report failures in governance such as QIA, risk management and delivery planning.

### 4.2 Commissioning Programmes 2017-18

2017-18 QIPP and CQUIN schemes are being managed using the PMO principles.

#### 4.2.1 Quality, Innovation, Productivity and Prevention (QIPP) programme

QIPP has been rated into four categories:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Definition</th>
<th>£’000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Requires significant work</td>
<td>1,363</td>
</tr>
<tr>
<td>Amber</td>
<td>Requires some work</td>
<td>833</td>
</tr>
<tr>
<td>Green</td>
<td>Requires little work</td>
<td>5,197</td>
</tr>
<tr>
<td>Blue</td>
<td>Delivered</td>
<td>2,975</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>10,369</td>
</tr>
</tbody>
</table>

The QIPP risk dashboard is set out in Fig. 12
QIPP Dashboard

<table>
<thead>
<tr>
<th>QIPP Ref</th>
<th>CCG</th>
<th>QIPP plan</th>
<th>progress</th>
<th>CAG</th>
<th>Value (£)</th>
<th>Forecast (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIPP01</td>
<td>Southwark</td>
<td>Residential placements structure of teams</td>
<td>Action plans agreed, review of high cost placements underway</td>
<td>Psychosis</td>
<td>800,000</td>
<td>400,000</td>
</tr>
<tr>
<td>QIPP19</td>
<td>NHS England</td>
<td>PMIC &amp; C&amp;V Services</td>
<td>Aim is to recover QIPP through marginal rates of additional activity</td>
<td>PMIC</td>
<td>563,196</td>
<td>473,196</td>
</tr>
</tbody>
</table>

**Red Definition** Requires significant work

| QIPP17 | NHS England | Tier 4 Acute Admission Linked Patient Kent - (FYE 16/17) | CAMHS | £833,408 | £833,408 |
|         |             | ○ NHSE Kent, Surrey, Sussex have not engaged proactively with QIPP | Psychosis | 365,000 | 182,500 |
|         |             | ○ In-year savings at risk | Acute Care | 2,742,331 | 2,742,331 |
| QIPP07 | Lewisham | Reduction in Placements Funding | Delivered. However due to unexpected growth particularly with discharges from Acute wards we need to keep to agreed recovery plans to breakeven at year end | PMIC | 660,000 | 600,000 |
| QIPP04 | LSLC | Multiple OBD reduction plans | CIP over delivers against QIPP | PMIC | 764,855 | 764,855 |
| QIPP15 | Croydon | Increase in cross boundary flow income from Surrey/Sussex | Dispute with CCG on ownership | PMIC & Psychosis | 217,000 | 217,000 |
| QIPP18 | NHS England | Secure & Specialised MH - secure male | CAG confirmed action is complete. SLAM agreement with NHSE to reduce QIPP target with each repatriation must be tested against SLF finance arrangements | BDP | 300,000 | 300,000 |
| QIPP10 | Lewisham | LITT Team - move from Psychosis to primary | agree final transition model with CCG | Psychosis | 208,000 | 208,000 |
| QIPP16 | Croydon | Reduction in IAPT Costs/Activity | contract reduced and team removed but overhead contribution will not be saved | PMIC | 5,014,686 | 5,014,686 |
| QIPP03 | Southwark | Treatment teams redesign (ND leading health based model) | Delivered | PMIC & Psychosis | 200,000 | 200,000 |
| Croydon Bridge | Croydon Bridge | FYE delivery | Closed | Multiple | 1,059,000 | 1,059,000 |
| QIPP05 | Lewisham | Withdrawal from START (FYE from 1/7/16) | Complete | Psychosis | 44,250 | 44,250 |
| QIPP06 | Lewisham | CASCAD - (FYE from 1/7/16) | Complete | Psychosis | 36,270 | 36,270 |
| QIPP12 | Lewisham | Direct Payment Budget | Complete | Psychosis | 100,000 | 100,000 |
| QIPP08 | Lewisham | Cease AMH Programme Management | Complete | PMO | 110,000 | 110,000 |
| QIPP09 | Lewisham | IAPT (15% reduction) | Complete | PMIC | 467,000 | 467,000 |
| Accounts | Croydon | MHOA Acute OBD reduction | Complete | MHOA | 254,000 | 254,000 |
| Accounts | Lewisham | Reduction in CAMHS Transformation (Prenatal MH plus extension of Adult IAPT) | Complete | CAMHS | 88,000 | 88,000 |
| Accounts | Lewisham | Reduction in CAMHS Transformation (Disabilities & Long Term Med Conditions) | Complete | CAMHS | 50,000 | 50,000 |
| Accounts | Lewisham | MHOA Acute OBD reduction | Complete | MHOA | 204,000 | 204,000 |
| Accounts | Lambeth | MHOA - Continuing Care | Complete | MHOA | 362,580 | 362,580 |

**Green Definition** On track / requires little work

| QIPP01 | Southwark | Residential placements structure of teams | Delivered | PMIC & Psychosis | 5,197,186 | 5,104,686 |
| QIPP03 | Southwark | Treatment teams redesign (ND leading health based model) | Delivered | PMIC & Psychosis | 200,000 | 200,000 |
| Croydon Bridge | Croydon Bridge | FYE delivery | Closed | Multiple | 1,059,000 | 1,059,000 |
| QIPP05 | Lewisham | Withdrawal from START (FYE from 1/7/16) | Complete | Psychosis | 44,250 | 44,250 |
| QIPP06 | Lewisham | CASCAD - (FYE from 1/7/16) | Complete | Psychosis | 36,270 | 36,270 |
| QIPP12 | Lewisham | Direct Payment Budget | Complete | Psychosis | 100,000 | 100,000 |
| QIPP08 | Lewisham | Cease AMH Programme Management | Complete | PMO | 110,000 | 110,000 |
| QIPP09 | Lewisham | IAPT (15% reduction) | Complete | PMIC | 467,000 | 467,000 |
| Accounts | Croydon | MHOA Acute OBD reduction | Complete | MHOA | 254,000 | 254,000 |
| Accounts | Lewisham | Reduction in CAMHS Transformation (Prenatal MH plus extension of Adult IAPT) | Complete | CAMHS | 88,000 | 88,000 |
| Accounts | Lewisham | Reduction in CAMHS Transformation (Disabilities & Long Term Med Conditions) | Complete | CAMHS | 50,000 | 50,000 |
| Accounts | Lewisham | MHOA Acute OBD reduction | Complete | MHOA | 204,000 | 204,000 |
| Accounts | Lambeth | MHOA - Continuing Care | Complete | MHOA | 362,580 | 362,580 |

**Blue Definition** Delivered

| Accounts | Lambeth | MHOA - Continuing Care | Complete | MHOA | 362,580 | 362,580 |

**Total Overall** 10,968,890 9,696,390

**variant** 672,500

**Fig. 12 QIPP dashboard**

**QIPP Red risks**

- **Southwark Placements.** Value £800K. The plan to move people from high cost placements to lower cost alternatives is off track. Work is underway to recover the programme, but the current forecast is to deliver approximately £400K. Recovery planning is underway.

- **PMIC C&V Services.** Value £563K. The aim is to recover the QIPP reduction through marginal rates of additional activity, this will require close monitoring as it requires a significant uplift in activity. Work is underway to measure the performance of the service, however £90K is assessed as at risk, hence the forecast is devalued to £473K. Recovery planning is underway.
Downgraded from last review

- **OBD.** OBD is no longer reported as a QIPP risk, notwithstanding the on-going cost pressure, and is downgraded from red to green as a QIPP. The income reduction of £2,742K has been accounted for and removed from the baseline and beds have been removed under the CIP programme in order to reduce the associated cost. However, this has resulted on the reliance on overspill as the expected reduction in admissions and length of stay has failed to materialise and is now the subject of a large scale QI initiative and concerted management effort. The overspill position is manifesting as an overspend in the Acute Care CAG of £2,500K and is currently being reported as an overspend against the CAG.

- **Tier 4 Adolescent services.** Value £833K, downgraded from red to amber. NHSE London have accepted that no proposal was offered for the first 6 months of the year, therefore they have agreed to a mid-year review after Q2 with an expectation of being invoiced for the necessary value. There is an expectation that NHSE will propose alternative QIPP schemes to recover as much of the income as possible, which may have implications for next year, and discussions are still underway.

- **Secure Mental Health.** Value £765K, downgraded from amber to green. The Forensic Alliance have already repatriated the required number of patients and the full value of QIPP has been delivered. The QIPP is not shown as blue (delivered) as the risk share arrangement means that any unexpected growth in patient numbers could impact QIPP before the end of the year.

- **Lewisham Placements.** Value £365K. The QIPP is delivered and downgraded to green, however due to unexpected growth particularly with discharges from Acute wards recovery plans need to be managed to ensure the improvement is sustained.

4.2.2 Commissioning for Quality and Innovation (CQUIN) Schemes

CQUIN is valued at £5.9M and delivery progress is reported in full at the QSC, the following represents the financial position for CQUIN.

- **Q1 Award.** Specific award criteria were agreed with LSLC CCGs on 25 April and with NHSE on 29 June. There has been agreement to move some Q1 targets to Q2 due to late starts, but these do not affect the financial milestones. The Trust received a full award of Q1 CQUIN. Q2 CQUIN is anticipated to be the full award, however the risks outlined in the paragraphs below will crystallise in Q3 and Q4 respectively.

- **Flu Risk.** The Trust is working toward full achievement of the Flu CQUIN and has started the campaign planning. However, the increase in uptake from last year to achieve the target is over 300%, therefore all £160k of flu award is at risk. This risk is extremely likely to be realised and will start to impact in Q3.

- **STP engagement.** There are still no definitive plans on how to achieve the joint targets across the STP, therefore the £1.92M CQUIN award remains at risk. It is anticipated that the withhold of CQUIN under this category may be used to close year end positions at the discretion of the STP, this should become clearer at the end of Q2.
5. Programme Management Office (PMO)

5.1 Cost Improvement Programme (CIP)

**SLAM summary CIP status report**

**Trust Overview**

Aug-17

<table>
<thead>
<tr>
<th>£000s</th>
<th>Plan YTD</th>
<th>Actual YTC</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>
<th>%</th>
<th>Overview comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAG schemes:</td>
<td>5,182</td>
<td>3,913</td>
<td>(1,269)</td>
<td>75</td>
<td>13,556</td>
<td>10,804</td>
<td>(2,752)</td>
<td>(2,752)</td>
<td>454</td>
<td>79%</td>
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<tr>
<td>Corporate schemes:</td>
<td>1,339</td>
<td>1,627</td>
<td>288</td>
<td>41</td>
<td>8,658</td>
<td>4,670</td>
<td>(3,988)</td>
<td>(3,988)</td>
<td>536</td>
<td>53.9%</td>
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<tr>
<td>Trust wide schemes:</td>
<td>2,485</td>
<td>2,410</td>
<td>(75)</td>
<td>1,460</td>
<td>4,809</td>
<td>4,154</td>
<td>(655)</td>
<td>(655)</td>
<td>1,460</td>
<td>86.4%</td>
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<tr>
<td>Trust Total</td>
<td>9,206</td>
<td>7,951</td>
<td>(1,255)</td>
<td>1,576</td>
<td>27,022</td>
<td>19,627</td>
<td>(7,399)</td>
<td>(7,399)</td>
<td>2,430</td>
<td>73%</td>
</tr>
</tbody>
</table>

**CIPs / Cost Reduction**

<table>
<thead>
<tr>
<th></th>
<th>CIP Schemes</th>
<th>Cost Reduction Schemes</th>
<th>Trust Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan YTD</td>
<td>6,179</td>
<td>3,027</td>
<td>9,206</td>
</tr>
<tr>
<td>Actual YTC</td>
<td>6,032</td>
<td>1,918</td>
<td>7,951</td>
</tr>
<tr>
<td>YTD variance from Plan</td>
<td>(147)</td>
<td>(1,019)</td>
<td>(1,255)</td>
</tr>
<tr>
<td>Value of Additional Schemes YTD</td>
<td>1,576</td>
<td>6,810</td>
<td>1,576</td>
</tr>
<tr>
<td>Full year Plan</td>
<td>18,680</td>
<td>8,342</td>
<td>27,022</td>
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<tr>
<td>Full year Forecast</td>
<td>12,817</td>
<td>6,100</td>
<td>19,627</td>
</tr>
<tr>
<td>Full year variance from Plan</td>
<td>(5,863)</td>
<td>(1,532)</td>
<td>(7,399)</td>
</tr>
</tbody>
</table>

**Fig. 13 Trust August CIP position**

The chart above shows the Trust M5 position, showing a forecast variance from plan of £7,399K. A slight improvement on the gap from the previous month. The following narrative covers the recovery planning as a result of PMO scrutiny of all plans.

### 5.1.1 Recovery Planning

The table below shows each CAG and department contribution to the overall CIP position. The PMO is working with all underperforming CAGs and departments to develop emerging schemes to close the gap, however much of the recovery is non-recurrent and while closing the gap this year, will require further recurrent savings next year, which currently stands at a forecast CIP target of £18.2M. Therefore, a series of CEO assurance meetings will be starting in October to review the overspend position of each CAG and department with an aim to start recurrent recovery action prior to the new financial year.

The most at variance departments: Acute Care CAG; Estates and Psychosis CAG are already undertaking an overspend review to look for solutions to recover both CIP shortfall and departmental overspend.

