Board of Directors Meeting

To be held 23rd May 2017
3:00pm Learning Centre, Maudsley Hospital

AGENDA: Part 1

Opening Matters
1. Welcome and apologies for absence
3:00pm Page 13
2. Minutes, Action log review & Declarations of Interest
3:05pm Page 16
3. Patient Story – Acute CAG
3:15pm Page 17
4. Chief Executive’s Report

Quality & Safety
5. CQC re-inspection report – Adult Acute Pathway
3:20pm Page 20
6. Physical Healthcare
3:40pm Page 26
7. Workforce Race Equality Standard Update
3:50pm Page 32

Governance
8. Council of Governors Update
4:05pm Page 40
9. Scheme of Delegation
4:20pm Page 43

For Noting
10. South London Partnership – Draft Terms of Reference and Draft Memorandum of Understanding
Page 62
11. Kings Health Partner’s Hematology Institute - Strategic Outline Case
Page 76

Performance
12. Performance & Finance Report
4:40pm Page 85
13. Wrap-up and Next Meeting
Page 109

The next Board of Directors Meeting will be held on 27th June 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.
MINUTES OF THE HUNDRED AND SIXTH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST HELD ON 26 APRIL 2017

PRESENT

Roger Paffard Chair
Dr Neil Brimblecombe Director of Nursing
Kristin Dominy Chief Operating Officer
Alan Downey Non-Executive Director
Rachel Evans Director of Corporate Affairs
Mike Franklin Non-Executive Director
Louise Hall Director of Human Resources
Dr Michael Holland Medical Director
Dr Julie Hollyman Non-Executive Director
Professor Matthew Hotopf Non-Executive Director
Altaf Kara Director of Strategy and Commercial
June Mulroy Non-Executive Director
Dr Matthew Patrick Chief Executive
Anna Walker Non-Executive Director

IN ATTENDANCE

Lucy Canning Deputy Director of Strategy and Commerce
Tim Greenwood Deputy Director of Finance
David James Business Manager Trust Secretariat (Minutes)
Beverley Murphy Director of Nursing (Designate)
Gill Sharpe Governor
Caroline Sweeney Nurse Consultant – Violence Reduction

APOLOGIES

Duncan Hames Non-Executive Director
Gus Heafield Chief Financial Officer

DECLARATIONS OF INTEREST

Mike Franklin gave details of his adviser role in the Solicitors Regulation Authority.

MINUTES

Prior to the minutes being agreed Roger Paffard gave his thanks to Neil Brimblecombe for his work in the Trust and noted this would be his last formal Board meeting before retirement.

The minutes of the Board held on the 28 March 2017 were agreed, as an accurate record of the meeting.
BOD 54/17 MATTERS ARISING/ACTION POINTS REVIEW

Progress made on action points was noted.

Action: Roger Paffard/Rachel Evans

BOD 55/17 PATIENT STORY

The presentation was introduced by Dr Seth Bhunnoo Consultant Psychiatrist and Clinical Lead from the Wandsworth Drug and Alcohol Service and Annabel a patient who addressed the Board about her experiences as someone who had suffered from severe alcohol dependence.

Dr Seth Bhunnoo informed the Board that the present contract in Wandsworth began in April 2015 and involved several partners including the Trust.

Annabel stated that she is now 27 months sober and works as a service user representative with the Wandsworth Drug and Alcohol Service. She informed the Board she had been resistant to treatment and had often relapsed when in recovery. This had caused a family breakdown and her children being taken out of her care. She reported that only the persistence of a key worker resulted in her eventually staying in recovery.

The Board were advised that the present service offered a wide range of options to support individuals who wished to recover from their addictions. She specifically referred to two, which were psychological support and the peer mentoring service, which have been enhanced since she first became involved. Treatment centres had also allowed her to gather her thoughts and offered a place where her sobriety could be maintained.

Mike Franklin asked what support by the key worker had been the most significant and Annabel replied her persistence and the faith she had in that individual had been very beneficial.

Anna Walker observed that the extent of support offered by the team in the borough to clients was not what the Board usually heard. Annabel responded that it was to its credit that Wandsworth offered extensive support to individuals with addictions.

Dr Seth Bhunnoo added that funding was always an issue but the links with the 3rd sector allowed for access to a committed and passionate volunteer resource. Beverley Murphy asked if as a service user representative Annabel got to talk to new staff. She replied no, but added staff collaboration does occur.

Dr Seth Bhunnoo concluded that the Trust’s investment in quality was very important and the method of consortium working presently used in Wandsworth had taken time to settle in, but was now producing excellent results.

Roger Paffard gave his and the Board’s thanks to Annabel and Dr Seth Bhunnoo for the presentation
Matthew Patrick took his paper as read. Before highlighting a number of issues in the paper he thanked Neil Brimblecombe for his contribution to the Trust and welcomed Beverley Murphy to the Board.

Matthew Paffard mentioned the Mayor of London’s Thrive London project, a London-wide initiative aimed at improving the mental health of Londoners. The project is aimed at transforming how public services engage with mental health issues and it has a number of work streams, many targeting public mental health approaches but dovetailing closely with the implementation plan for the mental health 5 year forward view. However, due to the General Election public sector organisations are following Cabinet Office advice known as ‘purdah’ which prevents decision making during an election campaign period. Therefore, although no decisions will be made until after 8 June in this intervening period all political parties will informed of the project and the hope for its eventual delivery.

The Board were informed of a BME Network event on 27 March, chaired by Arleen Elson and attended by Roger Paffard, Mike Franklin and Matthew Patrick. This was an opportunity to share with how the Trust might deliver a step-change in the treatment and experience of BME staff within the Trust.

Together with the Network, the Trust has looked at proposals to reduce the number of disciplinary proceedings brought against BME staff, to increase the number of BME staff at Bands 8c and above and to increase the opportunities for mentoring, stepping-up and career development for BME staff. The next step in the work will entail the development of a set of very clear Key Performance Indicators (KPI’s) and a set of objectives and actions aimed at driving improvement that when complete will come to the Board.

Matthew Patrick was pleased to report that on 31 March 2017 Simon Stevens, the NHS England Chief Executive, announced that the Trust had been successful in the bid to become an NHS ‘Global Digital Exemplar’. The Trust are one of seven mental health organisations (and the only one in London) cited by NHS England as being amongst the most advanced IT hospitals in the NHS. This success means the Trust can access £5m in matched funding to help accelerate work to ensure that frontline staff can maximise their use of digital technology to improve clinical services for patients, resulting in better patient experience, outcomes and efficiency savings.

The Board noted the Report.

BOD 057/17 STAFF ENGAGEMENT and SURVEY ACTION PLANS

Louise Hall reported to the Board. The paper was taken as read but a brief summary was given to the Board.

The Staff Survey results for the Trust showed a broadly static picture. There had been some movement in some of the areas the Trust have focused on such as appraisal, but the shifts overall had not been significant.
Retaining staff engagement during a challenging year was an achievement, but given the importance of the workforce to everything the Trust does, the ambition for the forthcoming year is to deliver a step-change improvement to the Trust’s engagement levels through an ambitious plan of activity.

In some areas the Trust’s position has worsened and in these aspects of staff engagement it needs to take increased action. Staff reported that their reward and career development is less than satisfactory, which the Trust is now looking at on how best to respond. Directorates have also been asked to focus on a number of areas: support for staff health and wellbeing; management support including appraisal, communication and equal opportunities for career progression; tackling bullying, harassment and discrimination.

Matthew Hotopf commented that at the Institute of Psychiatry, Psychology and Neuroscience work on inclusion and diversity was found to progress when there was ‘buy in’ by managers through all levels of the organisation. This approach was noted by the Board.

Julie Hollyman observed that the communication with staff seemed to be focussed on the detail heavy SLaM News which did not address the concerns of distinct staff groups within the Trust. She was of the view that more face to face interaction was required that allowed for a local focus. Kristin Dominy responded that she would be keen to discuss the mechanisms that could be used to achieve this outcome, but problems with face to face interaction at the local level were it had proved difficult to include staff who worked at night.

In relation to moving the results from the survey forward in future years Louise Hall stated that the development of leadership at all levels of the Trust was required. Julie Hollyman was concerned that the measurement of leadership training was one of, how well it was received, and not if the participants had become better leaders at the end of it. Louise Hall was of the view that the success of the programme would only be possible when more staff accessed it and so a critical mass was reached within the organisation. However, it was noted that measurements of the success of the leadership programme required some focus on outcome.

Kristin Dominy asked if the process of appeals and grievances described with a flowchart in the paper had been stress tested. Louise Hall responded that it would be tested by use and the process should be seen as an enabler. Mike Franklin agreed with the idea of a stress test, but thought the process as described, would be effective.

Anna Walker noted the importance of the BME issues of which the Trust was aware and action was being taken, but it was also an issue of all staff feeling valued by the Trust. This was noted by the Board

Roger Paffard stated that clearly the Trust had to address a number of issues related to staff and therefore consideration should be given to establishing a Board Committee resource focussed on workforce issues.

**Action: Chairman to Investigate establishment of a Committee Resource Overseeing Workforce issues**
Matthew Patrick observed that the need to move forward and improve the staff responses required the development of Key Performance Indicators (KPIs). This was agreed by the Board.

Action: KPIs to be developed and returned to the Board in June 2017.

The Board noted the report.

BOD 058/17 STAFF HEALTH and WELL BEING

Louise Hall introduced the paper and it was taken as read.

Alan Downey thought the paper broad and he was unclear if the intention was to reduce harm or improve the general health of staff. He suggested that the priorities within the paper could have been more explicit.

Louise Hall responded that wellbeing was a broad concept but section 5 of the presentation did set out the 8 healthy workplace charter themes and there were measure of success set out in the paper.

Anna Walker noted the measures of success within the paper, but thought them insufficiently ambitious, such as that for the percentage of staff reporting their organisation definitely takes positive action on health and well-being.

There was a debate by the Board as to what target for the percentage of staff reporting their organisation definitely takes positive action on health and well-being should be. Mike Franklin agreed with Anna Walker and thought the target should be ambitious and suggested 51% in 2018. This suggestion was noted by Louise Hall.

The Board noted the report and approved the Staff Health and Wellbeing Plan 2017-2019.

BOD 059/17 VIOLENCE REDUCTION

Neil Brimblecombe introduced Caroline Sweeney, Nurse Consultant, Violence Reduction, the author of the paper which had been through a number of iterations including discussion by the Senior Management Team (SMT).

The Strategy has been developed to ensure that the Trust meets standards of best practice in line with the Code of Practice (2015), NICE Clinical Guideline NG10 (2015) and Department of Health guidance from the Positive and Safe initiative (2014) for the prevention and management of violence and the reduction of restrictive practices applied to service users.