The table below has an adjustment for MHOAD of £100k which is an additional non-recurrent lock-in that is not reported in the CIP tracker in figure 10.
### CAGs

<table>
<thead>
<tr>
<th>£000s</th>
<th>Target</th>
<th>Assured Forecast</th>
<th>Assured Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>1,961</td>
<td>1,531</td>
<td>-430</td>
</tr>
<tr>
<td>BDP and Addictions</td>
<td>1,080</td>
<td>996</td>
<td>-84</td>
</tr>
<tr>
<td>PMIC</td>
<td>2,211</td>
<td>2,312</td>
<td>101</td>
</tr>
<tr>
<td>Acute Care Pathway</td>
<td>5,499</td>
<td>3,517</td>
<td>-1,982</td>
</tr>
<tr>
<td>CAMHS</td>
<td>1,385</td>
<td>1,135</td>
<td>-250</td>
</tr>
<tr>
<td>MHOA &amp; Dementia*</td>
<td>1,420</td>
<td>1,412</td>
<td>-8</td>
</tr>
<tr>
<td><strong>Total CAG</strong></td>
<td>13,556</td>
<td>10,903</td>
<td>-2,653</td>
</tr>
</tbody>
</table>

### Non-CAGs

<table>
<thead>
<tr>
<th>Category</th>
<th>CAG</th>
<th>Non-CAG</th>
<th>Total</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates &amp; Facilities</td>
<td>2200</td>
<td>1054</td>
<td>3254</td>
<td>-1146</td>
</tr>
<tr>
<td>ICT</td>
<td>1215</td>
<td>1155</td>
<td>2370</td>
<td>-60</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>318</td>
<td>210</td>
<td>528</td>
<td>-108</td>
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<tr>
<td>HR</td>
<td>600</td>
<td>129</td>
<td>729</td>
<td>-471</td>
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<tr>
<td>Medical &amp; Prof Heads</td>
<td>361</td>
<td>170</td>
<td>531</td>
<td>-191</td>
</tr>
<tr>
<td>Nursing &amp; Prof Heads</td>
<td>866</td>
<td>301</td>
<td>1167</td>
<td>-565</td>
</tr>
<tr>
<td>Pathology &amp; Pharmacy</td>
<td>780</td>
<td>321</td>
<td>1101</td>
<td>-459</td>
</tr>
<tr>
<td>Finance</td>
<td>821</td>
<td>545</td>
<td>1366</td>
<td>-276</td>
</tr>
<tr>
<td>Strategy &amp; Commercial</td>
<td>411</td>
<td>261</td>
<td>672</td>
<td>-150</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>560</td>
<td>503</td>
<td>1063</td>
<td>-57</td>
</tr>
<tr>
<td><strong>Total non-CAG</strong></td>
<td>8659</td>
<td>4669</td>
<td>13328</td>
<td>-3990</td>
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</table>

**Total CAG & non CAG**: 22,215, 15,572, -6,643

### Trustwide and gap

<table>
<thead>
<tr>
<th>£000s</th>
<th>Target</th>
<th>Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-pay review</td>
<td>280</td>
<td>0</td>
<td>-280</td>
</tr>
<tr>
<td>Closure of McKenzie</td>
<td>400</td>
<td>400</td>
<td>0</td>
</tr>
<tr>
<td>Senior management review</td>
<td>150</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>SLFP Enhanced income</td>
<td>250</td>
<td>190</td>
<td>-60</td>
</tr>
<tr>
<td>16/17 MARS scheme</td>
<td>377</td>
<td>377</td>
<td>0</td>
</tr>
<tr>
<td>Non-rec. in year savings</td>
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<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>IOPPN review</td>
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<td>0</td>
<td>-250</td>
</tr>
<tr>
<td>Agency staff review</td>
<td>1,000</td>
<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>Offset: Overspill recharges</td>
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<td>0</td>
</tr>
<tr>
<td>Offset: BDP Estates recharge</td>
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<td>Unidentifieds - pay</td>
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<td>-1</td>
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<tr>
<td>Unidentified: non-pay</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unidentified: patient income</td>
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<td>0</td>
<td>-64</td>
</tr>
<tr>
<td>Unidentified: adjustment</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Disposal of properties</td>
<td>1,460</td>
<td>1,460</td>
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</tr>
<tr>
<td><strong>Total Trustwide and Gap</strong></td>
<td>4,809</td>
<td>4,154</td>
<td>-655</td>
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### Overall

<table>
<thead>
<tr>
<th>£000s</th>
<th>Target</th>
<th>Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total CAG</strong></td>
<td>13,556</td>
<td>10,903</td>
<td>-2,653</td>
</tr>
<tr>
<td><strong>Total non-CAG</strong></td>
<td>8,659</td>
<td>4,669</td>
<td>-3,990</td>
</tr>
<tr>
<td><strong>Total Trustwide and Gap</strong></td>
<td>4,809</td>
<td>4,154</td>
<td>-655</td>
</tr>
</tbody>
</table>

**Overall Total**: 27,024, 19,726, -7,298

**Bed Pressure**. Sustained effort across all Boroughs has seen the overspill position reduced to single figures, but there is still a danger of it creeping back up. Therefore, the cost estimate of overspill for the year remains at £2.5M and is being treated as an overspend against CAG plans to close beds. Work is continuously ongoing to understand the impact of beds and to determine if it is to be reported as a failure in CIP or an overspend against a reduced bed stock and OBD income; at the moment CIP is being reported as delivered, because beds have been taken out, but the CAG is now overspending because overspill is being used instead. The situation remains high risk.

### 5.1.2 Audit Committee Recommendations

There is a standing FPC CIP recommendation from the Audit Committee action point 519, May 2017: The Audit Committee recommends that the Finance and Performance Committee should:

(a) review the elements that SLaM management includes in Cost Improvement Plans and changes proposed thereto by SLaM management;
(b) monitor achievement of Cost Improvement Plan targets during the year.

This month the recommendation is be met by:

(a) The PMO report of changes to the CIP portfolio to the FPC, this has been completed this month in the summary of the CIP recovery position.
(b) The PMO report of the achievement and forecast of CIP targets.

This is now routinely reported to the committee, therefore reference to this Audit Committee action will not be specifically included in future reports.
6. Emergency Planning
The NHSE (London) annual assurance process is currently taking place. SLaM has submitted evidence relating to core EPRR standards to NHSE (London) which will be assessed on 6th November (with the Trust Emergency Planning Manager and Accountable Emergency Officer in attendance). The Board will be updated on the Trust rating.

The Trust is continuing to work with NHSE (London), and the London Ambulance Service (LAS) to create a bespoke Hazardous Material (HazMat) and Chemical Biological Radiological Nuclear and explosives (CBRNe) ‘train the trainer’ course, specifically aimed at Mental Health Trusts. The training is planned to be signed off by LAS in mid-November and then will be rolled out.

In response to the recent ransomware / cyber security incident that affected a substantial proportion of NHS organisations, a SLaM Information and Communication Technology (ICT) ‘task and finish’ group has been set up. This group is to be chaired by the Chief Operating Officer and will have its first meeting in November 2017 where scope / objectives will be set.

7. Conclusion
The Trust continues to meet the performance-related NHS Improvement Single Oversight Framework indicators with the exception of IAPT recovery. There are a number of risks and associated actions set out in the report.

The contract refresh discussions to confirm 2018/19 (the second year of the 2017/19 contracts) are critical to ensure areas of pressure are addressed. If there is a significant gap between the contract values, QIPP plans and the finance available for services there will be rapid escalation in November (COO and CFO) and then to the Chief Executive in December. The Board is asked to support this streamlined approach and to confirm that the Trust process is for QIPP schemes to undertake Quality Impact Assessment prior to sign-off and the risk for QIPP plans remains with commissioners.

The pressure in the acute inpatient pathway remains significant with particular heat in Lambeth and Lewisham. Actions continue to be based on a whole system approach covering both inpatient and community services to achieve the necessary flow. Additional reporting work is required to present the areas of pressure in community services.

CIP delivery shows a forecast variance of £7.4 million behind plan. The PMO is working with all underperforming CAGs and departments to develop emerging schemes to close the gap, however much of the recovery is non-recurrent and while closing the gap this year, will require further recurrent savings next year, which currently stands at a forecast CIP target of £18.2M.

Continued progress is evident with our emergency preparedness.
## Appendix 1 - Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascom</td>
<td>Alarm / communications system supplied by Ascom UK, a telecommunications company</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bringing together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy (CBTp is CBT of psychosis)</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation: A fund where payment is contingent on delivery on quality improvements and meeting milestones agreed with commissioners.</td>
</tr>
<tr>
<td>CYP</td>
<td>Children &amp; Young People</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>DTOC</td>
<td>Delayed Transfers of Care</td>
</tr>
<tr>
<td>EI</td>
<td>Early Intervention: First Episode Psychosis</td>
</tr>
<tr>
<td>ePJS</td>
<td>Electronic Patient Journey System: Clinical records system</td>
</tr>
<tr>
<td>EPRR</td>
<td>Emergency Preparedness, Resilience and Response</td>
</tr>
<tr>
<td>GSTT</td>
<td>Guys &amp; ST Thomas' NHS Foundation Trust</td>
</tr>
<tr>
<td>HTT</td>
<td>Home Treatment Team</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>LSLC</td>
<td>Lambeth, Southwark, Lewisham &amp; Croydon (CCGs)</td>
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<tr>
<td>MHOA</td>
<td>Mental Health of Older Adults</td>
</tr>
<tr>
<td>MHSDS</td>
<td>Mental Health Services Data Set: National dataset submitted to NHS Digital (formerly known as the Health &amp; Social Care Information Centre)</td>
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<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement: the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>NHSP</td>
<td>NHS Professionals</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence: provides national guidance and advice to improve health and social care</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>PMF</td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td>PMO</td>
<td>Programme Management Office</td>
</tr>
<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help enhance services and improve their cost effectiveness</td>
</tr>
<tr>
<td>SOF</td>
<td>Single Oversight Framework: NHSI assurance and performance mechanism</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
Appendix A Performance Management Framework Trust Summary

Finance & CIPs

Workforce

Please refer to Board Finance Report

Acute CAG overspill (April - August)

Activity

Delayed Discharges - Days Lost

Adult OBD Against Monitor Plan (excl. Private Overspill)

Sickness (in arrears)

Agency Cost (Phased NHS Ceiling)

Admin Vacancies, Bank & Agency WTE Usage (in arrears)

Safers Staffing: Wards Breaching 20% of shifts (in arrears)

Nursing Vacancies, Bank & Agency WTE Usage (YTD) in arrears

Relative Sickness (wte) & Sickness Rolling Year %

All Staff - Annual Leave Planning

Vacancy WTE

Admin Vacancy WTE, Bank & Agency Usage (in arrears)

Admin NHSP Bank (WTE)

Admin Agency (WTE)

Admin Casual vacancies (WTE)

Admin Cost (Phased NHS Ceiling)

Spend

Indicative Ceiling Value

Sickness Rolling Year %

Agency Vacancy WTE, Bank & Agency Usage (in arrears)

Agent Cost (Phased NHS Ceiling)

Admin NHSP Bank (WTE)

Admin Agency (WTE)

Admin Casual vacancies (WTE)
Introduction

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

The Finance & Performance Committee continues to receive updates on a number of key regulator operational performance indicators (Effectiveness: including waiting time standards for IAPT, Early Intervention, Delayed Transfers of Care, Home Treatment Team Gatekeeping and Acute Overspill).

The Quality Improvement Team led Quality Dashboard continues to be developed. This report will be discontinued in due course with the relevant information reported in either the QI QSC Dashboard or the Chief Operating Officers report to the QSC.

The report has been amended to reflect the next iteration of the QI QSC dashboard, and the Trust Quality Priorities are now reported through the QI dashboard. Therefore safer staffing, violence and prone restraint reporting as Trust Quality Priorities have been removed from this dashboard.

Exception reporting:

IAPT Recovery Rate is reported in the main body of the Chief Operating Officer’s Quality report to the QSC.

Safe

<table>
<thead>
<tr>
<th>QUESTT Incorporates the following Metrics:</th>
<th>Level 0 (Score = 9 or less)</th>
<th>Level 1 (Score = 10 – 16)</th>
<th>Level 2 (Score = 17 – 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New or no Ward Manager in post (within last 6 months) , 2. Vacancy rate higher than 7% , 3. Bank shifts is higher than 6% , 4. Sickness absence rate higher than 3% , 5. No monthly MPT review of key quality indicators (e.g. peer review or governance team meetings, 6. Planned annual appraisals not performed, 7. Planned clinical supervision sessions not performed, 8. No formal feedback obtained from patients during the month (e.g. questionnaires or surveys), 9. 2 or more formal complaints in a month, 10. No evidence of resolution to recurring themes, 11. Unusual demands on service exceeding capacity to deliver, 12. Number of hours of enhanced levels of observation exceed 120, 13. Ward/department appears untidy/disrepair, 14. No evidence of effective multidisciplinary/multi-professional team working, 15. On-going investigation or disciplinary investigation</td>
<td>Level 0 (Score = 9 or less)</td>
<td>Level 1 (Score = 10 – 16)</td>
<td>Level 2 (Score = 17 – 23)</td>
</tr>
</tbody>
</table>
Caring & Responsive

Safety Continued

Do you feel involved in your care? Quality Priority

New Complaints - 2015 - 2017

New Serious Incidents

Unauthorised Absences (Detained Patients)

Seven Day Follow Up

99.3% 92.2% 0.0%

Followed up within 7 days of discharge of patients had a brief or full risk screen of patients had a child need risk screen

Do you feel involved in your care? 2015 - 2017

New Complaints

Unauthorised Absences

New Serious Incidents

Unauthorised Absences - Detained Patients

Seven Day Follow Up

99.3% 92.2% 0.0%

Followed up within 7 days of discharge of patients had a brief or full risk screen of patients had a child need risk screen
The LEAP system for training and learning was introduced in December. November data was not available due to the transition. For the core skills framework subjects a total of 25 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%).
REPORT TO THE TRUST BOARD: PUBLIC
31st OCTOBER 2017

Title  Finance Report As At 30th September 2017
Author  Tim Greenwood & Mark Nelson
Accountable Director  Gus Heafield

Purpose of the paper

The Finance Report provides an update on the financial position of the Trust as at 30th September 2017 (month 6). The summary financial statement and calculation of the Use of Resource rating from the NHSI month 6 submission is attached to the report in Table 2.

The Board is asked to approve the report including consideration of the pressures, risks and mitigations in place to meet the NHSI control total.

Executive summary

1) Current Position

At Month 6 ytd, the Trust had made a deficit of £2.2m, a favourable variance of £0.03m against its quarter 2 control total.

The underlying position remains as before, driven by a combination of cost pressures, particularly acute overspill, complex placements and unmet CIPs and QIPPs. The acute overspill position has stabilised and although there was a small increase in usage of beds in the month this was more than offset, financially, by backdated overseas visitors income. Overspill has since come down and at 12/10/17 there was just one overspill bed in operation.

Additional savings targets of £4.3m have now been allocated against CAG (£1.1m) and infrastructure (£3.2m) budgets. These are mainly phased to come in from month 6 but the schemes themselves are still largely being developed. The PMO are working with services to develop and clarify savings plans for presentation at a series of Chief Executive reviews later this month. These measures are necessary given the phasing of the plan which moves from a deficit position over the first 6 months to a surplus by the end of the year. Additional mitigations are also being sought including the use of lock-ins (£0.8m now held centrally), discretionary non-pay measures, collaborative savings and an increased focus on agency use.

Table 1 highlights the year to date (ytd) position by service including a brief narrative regarding their main financial issues.

The Trust’s cash position remains robust at £46m in September (a £9m favourable variance from plan). This position is driven by unplanned STF funding, capital slippage and property sales and is expected to remain strong throughout the remainder of the year.

The Trust has invested £1.5m of capital expenditure to date (£6.6m below plan) but expects to spend £13m capital (£7m below plan) having rolled forward £6.9m of Douglas Bennett House investment.

The Trust is currently rated by NHSI as a 3 against use of resources (where 1 is best out of a 1-4 range – see Table 2). The rating was originally scored at 2 but due to an override has been downgraded to a 3. The override kicks in due to a score of 4 against the Trust’s I&E margin...
2) Key Risks/Drivers

- The use of acute overspill beds has resulted in a cost pressure, after application of risk shares, of £2.2m after 6 months. Through the introduction of a range of measures, overspill numbers have fallen although, as indicated last month, the numbers did rise slightly in September due in part to the impact of the August holiday period. Since then, the indications are that numbers have started to fall again going into October. At the same time CCG contracted bed numbers continue to fall in line with QIPP plans. The target trajectory aims to contain the Trust’s financial exposure to c£2.5m by increasing average discharge rates and reducing overspill in line with planned funding.