The Strategy provided a framework for the Trust to improve practice in violence prevention and management and reducing restrictive practices and to achieve quality priorities. There were two quality priorities: To reduce incidents of violence across in-
patient services by 50% in 2017 and to reduce incidents of prone restraint by 20% in 2017/18.

The Four Steps to Safety programme is supported by the Strategy and it also promotes the use of quality improvement methods to reduce violence and the use of restrictive practices. Governance structures for the implementation and monitoring of the strategy were detailed in the paper.

Roger Paffard noted and approved of the ambitious targets within the Strategy and this was endorsed by Anna Walker. However, Anna Walker noted that the reporting of prone restraint in the Trust was above the national average and within the upper range of reported incidents nationally in 2016. Neil Brimblecombe responded that further work taking place on prone activity within the Trust and Beverly Murphy added that over ambitious targets to reduce use may be a disincentive to staff reporting incidents.

Beverley Murphy observed that the use and reduction of restrictive practice, was not explicit in the Strategy. This was noted by Neil Brimblecombe but he advised the Board that the structure of the Strategy was set by Department of Health guidelines. Caroline Sweeney added that the use of blanket restrictions within the Trust was being looked into and the Board was informed that wards are to look at the restrictions presently in place and if there was no rationale for them they would be removed.

Julie Hollyman commended the working collaboratively with service users and their carers’ elements of the Strategy, but requested an amendment to make the carer involvement and access explicit. This was particularly relevant to access to patients by carers who could be in a better position to de-escalate or calm difficult situations. It was agreed that there should be an amendment to the Strategy making access to patients by their carers explicit.

The Board noted that the action plan for the strategy will go to the Quality Committee for oversight and challenge.

The Board approved the strategy on the condition that an amendment to make carer access to patients explicit is included in the final draft.

BOD 060/17 UPDATE FROM THE COUNCIL OF GOVERNORS

Rachel Evans introduced the paper.

It was reported a group of Governors met with the Non-Executive Directors on 28 March to discuss (a) resourcing for carers to become fully involved in Trust consultations and involvement activities, (b) NED views on a Governor observer attending Board Committee meetings, (c) opportunities for progression and development for Band 4 nurses, and (d) the governance of the South London partnership. This was seen as a very positive meeting.

There was a joint NED and Governor visit to the Children and Adolescent Mental Health Service in the Michael Rutter Centre. The visiting team heard about a diverse range of services – Eating Disorders Service, Obsessive Compulsive Disorder Service, Child Anxiety and Post Traumatic Stress Disorder Service and others. The
team reported they had been impressed with the passion and commitment of all the staff they met.

An annual Governor survey was launched on 3 April to gather Governor views on a range of issues. This included questions on: the quality of induction; the quality of the communications; topics discussed at the Council of Governor meetings; preferred timing of those meetings and behaviours demonstrated by staff and governors.

**The Board** noted the Report

**BOD 061/17 UPDATE from QUALITY SUB COMMITTEE**

The paper was taken as read and Anna Walker stated that some issues she had intended to raise had been covered by previous Board discussions regarding the use of prone restraint and staff recruitment.

Anna Walker also commented that the subcommittee had not been able to see or review the Quality Account for 2016/17 or the Trust priorities for 2017/18. This may have occurred due to workload issues, but it would have to be addressed in terms of the planning for 2018/19. This was noted by the Board.

On the matter of subcommittee reports to the Board, Anna Walker requested a consistent format be used. Rachel Evans replied that a move to a more universal format for all subcommittee reports to the Board is under development.

**The Board** noted the report.

**BOD 062/17 UPDATE from FINANCE and PERFORMANCE SUB COMMITTEE**

The report was taken as read.

**The Board noted the report.**

**BOD 063/17 UPDATE from the AUDIT COMMITTEE**

The report was taken as read.

**The Board noted the Report**

**BOD 064/17 BOARD ASSURANCE FRAMEWORK (BAF)**

Rachel Evans presented the paper
The BAF presented was an update from the last iteration seen by the Board in September 2016. It had been discussed by the Audit Committee in March 2017 and note was taken of amendments requested after comment and discussion. It was also recognised that the link/consistency between the framework and local risk registers remained an issue requiring further attention. This was noted by the Board.

It was suggested and agreed that the BAF both in terms of risks and mitigations for 2017/18 should be reviewed at the June Board Workshop.

**Action: Board Workshop session on the BAF to be held in June 2017**

The Board noted the BAF and approved a review in June 2017

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**BOD 065/17 PERFORMANCE REPORT**

Kris Dominy introduced the paper. She confirmed to the Board that both the Quality and Finance and Performance subcommittees had previously reviewed the report.

The Trust continues to meet the majority of the performance-related NHS Improvement Single Oversight Framework indicators with a number of risks and associated actions noted in the report.

The IAPT recovery rate performance is continuing to improve in three of the four IAPT services and the target was achieved in March although not across the whole quarter. The action plan to mitigate the impact of the ward changes and associated reduction in adult inpatient beds on site is being implemented and will improve the full system working in Croydon across community and inpatient services.

The effective use of the PMO is expanding and supporting major change initiatives, Cost Improvement Programmes (CIPs), Quality, Innovation, Productivity and Prevention Programme (QIPPs) and Commissioning for Quality and Innovation (CQUINs) for 2017/18. This approach will both support implementation and also future discussions with commissioners as we work together to define the overall mental health system.

Three commissioners have confirmed their plans to continue to meet the Mental Health Investment Standard.

The Trust recorded 5.1% of bed days (1007) being lost to delayed transfers of care. Over 46% of these related to patients in Croydon Local Authority, with the attribution being even between the NHS and Social Care. The majority of delays relate to availability of residential, nursing home or awaiting assessment issues.

Roger Paffard expressed concern at the figures and noted that extra monies for social care had been made available by central government to local authorities. Kristin Dominy stated she did not know if Croydon had been in receipt of these funds. Roger Paffard responded the funds should be with all local authorities and he added that NHS Improvement had requested examples from Trusts of any concerns they had that social care improvements had not been seen although monies had been allocated. The Board noted this issue.
Actions for the Croydon system to eliminate external overspill include: weekly senior management meetings; weekly bed management meeting; twice weekly teleconference to discuss progress with discharges; monthly interface meetings and weekly CCG delayed transfer of care meetings. It was also noted that further clinical engagement was required to assist with amending certain behaviours within the borough. This was noted and agreed by the Board.

**Action: Review of Croydon System and Actions at the May Board**

Neil Brimblecombe informed the Board that the report showed a drop in the restraint figures suggesting that the previously reported rises had not been statistically significant, but concern remained in this area and work to investigate this issue, as reported previously to the Board, was on going.

The centralised Place of Safety (POS) became operational across all four boroughs in February 2017. However over the year, ward nursing expenditure was above budget and the majority of the overspend occurred in the acute care pathway CAG including the 4 PICUs which together were £1.14m overspent. Therefore the new standalone POS appears to have made little financial difference to PICU overspends. Work was in progress to address this issue and actions to investigate this further had been agreed by the Board.

The Board approved the Report

**BOD 066/17 FINANCE REPORT**

Tim Greenwood introduced the paper and it was taken as read

June Mulroy advised the Board that the report provided an update on the financial position of the Trust as at 31st March 2017 (month 12) but further detail was required as the Trust had recently received the final notification from NHSI on the Sustainability and Transformation Fund (STF) payments for 2016/17 to include in the accounts

There has been confirmation of the planned STF of £2.28m for hitting the control total targets, plus an incentive scheme payment was higher than expected at £5.7m, and there was an unexpected further bonus to the value of £1.266m. The latter STF funding came from a fund that comprised of resources not distributed to some providers nationally because they did not hit their control targets.

The improvement in the year end position has enabled the Trust to maintain its use of resource rating at a two, however verbally the Trust has been informed that this rating may improve to a one which, could result in reduced regulatory oversight in line with the NHSI Single Oversight Framework.

The actual payments will not be paid until after the final accounts are complete and submitted at the end of May 2017. Therefore, the final process for agreeing and making payments will be formally notified to the Trust at a later date.
There was some frustration that this notification came so late in the financial year and is not available to offset revenue in 2017/18. Communication of the results to staff will be difficult as the Trust has now has a surplus of approximately £3.7m compared with the planned control total deficit of £4.1m.

The Board noted staff committed to achieving a challenging deficit control total now faced results that show a Trust surplus. The Board noted the achievement of staff and supported robust and clear communication with staff to explain the circumstances that resulted in the surplus for 2016/17.

Discussions are on-going on how best to use the extra funds but they cannot be used as part of revenue and so consideration of Capital use is taking place.

Underlying issues going forward were reported as: Both acute bed usage and use of overspill beds increased again in March 2017. Acute overspill averaged 46 in the month and is up to levels not seen since September 2016. This is partly due to bed closures at Foxley Lane and Bridge House but may also be impacted by the recent CQC visit and changes to the bed management structure. The 2017/18 Plan does not allow for such levels of overspill and this will become an immediate cost pressure going into the next year.

Southwark placements were £0.6m overspent at year end, although this is still subject to discussion between the Trust, CCG and Local Authority. Complex placements remain a high cost, high risk area for the Trust which will require management focus during the 2017/18.

There has been little change in agency usage in the month and the Trust ended the year £0.8m above the NHSI+25% ceiling. This impacted on one element of the use of resource rating, but not the overall score. This will be an area of continued focus in 2017/18.

Ward nursing costs remain a concern. Although the adverse variance from budget was £0.8m lower than in 2015/16, the wards still ended the year £1.9m overspent. In particular the 4 PICUs have exceeded staffing establishments by £1.14m. Going into 2017/18 the PICU budgets have been revised with the clear expectation that these wards will work within the new budget. The Board noted the comment by Tim Greenwood that the expectation had been that the opening of the POS on the Maudsley site would have resulted in reduced PICU expenditure.

**Action: Analysis of Place of Safety and PICU costs to come to the Board**

The Trust delivered 79% of its CIP target this left the Trust with a £6.1m shortfall on its target, but additional in year savings generated from tight controls and close monitoring, combined with the non-recurrent utilisation of contingency reserves, the release of balance sheet provisions and better than planned activity driven income meant that the Trust was able to improve on its deficit control total at year end.

**The Board** Approved the Report
No other business was discussed.

BOD 068/17 FORWARD PLANNERS & DRAFT AGENDA –

This was noted by the Board.

The date of the next meeting will be:
Tuesday 23 May 2016 – 3:00pm
Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ

Representatives of the press and members of the public were asked to withdraw from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
(Section 1 (2) Public Bodies Admission to Meetings Act 1960)
### Board meeting 23 May – action points

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue/Board Paper</th>
<th>Action</th>
<th>By</th>
<th>When</th>
<th>Status</th>
<th>RAG</th>
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<tbody>
<tr>
<td></td>
<td>September 2016 meeting</td>
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<td>1</td>
<td>Revalidation Annual Report</td>
<td>Initially intended that brief paper to be brought to the Board on the progress toward delivery of the organisational action plan. Update: Given new recruitment, now proposed to role this into the Annual Revalidation Report in June.</td>
<td>MH</td>
<td>June 17</td>
<td>Due at June meeting</td>
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<td></td>
<td>November 2016 meeting</td>
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<td>2</td>
<td>Scheme of delegation.</td>
<td>Due to be brought back in April 17. Deferred to May 2017</td>
<td>GH</td>
<td>May 17</td>
<td>On Schedule</td>
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<td></td>
<td>February 2017 meeting</td>
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<td>3</td>
<td>Safer Staffing</td>
<td>Quality Committee to receive new reporting template reflecting changes proposed at the February Board</td>
<td>NB / BM</td>
<td>June 17</td>
<td>April Board 2017 informed that new guidance means that an amended approach is needed, so will report in June.</td>
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<td>4</td>
<td>Performance Report</td>
<td>Chair to write to Croydon CCG expressing concern over access to</td>
<td>RP</td>
<td>May</td>
<td>Face to Face meeting requested.</td>
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<td>Ref</td>
<td>Issue/Board Paper</td>
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<td>CAMHS in that Borough.</td>
<td>Agreed (March 2017) that face to face meeting would be preferable.</td>
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<td><strong>March 2017 meeting</strong></td>
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<td>5</td>
<td>Performance Report</td>
<td>Analysis of ethnicity of Patients who receive prone restraint to be undertaken</td>
<td>KD/NB</td>
<td>May 2017</td>
<td>On schedule</td>
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<td></td>
<td><strong>April 2017 meeting</strong></td>
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<td>6</td>
<td>Staff Engagement and Survey Action Plans</td>
<td>Chairman to Investigate establishment of a Committee Resource overseeing Workforce issues</td>
<td>RP</td>
<td>May 2017</td>
<td>Proposals currently being developed.</td>
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<td>7</td>
<td>Staff Engagement and Survey Action Plans</td>
<td>KPIs to be developed and returned to the Board.</td>
<td>LH</td>
<td>June 2017</td>
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<td>8</td>
<td>Performance Report</td>
<td>Review of Croydon and Trust Actions taken</td>
<td>KD</td>
<td>May 2017</td>
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<td>9</td>
<td>Finance Report</td>
<td>Review of Place of Safety and PICU costs to the Board</td>
<td>GH/KD</td>
<td>July 2017</td>
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<td>10</td>
<td>Board Assurance Framework</td>
<td>Review of BAF for 2017/18 June Board Workshop</td>
<td>GH</td>
<td>June 2017</td>
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Code:

Green – completed
Amber – on schedule
Red – not on schedule
The Patient Story

- Over many years, patients told us that they would like more activities available on the wards at the Ladywell Unit
- Lack of resources & complicated management structures made things difficult
- People tried to improve things:
  - Linkworkers ran activities – art groups & poetry groups
  - Volunteers ran activities – Friends of Ladywell
  - Activities programme co-ordinator employed across the unit, but this role could not be sustained
- Activities remained patchy.
- The new Acute CAG brought together the wards under one management system.
- The management agreed it was essential that OT's were available on all the hospital sites.
- As this is being actioned, systematic improvements are beginning to be made and this is better for patients.
A – Conclusion of the inquest into the death of Mr. Olaseni Lewis

1. Almost 7 years after his tragic death, the three-month inquest into the death of Mr. Olaseni Lewis concluded on Tuesday 9th May. Mr Lewis was a 23-year-old IT analyst and engineer who was admitted to Bethlem Royal Hospital on 23 August 2010. He later died at Mayday Hospital on 3 September 2010 following a prolonged restraint by the Metropolitan Police on the Bethlem site. He was found to have died of brain injury, cardiorespiratory arrest and restraint associated with acute behavioural disturbance.

2. The jury’s narrative concluded that three elements had, on the balance of probabilities, contributed to Mr Lewis’ death. These were (a) the prolonged restraint by the Metropolitan Police, including excessive force, pain compliance techniques and multiple mechanical constraints; (b) the failure of Dr Naqvi, now at another Trust, to respond to the medical emergency caused by Mr Lewis’ pulse of 45 – 50 bpm, and (c) the failure of the Metropolitan Police to follow their own training.

3. The jury also identified other areas of concern, including that the admissions process had been unsatisfactory, that the Trust had insufficient suitably-trained staff, and that there had been failures of communication between the Metropolitan Police and medical staff. These are all concerns that were identified in the Trust’s internal investigation in 2011 and where, in the intervening period, substantial improvements have been delivered.

4. The jury’s conclusions were covered by the BBC, ITV, Channel 4, the Guardian, the Independent and local media, amongst others. The media focus was predominantly on the finding of ‘excessive force’ by the Metropolitan Police and the wish of the Lewis family for the CPS to reconsider the case against the officers. There was also coverage of the failings in relation to the admission processes and the actions of Dr Naqvi.
5. As a Trust, we have had a senior manager in court for every day of the three-month inquest. We have wanted to hear the evidence in person so that we could understand exactly what happened. This has been particularly important given that very few members of the Senior Management Team were at the Trust when the tragedy happened and we have wanted to be in the best possible position to learn lessons for the future. We have also wanted to show our strong support for the Lewis family and to continue to offer our heartfelt condolences to the Lewis family, his friends and his community.

6. Every senior manager who has attended the court has felt personally moved by this tragedy and is determined to ensure such failures do not happen again. The organisation has learnt a great deal and made changes to how we work resulting directly from Mr Lewis' death. Since the incident, we have introduced new processes to improve how we train and support staff and have improved how we work with the Metropolitan Police in high-risk situations. We are committed to working even more closely with local communities to ensure that the services we provide are high-quality and effective as well as committing to excellent local initiatives, such as Black Thrive.

B – CQC report on our acute wards and psychiatric intensive care units

7. The CQC report arising from the re-inspection of our acute wards and psychiatric intensive care units was published on 5 May. A substantive paper on the findings is being presented to the Board this month, but I wanted to express my commitment to the Trust taking full action in relation to the areas where continued improvement is needed. I also wanted to extend my warm congratulations and thanks to staff for their hard work and commitment in delivering improvements that mean that the Trust no longer has any “inadequate” ratings and these wards and units are now rated “good” for being caring and responsive.

C – Mental Health Awareness Week

8. As part of Mental Health Awareness Week starting on 8 May, there was coverage by ITV of the excellent work being undertaken by Dr Emma Williamson, a clinical psychologist at the Trust, and her team. Dr Williamson leads a pioneering team whose office in a homeless hostel in Vauxhall run by the London charity, Thames Reach. They are the only team of NHS psychologists in the country to be based in a hostel. This enables them to build trust and engagement but also to be immediately available when a crisis occurs.

9. ITV reported that "[l]ast year, 3724 people with mental health problems were sleeping on the capital’s streets, an increase of 52% in the last five years. The latest official figures show that 50% have an identified mental health issue, although psychologists believe the true figure to be much higher."

D - British Medical Journal Awards

10. On May 4, the British Medical Journal’s prize for Mental Health Team of the Year was awarded to the "FREED" team from South London and Maudsley NHS FT and the Institute of Psychiatry, Psychology and Neuroscience. I am delighted that the work of this excellent team has been recognised at these prestigious awards and congratulate them for their well-deserved success.
11. First episode and rapid early intervention for eating disorders (FREED) is a novel service for young people with a first episode of an eating disorder, which focuses on optimal delivery of rapid, tailored and integrated care. The introduction of FREED has been shown to significantly improve treatment uptake, clinical outcomes and service satisfaction and reduces needs for in-patient care. The approach has been such a success that it is currently being rolled to three other large mental health trusts.

Dr Matthew Patrick
Chief Executive
Title | CQC re-inspection report – Adult Acute Pathway
Author | Mary O’Donovan, Head of Quality
Accountable Director | Beverley Murphy, Director of Nursing

Purpose of the paper

1. To report the findings and outcome of the re-inspection by the CQC in January 2017 of the Adult Acute and PICU Pathway.
2. To note noting the key issues raised and highlighted risks.

Executive summary

The background is that the Trust was subject to a comprehensive Care Quality Inspection (CQC) during the week commencing 21st September 2015. The overall Trust rating was ‘good’ but the service was rated as ‘requires improvement’ and the rating for the safety domain in the acute and psychiatric intensive care units (PICU) was ‘inadequate’. An improvement plan was agreed, implemented and monitored.

The Acute and PICU care pathway was re-inspected January 2017. The key finding is that the service continues to be rated as ‘requires improvement’ but there have been improvements meaning that there is no longer an ‘inadequate’ rating. The team identified various improvements and these are set out in section 3. The work of the clinical staff in making these improvements is clearly acknowledged.

The key areas that we will continue to work on are set out in section 4 and include elements on staffing, safeguarding, ligatures, restraint, fire drills, supervision and governance. There is already trust-wide quality improvement work underway on both staffing and restraint, as detailed in the paper.

The Director of Nursing has met with the Clinical and Service Director to consider the ‘MUST’ and ‘SHOULD’ do actions. The Clinical and Service Directors are leading the process of developing an action plan at CAG level which will be scrutinised by the Director of Nursing and Chief Operating Officer. Once approved it will be provided to the CQC and be implemented across the CAG. The deadline is 22nd May 2017.
CQC Re-inspection Report – Adult Acute Pathway

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’ but the rating for the Acute and PICU pathway was ‘requires improvement’ and the rating for the safety domain in the acute and psychiatric intensive care units (PICU) was ‘inadequate’.

The Acute and PICU care pathway was re-inspected January 2017. The paper sets out why the re-inspection took place, the findings and the subsequent quality rating.

2.0 Re-Inspection Ratings
Following the initial round of CIH inspections all Trusts that were rated required improvement overall or for a specific service line would be subject to further inspection. Therefore, the inspection of the Acute and PICU wards was anticipated, especially as the safety domain was rated as ‘inadequate’.

The September 2015 CQC inspection findings outlined ten MUST and thirteen SHOULD improvement actions. The re-inspection in January 2017 assessed if the Acute and PICU pathway had made the required improvements, following the previous comprehensive inspection of the trust in September 2015.