- The forecast financial exposure on acute overspill relies upon the operation of risk shares. In the case of Lambeth however, the agreed risk share only dealt with over-performance up to 8% whereas the actual over-performance has been running at c30%. Discussions have taken place with the CCG to agree remedial action and bring the numbers back into plan by September 2018. This would still leave the over-performance in 17/18 above 8% with a risk share value of £1.2m. The CCG have made a proposal as to how this will be handled which the Trust have responded positively to. A final agreement is expected shortly.

- In order to deliver on its control total for 17/18, the Trust has set a savings target of £27m (16/17 £29.2m). As at month 6, the Trust had generated CIP savings of £9.8m. Due to the inclusion of lock-ins and previous gains from property disposals, the Trust remains ahead of its NHSI CIP plan by £0.5m. However, forecast CIP savings are not expected to keep pace with a savings target that is set to accelerate over the remaining months (with 66% of savings due over the 2nd half of the year). Without additional schemes and mitigations the forecast shortfall from the original £27m target is £6.9m (a 74% achievement). As described above the Trust is developing in year plans to close its forecast CIP gap with the Trust’s PMO ensuring that any slippage is arrested/minimised and that substitute schemes are developed. In addition further gains from property disposals are expected to yield an additional c£3m in savings by year end. Further details on the Trust’s CIP performance can be found in Table 3.

- Southwark placements remain a concern and are £1.1m overspent (before application of risk shares and the 17/18 QIPP), an increase in the adverse variance of £176k in the month. Although additional CCG funding was put into the 2017/18 contract, a higher value QIPP of £533k has also been applied to placements leaving a net reduction in funding this year. In addition a QIPP of £267k is also being applied to the teams that manage the placements. The plans to address both the QIPP and current underlying overspend are thus proving a considerable challenge. Although the CCG are undertaking monthly reviews with the Local Authority and Trust to review progress, monitor action plans, and improve processes and quality of information, the position has yet to improve and the Trust is now forecasting an overall deficit of £1.5m after taking account of QIPP and risk shares. This position is subject to ongoing discussions between the CCG and Council regarding the funding responsibility of various placements and until these are resolved there is a risk that the SLaM position could deteriorate further as there are different risk shares in place depending upon who is the responsible commissioner. Lewisham placements (where a QIPP of £365k has been applied) are also overspending whilst Lambeth placements, under the Integrated Personalised Support Alliance, remain in balance.

- Agency usage over the first 6 months is c23% below the NHSI ceiling – a much improved position compared to 2016/17. However the monthly ceiling is set to fall over the remainder of the year and to ensure we remain on track a number of high usage areas including band 5 nurses, CPNs, care support workers and medical have been targeted for further reductions. The Trust also requires such reductions if it is to meet the agency CIP target within the Trust overall programme.
In addition to external overspill, the cost of running our own beds remains a concern with 7 wards +20% above funded nursing establishment. The ward budgets in the ACP CAG were fully revised in 2017/18 and most are now operating within plan. A further review of the Gresham 1 ward budget has concluded that due to the layout of the ward, it requires higher levels of nursing staff compared to other similar sized wards in the Trust. A budget adjustment will be made to reflect this. 2 of the PICUs continue to employ more staff than funding whilst slippage on 2 of the triage ward conversions has meant that the staffing budgets no longer match the cost of running the wards. The Lambeth Triage ward has converted to an acute ward and its costs are expected to move in line with budget from October whilst the Johnson PICU Unit is subject to a QI special observations project. The Lewisham Triage ward has yet to convert (causing an overspend of £34k per month).

CCG and NHSE QIPP schemes total £10m in 17/18.

The CCG schemes are aimed primarily at reductions in Adult/MHOA acute occupied bed days (obds) and complex placements and changes to community services including IAPT. 3 of the CCGs are above their contracted adult bed numbers and this is impacting on the delivery of their QIPP schemes, particularly in Lambeth where no QIPP is currently being realised.

As indicated previously there are also high risks attached to the Southwark placements and placement team QIPP of £800k where, despite a milestone plan being worked through with the CCG, the forecast overspend requires significant savings to be made beyond just the QIPP reduction.

In Croydon a proposed QIPP of £600k involving recharging other CCGs for their use of beds has been disputed following a review of audit data and is expected to fall significantly. A revised proposal is awaited by SLaM.

The NHSE schemes also involve a reduction in beds across forensic, CAMHS and Eating Disorder. The forensic bed reduction is working to plan but the Trust is continuing to meet with NHSE to ensure there is clarity about the £1.1m of savings plans in CAMHS and Eating Disorders. To date no agreement has been reached as to how these QIPPs will be delivered and it is therefore the intention of the Trust to invoice NHSE for the QIPP that has been removed.

Last year the Trust performed well against its cost and volume income targets (higher risk income that relates directly to increases/decreases in activity). However the performance overall, masked areas where income was not on plan. Some of these areas have continued to underperform going into 2017/18 and are now driving the bottom line deficit of £0.5m at month 6. These areas include Heather Close and Neuro Psychiatry, Eating Disorder and Affective Disorder Outpatients and several CAMHS outpatient services.

3) Forecast

At Month 6, the Trust is still forecasting to meet its NHSI surplus control total of £2.2m (including STF). This is seen as challenging but achievable. The Trust has identified financial risks totalling £10.5m by year end. The principal drivers behind this figure are –

- Red rated CIPs
- Delivery of QIPPs
- Demand pressures on beds and placements
- Other net pressures

Plans are currently being implemented to mitigate these risks utilising the Trust PMO Function, including –

- Significant clinical engagement on variation and delivery of the acute bed targets
- Development and application of QI programmes
- Development of additional savings plans in line with updated CIP targets
- Further collaborative savings through our South London Mental Health and Community Partnership with Oxleas and South West London and St Georges Trusts and the STPs
- Non-recurrent savings measures such as asset sales, use of lock-ins, balance sheet analysis review and examination of discretionary expenditure.

Although we are forecasting that we will hit the control total, there are still significant risks in delivery as detailed in the report and to do so we are reliant on non-recurrent savings in total of £10m. We are focussing on increasing the delivery of recurrent schemes this year to reduce the reliance on non-recurrent items. This will mean that our target for recurrent savings in 2018/19 will need to increase to cover the extent of any non-recurrent elements this year (so from £8m to £18m based on our current planning) and subject to the outcome of any commissioning discussions around CIP, QIPP and CQUIN targets.
### 1) Financial Summary

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>Variance Last Month (£)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Full Year Live</td>
<td>Current Month</td>
<td>Variance From Live</td>
</tr>
<tr>
<td></td>
<td>Budgets (£)</td>
<td>Actual (£)</td>
<td>Budgets (£)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2017/18 Mth 1</td>
<td></td>
<td>2017/18 Mth 2</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>52,248,400</td>
<td>4,541,800</td>
<td>218,300</td>
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<tr>
<td>02. Acute Care Pathway</td>
<td>44,527,200</td>
<td>3,582,300</td>
<td>(131,500)</td>
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<tr>
<td>03. P Med &amp; Integrated Care</td>
<td>(524,600)</td>
<td>(173,500)</td>
<td>(151,100)</td>
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<tr>
<td>04. Behavioural And Dev. Psych</td>
<td>(370,700)</td>
<td>(172,800)</td>
<td>(120,600)</td>
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<td>05. Child &amp; Adolescent Service</td>
<td>132,800</td>
<td>(54,900)</td>
<td>30,200</td>
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<tr>
<td>06. MOHA And Dementia</td>
<td>316,100</td>
<td>13,600</td>
<td>7,500</td>
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<td>07. Addictions</td>
<td>0</td>
<td>(3,700)</td>
<td>(3,700)</td>
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<tr>
<td>08. Clinical Support Services</td>
<td>1,505,200</td>
<td>219,400</td>
<td>39,300</td>
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<tr>
<td>09. Infrastructure Directorates</td>
<td>53,705,900</td>
<td>4,700,000</td>
<td>319,800</td>
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<tr>
<td>10. Corporate Income</td>
<td>(102,272,300)</td>
<td>(8,371,900)</td>
<td>107,300</td>
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<tr>
<td>Operational Deficit</td>
<td>49,268,000</td>
<td>4,280,300</td>
<td>315,500</td>
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<tr>
<td>EBITDA</td>
<td>(19,902,000)</td>
<td>(1,216,800)</td>
<td>230,300</td>
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<td>11. Corporate Other</td>
<td>(69,789,084)</td>
<td>(5,497,100)</td>
<td>(842,739)</td>
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<td>12. Unidentified/Unallocated CIPs</td>
<td>(3,674,816)</td>
<td>0</td>
<td>31,539</td>
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<td>13. Contingency - planned</td>
<td>1,500,000</td>
<td>0</td>
<td>(125,000)</td>
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<td>14. Other reserves/provisions</td>
<td>2,793,900</td>
<td>0</td>
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<tr>
<td>Corporate Other</td>
<td>(69,170,000)</td>
<td>(5,497,100)</td>
<td>(85,200)</td>
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<tr>
<td>EBITDA</td>
<td>(19,902,000)</td>
<td>(1,216,800)</td>
<td>230,300</td>
</tr>
<tr>
<td>15. Post EBITDA Items</td>
<td>22,420,000</td>
<td>1,276,700</td>
<td>(224,200)</td>
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<tr>
<td>Trust Financial Position</td>
<td>2,518,000</td>
<td>59,900</td>
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<td>Items Not Included In NHSI Target</td>
<td>(4,780,000)</td>
<td>(43,000)</td>
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<td>NHSI Control Total</td>
<td>(2,262,000)</td>
<td>16,900</td>
<td>6,100</td>
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</table>

### Area

<table>
<thead>
<tr>
<th>Area</th>
<th>2017/18 Mth 1 Variance £000</th>
<th>2017/18 Mth 2 Variance £000</th>
<th>2017/18 Mth 3 Variance £000</th>
<th>2017/18 Mth 4 Variance £000</th>
<th>2017/18 Mth 5 Variance £000</th>
<th>2017/18 Mth 6 Variance £000</th>
<th>2017/18 Total Variance £000</th>
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</thead>
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<tr>
<td>CAGs</td>
<td>1,052</td>
<td>708</td>
<td>831</td>
<td>322</td>
<td>895</td>
<td>(151)</td>
<td>3,657</td>
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<tr>
<td>Infrastructure Directorates</td>
<td>95</td>
<td>319</td>
<td>(80)</td>
<td>285</td>
<td>467</td>
<td>360</td>
<td>1,446</td>
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<tr>
<td>Corp Income</td>
<td>(72)</td>
<td>61</td>
<td>(220)</td>
<td>(322)</td>
<td>151</td>
<td>107</td>
<td>(295)</td>
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<tr>
<td>Other including reserves &amp; provisions released</td>
<td>548</td>
<td>104</td>
<td>31</td>
<td>55</td>
<td>194</td>
<td>(811)</td>
<td>121</td>
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<tr>
<td>Use of Reserves</td>
<td>(848)</td>
<td>(317)</td>
<td>(449)</td>
<td>10</td>
<td>(1,423)</td>
<td>725</td>
<td>(2,302)</td>
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<tr>
<td>Total EBITDA</td>
<td>775</td>
<td>875</td>
<td>113</td>
<td>350</td>
<td>283</td>
<td>230</td>
<td>2,627</td>
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</table>

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

<table>
<thead>
<tr>
<th>Area</th>
<th>2017/18 Mth 1 Variance £000</th>
<th>2017/18 Mth 2 Variance £000</th>
<th>2017/18 Mth 3 Variance £000</th>
<th>2017/18 Mth 4 Variance £000</th>
<th>2017/18 Mth 5 Variance £000</th>
<th>2017/18 Mth 6 Variance £000</th>
<th>2017/18 Total Variance £000</th>
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<tbody>
<tr>
<td>Ward Nursing*</td>
<td>109</td>
<td>51</td>
<td>270</td>
<td>203</td>
<td>117</td>
<td>132</td>
<td>682</td>
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<tr>
<td>Agency Premium @ 20%</td>
<td>251</td>
<td>209</td>
<td>223</td>
<td>281</td>
<td>270</td>
<td>167</td>
<td>1,401</td>
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<tr>
<td>Acute Overspill**</td>
<td>941</td>
<td>509</td>
<td>578</td>
<td>668</td>
<td>124</td>
<td>(75)</td>
<td>2,745</td>
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<tr>
<td>Unmet CIPs**</td>
<td>54</td>
<td>(53)</td>
<td>(918)</td>
<td>381</td>
<td>(57)</td>
<td>89</td>
<td>(504)</td>
</tr>
<tr>
<td>Placements***</td>
<td>150</td>
<td>173</td>
<td>189</td>
<td>339</td>
<td>162</td>
<td>216</td>
<td>1,239</td>
</tr>
<tr>
<td>CPC/C&amp;V Income</td>
<td>147</td>
<td>147</td>
<td>95</td>
<td>(50)</td>
<td>235</td>
<td>(39)</td>
<td>527</td>
</tr>
<tr>
<td>Total</td>
<td>1,652</td>
<td>1,036</td>
<td>447</td>
<td>1,822</td>
<td>851</td>
<td>490</td>
<td>6,290</td>
</tr>
</tbody>
</table>

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

- **Acute/PICU Overspill**

Overall 9 overspill beds were used by the Trust in September, an increase of 3 compared to the previous month. The use of overspill beds has resulted in a cost pressure, after application of risk shares, of £2.3m after 6 months. The forecast £2.5m deficit caused by overspill assumes that the Trust will now use a monthly average of 5.3 overspill beds over the remainder of the year compared to an average of 28 beds over the first half. This is a tight position to maintain but overspill has fallen with intensive work being undertaken under the QI initiative to enable further reductions to be made.

The use of all acute/PICU beds (internal and external) by LSL&C CCGs is shown in the tables below:

![Total Acute/PICU Beds Used By LSLC CCGs Since 1/4/16](image)

![Total LSLC CCG Acute/PICU Beds Used Since 1/4/16](image)

Overall local CCG bed usage increased in September by 2 beds whilst contracted bed numbers also decreased by 1. The increase occurred across Southwark, Lewisham and Croydon with a small reduction in Lambeth. When compared to contracted bed numbers, the main outlier continues to be Lambeth where bed numbers are now 27% above their contracted level of activity. Discussions with the CCG, regarding the risk share, have taken place given the risk share sets a cap at +8% and a way forward is being agreed. The second graph above indicates the potential disparity between CCG contracted beds which are falling and the Trust’s bed stock and actual use of beds which are converging. The Trust is making better use of its beds with activity more aligned with bed stock. If the Trust could eliminate overspill and keep to its bed stock numbers, additional net income could be generated through the CCG risk share arrangements.
Use of Agency Staff

NHSA have set a ceiling to spend no more than £17.4m on all agency staff. In 2016/17 the Trust spent £22.6m on agency. Agency spend is still below the ceiling after 6 months although the target is phased to decrease over the remainder of the year. The position improved in month 6 following a review of coding that moved costs out of agency spend. The forecast below which is based on a prudent, simple extrapolation of the year to date position shows that further work is therefore required if the Trust is to keep within the NHSA ceiling. A number of initiatives are in place to bring about a reduction targeting band 5 nurses, CPNs, care support workers, nurse team leaders, A&C and medical.