Following the re-inspection the overall rating for the Trust remains at ‘Good’. Whilst the overall rating for the Acute and PICU pathway remains at ‘requiring improvement’ the pathway and subsequently the Trust no longer have any services rated ‘inadequate’ in any of the five domains. The previous rating of ‘inadequate’ for the safety domain in the Acute and PICU pathway has now been revised to ‘requiring improvement’ following noted improvements during the re-inspection in January 2017. The table below outlines the revised rating for the pathway.

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

*Table one: CQC Rating, May 2017*

3.0 Improvements and good practice
The CAG developed an improvement plan and we are indebted to the ward and corporate teams for delivery of the plan.
3.1 Improvements since 2015
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>
<tbody>
<tr>
<td>Safe</td>
<td>• All required emergency equipment and medication was in place and in date.</td>
</tr>
<tr>
<td></td>
<td>• All the wards had appropriate alarms available and they were in good working order.</td>
</tr>
<tr>
<td></td>
<td>• Staff completed risk assessments and the assessments were regularly reviewed. The trust was rolling out a new risk assessment template, which was working well.</td>
</tr>
<tr>
<td></td>
<td>• Staff escalated concerns about patients’ physical health promptly.</td>
</tr>
<tr>
<td></td>
<td>• Staff recorded more detailed information that allowed the trust to accurately monitor how restraint was used.</td>
</tr>
<tr>
<td></td>
<td>• Staff on Lambeth Triage understood the meaning of seclusion and if patients were prevented from leaving their rooms for a period the seclusion policy was followed.</td>
</tr>
<tr>
<td></td>
<td>• Acute wards and three of the four PICUs fridge temperatures were being regularly monitored and recorded.</td>
</tr>
<tr>
<td></td>
<td>• Staff were mitigating environmental risk posed to patients by a staircase in the garden on ES1.</td>
</tr>
<tr>
<td>Effective</td>
<td>• Patients had their status under the Mental Health Act (MHA) recorded correctly.</td>
</tr>
<tr>
<td></td>
<td>• Informal patients were now provided with accurate information about their rights.</td>
</tr>
<tr>
<td></td>
<td>• Majority of staff had completed training in the MCA and understood how it applied in practice.</td>
</tr>
<tr>
<td></td>
<td>• Staff assessed the physical health needs of patients well. Many physical health care plans were very detailed and provided clear guidance to staff on how best to support patients with long term conditions, such as diabetes.</td>
</tr>
<tr>
<td></td>
<td>• Staff actively supported patients to stop smoking and provided good access to nicotine replacement therapy with a range of products available to patients.</td>
</tr>
<tr>
<td>Caring</td>
<td>• The majority of patients described staff as kind and caring. Staff interacted with patients in a respectful manner. They spent time with patients and offered practical and emotional support. Staff understood the individual needs of patients.</td>
</tr>
<tr>
<td></td>
<td>• Quality of care plans had improved on the acute wards. Most patients had care plans in place that were holistic, patient centred and recovery orientated.</td>
</tr>
<tr>
<td>Responsive</td>
<td>• Staff kept viewing panels and exterior curtains closed, maintaining patients’ privacy and dignity.</td>
</tr>
</tbody>
</table>
- Wards provided a range of activities to patients including access to the gym.
- Rooms available for patients to meet privately with advocates.

**Well Led**
- Staff morale was generally good. Staff felt well supported by managers and colleagues. The trust and ward staff were committed to quality improvement and innovation.
- Temporary staff completed a brief induction when working on a ward for the first time.
- The trust had significantly reduced the number of patients being cared for in other hospitals, outside the local area, in the last 15 months. Most patients were on wards located in, or close to, their home boroughs.
- Good working relationships between ward staff and home treatment teams supported the delivery of effective patient care through the acute care pathway.

*Table Two: CQC Acute wards for adults of working age and psychiatric intensive care units, summary of findings*

### 3.2 Good Practice
The CQC highlighted the implementation of the E-obs as good practice. The further roll out to an increased number of wards is a quality priority this year.

### 4.0 Areas for Improvement
Following the inspection, the Trust now has several improvement actions the CQC state the trust 'MUST' and 'SHOULD' respond to, these are outlined in the tables below.

#### 4.1 MUSTS

<table>
<thead>
<tr>
<th>Number</th>
<th>Must</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Staffing</td>
<td>The Trust must continue to address the high number of nursing vacancies on some wards.</td>
</tr>
<tr>
<td>2</td>
<td>Safeguarding</td>
<td>The Trust must ensure that all staff recognise potential abuse and report safeguarding concerns appropriately.</td>
</tr>
<tr>
<td>3</td>
<td>Ligatures</td>
<td>The Trust must ensure that all ligature anchor point risks on the psychiatric intensive care wards are recorded on the ward ligature risk assessment and that staff are aware of the risks and how they are mitigated.</td>
</tr>
<tr>
<td>4</td>
<td>Restraint</td>
<td>The Trust must develop clear plans to reduce the number of patients being restrained in the prone position and monitor the impact of actions taken.</td>
</tr>
<tr>
<td>5</td>
<td>Fire drills</td>
<td>The Trust must ensure that information about fire safety procedures and evacuation is up to date on all wards. Fire drills must take place regularly.</td>
</tr>
<tr>
<td>6</td>
<td>Supervision</td>
<td>The Trust must ensure that all staff have regular managerial and clinical supervision.</td>
</tr>
<tr>
<td>7</td>
<td>Governance</td>
<td>The Trust must ensure that governance processes are sufficiently robust so that they identify where improvements need to be made.</td>
</tr>
</tbody>
</table>

*Table Three: CQC Acute wards for adults of working age and psychiatric intensive care units, MUST DO actions 2017*
4.2 SHOULDs

<table>
<thead>
<tr>
<th>Number</th>
<th>SHOULD</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PEST control</td>
<td>The Trust should take all necessary steps to ensure effective pest control on the wards at Maudsley Hospital.</td>
</tr>
<tr>
<td>2</td>
<td>MCA mandatory training</td>
<td>The Trust should ensure that staff continue to increase their completion of mandatory training, including Mental Capacity Act 2005 training.</td>
</tr>
<tr>
<td>3</td>
<td>AWOL POWELL</td>
<td>The Trust should consider why the number of detained patients leaving without authorisation on Powell ward is much higher than other acute wards, with a view to reducing this number. In addition the trust should review the safety and security of the garden fence on Johnson ward to prevent patients going absent without authorisation.</td>
</tr>
<tr>
<td>4</td>
<td>Seclusion</td>
<td>The Trust should ensure that the seclusion rooms on Johnson and Eden PICUs are repaired promptly.</td>
</tr>
<tr>
<td>5</td>
<td>Croydon PICU Leave</td>
<td>The Trust should review the practice of limiting all patients on Croydon PICU to a maximum of 30 minutes of leave at any one time and ensure that the granting of leave is based on an individual assessment of risk.</td>
</tr>
<tr>
<td>6</td>
<td>PICU care plans</td>
<td>The Trust should ensure that patient care plans on the PICUs are individualised and goal orientated.</td>
</tr>
<tr>
<td>7</td>
<td>LD training</td>
<td>The Trust should ensure that planned training in learning disabilities and autism is made available to all staff on acute wards and PICUs.</td>
</tr>
<tr>
<td>8</td>
<td>Clare ward weekend leave</td>
<td>The Trust should ensure that any patients transferred to Clare ward at the weekend are not unnecessarily restricted to the ward.</td>
</tr>
<tr>
<td>9</td>
<td>Confidential patient information</td>
<td>The Trust should ensure that confidential patient information is not visible to other patients and visitors to the wards.</td>
</tr>
<tr>
<td>10</td>
<td>Hot and cold drinks</td>
<td>The Trust should ensure that patients know that they can have a hot or cold drink when they want one, including at night.</td>
</tr>
<tr>
<td>11</td>
<td>Storage locks</td>
<td>The Trust should review the possibility of providing more accessible lockable storage for patients.</td>
</tr>
<tr>
<td>13</td>
<td>Ladywell ward temperatures</td>
<td>The Trust should ensure that ward temperatures at the Ladywell Unit are comfortable for patients and staff.</td>
</tr>
</tbody>
</table>

Table Four: CQC Acute wards for adults of working age and psychiatric intensive care units, SHOULD DO actions 2017

4.3 IMPROVEMENTS UNDERWAY

Some key Trust wide quality improvement initiatives already taking place, two of which are outlined below.

Reducing Restraint

A three-year strategy to reduce restrictive interventions has been developed by the Trust and was ratified by the Board in April 2017. The strategy provides a framework for the reduction of restrictive interventions across all in-patient services in line with the DH Positive and Safe initiative (2014) and other relevant national guidance including NICE guideline NG10. The strategy delivery is monitored by the Trust Safe and Therapeutic Services Committee.

As part of this strategy the Trust is in the process of implementing a violence reduction programme called ‘Four Steps to Safety’ which is being delivered collaboratively with Devon Partnership NHS Trust and is sponsored by the Health Foundation.

The Four Steps to Safety project is a system for safer care and uses a series of evidence based clinical interventions which are implemented using quality improvement methods. The project aims to reduce the levels of violence and aggression by 50% across all inpatient wards achieving better and safer care for the patients and better, safer working environment for the staff. An important part of the project is to enable clinical staff to embed a system of care which is proactive, rather than reactive.
This work was designed and is delivered in partnership with people with lived experience of inpatient services. The programme is being delivered to 48 inpatients wards across the trust and is due to be completed by September 2017.

To deliver the strategy, a Trustwide implementation plan will be developed in collaboration with CAG Heads of Nursing. CAG's will also develop local implementation and action plans that address the delivery of the strategy across their services, addressing the specific needs of their service users. Implementation plans will be monitored through the Safe and Therapeutic Services committee and CAG governance structures.

**Staffing**
The Trust has worked hard to increase its presence across London and the country. We have attended RCN recruitment Fairs and hosted successful open days at the Bethlem, Kent, Maudsley and Lewisham. We have had a timetable of monthly assessment centres for Band 5 nurses where we have seen a month on month increase in attendance due to our advertising campaigns in the Metro/Evening Standard and local newspapers.

We have also had a Learning Disability conference to showcase and celebrate the Trust’s Learning Disability nurses. It was a widely-promoted event. We invited university students and many were expressed an interest to work for the Trust once they qualified.

In partnership with the other two mental health Trusts who comprise the South London Partnership – Oxleas and South West London and St Georges, an agreement has been reached to take a common approach to the development of band 4 Assistant Practitioners (AP) staff to work in inpatient care areas. Assistant Practitioners will receive robust training with our partner University LSBU, including an initial two-week course focusing on mental health practice and then complete a Foundation degree level course via day release for 18 months. The first cohort of 12 students from SLaM is underway and is of a high caliber. As discussed at the Board April 2017 the approach to staff retention and rewards is currently being revised.

The focus of increasing staff recruitment and retention will remain a priority.

**5.0 Governance and Assurance**
The Director of Nursing has met with the Clinical and Service Director to consider the ‘MUST’ and ‘SHOULD’ do actions. The Clinical and Service Directors are leading 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 and be implemented across the CAG. The deadline is 22nd May 2017.

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

Mary O’Donovan
Head of Quality
REPORT TO THE TRUST BOARD:  PUBLIC  
DATE: 23rd May 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Physical Health Thematic Review - highlight report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Jan Luxton, Nurse Consultant Physical Well-being</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Beverley Murphy, Director of Nursing</td>
</tr>
</tbody>
</table>

**Purpose of the paper**

At the February 2017 Quality Sub Committee (QSC), following receipt of thematic review of physical health including implementation of physical EObs, the committee requested that the Trust Board be sighted on the progress and challenges against the 2016-17 quality priorities in physical health.

**Executive summary**

The Quality Sub Committee receives assurance reports about the delivery of physical health care within the Trust. As set out in the paper challenges in maintaining good physical health for people with a mental health problem is well recognised. On receiving a report in February, the committee requested the Board be sighted on progress and challenges against the 2016 quality priorities.

The paper sets out the background and importance of why SLaM is focussed on improving the physical health care provided within services.

The key area at section 2 sets out the priorities for 2016 – 17 and the achievements in year as well as the challenges that are currently being considered. The next steps set out the targets for the coming year and who will deliver these.

The financial, regulatory and sustainability risks are broadly outlined as well as the potential risks to the safety of people who use services. The Director of Nursing is addressing the risks to progressing further.

The Board is asked to note the content of the report.

**Committees where this item has been considered**

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee/Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/02/2017</td>
<td>Quality Sub-Committee</td>
</tr>
</tbody>
</table>
1.0 **Background**

1.1 Having a serious mental illness (SMI) is associated with a life expectancy that is 20% shorter than average and the mortality gap relative to the general population is increasing. The majority of deaths (75%) are from natural causes, i.e. cardiovascular, respiratory and infectious diseases. These are the same conditions which are responsible for the mortality seen in the general population, the key difference is that people with SMI die from these physical conditions some 15-25 years earlier than expected (Chang et al 2011, Hoang et al 2011).

1.2 People with SMI have higher rates of cardiometabolic risk factors than usual but they do not have the same access as the general population to interventions or health promotion services to help prevent/manage these risk factors which can reduce the likelihood of developing the long-term cardiovascular conditions associated with them. It is known that obesity and smoking are particularly important risk factors for cardiometabolic disorders and these are highly prevalent in SMI. More than 40% of all tobacco smoked is by people with SMI, and 48% of people with SMI are obese compared with 22% of the UK population (HSCIC, 2016; Gardner-Sood et al 2015).

1.3 In 2009 NHS England recognised the importance of improving cardiometabolic assessment in people with SMI and first incentivised mental health trusts via the CQUIN scheme. NHS England acknowledges there is no quick-fix to this unmet need and continues to incentivise mental health providers to improve physical health assessment and intervention through to 2019.

1.4 Beyond the chronic multi-morbidity of physical and mental illness, the Trust has recognised the risks associated with acutely medically deteriorating patients with adverse outcomes including premature death within the mental health in-patient setting. Quantitative data on this is scarce: the National Patient Safety Agency (NPSA, 2007) reported that 32 out of 605 (5.3%) claims in 2005 concerning the quality of care come from unexpected death following referrals made by mental health trusts to accident and emergency. In 2016 the Trust reviewed its use of a modified early warning score (MEWs) for the monitoring of vital signs and the early detection of deteriorating patients. That review recommended a move from the non-validated MEWs to the evidence-based national early warning score (NEWs) using eObs. The benefits to service users and staff are that the Trust was now adopting vital sign parameters as validated by the best evidenced-based research from the Royal College of Physicians through a tool standardised with the London Ambulance Service and local Acute Trusts.

1.5 The Trust has acknowledged physical health as a quality priority since 2016, continuing into 2017-18; the Trust has a CQUIN scheme to the value of circa £900,000 to improve physical health assessment, intervention and communication through to 2019; and has a five-year (2016-2021) strategic plan in place to improve physical healthcare and reduce excess mortality including embedding NEWs into eObs as a digital health priority.

2.0 **Summary of Progress with Physical Health Targets 2016-17**

There were seven major work-streams attached to the Trust Quality Priorities and CQUIN throughout 2016-17, below is a summary of each and the progress and challenges.

2.1 **Priority 1** - EPJS redesign to support the physical healthcare quality priority and CQUIN achievement - assessment and intervention in early intervention and community service users on CPA.

    Reason for change: community-based services were expected to capture physical health assessments through an in-patient physical health tool which was not fit for this purpose.

    **Progress** - **Achieved.** During Q1 a series of service user focus groups and clinical consultations were hosted on which to base the redesign. Q2 saw the EPJS community physical health assessment and intervention tool developed, tested and piloted. Q3 the tool launched in November 2016.

2.2 **Priority 2** - Develop IT systems which support physical health monitoring and identification of high risk service users, using established physical health monitoring tools, e.g. Q-Risk2 or Bradford Tool which will allow instant cardiovascular risk estimation.
Progress - Not achieved. The Trust has been unable to incorporate Q-Risk2. The physical health CQUIN team have been unsuccessful in securing the finance for the Q-Risk2 licence within EPJS. The Bradford tool is not available for EPJS platform.

In terms of patient impact this means the clinical teams and CAG governance structures have no automated way of identifying high CVD risk patients within EPJS and therefore cannot systematically identify and manage their high risk patients (as priority 3). Clinical risks will continue to be managed on an individual basis. QRisk 2 was not specified in CQUIN so should have no financial impact.

2.3 Priority 3 - Develop a RAG rating approach at clinician level to identify and manage patients with high CVD risk based on risk score.

Progress – Not achieved. This was dependent on achieving priority 2 and as such the impact on patient safety is as above.

2.4 Priority 4 - Introduce physical health self-monitoring pods for community service users to encourage proactive and independent access to physical health checks (for recording weight, body mass index (BMI), blood pressure, activity and smoking status recorded into EPJS).

Progress - Not achieved. Suitable physical health monitoring pods have been identified trialled by clinical and service user evaluation at St Giles Centre.

This quality priority sits across the Trust’s physical and digital health aspirations to be innovative and not only driven by CQUIN but by our Physical Health Strategy. However, this initiative would ultimately support the CQUIN for 2017-19 where 65% of all community service users on CPA (as opposed to just ten teams for 2016-17) should have annual physical health screening. This expansion of the CQUIN will have a significant human resource impact for teams to have to complete physical health assessments and interventions at CPA and on admission to service. Our vision is self-monitoring, will reduce some of this impact for staff; feed directly into EPJS; links to My Health Locker and Physical Health Plan.

For service users, the impact of this not being achieved in 2016 - 17 is that they will continue to have to directly access healthcare professionals for physical health monitoring as opposed to taking a self-management approach.

No financial impact on CQUIN 2016/17.

2.5 Priority 5 - Develop CRIS data extract to review the quality of completion of physical health assessments and inform targeted clinical activity based on physical health assessment results.

Progress – Achieved. The CRIS data extract on physical health assessment and intervention has been successfully developed and refined, and is being used by early intervention in psychosis clinicians to determine clinical need for targeted interventions at population level.

2.6 Priority 6 - Develop CRIS data extract to inform performance monitoring for CAGs against Trust quality priorities and CQUIN milestones.

Progress – Achieved. Due to changes in CQUIN project support there are some delays of the CRIS data, this is in hand..

2.7 Priority 7 - Physical health awareness to be part of the mandatory training programme for all staff regardless of discipline and seniority.

Progress – Partially achieved. Trust Induction Values Day now includes a level 1 awareness session on physical health and wellbeing in SMI. The CQUIN scheme expects the Trust to have mandatory level 1 for all staff and Level 2 e-learning for all clinicians. This will have major human resource (time) impact across the Trust and requires further consideration.
The full report to the QSC included a progress report against the Trust Physical Health Strategy (year one). There is still much work to be done to ensure systems are developed and embedded to support the physical health and wellbeing of our service users. For physical health to be given the priority it needs in both policy and action.

3.0 Next steps

3.1 The physical health lead clinicians submit the brief plan for 2017-18 below for approval

<table>
<thead>
<tr>
<th>Month</th>
<th>Activity based on year-two of Physical Health Strategy, current quality priorities and CQUIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly</strong></td>
<td><strong>Quarter 1-4</strong> CRIS data extract on physical health assessment and intervention performance achievements at trust, CAG and team level ready for release to CAGs performance and governance leads.</td>
</tr>
<tr>
<td><strong>Quarters 1-2</strong></td>
<td>Commence focused consultations with clinical staff and service users for EPJS in-patient physical health screening tool redesign. Leads: Nurse Consultant and PHPS. Continue to explore funding options for physical health self-monitoring pods in key outpatient hubs. Leads: Lead Consultant Psychiatrist and PHPS. Identify and confirm Physical Health Lead Psychiatrist for Psychosis CAG for GP liaison aspect of CQUIN. Work with local commissioning bodies with the aim of developing further integrated patient records with primary and secondary acute services. Leads: Physical health-lead Consultant Psychiatrist. Level 2 Physical Health for Clinicians e-learning package to be developed and training commenced. Leads: Education and Development; Consultant Psychiatrist; Nurse Consultant and PHPS. Staff training to be delivered on physical eObs at Ladywell. Physical Health monitoring tools for: fluid balance; food intake; blood glucose; weight/BMI/waist circumference; neurological observations to be tested and launched on eObs at Ladywell. Roll-out to next site to be confirmed. Leads: eObs Clinical Lead and Nurse Advisor, Professional Standards.</td>
</tr>
<tr>
<td><strong>Quarters 2-3</strong></td>
<td>EPJS phase 2 in-patient physical health screen development. Leads: Nurse Consultant; PHPS and EPJS team. <strong>(Subject to EPJS development work-streams.)</strong> All CAGs to have a prevention strategy in place for their particular service area which aims to reduce exposure to modifiable physical health risk factors and promote physical health care in their client group. Leads: CAG Clinical Directors/Director of Nursing. CQUIN submission to commissioners (tbc by Contract Team). EObs training roll-out. Leads: eObs Clinical Lead and Nurse Advisor, Professional Standards.</td>
</tr>
</tbody>
</table>
| **Quarters 2-3** | Develop CRIS data extract system to capture patient outcomes in terms of BMI and smoking cessation in EIPT. Leads: CRIS team and PHPS. Pilot; feedback; refine and launch physical health in-patient screen. Incorporate Q-Risk2 into both community and in patient physical health screens to identify high cardiovascular risk patients. Leads: Nurse Consultant and PHPS. **(Subject to funding for license for Q-Risk2 and EPJS development.)**
3.2 The Board can be encouraged by the progress made throughout 2016–17 but are asked to be cognisant of the challenges ahead. There is work to be done with the CAGs to explore how the necessary action can be resourced. The Director of Nursing and Chief Operating Officer will lead this discussion.