Ward/Unit Nursing Costs

At month 6 ward nursing costs overspent by £132k (£882k ytd). This is similar to the 2016/17 average but still +3% above budgets that have been set at safer staffing levels. The majority of the overspends occurred in the ACP CAG including the 2 remaining Triage wards (£395k overspent ytd) where plans to convert them to acute wards have been delayed and 2 of the PICUs which taken together are 18% over budget. The Lambeth Triage ward has now converted and new staffing rotas in place from October.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Plan Beds @ 95%</th>
<th>Actual Beds</th>
<th>Variance Beds</th>
<th>Variance %</th>
<th>Last Mth Variance Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>79</td>
<td>100</td>
<td>21</td>
<td>27.0%</td>
<td>22</td>
</tr>
<tr>
<td>Southwark</td>
<td>73</td>
<td>78</td>
<td>5</td>
<td>6.9%</td>
<td>4</td>
</tr>
<tr>
<td>Lewisham</td>
<td>63</td>
<td>72</td>
<td>9</td>
<td>13.9%</td>
<td>8</td>
</tr>
<tr>
<td>Croydon</td>
<td>84</td>
<td>83</td>
<td>-0</td>
<td>-0.5%</td>
<td>-1</td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>333</td>
<td>35</td>
<td>11.6%</td>
<td>33</td>
</tr>
</tbody>
</table>
• Cost per Case/Cost and Volume Income

The overall position continues to underperform, particularly in 3 of the CAGs –

- Psychosis – Heather Close is now £125k below target levels following an increase in the income target and a continuing number of unused cost per case beds. It is also £100k over on expenditure budgets. In addition the Psychosis Unit is £197k below income target (although offset by a pay underspend) whilst the PICUP service has not been able to meet its increased 17/18 income target.

- Psych Medicine & Integrated Care – are not meeting activity/income targets in several outpatient services particularly neuro psychiatry (£151k ytd), eating disorders (£125k ytd) and affective disorders (£69k ytd). All have savings plans under review. It is a similar position on eating disorder inpatient services (£146k ytd) where an NHSE QIPP has been applied but where there is currently no compensating increase in income or reduction in cost. The Trust is in discussions with NHSE regarding the QIPP and how it is to be realised and is expecting to raise an invoice shortly to recover the funding.

- CAMHS – the underperformance currently relates to outpatient services where several of the teams are currently off target. This is expected to improve but there remain outstanding issues with NHSE regarding the £0.8m QIPP that has been applied to the Kent inpatient contract with no agreement as to how this saving is to be achieved. Again the Trust is expecting to raise an invoice shortly to recover the funding.

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 6 £’000</th>
<th>Actual Invoiced At Month 6 £’000</th>
<th>Surplus/ Deficit(-) At Month 6 £’000</th>
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</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>3,977</td>
<td>3,685</td>
<td>293</td>
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<tr>
<td>Behavioural &amp; Developmental</td>
<td>11,470</td>
<td>11,985</td>
<td>515</td>
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<tr>
<td>Psych Med &amp; Integrated Care</td>
<td>10,310</td>
<td>9,916</td>
<td>394</td>
</tr>
<tr>
<td>CAMHS</td>
<td>13,354</td>
<td>12,975</td>
<td>379</td>
</tr>
<tr>
<td>MHOA</td>
<td>30</td>
<td>53</td>
<td>23</td>
</tr>
<tr>
<td>TOTAL</td>
<td>39,141</td>
<td>38,614</td>
<td>527</td>
</tr>
</tbody>
</table>

• Complex Placements

Lambeth placements remain within budget. However Lewisham are overspending (£174k ytd) where a £365k QIPP was applied at the start of the year means their QIPP of £365k. In Southwark, placements continue to overperform on both the CCG and Local Authority elements of the budget. The ytd overspend of £1.1m is split between the CCG (£406k) and the local authority (£659k) but this excludes an £800k CCG QIPP for which plans are still being developed/agreed. The local authority overspend is subject to a 100% risk share but –

- this is accessed via the CCG contract and requires agreement from the local authority to pay the CCG. Issues are being raised by the local authority regarding the timeliness of reviews and these will need to be addressed to ensure full payment is made
- the CCG and local authority are still examining how each individual placement is funded i.e. are they a CCG funded, a local authority funded or a jointly funded placement and if so what % split is applied. Until these issues are resolved there remains a risk that retrospective shifting of responsibility/liability will impact on the Trust’s risk share values with both the Local Authority and the CCG
- The QIPP referred to above applies to CCG funded placements only and so any Local Authority savings resulting from the QIPP plan are likely to impact on the risk share rather than the CCG QIPP target

The CCG are undertaking monthly reviews with the Local Authority and Trust to review progress, monitor action plans, and improve processes and quality of information. However the position does not appear to be improving and it is now very unlikely that the financial targets will be met. The forecast overspend on the CCG element of placements is now estimated at £1.8m (including the £800k QIPP).
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMH</td>
<td>Adult Mental Health – used in this report to cover a programme of investment in community schemes that aim to reduce the usage of acute/triage beds in the Trust</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bring together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CIPs</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CPC/C&amp;V</td>
<td>Cost per Case and Cost and Volume income varies depending upon the amount of clinical activity being undertaken</td>
</tr>
<tr>
<td>EBITDA</td>
<td>Earnings before interest, tax, depreciation and amortisation is an accounting measure used as a proxy for an organisation’s current operating profitability</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>MHOA</td>
<td>Mental Health of Older Adults</td>
</tr>
<tr>
<td>NCA</td>
<td>Non Contracted Activity - a patient treated by SLaM where no contract exists between the Trust and the Commissioner (e.g. a Lewisham resident who has a Bromley GP will not be charged against the Lewisham contract but will be invoiced as an NCA to Bromley CCG)</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement – 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 – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit - provide mental health care and treatment for people whose acute distress, absconding risk and suicidal or challenging behaviour needs a secure environment beyond that which can normally be provided on an open psychiatric ward</td>
</tr>
<tr>
<td>PoS</td>
<td>Place of Safety – under section 136 of the Mental Health Act, the police have the power to take an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a “place of safety” where they may be assessed by a doctor</td>
</tr>
<tr>
<td>QIPP</td>
<td>The Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help reduce the cost of services to the CCG</td>
</tr>
<tr>
<td>STF</td>
<td>Sustainability &amp; Transformation Fund that is intended to support providers to move to a sustainable financial footing</td>
</tr>
<tr>
<td>Triage</td>
<td>Triage ward – used to admit patients for a short period of time where their needs are assessed before being either discharged to the care of community teams or transferred to an acute ward</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent – is a concept used to convert the hours worked by several part-time employees into the hours worked by full-time employees e.g. 1 wte = 1 full time employee</td>
</tr>
<tr>
<td>YTD</td>
<td>Year To Date</td>
</tr>
</tbody>
</table>
1) At Month 6 the Trust made a deficit of £2.2m, a small favourable variance of £29k against the NHSI  control total of £3.8m. This position is driven by a combination of cost pressures, particularly acute overspill, complex placements, unplanned STF funding, capital slippage and property sales and is expected to remain strong throughout the remainder of the year.

2) The underlying position remains as before, driven by a combination of cost pressures, particularly acute overspill, complex placements, unmet CIPs and QIPPs. Additional savings targets of £4.3m have now been allocated against CAG (£1.1m) and the forecast overspend requires significant savings to be made beyond just the QIPP.

3) The Trust is currently rated by NHSI as a 3 against use of resources (where 1 is best out of a 1-4 range). The rating was originally scored at 2 but due to overspends has been downgraded to a 3. The overspends are due to scores of 4 against the Trust’s I&E margin. This relates to the deficit position planned for the first half of the year.

4) The Trust’s cash position remains robust at £46m in September (a £9m favourable variance from plan). This position is driven by the performance v CIP - £0.5m above NHSI Plan - 8% > target (inc profits on sale of assets & lock-ins).

5) The Trust has invested £1.5m of capital expenditure to date (£6.6m below plan) but expects to spend £13m (£7m below plan) having rolled forward £6.9m of Douglas Bennett House investment.

6) The use of acute overspill beds has resulted in a cost pressure, after application of risk shares, of £2.2m after 6 months. The numbers are: 2.0%, 3.4%, 3.7%, 5.3%.

7) The use of acute overspill beds has resulted in a cost pressure, after application of risk shares, of £2.2m after 6 months. The numbers are: 2.0%, 3.4%, 3.7%, 5.3%.

8) The Trust has invested £1.5m of capital expenditure to date (£6.6m below plan) but expects to spend £13m (£7m below plan) having rolled forward £6.9m of Douglas Bennett House investment.

9) The use of acute overspill beds has resulted in a cost pressure, after application of risk shares, of £2.2m after 6 months. The numbers are: 2.0%, 3.4%, 3.7%, 5.3%.
### The South London and Maudsley NHS Foundation Trust - Operating Budgets

#### Table 1

**September 2017**

**Full Year Live**

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>Variance Last Month (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1) Estates &amp; Facilities</td>
<td>14,935,403</td>
<td>1,455,202</td>
<td>242,000</td>
</tr>
<tr>
<td>A2) Hotel Services</td>
<td>10,799,199</td>
<td>1,509,300</td>
<td>53,200</td>
</tr>
<tr>
<td>B) Nursing &amp; Quality</td>
<td>4,061,000</td>
<td>591,500</td>
<td>5,000</td>
</tr>
<tr>
<td>C) Information &amp; I.T.</td>
<td>7,605,518</td>
<td>547,400</td>
<td>(17,800)</td>
</tr>
<tr>
<td>D) Finance And Corp Governance</td>
<td>3,596,100</td>
<td>254,900</td>
<td>5,000</td>
</tr>
<tr>
<td>E) Human Resources</td>
<td>3,868,000</td>
<td>244,900</td>
<td>5,000</td>
</tr>
<tr>
<td>F) Organisation &amp; Community</td>
<td>1,061,800</td>
<td>179,800</td>
<td>12,000</td>
</tr>
<tr>
<td>G) Clinical Effectiveness</td>
<td>4,726,000</td>
<td>586,500</td>
<td>18,400</td>
</tr>
<tr>
<td>H) Medical &amp; Clinical Governance</td>
<td>4,568,500</td>
<td>586,500</td>
<td>(14,200)</td>
</tr>
<tr>
<td>J) Chief Operating Officer</td>
<td>3,688,000</td>
<td>357,700</td>
<td>115,000</td>
</tr>
<tr>
<td>L) Corporate Other</td>
<td>15,464,100</td>
<td>2,301,500</td>
<td>(12,000)</td>
</tr>
</tbody>
</table>

**Notes to Re Mth 6**

- New 16/17 CIPs, unfunded cost of JW Hse, capital planning pay costs, rented accommodation income shortfall, discontinued NHS Properties rentals, 16/17 car parking CIP and maint costs at BRH
- Planned costs of ending the Aramark contract plus additional costs of new contract that can't be recovered from CAGs (as budget will result in a reduction in the CAG overspend noted)
- Unmet CIPs offset by underspends elsewhere. From month 7 the welfare CIP scheme noted to be expected.
- Restricted credit noted here this month
- Impact of Ortus, new higher cost occupational health contract, loss of Croydon LA training income and training DNA income plus new CIP target applied this month
- Recruitment costs, SLP costs and double running of executive post
- Unfunded postcommitments, use of CRTS's and increase in junior doctor on call expenditure
- Forecast increase in costs due to new RCP funding guidance which stipulates that anaesthetists have to have a say in how the funds are used, which could lead to an increase in costs
- New CIP target applied this month

**Corporate Analysis**

<table>
<thead>
<tr>
<th>Items Not Included In NHSI Target</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>Variance Last Month (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1) Estates &amp; Facilities</td>
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<td>1,455,202</td>
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</tr>
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<td>53,200</td>
</tr>
<tr>
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<td>591,500</td>
<td>5,000</td>
</tr>
<tr>
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<td>547,400</td>
<td>(17,800)</td>
</tr>
<tr>
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<td>3,596,100</td>
<td>254,900</td>
<td>5,000</td>
</tr>
<tr>
<td>E) Human Resources</td>
<td>3,868,000</td>
<td>244,900</td>
<td>5,000</td>
</tr>
<tr>
<td>F) Organisation &amp; Community</td>
<td>1,061,800</td>
<td>179,800</td>
<td>12,000</td>
</tr>
<tr>
<td>G) Clinical Effectiveness</td>
<td>4,726,000</td>
<td>586,500</td>
<td>18,400</td>
</tr>
<tr>
<td>H) Medical &amp; Clinical Governance</td>
<td>4,568,500</td>
<td>586,500</td>
<td>(14,200)</td>
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<tr>
<td>J) Chief Operating Officer</td>
<td>3,688,000</td>
<td>357,700</td>
<td>115,000</td>
</tr>
<tr>
<td>L) Corporate Other</td>
<td>15,464,100</td>
<td>2,301,500</td>
<td>(12,000)</td>
</tr>
</tbody>
</table>

**Notes to Re Mth 6**

- Net gap between funding and expenditure budgets (shortfalls against infrastructure savings and Trustwide savings plans) after lock ins. The shortfall v 4% CIPs now held in CAGs/Corp
- New CIP target applied this month
- Net gap between funding and expenditure budgets (shortfalls against infrastructure savings and Trustwide savings plans) after lock ins. The shortfall v 4% CIPs now held in CAGs/Corp
- Includes 0.5% CQUIN held back against non achievement of STP control total
- Includes an additional 16/17 CIPs incentive payment made in 17/18 of £419k
- Includes an additional 16/17 CIPs incentive payment made in 17/18 of £419k
- Includes an additional 16/17 CIPs incentive payment made in 17/18 of £419k
- Includes an additional 16/17 CIPs incentive payment made in 17/18 of £419k
- Includes an additional 16/17 CIPs incentive payment made in 17/18 of £419k
- Includes an additional 16/17 CIPs incentive payment made in 17/18 of £419k
## Table 2

### NHSI Summary For South London & Maudsley NHS Foundation Trust

#### Key data

<table>
<thead>
<tr>
<th>Key data</th>
<th>PLAN 30/09/2017</th>
<th>ACT 30/09/2017</th>
<th>VAR 30/09/2017</th>
<th>PLAN 31/03/2018</th>
<th>FORECAST 31/03/2018</th>
<th>VAR 31/03/2018</th>
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</thead>
<tbody>
<tr>
<td>Performance against control total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus/(deficit) before impairments and transfers</td>
<td>(2,579)</td>
<td>(2,131)</td>
<td>448</td>
<td>1,828</td>
<td>2,289</td>
<td>461</td>
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<tr>
<td>Adjusted financial performance surplus/(deficit) including STF</td>
<td>(2,321)</td>
<td>(2,292)</td>
<td>29</td>
<td>2,344</td>
<td>2,386</td>
<td>42</td>
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<tr>
<td>Control total</td>
<td>(2,363)</td>
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<td>0</td>
<td>2,262</td>
<td>2,262</td>
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<tr>
<td>Performance against control total excluding STF</td>
<td>(2,321)</td>
<td>(2,292)</td>
<td>29</td>
<td>2,344</td>
<td>2,386</td>
<td>42</td>
</tr>
<tr>
<td>Less sustainability &amp; transformation fund (STF)</td>
<td>(781)</td>
<td>(781)</td>
<td>0</td>
<td>(2,262)</td>
<td>(2,262)</td>
<td>0</td>
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<tr>
<td>Adjusted financial performance surplus/(deficit) excluding STF</td>
<td>(8,175)</td>
<td>(8,183)</td>
<td>82</td>
<td>124</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control total excluding STF</td>
<td>(8,175)</td>
<td>(8,183)</td>
<td>82</td>
<td>124</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance against control total excluding STF</td>
<td>43</td>
<td>72</td>
<td>29</td>
<td>82</td>
<td>124</td>
<td>42</td>
</tr>
</tbody>
</table>