3.3 Risks

3.3.1 Financial

The value of the 16–17 CQUIN was £950,000 across the 4 commissioning boroughs; the final realised value is not yet known as we await final commissioner feedback. In 17 – 19 the value of the CQUIN is £490,000 which will only be realised if all actions are met. (The change in value is connected with a move of nearly half of overall CQUIN funding to STP and financial control totals.)

3.3.2 Regulatory

The Board can be assured that trust wide there are clear standards and staff with appropriate skills to ensure care is safe and responsive and that services meet regulation 12 as set out in the CQC regulations.

3.3.3 Safety

The immediate safety of service users is protected by individual risk assessment and comprehensive plans of care. In line with reducing excess mortality due to preventable physical health conditions, the Trust is currently unable to develop a high-risk register of patients (based on CVD risk) for targeted intervention/support without integration of QRisk2 or similar into EPJS.

3.3.4 Sustainability

Progress has not been made at the pace set out largely due to resource. The incoming Director of Nursing has agreed to take the lead for the delivery of the physical health care strategy; she will work with CAGs to explore the options to deliver a consistent and sustainable approach to improving physical health care across the Trust in line with the CQUIN requirements.

4.0 Structure

4.1 The QSC supported the view that an Executive-level lead should Chair the Trust Physical Health Committee, to give that committee the direct line of sight to the Board. This has been achieved.

4.2 SLaM has a senior Board member who is the named lead for physical health and resuscitation in the Trust – Dr Michael Holland, Medical Director. In addition, the Director of Nursing is also a named lead for physical health in the Trust and Chairs the eObs Executive Board.
4.3  SLaM has a Nurse Consultant who is responsible for broad aspects of physical wellbeing, who leads on physical health policies; NICE guideline appraisals; supports clinical practice; quality improvement; teaching and learning. Chairs the Physical Healthcare and Medical Devices Committees, and manages contracts for provision of Tissue Viability and Medical Device servicing.

4.4  Two Consultant Psychiatrists, lead the physical health CQUIN project team. There is a resourcing issue which is under discussion.

4.5  The CQUIN project during 2016-17 has been supported by:
  ➢ The Physical Health Programme Specialist nurse (PHPS)
  ➢ The Quality Team assisted with data collection and submissions for national audits and quality priorities; and,
  ➢ Contracts Team (withdrawn from March 2017) assisted with performance monitoring and CQUIN contracts submissions.

Jan Luxton, Nurse Consultant Physical Well-being

## Purpose of the paper

The purpose of this report is to set the foundations for change for equality and inclusion within the Trust especially for BME staff where their reported experience is less favourable than white staff. This report also incorporates the Trust Workforce Race Equality Standard metrics for 2016-17 in accordance with the national contract under NHS England requirements.

The report identifies the difference in experience between white and BME staff and applicants through the 9 different standards including Board composition and the proportional ethnicity of staff across the different pay scales and bandings. Four standards are taken from the Annual Staff Survey.

The Board are asked to note the content of the report and support the following recommendations and actions:

- To approve actions and targets outlined for change.
- To note and approve the publication of the WRES metrics and submission to NHS England in July 2017.
- Continue work with the BME Network to inform the work programme for the Tackling Snowy White Peaks working group.
- Delivering the specific actions relating to (a) the representation of BME staff at bands 8c and above, (b) eliminating the over-representation of BME staff in disciplinary proceedings and (c) improving the career development opportunities for BME staff.
- Development of a staff engagement strategy with an emphasis on equalities and review of management and leadership development programmes and their impact on staff experience and ethnicity.
Executive summary

Our workforce is our most valuable asset and it is imperative that all staff feel valued supported and engaged in order to provide the highest quality of service. Feedback from the Staff Survey and the BME Network indicates that the experiences by our BME staff are reported as less positive. Diversity and inclusion are core to the delivery of good high quality services by motivated and engaged staff.

The Trust Board and Senior Management team, led by the Chair and Chief Executive, have established that the experiences of BME staff within the workforce as a key organisational priority. The data for the WRES confirms taking action on equalities is the right thing to do and work with the BME Network is progressing to implement changes in the short and longer term. Accordingly, the Board are asked to prioritise the following actions and targets.

Our aspiration by Spring 2021, is to:

- Achieve representation of BME staff at pay bands 8c and above that reflects the proportion of BME staff in our workforce. This will involve increasing the numbers of BME staff at bands 8c and above from 21 to 55 (on current numbers). Our aim will be to achieve linear progress towards this goal at a minimum. We will track progress on a yearly basis.

- Eliminate the over-representation of BME staff involved in disciplinary proceedings as they are currently 3.5 times more likely to be targeted. This will involve rapidly reducing the proportion of BME staff involved in disciplinary proceedings. We aim to make significant progress in reducing the over-representation within the first year.

- Improve the Career Opportunities offer for BME. We aim to ensure that there is no perceived difference in the access to career opportunities between BME and White staff as reported in the yearly staff surveys. BME staff currently score this at 66% as compared with 85% for White staff.

The report identifies the difference in experience between white and BME staff and applicants through the 9 different standards including Board composition and the proportional ethnicity of staff across the different pay scales and bandings. Four standards are taken from the Annual Staff Survey. The full data for each metric has been analysed to identify if there are any specific issues. It is known that the proportion of BME staff in the higher bandings decrease as the level of banding increases.

The Trust Board is asked to review the paper, actions and to endorse the publication of the data in line with reporting requirements.
WORKFORCE RACE EQUALITY STANDARD 2016-2017

The purpose of this report is to present the Trust Workforce Race Equality Standard metrics for 2016-17 in accordance with the national contract and under NHS England requirements.

The report identifies the difference in experience between white and BME staff and applicants through the 9 different standards including Board composition and the proportional ethnicity of staff across the different pay scales and bandings. Four standards are taken from the Annual Staff Survey.

It is acknowledged that staff who are more engaged and supported by their organisation are more likely to provide a better and higher quality of patient or service user care. Research shows that the unfair treatment of BME staff adversely affects the care and treatment of all patients and precious resources are wasted through the impact of such treatment on morale, discretionary effort and a loss of talent.

The data within this report will be included in the mandatory submission to NHS England in July 2017 and provided to our lead commissioner. The data must also be published on the Trust’s website.

1 Percentage of BME staff in Bands 1-9, Medical and VSM (including Executive Board members and senior medical staff) compared to the percentage of BME staff in the overall workforce.

The overall organisational workforce profile is broadly similar to the local populations and has been the case over the past couple of years of reporting for the WRES. This year the descriptor for metric 1 has changed to cover ethnicity in all bands and grades whereas previously reporting was limited to band 8A and above and senior medical posts. In
comparing to previous years and this year, the proportion of BME staff in bands 8A and above was 17.05% in 2015, 18.87% in 2016 and 19.04% in 2017.

The highest proportion of BME staff compared to White staff are in Band 1 although it should be noted that this group only consists of four staff. Bands 2, 3 and 5 are then the next proportionally highest for BME staff. Band 4 is the most reflective of the overall organisational ethnicity profile closely followed by Band 6. The proportion of BME staff in the higher bandings decrease as the level of banding increases from Band 7 upwards with no BME staff in Band 8D.

Targets over forthcoming years to increase the representation of BME staff in Bands 8C and above to reflect their overall workforce profile have been included in this report as an action and recommendation.

2. Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>White</th>
<th>BME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of shortlisted applicants</td>
<td>1671</td>
<td>1794</td>
</tr>
<tr>
<td>Number appointed from shortlist</td>
<td>354</td>
<td>197</td>
</tr>
<tr>
<td>Ration shortlisted/appointed</td>
<td>0.211</td>
<td>0.109</td>
</tr>
</tbody>
</table>

Relative likelihood of White staff being appointed from shortlisting compared to BME staff is (0.211/0.109) is therefore 1.93 times greater compared to 1.89 times in the previous year.

We have commenced our Apprenticeship programme which offers the opportunity for people to start a career within the health service and which makes this more accessible to people from the local community. We will be introducing our Associate Practitioner role to improve access to nursing careers for bands 2-4 and need to ensure there is a meaningful career pathway through all bands by using talent management approaches underpinned by appraisals and PDPs.

The Tackling Snowy White Peaks Working group will also be looking at the processes for recruitment and acting up within the Trust to ensure that opportunities to advance are promoted and visible.

3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.

Note: this indicator will be based on the data from a two-year rolling average of the current year and the previous year.

<table>
<thead>
<tr>
<th>2015-2016</th>
<th>White</th>
<th>BME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff in the workforce</td>
<td>2731</td>
<td>1881</td>
</tr>
<tr>
<td>Number of staff entering the formal disciplinary</td>
<td>19</td>
<td>40</td>
</tr>
</tbody>
</table>
Relative Likelihood of BME staff entering the formal disciplinary process compared to White staff is 0.0212/0.006 = 3.5 times greater.

### 2016-2017

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>White</th>
<th>BME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff in the workforce</td>
<td>2656</td>
<td>1897</td>
</tr>
<tr>
<td>Number of staff entering the formal disciplinary process</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Ratios</td>
<td>10/2645 = 0.003</td>
<td>19/1897 = 0.010</td>
</tr>
</tbody>
</table>

Relative Likelihood of BME staff entering the formal disciplinary process compared to White staff is 0.0212/0.006 = 3.3 times greater.

The data indicates there has been a marginal reduction in the likelihood of BME staff entering formal disciplinary processes from the previous year but still remains significantly higher than white staff.

The actual numbers of staff overall entering formal disciplinary processes has halved from the previous year and significantly lower from the first year of reporting where there were 116 individuals and which is now 29. This is the result of using formal conversations rather than invoking formal disciplinary processes and applying disciplinary sanctions.

It is anticipated that the work being undertaken by the “Tackling Snowy Peaks Working Group” including the introduction of the Review and Reflect Checklist should have a positive effect on the total number of people entering formal disciplinary processes and the proportion of those who are from a BME ethnic background.

| 4 | Relative likelihood of BME staff accessing non mandatory training and CPD as compared to White staff. |
There is no material difference in the proportion of BME and white staff accessing CPD training in the last year. It should be noted that the numbers accessing CPD has reduced due to reductions in funding from Health Education England.