#### EBITDA

<table>
<thead>
<tr>
<th>EBITDA</th>
<th>PLAN 30/09/2017</th>
<th>ACT 30/09/2017</th>
<th>VAR 30/09/2017</th>
<th>PLAN 31/03/2018</th>
<th>FORECAST 31/03/2018</th>
<th>VAR 31/03/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus/(deficit)</td>
<td>5,412</td>
<td>3,760</td>
<td>(1,652)</td>
<td>17,898</td>
<td>12,846</td>
<td>(5,052)</td>
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<tr>
<td>Excluding STF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Efficiencies

<table>
<thead>
<tr>
<th>Efficiencies</th>
<th>PLAN 30/09/2017</th>
<th>ACT 30/09/2017</th>
<th>VAR 30/09/2017</th>
<th>PLAN 31/03/2018</th>
<th>FORECAST 31/03/2018</th>
<th>VAR 31/03/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross capital expenditure</td>
<td>8,086</td>
<td>1,460</td>
<td>6,626</td>
<td>20,058</td>
<td>13,019</td>
<td>7,039</td>
</tr>
<tr>
<td>Disposals / other deductions</td>
<td>(2,100)</td>
<td>(1,697)</td>
<td>(403)</td>
<td>(20,800)</td>
<td>(18,429)</td>
<td>(2,371)</td>
</tr>
<tr>
<td>Charge after additions/deductions</td>
<td>5,986</td>
<td>(217)</td>
<td>6,203</td>
<td>(742)</td>
<td>(5,410)</td>
<td>4,668</td>
</tr>
<tr>
<td>Less donations and grants received</td>
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<td>6,203</td>
<td>(742)</td>
<td>(5,410)</td>
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#### Use of resources risk rating summary

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<th>ACT 30/09/2017</th>
<th>VAR 30/09/2017</th>
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### Risk rating after overrides

| Risk rating after overrides | 3 | 1 | 1 | 1 | 1 | 1 |
### Table 3  Summary CIP Performance

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<th>Financial Position M6</th>
<th>RAG Ratings &amp; Risks</th>
<th>Income/Cost Type</th>
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<th>FY Forecast 17/18</th>
<th>FY Variance 17/18</th>
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<td><strong>Total CIPs 199</strong></td>
<td><strong>Low</strong></td>
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<td><strong>CYP £’000s</strong></td>
<td><strong>Forecast £’000s</strong></td>
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#### Summary of Progress

The in month position at Month 6 is £166k behind target but £504k ahead of the YTD target of £9.8m. The main driver behind the ytd position is ACP which is £1.1m YTD underachieved as a result of the impact of acute overspill. This has been offset by lock ins and gains from property disposals. The full year forecast is £20.1m which is £6.9m behind the target of £27m. This represents an achievement of 74%. There has been a favourable shift in the forecast of £0.5m which is mainly due to the inclusion of lock ins. Note that additional CIP targets of £4.3m were allocated to CAGs/Infrastructure this month which has impacted on their positions.

The key movements contributing to the forecast variance are:

- **Overspill on beds**
  - £1.30
- **CAGs - Adjustment for slippage on identified schemes:**
  - ACP - triage shortfall which is partially offset by delayed opening of Fitzmary ward
  - £0.20
- **BDP - short fall due to the allocation of the additional target schemes still to be identified (£140k ) but is partially offset by lock in (NR) £50k**
  - £0.08
- **CAMHS - Shortfall due to the allocation of the additional target schemes still to be identified**
  - £0.25
- **MNDAD - shortfall due to the allocation of the additional target schemes still to be identified (£220k ) but is partially offset by lock in (NR) £100k and overperformance on the Memory service**
  - £0.01
- **Psychosis - Shortfall due to the allocation of the additional target schemes still to be identified , however new schemes of around £300k in relation to Lambeth and Croydon have been added to add on to theslippage ( £0.23)**
- **Trustwide- assumption of nil delivery including IOPPN £0.3m , non pay £0.5m and the transfer of £0.5m of unidentified CIPs from ICT.**
  - £0.17
- **Corporate Services :**
  - Estates -main contributors to the slippage includes- write down of accommodation £0.07m, restructure of the team (£0.2m) and consultancy cost reductions (0.1m), property disposals (0.2m)plus unidentified additional target of £0.61m
  - £1.20
- **ICT - shortfall against the cloud(£0.07m) and discretionary spend (£0.06m) project and the partial shortfall (£0.04m) against the additional target**
  - £0.17
- **Professional Heads - Welfare Rights Service forecast prudently written down while options appraisal is finalised, additional target unidentified £25k) offset by a lock in (NR) £100k**
  - £0.15
- **Finance - slippage mainly due to shortfall of additional target (£298k) offset by lock in (NR) £30K**
  - £0.30
- **Strategy - slippage mainly due to shortfall of additional target (£250k) offset by lock in (NR) £100K**
  - £0.15
- **COO - identification of a NR scheme to cover the additional target (207k). There is a lock in (NR) £150k which is partially offset against underperformance on training .**
  - £0.13
- **Chief Executive-slippage mainly due to shortfall of additional target (£0.7m).**
  - £0.10
- **HR-slippage mainly due to shortfall of additional target (£500k) offset by lock in (NR) £29K**
  - £0.47
- **Medical-slippage mainly due to shortfall of additional target (£230k)plus a write down on the senior management review**
  - £0.30
- **Pathology and Pharmacy -slippage mainly due to shortfall of additional target (£397k), a write down by (£100k) on the drugs expenditure program with another £100k cumulative slippage on Patient Own Drugs and Community dispensing schemes**
  - £0.59

**Summary**

| CAGS | 2.0 |
| Trustwide | 1.3 |
| Corporate | 3.6 |
| **Total** | **6.9** |
REPORT TO THE TRUST BOARD: PUBLIC
31 October 2017

| Title                  | Conflicts of Interest Policy  
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<td>Gifts and Hospitality Policy</td>
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<tr>
<td>Author</td>
<td>Charlotte Hudson, Deputy Director of Corporate Governance</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
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</tbody>
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Purpose of the paper

NHS England introduced a new policy this year on managing conflicts of interest in the NHS. NHS England has published a Model Policy that sets out the minimum standards required. The Trust is proposing to adopt the Model Policy in its entirety, subject to some areas where we intend to retain more stringent requirements.

The Board is asked to note the new Conflicts of Interest Policy, whose presentation to the Board is supported by the Audit Committee, and amendments to the Gifts and Hospitality Policy. Both have been ratified by the Senior Management Team.

Executive summary

NHS England introduced a new policy in April 2017 on managing conflicts of interest in the NHS. The policy was published earlier in the year but the implementation guidance was delayed by the election. The policy has been in force since June and needs to be adopted and implemented within the Trust as soon as possible.

The policy goes further than the previous Conduct of Business guidance and requires that the declarations of all ‘decision-making staff’ are captured and published. To date, only the declarations of Board members and Governors have needed to be captured on our public registers.

NHS England has published a Model Policy that sets out the minimum standards required. The Trust is proposing to adopt the Model Policy in its entirety, subject to some areas where we intend to retain more stringent requirements.

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
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<tbody>
<tr>
<td>August 2017</td>
<td>Joint Staff Committee (by correspondence)</td>
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<tr>
<td>18/09/17</td>
<td>Audit Committee</td>
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</table>
Introduction

1. NHS England introduced a new policy this year on managing conflicts of interest in the NHS. The policy was published earlier in the year but the implementation guidance was delayed by the election. The policy has been in force since June and needs to be adopted and implemented within the Trust as soon as possible.

2. The policy goes further than the previous Conduct of Business guidance and requires that the declarations of all ‘decision-making staff’ are captured and published. To date, only the declarations of Board members and Governors have needed to be captured on our public registers.

3. NHS England has published a Model Policy that sets out the minimum standards required. The Trust is proposing to adopt the Model Policy in its entirety, subject to some areas where we intend to retain more stringent requirements.

Proposed Conflicts of Interest Policy

4. The proposed Conflicts of Interest policy for the Trust is at Appendix 1. The policy draws closely on the NHSE model policy, subject to the following changes.

   a. It does not include the model policy sections relating to gifts and hospitality. This is because we intend to retain much of our existing policy on gifts and hospitality, as set out in the document – ‘Gifts, Hospitality and Sponsorship – policy and processes’, as this policy is already widely understood and applied across the Trust and is generally more stringent than Model Policy, which is permitted. There are, however, some minor, general changes and updates which have been made to that policy, which are outlined at (5) below.

   b. We are strengthening the wording on the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative, to reflect the Trust’s position that all relevant staff must consent to the disclosure of information about payments from the pharmaceutical industry.

   c. We are clarifying the description of ‘decision-making staff’ so that it sets out clearly which staff within the Trust are captured.

   d. There are some areas where the wording is clarified, or duplication removed, to make the policy easy to understand for the SLaM audience.

Gifts and Hospitality Policy

5. The updated Gifts and Hospitality policy for the Trust is at Appendix 2. It remains largely unchanged from the previous Gifts, Hospitality and Sponsorship policy, save that:

   a. Reference to sponsorship has been removed as this now falls within the Conflicts of Interest policy;

   b. An update has been made to reflect the circumstances in which low-value gifts from suppliers or potential suppliers can be accepted (as per NHS England guidance);

   c. The formatting has been updated to reflect current Trust practice for policy documentation;

   d. References have been updated to include the Bribery Act 2010;

   e. Wording has been updated to reflect current terminology;

   f. Declarations of a gift or hospitality must be made within 28 days of receipt of that gift or hospitality, as per NHS England guidance;
g. Clarification has been provided regarding attendance at conferences.

6. The Senior Management Team has ratified the updates to the Gifts and Hospitality Policy. The new version will be placed on the intranet and brought to the attention of SLaM staff via internal communications and the intranet landing page.

Implementation of the Conflicts of Interest Policy

7. Some elements of the policy are already in place. These include:
   
a. Board declarations – published quarterly as part of our public Board papers. We will continue with this approach and the Board register will be completed manually by the Trust Secretary and her team.

b. Declarations of interest forms are already completed when staff join the Trust. These are required as part of our staff contract. The declarations are considered by the HR Director and the line manager on receipt and adjustments are made where necessary.

c. Declarations are currently being sought from medical staff as part of their annual appraisal exercises. We are exploring with the Medical Director and the Chief Information Officer how best to avoid any unnecessary duplication in the respective processes.

8. We are working with the Chief Information Officer and his team to develop an electronic system that enables:
   
a. all decision-making staff to complete details electronically about their interests, including other occupations, loyalties etc. and keep this up-to-date;

b. the content of declarations by decision-making staff to be uploaded automatically onto a register to enable easy regular publication;

c. all decision-making staff to indicate in their entries whether they are Band 8d and above. If not, their names will be withheld on the register in line with the standards under the Freedom of Information rules, but other details – role, interest etc will be published;

d. interests that have been removed from the register to remain visible for at least 18 months.

e. decision-making staff to indicate, where appropriate, that their previous entry remains correct. There will be an annual exercise to remind decision-making staff to update their entries or confirm that there are no changes.

9. The proposed new policy will be brought directly to the attention of all decision-making staff in the Trust during November, with the wider policy brought to the attention of all staff as part of the weekly e-newsletter and signalled on the intranet, together with a simple summary of the policy.

10. All decision-making staff will be asked to complete a declaration via the intranet portal and a Register will be created. It is the responsibility of each appropriate member of the Senior Management Team to (a) verify that the list of identified decision-makers is accurate and (b) ensure compliance. Where there may be persons who are, or who are perceived to be, operating on behalf of the Trust in a position as a decision-maker but who are not captured by the broad definition of staff as given, Executive Directors are expected to identify them during this process. The Register will be published online following a two-week implementation period following launch.

11. Limitations of functionality presented by the current intranet mean that monitoring of compliance (including the capture of nil returns) will need to be undertaken manually until such point as a new intranet can provide enhanced back-end features e.g. linking entries to individuals. The Corporate Affairs team will work with ICT on the development of a new interface to capture declarations.
12. Internal Audit will undertake a review of the implementation in March 2018 and suggest possible improvements.

Consultation

13. A draft paper setting out the proposals for the Conflict of Interest policy was shared with the Joint Staff Committee for their comments. Comments were received from the GMB Union expressing their support for the policy and the protection it provides to service users and carers. The points they made include the following:

- They advocate a wide approach, requiring all budget holders to complete the declaration forms. Given that there are 628 persons in SLaM with the power to approve invoices, it is proposed to start by including the c.182 people in SlaM with the power to approve invoices above £10,000 and to consider whether to extend further when the policy is reviewed after 4 months.

- They want all managers to be able to demonstrate that they act impartially when hiring staff and agency workers. The conflict of interest policy would apply to recruitment decisions and would need to be declared and managed accordingly.

- They want payments from pharmaceutical industry to be banned completely. Their comments have been forwarded to David Taylor, Director of Pharmacy and Pharmacology for consideration, but it is proposed to retain the existing working which is already stricter than the Model Policy.

14. A report and a draft version of the policy also went to the Audit Committee on 18 September 2017. The Committee noted the draft policy and supported presentation of a final draft to the Board in October 2017, seeking Board approval, based on the following views for consideration:

- Clarity around the scope of the policy to include decision-makers who are not directly employed by SLaM and who may not otherwise be picked up by the definition. The application of the policy will be reviewed after 4 months and potentially extended.

- The minimum period for expired interests to remain on the register should be extended to 18 months from six, given that those reviewing older documents, such as past years’ accounts, may wish to be aware of relevant entries on the register. This has been amended.

15. Input has also been received and incorporated from Fiona Gaughran and her team, the Internal Audit team, the Pharmacy team, the Finance team and the HR team.

16. The Board is asked to note the policy and highlight any concerns.
**MANAGING CONFLICTS OF INTEREST POLICY**

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<td>Senior Management Team</td>
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<tr>
<td>Date Ratified:</td>
<td>23 October 2017</td>
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<tr>
<td>Date Policy Comes into Effect:</td>
<td>Immediate</td>
</tr>
<tr>
<td>Author:</td>
<td>Rachel Evans &amp; Charlotte Hudson, based on NHSE Model Guidance</td>
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<tr>
<td>Responsible Director:</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
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<td>Responsible Committee:</td>
<td>Senior Management Team</td>
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<td>Responsible Committee Approval Date:</td>
<td>23 October 2017</td>
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<td>Review Date:</td>
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Managing Conflicts of Interest in the NHS v 1.0
November 2017
## Document History

### Version Control

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<th>Summary of Changes</th>
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<td>Conduct of Business guidance replaced with the new guidance based on NHSE Model Policy.</td>
<td>Major Changes – agreed at the Senior Management Team.</td>
<td>Rachel Evans and Charlotte Hudson</td>
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### Consultation

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<td>Scope of policy to be expanded over time.</td>
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<td>18/09/17</td>
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### Plan for Dissemination of Policy

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## Key changes to policy:

Managing Conflicts of Interest in the NHS v 1.0 November 2017
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1. **Introduction**
South London and Maudsley NHS Foundation Trust (the ‘organisation’), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

This policy is based on the NHS England Model Policy on Managing Conflicts of Interest in the NHS.

2. **Definitions**
A ‘conflict of interest’ is:

“A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer-funded health and care services is, or could be, impaired or influenced by another interest they hold.”

A conflict of interest may be:
- **Actual** - there is a material conflict between one or more interests
- **Potential** – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

At South London and Maudsley NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as ‘staff’ and are listed below:
- All salaried employees
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

3. **Purpose and Scope of the Policy**
This policy will help our staff manage conflicts of interest risks effectively. It:
- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests
This policy should be considered alongside these other organisational policies:
- Gifts and Hospitality policy and procedure
- Standing financial instructions
- Relevant HR policies

4. **Roles and Responsibilities**
All staff are required to declare interests as defined in this policy.

This policy will be reviewed every two years unless an earlier review is required. This will be led by the Director of Corporate Affairs. Responsibility for the implementation of this policy and guidance lies with the Director of Corporate Affairs.

5. **Interests**
Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit\(^1\) from the consequences of a decision they are involved in making.

- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect interests:**
  Where an individual has a close association\(^2\) with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

6. **Decision-making staff**
Some staff are more likely than others to have a decision-making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as ‘decision-making staff.’

Decision-making staff in this organisation are:

- All Non-Executive Directors
- All Executive Directors
- All members of the Senior Management Team
- All members of the Executive, which includes the Clinical Academic Group Service, Clinical and Academic Directors; the Professional Heads of Occupational Therapy,

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\(^1\) This may be a financial gain, or avoidance of a loss.

\(^2\) A common-sense approach should be applied to the term ‘close association’. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.
Pharmacy, Psychology and Psychotherapy; the Director of Estates, Facilities and Capital Planning; the Chief Information Officer; and the Research and Development Director

- All staff at Agenda for Change Band 8d and above
- All medics with line-management responsibility [this may be expanded later]
- All managers within the Estates, Commercial and Information Technology teams.
- All those on placement panels for the use of residential homes
- All budget holders with authority to approve invoices of £10,000 and above.

7. Identification, declaration and review of interests

7.1 Identification & declaration of interests
All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered.

All declarations should be made via the portal available on the intranet so that a register can be published. Declarations by anyone without access to the intranet should be made in writing to their line manager and to their HR Business Partner or the Director of Corporate Affairs containing information about the nature of the interest, relevant dates and any other relevant information (e.g. action taken to mitigate against a conflict).

Declarations should be made:
- on joining the organisation;
- when moving to a new role or when responsibilities change significantly;
- as soon as circumstances change and new interests arise.

All staff are required to bring any interests that are relevant to the matters in discussion at a meeting to the notice of the Chair and other attendees.

After expiry, an interest will remain on registers for a minimum of 18 months and a private record of historic interests will be retained for a minimum of 6 years.

This policy will be reviewed every two years unless an earlier review is required. This will be led by the Director of Corporate Affairs. Responsibility for the implementation of this policy and guidance lies with the Director of Corporate Affairs.

7.2 Proactive review of interests
We will prompt decision-making staff annually to review the declarations or nil returns they have made. They will be required to update their entries or confirm that they remain accurate.

8. Records and publication

8.1 Maintenance
The organisation will maintain one register for members of the Board and one register for all other decision-making staff within the Trust. The Gifts and Hospitality register is a separate document.

8.2 Publication
We will:
- Bring the Board’s register to the Board every quarter and refresh at least quarterly.
• Bring the register for all other decision-making staff to the Board annually and refresh the information at least annually.
• Make this information available via the Trust's website

If decision-making staff have substantial grounds for believing that publication of their interests should not take place, then they should contact the Director of Corporate Affairs to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

8.3 Wider transparency initiatives

South London and Maudsley FT NHS Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff must give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. They are strongly encouraged to declare their earnings by name rather than anonymously. All potential conflicts of interest arising from work within the industry should be declared to the Trust's Drugs and Therapeutic Committee.

This includes payments relating to:
- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website: http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

9. Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the actions that should be considered include:

- restricting staff involvement in associated discussions and excluding them from decision-making
- removing staff from the whole decision-making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and South London and Maudsley FT NHS Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence. Any dispute in regard to these issues is to be referred to the Director of Corporate Affairs.
10. **Management of interests – advice in specific contexts**

10.1 **Strategic decision-making groups**

In common with other NHS bodies South London and Maudsley FT NHS Trust uses a variety of different groups to make key strategic decisions about things such as:
- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation, these groups include:

- Board of Directors
- Business Development and Investment Committee
- Audit Committee
- Finance and Performance Committee
- Quality Committee
- Drugs and Therapeutic Committee
- Education and Training Committee
- Information Security Committee
- Placement panels for residential care etc.

These groups should adopt the following principles:
- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation’s registers.
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:
- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made, but the issue should be considered very carefully. Good judgement is required to ensure proportionate management of risk.

10.2 **Procurement**

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified.
and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

11. **Common situations where interests need to be declared and managed**

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared. Please also refer to the Gifts and Hospitality policy and procedures published on the intranet.

11.1 **Outside Employment**

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises. This should state the nature of the employment, who it is with, a description of duties, time commitment etc. The Trust has a Secondary Employment Policy which contains a form that is required to be signed and placed on file in relation to secondary work – it also includes bank and agency working if undertaken on a regular basis.

11.2 **Shareholdings and other ownership issues**

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.
- There is no need to declare shares or securities where these amount to less than a 1% shareholding in a publicly listed company.

11.3 **Patents**

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation’s own time, or uses its equipment, resources or intellectual property.

11.4 **Loyalty interests**

Loyalty interests should be declared by staff involved in decision-making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision-making fora that can influence how an organisation spends taxpayers’ money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision-making responsibilities.
11.5 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances, they may be accepted but should always be declared. A senior manager in the team should declare the interest together with a clear reason as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation’s own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation’s own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.
- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.6 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the organisations and the NHS.
- Staff arranging sponsored events must declare this to the organisation.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation’s discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

11.7 Sponsored research

- All decision-making staff involved with sponsored research should make a declaration, setting out the nature of their involvement and any other relevant information, including what benefit the sponsor derives from the sponsorship and any action taken to mitigate against a conflict.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

The organisation will retain written records of sponsorship of research, in line with the above principles and rules.

11.8 Sponsored posts

- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.
- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor’s products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.
- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.

11.9 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

3 Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf
4 These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf

South London and Maudsley NHS Foundation Trust
Managing Conflicts of Interest in the NHS v 1.0
November 2017

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12. **Dealing with breaches**

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

12.1 **Identifying and reporting breaches**

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to their line manager or the Director of Corporate Affairs.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Ever individual has a responsibility to do this. For further information about how concerns should be raised please see the intranet guidance on whistleblowing and Freedom to Speak Up.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation, the organisation will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

12.2 **Taking action in response to breaches**

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand, or signposting to training and/or guidance).
• Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
• Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
• Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
• Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

12.3 Learning and transparency concerning breaches
Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee quarterly.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Trust’s website as appropriate, or made available for inspection by the public upon request.

13. Review
This policy will be reviewed every two years unless an earlier review is required. This will be led by the Director of Corporate Affairs.

14. Monitoring Compliance

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</table>
15. **Associated Documentation**

- Freedom of Information Act 2000
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- SLaM Whistleblowing Policy (2015)

16. **References**

- NHS England Managing Conflicts of Interest in the NHS model policy

17. **Freedom of Information Act 2000**

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).
# GIFTS AND HOSPITALITY POLICY AND PROCEDURE

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<td>Senior Management Team</td>
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<tr>
<td>Date Ratified:</td>
<td>23 October 2017</td>
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<tr>
<td>Date Policy Comes into Effect:</td>
<td>Immediate</td>
</tr>
<tr>
<td>Author:</td>
<td>Charlotte Hudson, Deputy Director of Corporate Governance</td>
</tr>
<tr>
<td>Responsible Director:</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
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<td>Responsible Committee:</td>
<td>Senior Management Team</td>
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<td>23 October 2017</td>
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<td>Review Date:</td>
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## Document History

### Version Control

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<td>October 2017</td>
<td>Sponsorship transferred to the Conflicts of Interest policy; References updated to include Bribery Act 2010; Guidance from NHSE on small gifts inserted and clear reference to concessionary conference attendance made within document. Wording updated to reflect current terminology; Declarations to be made by staff within 28 days of receipt (previously a quarterly return)</td>
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### Consultation

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### Plan for Dissemination of Policy

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<td>Email; intranet</td>
<td>Electronic</td>
<td>Charlotte Hudson</td>
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Key changes to policy:

- Sponsorship transferred to the Conflicts of Interest policy;
- References updated to include Bribery Act 2010;
- Guidance from NHSE on small gifts inserted and clear reference to concessionary conference attendance made within document.
- Wording updated to reflect current terminology.
- Declarations to be made by staff within 28 days of receipt (previously a quarterly return).
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APPENDIX 1: STATUTORY AND OTHER OBLIGATIONS (KEY POINTS/EXTRACTS) ..........12
1. **Introduction**

South London and Maudsley NHS Foundation Trust (the ‘organisation’), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our service users.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of service users.

This policy is based on the NHS England Model Policy on Managing Conflicts of Interest in the NHS.

This Policy should be read with the Trust’s Policy on Conflicts of Interest (where issues regarding sponsorship are more fully explained), Standing Financial Instructions and relevant HR policies and procedures.

2. **Definitions**

<table>
<thead>
<tr>
<th>Term or abbreviation</th>
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<tr>
<td>Affecting decisions</td>
<td>Acceptance of an inappropriate offer of a gift, hospitality or sponsorship from a third-party donor affects (or can be perceived as affecting) SLaM’s clinical, financial or other decisions involving that third party or third parties connected with them. Note the following: ‘affecting’ in this context means that, other factors remaining constant, SLaM would have made a different decision if the gift, hospitality or sponsorship had been received from another completely unconnected third party; and the term ‘connected’ is intentionally not defined in this context, and is a matter of judgment in the circumstances.</td>
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<td>Connected third parties</td>
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At South London and Maudsley NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as ‘staff’ and are listed below:

- All salaried employees
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

3. **Purpose and Scope of the Policy**

The provisions of this policy document apply to:

a) All SLaM staff directly or indirectly employed or contracted with SLaM (including executive and non-executive Board members); and

b) receipt from commercial or non-commercial sources of any gift or hospitality
If SLaM staff do not comply with the provisions of this policy document, disciplinary or other action may be taken against them in line with, for instance, the terms of their contractual or other agreement with SLaM.

‘Gifts and hospitality’ includes any personal expense paid for by a third party whether payment is made directly, indirectly (on behalf of the third party) or by reimbursement.

‘Sponsorship’ issues are fully addressed in the Trust’s Conflicts of Interest Policy.

The organisation’s statutory, regulatory and performance management obligations with regard to gifts and hospitality are noted in Appendix 1.

The key objective of the provisions in this policy document is to ensure that SLaM maintains appropriate relationships with third party donors (such as service users and their relatives) and any inappropriate offers of gifts or hospitality are refused.

This policy should be considered alongside these other organisational policies:
- Conflicts of interest policy and procedure
- Standing financial instructions
- Relevant HR policies

Potential adverse outcomes
If SLaM does not achieve the key objective, potential adverse outcomes include these:

a) SLaM rejects gifts and/or hospitality the acceptance of which would have maintained appropriate relationships with service users or other third parties without affecting (and without seeming to affect) SLaM’s decisions;

b) patient care suffers, for example because some service users, suppliers or other third parties have been dealt with preferentially as a result of receipt of gifts or hospitality or because such receipt has influenced purchasing decisions;

c) SLaM’s reputation and/or that of its staff suffers because some service users, suppliers or other third parties receive preferential treatment (or appear to receive it) as a result of gifts or hospitality;

d) SLaM is associated with a third party with activities incompatible with the NHS’s and/or SLaM’s aims; and

e) SLaM loses control of certain operations through being beholden to another party.

4. Roles and Responsibilities

All staff are responsible for making declarations as defined as required in this policy.

Each Director is responsible to the Chief Executive for ensuring that entries on their directorate’s section of the electronic Trust Register are complete and accurate, based on the ‘Gifts Hospitality and Sponsorship’ forms forwarded to them, and that they make a quarterly return to the Chief Executive.

The Chief Executive (or officer or other party delegated by the Chief Executive) is responsible for periodically performing an evidenced review of the Trust Register, decide corrective action (if necessary) and report matters to the next Audit Committee meeting.

The Director of Corporate Affairs is responsible for review of this policy every two years, or when circumstance requires, or when NHS guidance / policy is renewed.
5. **Objectives**

The key objective of the provisions in this policy document is to ensure that SLaM maintains appropriate relationships with third party donors (such as service users and their relatives) and refuses any inappropriate offers of gifts or hospitality. Issues related to sponsorship of posts or activities are addressed in the Trust’s policy on Conflicts of Interest.

Acceptance of an inappropriate offer of a gift hospitality or sponsorship from a third-party donor affects (or can be perceived as affecting) SLaM’s clinical, financial or other decisions involving that third party or third parties connected with them.

To this end, SLaM maintains a balanced stance towards accepting offers of gifts, hospitality or sponsorship, recognising the real and perceived risks and benefits thereof. SLaM thus requires:

a) such offers to be considered by the proposed recipient and their line manager (or equivalent) to assess whether the key objective will be met if the offer is accepted. That assessment takes account of the guidance in this policy document or (in situations not covered by this specific guidance) takes account of analogous principles; and

b) declaration in a publicly available register of all but the more insignificant offers of gifts or hospitality.

That register is compiled and maintained as follows:

a) SLaM staff maintain their own records of declarable matters using the ‘Gifts Hospitality and Sponsorship form, which also evidences the approval of their line manager (or equivalent);

b) SLaM staff forward the hard copy of their form to their relevant Director within 28 days of receipt of the gift or hospitality, and retain a copy for their own records;

c) each director is responsible to the Chief Executive for ensuring that entries on their directorate’s section of the electronic Trust Register are complete and accurate, based on the Gifts, Hospitality and Sponsorship forms forwarded to them; and

d) as a confirmation additional to that in (b) above, certain SLaM staff (senior manager or equivalent level and above) complete and send to the Chief Executive’s office a hard copy ‘Annual declaration of gifts, hospitality and sponsorship as at each financial year end.

e) An electronic copy of the overall declarations for staff within the Trust is to be maintained and to be made available for public inspection.

The scope of the work of SLaM’s counter fraud function, internal audit and external audit includes review of compliance with the provisions of this policy document.

6. **Risk and control**

6.1 **High level controls**

To help ensure that SLaM achieves the key objective, SLaM has put in place overall high-level controls including:

a) classification of gifts and hospitality in this policy document, and documentation of the policies and processes that apply dependent upon that classification;

b) clearly defined, and separated, roles and responsibilities for authorising, reporting and monitoring gifts and hospitality;

c) regular reporting of gifts, hospitality and sponsorship details, including public access to the relevant registers; and

d) inclusion of compliance with these polices and processes within the scope of review by SLaM’s counter fraud function, internal audit and external audit.
Set out in Table 1 below is a more detailed analysis of:

a) key risks identified by SLaM that could prevent SLaM from meeting its key objective; and

b) key controls set up by SLaM to mitigate those risks.