The ability to access learning and development is critical to staff engagement and to gain new skills. The BME network have highlighted that access to a mentoring scheme would be seen as beneficial where formal study is not always available.

Staff Survey Questions (Standards 5-8)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>White</th>
<th>BME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff in workforce</td>
<td>2656</td>
<td>1897</td>
</tr>
<tr>
<td>Number of staff accessing non-mandatory training and CPD</td>
<td>122</td>
<td>88</td>
</tr>
<tr>
<td>Ratio</td>
<td>0.045</td>
<td>0.046</td>
</tr>
</tbody>
</table>

The staff survey results indicate an improvement in some areas in the experience of BME staff compared to the previous year although that experience is still less favourable compared to the national average and to the experience of white colleagues. The area of most significant difference in the experiences of white and BME staff as reported through the survey is the percentage of staff who have experienced discrimination at work from their manager/team leader of other colleague which is more than double for BME staff compared to white staff. This along with the percentage of staff believing the organisation provides equal opportunities for career progression and promotion indicates a need to radically review how BME staff are engaged, valued and supported within the Trust.
A central feature of this will be to develop and implement a new staff engagement strategy with an emphasis on equalities. This will include reviewing our leadership and management development programmes to ensure they incorporate inclusive leadership in relation to unconscious bias and to reflect best practice. We will also need to ensure that managers and leaders, both new to the organisation and those being promoted within it, have the right leadership skills to ensure staff feel valued and included in decisions that affect them especially in periods of organisational change.

The Staff Survey Action plan is focused on the following six key areas which interrelate with themes arising from the WRES metrics.

- Career development, opportunities and increased visibility of these
- Health and wellbeing for staff
- Bullying and harassment and discrimination
- Reduction in violence and aggression
- The role of the manager and positive proactive leadership, including good communication and engagement
- Reward and recognition

A detailed Action Plan has been developed for the Staff Survey which will focus on the above areas is attached as Appendix 1.

| 9 | Boards are expected to be broadly representative of the population they serve. |

**Board Composition**

The Board composition is presently less reflective of the local populations across our four main boroughs where we provide services and which tends to have a white population of between 53% and 57% depending on the actual borough.
Recommendations:

- To approve actions and targets outlined for change.
- To note and approve the publication of the WRES metrics and submission to NHS England in July 2017.
- Continue work with the BME Network to inform the work programme for the Tackling Snowy White Peaks working group.
- Delivering the specific actions relating to (a) the representation of BME staff at bands 8c and above, (b) eliminating the over-representation of BME staff in disciplinary proceedings and (c) improving the career development opportunities for BME staff.
- Development of a staff engagement strategy with an emphasis on equalities and review of management and leadership development programmes and their impact on staff experience and ethnicity.
Title | UPDATE FROM THE COUNCIL OF GOVERNORS
---|---
Author | Rachel Evans

Purpose of the paper
To update the Board on the recent activity of the Council of Governors.

New Governor

1. The Council of Governors welcomed a new Governor this month – Clara Martins de Barros. Clara is a Service User Governor and fills the vacancy arising from the resignation of Adam Black. Adam has contributed a considerable amount to the Trust as a Governor and we thank him for his substantial contribution and wish him all the very best for the future.

NHS Providers – Governor Focus

2. The Lead Governor attended the Governor Focus conference organised by NHS Providers on 4 May. This included useful presentations on a range of topics, including different perspectives on Sustainability and Transformation partnerships and a presentation by Dr Henrietta Hughes on the Freedom to Speak Up initiative. The slides have been circulated to all Governors.

Quality Working Group

3. The Quality Working Group met on 9 May under its new Chair, Marnie Hayward. There was a full agenda, which included looking at the draft Quality Accounts, the update on PEDIC and the visit by Marnie Hayward, Jeannie Hughes and Jenny Cobley to the A&E departments at Kings College Hospital and St Thomas’s.

Matters arising included concerns raised by staff governors and Healthwatch Lambeth about staff welfare and safe staffing levels in community services. The group acknowledged the publication of
the CQC report of the re-inspection of Acute adults and PICU services and will consider the findings at its next meeting along with the Trust action plans.

Whilst the group were pleased to see 'safe' has improved from 'inadequate' to 'requires improvement' in the CQC re-inspection of Acute adult and PICU services we are concerned that new concerns had been identified and other previously raised concerns have deteriorated. We are particularly concerned that the CQC doesn't think the Trust has robust enough governance structures in place to identify where improvements may be needed and look forward to receiving the Trust's action plans.

Jeannie Hughes was confirmed as Deputy Chair of the group after a unanimous vote.

**Membership and Involvement Working Group**

4. The Membership and Involvement Working Group met on 10 May, chaired by Tom Flynn. The group considered a revised Governors Handbook – designed to be more accessible for new Governors and clearer about what being a Governor involves. The Group also advised on the planning for the Annual Members Meeting in September and considered the results of the recent Annual Governors’ survey.

**Bids Group**

5. The Bids group met on 11 May, chaired by David Blazey. The group considered the progress of the 'Let's Smile' scheme, the issues arising at year-end and the plans to visit the successful bidders. The group also considered how best to showcase the scheme at the Annual Members Meeting.

**Annual Governor survey**

6. The annual Governor survey concluded at the end of April and gathered Governor views on a range of issues. These included questions on the quality of induction and training given to Governors, the quality of the communications to Governors, the topics discussed at the Council of Governor meetings, the preferred timing of those meetings and the behaviours demonstrated by staff and governors.

7. The results of the Survey were considered at the Membership and Involvement Working Group and recommendations will be presented to the Council of Governors meeting in June.
Involvement Oversight Group

8. Service user and Carer governors have been invited to join the Involvement Oversight Group, which meets for the first time on 15 May, chaired by Julie Hollyman.

Members Seminar

9. The Governors are hosting a Members’ Seminar at lunchtime on Thursday 25th May. Dr. Fiona Gaughran, Lead Consultant Psychiatrist and Director of Research and Development at the Trust will be talking about the disparity in life expectancy for people with and without mental health issues and how we can address it.
Purpose of the paper

The Trust’s Scheme of Delegation was reviewed and an updated scheme was approved at the Board in November 2016.

When it was approved, the Board requested an update in April as a result of a further focussed review in some specific areas including the development of the governance arrangements for our South London Partnership, and the implications of the financial planning for 2017/18 and beyond.

The paper sets out briefly the work that has been undertaken since November and the ongoing workstreams.

The Trust Board is to note the amendments and the ongoing work underway including that with our partners in SLP. We will keep the Scheme of Delegation under review as these workstreams progress but unless appropriate do not propose a further update before 31 March 2018.

Executive summary

The Scheme of Delegation as presented to the Board in November 2016 has been updated to reflect the latest structures and governance arrangements in the Trust, including minor corrections to job titles and descriptions.

Further to the areas identified for further review in November 2016:

- The description of the process for the appointment of the deputy chair has been aligned with the constitution and NHS Improvement Foundation Trust Code of Governance
- I have not updated the Scheme of Delegation to include all the sub-committees as this is not necessary – there is a general provision at 1.4.1 covering the establishment of the sub-committees and that the role of the committee including any delegated authority is covered in Terms of Reference agreed by the Board
- The Scheme of Delegation includes a reference to the Constitution for the roles and duties of Governors (1.3.12) and the appointment of the Chair and Non-Executive Directors (1.4.2)
- No further changes were necessary as a result of the ongoing evolution of the Governance arrangements in respect of the Council of Governors – these are covered already in the general reference to the Constitution

The Appendix A represents new authorisation limits built into the latest Trust Procurement Policy. This has been the subject of consultation with our partners in South London Partnership (SLP) with a view to finalising a unified policy which would apply across all three Trusts in the next few months. This is an example of the work underway to review and rationalise policies across SLP in order to streamline
systems and improve efficiency, effectiveness and value for money.

Specific Changes to delegations updated in this version are:

**Page 4 Direct Operational Issues**

1.8.5 The Board shall approve the acquisition, disposal and writing down of the value of the Trust’s fixed assets where the value (or write down as appropriate) exceeds £5,000,000 in any one instance. The Board will delegate authority to the Chief Executive and Chief Financial Officer where the value is less than £5,000,000 provided that the Audit Committee is informed and the matter is recorded in the minutes.

**Changed from:** £750,000

1.8.7 The Board shall approve the introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure in excess of £5,000,000. The Board will delegate authority to the Chief Executive and Chief Financial Officer where the value is less than £5,000,000 provided that the appropriate Board sub-committee is informed and the matter is recorded in the minutes.

**Changed from:** £1,000,000

**Page 6 Delegation to Committees**

2.1.1 When the Board meets in private to consider items which are confidential because the nature of the discussions requires contractual, commercial or personal confidentiality the Board in public will receive an appropriate report as soon as practical.

**Changed from:** Note that when the Board is not meeting as the Trust in public session it operates as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

Work is ongoing to rationalise and streamline the details authorised signatory lists for all budgets across the Trust – these are being signed off in parallel with the changes to budgets by the Director of Finance and the appropriate Directors in accordance with the Delegated Authority in the Scheme.

Further work to rationalise and make these key governance documents consistent between the South London Partnership Trusts is underway.
South London and Maudsley NHS Foundation Trust
Board Reservation and Delegation of Powers

INTRODUCTION

Overview
This document clarifies the powers reserved to the Board, and sets a framework for how the Board has agreed to delegate its powers. However, the Board remains accountable for all of its functions and therefore expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

This document has effect as if incorporated into Standing Orders. In case of any conflict between the requirements of this document and the Constitution, Standing Orders and/or Standing Financial Instructions, the requirements of the Constitution, Standing Orders and/or Standing Financial instructions shall prevail.

Definitions:
The Board of Directors (‘Board’) comprises the Chairman, Chief Executive, Non-Executive Directors and Executive Directors.

The Senior Management Team (SMT) comprises the Executive Directors, Director of HR, Director of Strategy and Commercial and Director of Corporate Affairs.

The Executive comprises the:
(a) Chief Executive;
(b) Executive Directors;
(c) Director of Corporate Affairs;
(d) Professional Heads of Occupational Therapy, Pharmacy, Psychology and Psychotherapy;
(e) Director of Human Resources, Organisational Development and Education and Training;
(f) Director of Estates, Facilities and Capital Planning;
(g) Chief Information Officer;
(h) Research and Development Director;
(i) Strategy and Commercial Director;

Role of the Chief Executive
All powers of the Trust which have not been retained as reserved for the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Trust’s Standing Orders and Standing Financial Instructions identify which functions the Chief Executive will perform personally and those, which have been delegated to other directors and officers.
All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accountable Officer the Chief Executive is accountable to the Accounting Officer of the Department of Health for the funds entrusted to the Trust.