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Key risk: description</th>
<th>Key controls mitigating key risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R1</strong></td>
<td>The recipient does not properly understand the negative implications of accepting a particular offer.</td>
<td>All SLaM staff have access to this policy document, and receive relevant training. Management independently reviews offers and authorises if appropriate.</td>
</tr>
<tr>
<td><strong>R2</strong></td>
<td>The inappropriate effect of accepting an offer is magnified because only the donor and recipient know about that acceptance</td>
<td>SLaM staff maintain registers of gifts, hospitality and sponsorship, which the public may inspect. Management periodically and independently reviews the registers. If SLaM staff become aware of potential inappropriate offers to others, they report suspicions to independent management and/or to SLaM’s counter fraud function.</td>
</tr>
<tr>
<td><strong>R3</strong></td>
<td>The combined effect of accepting a series of individually appropriate offers is itself inappropriate</td>
<td>This policy document includes guidance on this point. SLaM staff maintain registers of gifts, hospitality and sponsorship, which the public may inspect. Management periodically and independently reviews the registers.</td>
</tr>
<tr>
<td><strong>R4</strong></td>
<td>An inappropriate offer is refused but still generates an inappropriate effect because only the intended donor and the ‘refuser’ know about the refusal.</td>
<td>SLaM staff maintain registers of gifts, hospitality and sponsorship, which the public may inspect. Management periodically and independently reviews the registers.</td>
</tr>
</tbody>
</table>

*Relative rating of risks is irrelevant in this case

## 6.2 Key Policies

SLaM maintains a balanced stance towards accepting offers of gifts and hospitality recognising the real and perceived risks and benefits thereof.

SLaM thus requires:

a) such offers to be considered by the proposed recipient and their line manager (or equivalent) to assess whether the key objective will be met if the offer is accepted. That assessment takes account of the guidance in this policy document (and Conflicts of Interest) or (in situations not covered by this specific guidance) takes account of analogous principles;

b) refusal of offers which, if accepted, would cause a breach of the key objective; and
c) declaration in a publicly available register of all but the more insignificant offers of gifts and hospitality.

6.3 Key Processes and Controls: Declaring Items

Individual records
As soon as a declarable matter arises, SLaM staff declare it on the ‘Gifts, Hospitality and Sponsorship’ form. If unsure whether or not to declare a matter, SLaM staff should declare the matter. Declaring a matter is not a substitute for refusing an inappropriate item. SLaM staff and their line managers (or equivalent) sign the hard copy ‘Gifts, Hospitality and Sponsorship’ form to evidence any approval required prior to acceptance of an offer of gifts, hospitality or sponsorship.

The ‘Gifts Hospitality and Sponsorship’ form is available in electronic format to all staff on SLaM’s intranet. SLaM staff should forward the hard copy of their form to their relevant director within 28 days of receipt of a gift or hospitality and retain a copy for their own records. Each Director should submit a quarterly return to the Chief Executive.

Trust register of gifts hospitality and sponsorship
Each director is responsible to the Chief Executive for ensuring that entries on their directorate’s section of the electronic Trust Register are complete and accurate, based on the ‘Gifts Hospitality and Sponsorship’ forms forwarded to them.

The Chief Executive (or officer or other party delegated by the Chief Executive) periodically performs an evidenced review of the Trust Register to gain assurance about compliance with Trust policy and to assess the nature and extent of gifts, hospitality and sponsorship. The electronic Trust Register can be filtered and sorted to assist any such review. The Chief Executive (or officer or other party delegated by the Chief Executive) decides the corrective action (if any) necessary and reports matters to the next Audit Committee meeting. For instance, the review may highlight a pattern of inappropriate offers from the same source, and even though SLaM staff have refused and declared those offers, the Trust may wish to take further corrective action direct with the source of those offers. The Trust Register is also available for public inspection, and for review by the counter fraud function, internal auditors and external auditors.

As at each financial year end, the Chief Executive’s office selects relevant senior SLaM staff and requires them, in addition to the quarterly reporting noted above, to complete and send to the Chief Executive’s office a hard copy ‘Annual declaration of gifts hospitality and sponsorship’ and to sign and date their declaration to confirm that:

a) either they received no declarable gifts and/or hospitality and/or sponsorship during the financial year or the entries for them on the Trust Register are complete and accurate as at the financial year end; and

b) all SLaM staff for whom they are ultimately responsible are aware of the provisions of this policy document to the extent required by their role. This could be dealt with through the existing annual appraisal system, for instance.

Sponsorship issues have been deleted from the policy as now covered by the Trust’s Conflicts of interest Policy.

6.4 Key Processes and Controls: Gifts and Hospitality

6.4.1 Refuse and declare
SLaM staff politely and firmly refuse and declare on their hard copy of the ‘Gifts Hospitality and Sponsorship’ form (for (a) to (e) the value is irrelevant):

a) any cash or cheque or other money transfer (but see also 6.4.4);
b) any vouchers exchangeable for cash;  
c) any vouchers exchangeable for goods or services;  
d) any holiday or travel event;  
e) any hospitality event (defined as attendance at a sporting event, concert or similar);  
f) any lunch or meal or other hospitality or bottle(s) of beverage or box(es) of chocolates or similar items provided on one occasion to the SLaM staff member for which the cost to the provider is more than £40; and/or  
g) any declarable (see 6.4.3) lunch or meal or other hospitality or bottle(s) of beverage or box(es) of chocolates or similar items provided to the SLaM staff member by the same provider during a financial year which causes the total cost to the provider of such items to exceed £80.

6.4.2 Accept and declare  
SLaM staff declare the following on a hard copy of the ‘Gifts Hospitality and Sponsorship’ form and can accept these items subject to prior approval from their line manager (or equivalent) and in the case of item (e) that line manager (or equivalent) should be at associate director level or higher:

a) any lunch or meal or other hospitality or bottle(s) of beverage or box(es) of chocolates or similar items provided on one occasion to the SLaM staff member for which the cost to the provider is more than £20 but less than or equal to £40;  
b) any declarable (see 6.4.3) lunch or meal or other hospitality or bottle(s) of beverage or box(es) of chocolates or similar items provided to the SLaM staff member by the same provider during a financial year which causes the total cost to the provider of such items to exceed £40 but is less than or equal to £80;  
c) a diary, calendar, pen or other item of stationery not containing an advertisement for the organisation to which the donor belongs (see 6.4.3)  
d) any lunch or meal or other hospitality where the SLaM staff member’s partner is in attendance and where the partner’s attendance is worth more than £40; and/or  
e) the situation that the SLaM staff member is a named beneficiary in the will of a patient. The safest and normal response would be politely and firmly to request the patient to change the will so that the SLaM staff member is not a named beneficiary. This helps to avoid any risk of undue influence (actual or perceived) and the negative implications thereof.  
f) Invitations valued at over £50 (such as invites to Conferences) should be treated with caution and only be accepted on behalf of an organisation, not in a personal capacity. These events should be declared by staff.

6.4.3 Accept and do not declare  
Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value. However, Trust staff can accept without declaring on the ‘Gifts Hospitality and Sponsorship’ form:

a) Low cost branded promotional aids such as pens or post-it notes may be accepted where they are under the value of £6 in total; and/or  
b) any lunch or meal or other hospitality or bottle(s) of beverage or box(es) of chocolates or similar items provided on one occasion to the SLaM staff member for which the cost to the provider is less than £20; if that cost is £20 or more the item is declarable (that is, should be declared on the ‘Gifts Hospitality and Sponsorship’ form).

6.4.4 Charitable donations (do not declare)  
Cash or cheques may be donated to the Charitable Trust funds (specifying general fund or a specific fund) if the donor takes the cash/cheque directly to the hospital cashier and if any cheques are made directly payable to ‘South London and Maudsley NHS Foundation Trust Endowment’. Such donations are not declarable on the ‘Gifts Hospitality and Sponsorship’ form.
7. **Key Processes and Controls: Reporting Suspicions**

SLaM staff are not required actively to seek out breaches of the provisions of this policy document. However, if SLaM staff become aware of actual, suspected or potential breaches they report these to an appropriate, independent member of management and/or the counter fraud function. SLaM’s requirements in this regard are separately documented.

8. **Monitoring Compliance**

<table>
<thead>
<tr>
<th>What will be monitored i.e. measurable policy objective</th>
<th>Method of Monitoring</th>
<th>Monitoring frequency</th>
<th>Position responsible for performing the monitoring/performing co-ordinating</th>
<th>Group(s)/committee (s) monitoring is reported to, including responsibility for action plans and changes in practice as a result</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLaM maintains appropriate relationships with third party donors (such as service users and their relatives) and any inappropriate offers of gifts or hospitality are refused</td>
<td>Collated returns; assessment; proposed action</td>
<td>Quarterly; reporting undertaken annually; register publicly available.</td>
<td>All Directors</td>
<td>Audit Committee</td>
</tr>
</tbody>
</table>

9. **Associated Documentation**

Code of conduct for NHS boards (revised July 2004)
Managing Conflicts of Interest in the NHS Guidance for staff and organisations, NHS England
Health Service Guideline (93)5 (‘HSG(93)5’)

10. **References**

Bribery Act 2010

11. **Freedom of Information Act 2000**

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).
APPENDIX 1: STATUTORY AND OTHER OBLIGATIONS (KEY POINTS/EXTRACTS)

The ‘statutory, regulatory and performance management obligations’ with which the Trust needs to comply include the following. Extracts and key points only are noted. Compliance with the provisions of this policies and procedures document ensures material compliance with these statutory, regulatory and performance management obligations.

The Bribery Act 2010

The Act is concerned with bribery. In general terms, this is defined as giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so. This could cover seeking to influence a decision-maker by giving some kind of extra benefit to that decision maker rather than by what can legitimately be offered as part of a tender process.

This Act states that breaching these provisions of the Act renders an individual liable to prosecution and may lead to loss of employment and superannuation rights;

Code of conduct for NHS boards (revised July 2004)

The Code highlights the key public service values of accountability, probity and openness and under the heading 'Relations with suppliers' states that: ‘NHS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship. Suppliers should be selected on the basis of quality, suitability, reliability and value for money. The Department of Health has issued guidance to NHS organisations about standards of business conduct (ref: HSG(93)5).’

Managing Conflicts of Interest in the NHS Guidance for staff and organisations, NHS England

Publications Gateway Reference: 06419

All staff must be aware of how and to whom declarations should be made, declaring material interests at the earliest opportunity (and in any event within 28 days) via a positive declaration to their organisation.

Health Service Guideline (93)5 (‘HSG(93)5’)

Casual gifts

‘Casual gifts offered by contractors or others, eg at Christmas time, may not be in any way connected with the performance of duties so as to constitute an offence. Such gifts should nevertheless be politely but firmly declined. Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from service users or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.’ (HSG(93)5 paragraph 7 refers)

Hospitality

‘Modest hospitality provided it is normal and reasonable in the circumstances, eg lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer. Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.’ (HSG (93)5 paragraphs 8 and 9 refer)

Other matters
HSG (93)5 also cover matters including: outside employment; private practice; and commercial sponsorship. This has been updated by NHS England guidance issued in 2017.
REPORT TO THE TRUST BOARD: PUBLIC
31st October 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Freedom of Information (FOI) Committee Annual Report 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Archives and Assurance Manager</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Director of Corporate Affairs and Trust Secretary</td>
</tr>
</tbody>
</table>

Purpose of the paper

To provide an update to the Trust Board on the Trust FOI activity, the work of the FOI Committee, Trust FOI compliance, performance and quality management in 2016 – 17.

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

For the Board to note the report

Executive summary

The Freedom of Information Act (2000) (FOIA) puts a responsibility on all public organisations to facilitate access to information they hold about their business activities. This access can be facilitated by proactive publications and by providing access to public requestors of this information within 20 working days.

The Trust received and responded to 565 requests in the period of 1st April 2016 to 31st March 2017. In this period, 86% (485) of responses were sent within the 20-day statutory deadline and the remaining 14% (80) were marginally delayed but a response was sent with no more than 7 working days delay. The delay was due to operational issues such as staff shortages in processing requests and complex requests involving multiple areas – on average an FOI contained 8 questions which required thorough review to ensure accuracy of the information disclosed.

There was a 33% increase in the number of requests received in 2016-17 from previous financial years. 391 (69%) of the requests received were from the public and the media.

HR, Finance, Estates and Facilities, SUI/Patient Safety, Digital Services (IT) and Procurement departments received the highest number of requests relating to corporate functions, whilst CAMHS and Psychology services received the highest number of requests for clinical related information.

There was low reliance on exemptions (exemptions from information being disclosed) under the FOIA. The trust applied exemptions in 21 out of 565 requests (4%); which demonstrates the good practice of the Trust in open and transparent publications about its activities and proactively publishes information on its website. The most common reason we exempted information from being disclosed was requests where the information that was already published on the Trust’s website or publicly available via other means (Section 21 of FOIA).

The Trust achieved 100% compliance with the Corporate Records Assurance standards in version 14 of the Information Governance (IG) Toolkit in 2016-17 (See section 6). A significant part of the evidence that supports the Trust’s compliance is the IG Assurance Programme, which includes reviews undertaken independently, alongside internal audits undertaken by the Information Governance Team.

It is important to note that the number of FOIs received continues to increase, as well as the demands on staff resources. The FOI team continues to streamline the efficiency of its internal process, as well as incorporate FOI into Information Governance training to increase awareness and educate staff about processing requests. This has significantly helped in improving the responses to requests in line with the 20-day timeframe.

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/08/2017</td>
<td>Freedom of Information Committee</td>
</tr>
</tbody>
</table>
1. Responses within 20 days (Compliance Rates)

All public organisations are required to respond to requests for information within 20 working days of receipt.

In the period of April 2016 to March 2017, the Trust responded to a total of 565 requests. 86% of the responses were sent within 20 working days. Table 2 below shows a comparison to the previous years.

The overall annual compliance rate reduced by 7% compared to the previous year (overall compliance in 2016/17 was 86% compared to 94% in 2015/16). This was due to operational issues such as staff shortages in processing requests and multi-faceted requests involving multiple areas – on average an FOI contained 8 questions which required thorough review to ensure accuracy of the information disclosed.

Table 1 - Trust annual FOI performance 2016-2017

<table>
<thead>
<tr>
<th>FOI Requests</th>
<th>Total No of requests</th>
<th>Compliant requests</th>
<th>Non-Compliant requests</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (April 16 to June 16)</td>
<td>132</td>
<td>118</td>
<td>14</td>
<td>89%</td>
</tr>
<tr>
<td>Q2 (July 16 to Sept 16)</td>
<td>136</td>
<td>111</td>
<td>25</td>
<td>82%</td>
</tr>
<tr>
<td>Q3 (Oct 16 to Dec 16)</td>
<td>130</td>
<td>114</td>
<td>16</td>
<td>88%</td>
</tr>
<tr>
<td>Q4 (Jan 17 to Mar 17)</td>
<td>167</td>
<td>142</td>
<td>25</td>
<td>85%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>565</td>
<td>485</td>
<td>80</td>
<td>86%</td>
</tr>
</tbody>
</table>

Table 2 Compliance rate comparisons (April 2012 to March 2017)

<table>
<thead>
<tr>
<th>FOI Requests</th>
<th>Total No of requests</th>
<th>Annual increase in number of requests</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>565</td>
<td>33%</td>
<td>86%*</td>
</tr>
<tr>
<td>2015/16</td>
<td>376</td>
<td>12%</td>
<td>94%</td>
</tr>
<tr>
<td>2014/15</td>
<td>330</td>
<td>7%</td>
<td>95%</td>
</tr>
<tr>
<td>2013/14</td>
<td>307</td>
<td>28%</td>
<td>97%</td>
</tr>
<tr>
<td>2012/13</td>
<td>220</td>
<td>13%</td>
<td>98%</td>
</tr>
<tr>
<td>2011/12</td>
<td>192</td>
<td>7%</td>
<td>99%</td>
</tr>
</tbody>
</table>

* Reduced compliance due to the complexity of the request and numerous sources information had to be collated from and validated thoroughly before it could be disclosed.

2. Refusals and exemptions

Under the FOI Act organisations can withhold information in certain cases using relevant exemptions to all or part of the requests. We applied exemptions 21 cases in 2016/17 as shown in Table 2 below.
Table: 3 Exemptions applied to FOI requests in 2016-2017

<table>
<thead>
<tr>
<th>Exemption</th>
<th>Description</th>
<th>No of times used</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 12.</strong> Information</td>
<td>Request too extensive, will take costs of processing request over the appropriate limit (2.5 days).</td>
<td>3</td>
</tr>
<tr>
<td>requested too extensive</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Section 21</strong> Information</td>
<td>Already published as part of the Trust Publication Scheme on the Trust website.</td>
<td>12</td>
</tr>
<tr>
<td>accessible to applicant by other means</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Section 22.</strong> intended for future publication</td>
<td>Information intended for future publication</td>
<td>1</td>
</tr>
<tr>
<td><strong>Section 24</strong> National Security</td>
<td>Information relates to security matters and law enforcement</td>
<td>1*</td>
</tr>
<tr>
<td><strong>Section 31</strong> Law enforcement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Section 43:</strong> Commercial interest</td>
<td>Information likely to affect the commercial interests of the Trust</td>
<td>4</td>
</tr>
</tbody>
</table>

*1 of the requests had 2 exemptions applied (Section 24 and Section 31).

3. Internal reviews and complaints

If a requester is not satisfied with the way the trust has handled their request, they can ask for an internal review. If they remain unsatisfied with the response, they can write to the Information Commissioners Office (ICO) to review our decision.

There was one complaint and one request for internal review the Trust had to consider under FOI in the financial year 2016 - 17.

The request for internal review of the responses was conducted and the decision was maintained not upheld as that the information we provided was the agreed to be correct.

The complaint received was via the Information Commissioner’s Office (ICO), following the ICO’s investigation, and was upheld. The Trust had breach the FOIA which was due to an oversight by the team as the request was not processed.

Table: 4 – Categories of Requests per Quarter

<table>
<thead>
<tr>
<th>2015/16</th>
<th>Q1 April - June</th>
<th>Q2 July – Sept</th>
<th>Q3 Oct - Dec</th>
<th>Q4 Jan - Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic</td>
<td>10</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>Legal</td>
<td>13</td>
<td>6</td>
<td>7</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Media (local and National)</td>
<td>25</td>
<td>18</td>
<td>36</td>
<td>29</td>
<td>108</td>
</tr>
<tr>
<td>MP/Councillor</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>NHS</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>13</td>
<td>27</td>
</tr>
<tr>
<td>Public (individuals)</td>
<td>56</td>
<td>81</td>
<td>63</td>
<td>83</td>
<td>283</td>
</tr>
<tr>
<td>Public bodies</td>
<td>9</td>
<td>6</td>
<td>7</td>
<td>13</td>
<td>35</td>
</tr>
<tr>
<td>Researcher</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Voluntary/Campaign group</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td><em>What do they know</em></td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>6</td>
<td>23</td>
</tr>
</tbody>
</table>

*What do they know* is a registered organisation run by UK Citizens Online Democracy. Individuals can register and submit requests and all responses to requests are publicly available on the site.

5. Services receiving most enquiries.

Corporate Services

Human Resources received the largest number of enquiries, followed by Estate and Facilities and Finance, Procurement and Digital Services.

The enquiries included:

- Staff and agency expenditures, Trust expenditures and budget allocation, staffing numbers, vacancies, absences and agency staffing (nurses, locums, AHPs).
- Contracts, estates and maintenance information, waste management
- Cyber-attacks, security, ransomware, software and hardware contracts, ICT information asset and service provision
- Number of complaints, serious incidents (assaults, deaths, suicides, homicides, AWOL etc.)

Clinical Services

CAMHS and Psychology service received the most number of requests, which relates to:

- Referral waiting times, number of patients treated, average lengths of stay and activity datasets
- Eating Disorders (CAMHS and Adult services), out area placements, delayed discharges, referral waiting times, and junior doctor contracts.
## Table 5 – Number of request received per service

<table>
<thead>
<tr>
<th>Services/CAG</th>
<th>Number of requests received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and MAP CAG</td>
<td>2</td>
</tr>
<tr>
<td>Addictions</td>
<td>2</td>
</tr>
<tr>
<td>Behaviour and Development Psychiatry</td>
<td>6</td>
</tr>
<tr>
<td>CAMHS</td>
<td>20</td>
</tr>
<tr>
<td>MHOA</td>
<td>2</td>
</tr>
<tr>
<td>Psychosis</td>
<td>9</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>7</td>
</tr>
<tr>
<td>Psychology/Psychotherapy</td>
<td>20</td>
</tr>
<tr>
<td>Chief Executives Office</td>
<td>4</td>
</tr>
<tr>
<td>Patient Safety/SUI/PALs</td>
<td>20</td>
</tr>
<tr>
<td>Clinical Systems</td>
<td>6</td>
</tr>
<tr>
<td>Contracts and Performance</td>
<td>6</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
</tr>
<tr>
<td>Complaints</td>
<td>5</td>
</tr>
<tr>
<td>ECT</td>
<td>3</td>
</tr>
<tr>
<td>Estates and Facilities</td>
<td>37</td>
</tr>
<tr>
<td>Training/Nursing/Education</td>
<td>8</td>
</tr>
<tr>
<td>Finance</td>
<td>36</td>
</tr>
<tr>
<td>Finance and other corporate areas</td>
<td>13</td>
</tr>
<tr>
<td>Business Intelligence</td>
<td>26</td>
</tr>
<tr>
<td>Business Intelligence and other corporate areas</td>
<td>9</td>
</tr>
<tr>
<td>Human resources</td>
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</tr>
<tr>
<td>Human resources and other corporate areas</td>
<td>5</td>
</tr>
<tr>
<td>Digital Services</td>
<td>35</td>
</tr>
<tr>
<td>*IG</td>
<td>152</td>
</tr>
<tr>
<td>Infection Control</td>
<td>10</td>
</tr>
<tr>
<td>MHA</td>
<td>11</td>
</tr>
<tr>
<td>Neuroimaging Services</td>
<td>3</td>
</tr>
<tr>
<td>Nutrition and Dietetics/Occupational Therapy</td>
<td>3</td>
</tr>
<tr>
<td>Other corporate areas</td>
<td>11</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>3</td>
</tr>
<tr>
<td>Procurement</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>565</strong></td>
</tr>
</tbody>
</table>
*The requests received by IG Team were for information that was not relevant to the Trust or readily published on the Trust website, NHSE and NHS Digital sites.

6. Trust compliance with Corporate Information standards (IG Toolkit V14)

<table>
<thead>
<tr>
<th>No</th>
<th>Standard</th>
<th>2016-17</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-601</td>
<td>Documented and implemented procedures are in place for the effective management of corporate records.</td>
<td>Level 3</td>
<td>Yes</td>
</tr>
<tr>
<td>10-603</td>
<td>Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000.</td>
<td>Level 3</td>
<td>Yes</td>
</tr>
<tr>
<td>10-604</td>
<td>As part of the information lifecycle management strategy, an audit of corporate records has been undertaken.</td>
<td>Level 3</td>
<td>Yes</td>
</tr>
</tbody>
</table>

7. Publication Scheme

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

In October 2016 an annual review of the publication scheme was undertaken by the Information Governance team to ensure up-to-date information was available to support organisational transparency and in accordance with the publication scheme review guidance.

The Trust’s Publication Scheme provides useful information to the public in relation to the structure of the Trust, services provided, strategic priorities, spending and key policies. These are available on the Trust’s website at the following link:

http://www.slam.nhs.uk/about-us/freedom-of-information

8. Monitoring Implementation

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

The Committee aims to improve the awareness of the Freedom of Information Act (2000) and its relevant procedures throughout the Trust and to implement ways of embedding an openness culture to improve corporate transparency. The Freedom of Information Committee has overseen the delivery of the following in 2016-17:

- Review of the Trust’s FOI performance
- Review of FOI Policy (October 2015)
- The Trust FOI Annual Report 2015 - 16 (May 2016)
- Review of the Trust Publication Scheme (October 2016)
- Review of Information Assets (February 2016)
- Review of Information Assets process (March 2016)
- Review of the FOI Committee Terms of Reference (February 2017)
- Corporate area compliance spot-checks (ongoing).
- Monitoring follow-up actions and improvements arising from reviews undertaken throughout the year (quarterly)
9. Corporate Records Management Assurance

9.1 Review of Information Assets

In order to maintain the asset register in accordance with corporate records management good practice standards, the NHS Digital Information Governance Toolkit, the Trust’s register of information assets (RIA) was audited in December 2016.

All NHS organisations are required to maintain a register of all information assets. An information asset is a definable piece of information stored in any manner that is recognised as ‘valuable’ to an organisation. Important examples in the Trust are the electronic health records on ePJS and electronic staff records, ESR, both of which hold vital and sensitive personal information.

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

9.2 Corporate Area Compliance Spot-checks

Corporate area compliance spot checks are regularly conducted in corporate areas of the Trust. In June 2016 and February 2017, spot checks were conducted in the HR department and in August 2016 a spot-check exercise was conducted in CEO office.

This involved routine compliance spots checks of these areas, to provide and maintain assurance on information governance and security measures in place and to review the handling, usage and storage of personal confidential and sensitive patient information.

The findings showed the areas have compliant security measures in place in the areas that handled and used staff's identifiable, sensitive confidential and corporate information.

The recommendations of the previous spots checks have been reviewed and the actions identified have been completed.

9.3 Corporate Records survey/audit

A Trust-wide survey of staff awareness of their responsibilities for records keeping was conducted in November 2016. The survey was completed using online questionnaires disseminated to staff in corporate services.

The overall objective was to:

- Identify if there are any record keeping systems in operational areas which have not been recorded
- Highlight where non-compliance to the policy and procedures is occurring, and suggest adjustments.
- Set and maintain standards by completing the audit on an annual basis across the Trust.

The findings of the review showed that staff from corporate areas stored records electronically which are documented and reviewed at times to archive information which has reached required retention period. The access to these records is restricted to staff with a need-to-know where the records are created (departmental records). All staff in the areas reviewed have completed mandatory IG Training which covers records management, to ensure that local workforce are aware of their responsibilities in respect of records management.

However, there is a need for awareness and consistent approach to corporate records management across the Trust, as the responses to the survey was very low and did not allow identification/uncover issues or working practice with corporate records.
Overall the findings showed that there was good level of corporate records awareness, records and incident management, process and procedures.

10. Forward Plan

The Freedom of Information Committee will oversee the delivery of the following in 2017-18:

- Review of the Trust’s FoI performance (quarterly)
- Review of the Trust Corporate Records Management Policy
- Review of the Freedom of Information Policy (updates)
- Review of corporate records management
- Review of staff awareness
- Compliance Spot checks (update)
- Review of the Trust Publication Scheme
- Corporate Records Management Action Planning
- Review of Information Assets Register
- Review of the assurances required for NHS corporate records management standards (CareCERT)

11. Further Information

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

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

**Trust Publication Scheme** acts as a charter commitment to the kind of information the Trust routinely publishes.
REPORT TO THE TRUST BOARD: PUBLIC
19th September 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Report from previous month’s Part 2 meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>David James, Business Manager, Corporate Affairs</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
</tr>
</tbody>
</table>

Purpose of the paper

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 Part 2 (private) meeting the previous month.

Executive summary

The detail attached refers to September 2017 when there were two issues for discussion. Details are listed below.
<table>
<thead>
<tr>
<th>Ref</th>
<th>Item discussed</th>
<th>Summary of discussion</th>
<th>Lead Director</th>
<th>Reason for taking in P2</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOD PTII 34/17</td>
<td>TIER 4 CAMHS New Model of Care</td>
<td>The Board were advised that the purpose of the paper was to update them on the South London Partnership’s (SLP) bid to become a ‘New Model of Care’ site for Tier 4 CAMHS services</td>
<td>Altaf Kara</td>
<td>Commercial in confidence.</td>
</tr>
<tr>
<td>BOD PTII 35/17</td>
<td>Future commercial considerations</td>
<td>The Board discussed Commercial options going forward re: UAE</td>
<td>Altaf Kara</td>
<td>Commercial in confidence.</td>
</tr>
</tbody>
</table>
Board of Directors Meeting
To be held 28th November 2017
3:00pm Learning Centre, Maudsley Hospital

AGENDA: Part 1

Opening Matters
1. Welcome, apologies for absence, declarations of interest
2. Minutes, Action log review 3:00pm
3. Patient Story - Kathryn 3:05pm
4. Chief Executive’s Report Rachel

Presentation
5. R&D Fiona/Gill Page

Quality & Safety
6. Achieving 85% bed occupancy Kris/Beverly & Michael Page
7. Engagement Rachel Page
8. Physical Health Care Beverley Page
9. Carers Strategy Beverley Page
10. Learning from Deaths Michael Page
11. Freedom to Speak Up Guardian – Board Reporting Zoe Page
12. QI Update Beverley Page
13. Safer Staffing Beverley Page

Governance
14. Council of Governors Update Rachel Page

Performance
15. Performance Report Kris Page
16. Finance Report Gus Page

For Noting
17. Report from previous Month’s Part II Page
18. Wrap-up and Next Meeting

The next Board of Directors Meeting will be held on 19th December 2017 at 3:00pm, in the Learning Centre, Maudsley Hospital

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 and Venues for Board of Directors meetings in 2018

All Meetings to commence at 2:30pm and finish by 4:45pm

<table>
<thead>
<tr>
<th>DATE</th>
<th>VENUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 23rd January</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 20th February</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 20th March</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 24th April</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 22nd May</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 19th June</td>
<td>Boardroom, Bethlem Royal Hospital</td>
</tr>
<tr>
<td>Tuesday 24th July</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 18th September</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 30th October</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 27th November</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
<tr>
<td>Tuesday 18th December</td>
<td>Learning Centre, Maudsley Hospital</td>
</tr>
</tbody>
</table>