**Caution over the Use of Delegated Powers**

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a matter that in their judgment was likely to be a cause for public concern.

**Directors' Ability to Delegate their own Delegated Powers**

The Detailed Scheme of Delegation shows only the top level of delegation within the Trust. The Detailed Scheme of Delegation is to be used in conjunction with other systems such as the Team Leader Responsibilities and other established procedures within the Trust.

**Absence of Directors or Officers to whom Powers have been delegated**

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer’s superior unless the Board has approved alternative arrangements. If the Chief Executive is absent powers delegated to him/her may be exercised by the Chair after taking appropriate advice from the Director of Corporate Affairs and Chief Financial Officer.

1. **RESERVATION OF POWERS TO THE BOARD**

1.1. The Board has determined certain matters on which decisions are reserved to itself. These reserved matters are set out in paragraphs 1.2 to 1.10 below.

1.2. **General Enabling Provision**

1.2.1 The Board may determine any matter it wishes in full session within its statutory powers.

1.3. **Regulation and Control**

1.3.1. The Board is responsible for approving, maintaining, varying, amending and issuing the rules and constitution under which it conducts its affairs and under which the Trust conducts its affairs. These are documented as the Trust’s Constitution, Standing Orders, Standing Financial Instructions, Board Reservation and Delegation of Powers, and the Detailed Scheme of Delegation. The Board may suspend Standing Orders at any meeting subject to conditions set out in SO 3.

1.3.2. The Board shall require and receive declarations of directors’ interests which may conflict with those of the Trust and shall determine the extent to which a director may remain involved with the matter under consideration.

1.3.3. The Board shall require and receive declarations of interests from officers that may conflict with those of the Trust.

1.3.4. The Board shall be responsible for approving the disciplinary procedures for officers of the Trust.

1.3.5. The Board shall receive reports from committees (including those which the Trust is required by Secretary of State or other regulation to establish) and shall require appropriate action thereon.

1.3.6. The Board shall, in accordance with SO 4, consider for action or ratification any noncompliance with Standing Orders and any urgent decisions taken by the Chief Executive and the Chair.
1.3.7. The Board shall approve arrangements for dealing with complaints.

1.3.8. The Board shall approve organisational structures, processes and procedures to facilitate the discharge of business by the Trust and shall approve processes and procedures to agree modifications thereto.

1.3.9. The Board shall consider for action or confirmation the recommendations of the Trust’s committees where these do not have executive powers. The Board shall establish the Terms of Reference and reporting arrangements of all sub-committees (and other committees if required).

1.3.10. The Board shall approve arrangements relating to the discharge of the Trust’s responsibilities as a corporate Trustee for funds held on trust.

1.3.11. The Board shall approve arrangements relating to the discharge of the Trust’s responsibilities as a bailee for patients’ property.

1.3.12. The Trust Constitution sets out the role and duties of the Council of Governors.

1.4. Appointments

1.4.1. Board Committees
The Board retains responsibility for the establishment and dissolution of such Committees as it sees fit, or as advised by the Department of Health or the Independent Regulator of NHS Foundation Trusts. These Committees will be subject to the Terms of Reference, Membership and Constitution agreed by the Board.

1.4.2. Appointment of the Chair and Non-Executive Directors
The Council of Governors at general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors (see the Trust Constitution).

1.4.3. Appointment of Chief Executive
The Chair and Non-Executive Directors are responsible for appointing the Chief Executive.

1.4.4. Executive Directors
The Chair, Non-Executive Directors and Chief Executive are responsible for appointing the Executive Directors.

1.4.5. Associate Directors
The Board may appoint Associate Directors to join the Board who may be either Non-Executive or Executive. These appointments will be subject to the Trust’s Standing Orders as regards voting and other procedural issues.

1.4.6. Consultant Medical Staff
The Board is responsible for ratifying the appointment of Consultant Medical Staff, based on the recommendation of an Appointment Committee.

1.4.7. The Board will approve all appointments of Mental Health Act managers

1.4.8. The Board will approve appointments to outside bodies.
1.4.9. The Board, in consultation with the Council of Governors will appoint one of the Non-Executive Directors to be Senior Independent Director and Deputy Chair of the Board.

1.4.10. The Board will receive declarations required by SO8 from Board members and officers regarding any relationships with existing Board members and officers and candidates for such roles (this includes the Chair) and will decide any action necessary in response.

1.5. Remuneration and Conditions of Service of Executive Directors and Staff

1.5.1. The Trust’s Remuneration Committee is responsible for approving all pay scales and other financial arrangements concerning the pay and conditions of service of all employees of the Trust except those covered by nationally agreed arrangements.

1.5.2. This includes all forms of remuneration (for example: incremental scales, performance related payments, geographic or London Weighting allowances, allowances for supervision) as well as benefits-in-kind paid by the Trust.

1.5.3. Directors and Top Management Structure and Staffing

The Board is responsible for agreeing the Trust’s organisation structure and staffing level for the Chief Executive and Executive Directors and for one tier of senior management below Director. Decisions as to management arrangements below this level are delegated to the Executive.

1.6. Policy Determination

1.6.1. The Board is responsible for the approval of management policies including personnel policies incorporating the arrangements for the appointment, disciplining and remuneration of staff.

1.6.2. The Board is the final body of appeal by all Trust employees. The Board may delegate this to a specially constituted Committee in accordance with the Trust’s disciplinary procedure.

1.7. Trust Strategies, Business Plans and Budgets

1.7.1. The Board is responsible: for approving the Trust’s strategic directions and supporting strategies; for ensuring systems are in place whereby these will be implemented; and for monitoring implementation.

1.7.2. The Board is responsible for ensuring that the annual plan accords with Trust strategies, including approving the level of expenditure annually. Within this framework, the Board will delegate responsibility to the Executive for the processes of tendering, negotiating and agreeing income contracts and setting expenditure budgets.

1.7.3. The Board shall approve and monitor the Trust’s policies and procedures in relation to risk management.

1.8. Direct Operational Issues

1.8.1 The Board authorises the Chief Financial Officer to manage Public Dividend Capital on behalf of the Trust.

1.8.2 The Board will agree separate total cash limits for each proposed capital scheme with capital expenditure of £5,000,000 or greater, including all retentions, contingencies and all taxes. The scheme and capital cash limit shall be recorded in Board minutes. The Senior Management Team will ensure that schemes are monitored against the approved capital cash limit until completion (including retentions).
1.8.3 The Board shall consider for approval individual compensation payments over £50,000.

1.8.4 The Board shall agree action on litigation against or on behalf of the Trust over £100,000.

1.8.5 The Board shall approve the acquisition, disposal and writing down of the value of the Trust’s fixed assets where the value (or write down as appropriate) exceeds £5,000,000 in any one instance. The Board will delegate authority to the Chief Executive and Chief Financial Officer where the value is less than £5,000,000 provided that the Audit Committee is informed and the matter is recorded in the minutes.

1.8.6 The Board will approve any change of use of land and/or buildings in the Trust if the changed use lies outside the stated purpose of the Trust. Otherwise, the SMT will approve changes of use of land and/or buildings.

1.8.7 The Board shall approve the introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure in excess of £5,000,000. The Board will delegate authority to the Chief Executive and Chief Financial Officer where the value is less than £5,000,000 provided that the appropriate Board sub-committee is informed and the matter is recorded in the minutes.

1.8.8 Refer to the Trust’s Procurement policy regarding approval arrangements for tenders and contracts and where in-house services are subject to competitive tendering.

1.8.9 The Board will approve: banking arrangements (SFI 5 refers); arrangements for the Trust’s applications for new borrowings (SFI 11 refers); and arrangements for the Trust’s investment of temporary cash surpluses (SFI 11 refers).

1.8.10 The Board will approve arrangements for the Trust’s writing-off of losses and making of special payments (SFI 15 refers).

1.9 Financial and Performance Reporting Arrangements

1.9.1 The Board shall receive such reports as it sees fit from directors, committees, associate directors and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health, the Independent Regulator of NHS Foundation Trusts and the Charity Commission shall be reported at least in summary to the Board.

1.9.2 The Board will receive and approve monthly financial summaries and approve significant changes to budgets based on advice from the Finance and Performance Board Sub-Committee and Chief Financial Officer

1.9.3 The Board is responsible for the approval of the Annual Report and Accounts including those for the funds held on trust, taking into account the advice of the Audit Committee

1.9.4 The Board will approve an Annual Report on all reported serious untoward incidents.

1.9.5 The Board will receive and approve reports on contracts with commissioners signed in accordance with arrangements approved by the Chief Executive.

1.10 Audit Arrangements

1.10.1 The Board will receive annual reports from the Trust’s external auditor. The Board will ensure that arrangements are made to consider the reports and any recommendations, and that any action considered appropriate is taken based upon the recommendations of the Audit Committee.
1.10.2 To the extent that arrangements are not prescribed by law or regulation, the Board will ensure that effective audit arrangements, including arrangements for the separate audit of funds held on trust, are in place and will receive reports of Audit Committee meetings and take appropriate action.

2 DELEGATION OF POWERS

2.1 Standing Order 4 (‘SO 4’) allows the Board to delegate its functions to a committee, sub-committee, director or officer of the Trust or to a third party, in each case subject to the Trust’s Constitution and Terms of Authorisation and to any conditions set by the Board and/or the Independent Regulator of NHS Foundation Trusts. This document entitled ‘Board reservation and delegation of powers’ sets out those powers and has effect as if incorporated into Standing Orders.

2.1 Delegation to Committees

2.1.1 The Board may determine that certain of its powers shall be exercised by committees, or subcommittees or joint committees (‘committees’) which it has formally constituted. The composition and terms of reference of such committees shall be determined by the Board from time to time taking into account where necessary the requirements of the Secretary of State, the Independent Regulator of NHS Foundation Trusts and/or the Charity Commissioners (including the need to appoint an Audit Committee and a Remuneration Committee). The Board shall determine the reporting requirements in respect of the committees. In accordance with SO 5 committees may not delegate executive powers to sub-committee unless expressly authorised by the Board.

2.2 Delegation to Officers

2.2.1 Standing Orders and Standing Financial Instructions set out delegated responsibilities of the Chief Executive, the Chief Financial Officer and certain other officers. Delegation of these matters to lower levels is only permitted with the written approval of the Chief Executive who will, before authorising such delegation, consult with other senior officers as appropriate. All matters concerning finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

2.2.2 Matters that the Board has neither reserved to itself nor delegated to Trust officers shall be managed by the appropriate directorates and Clinical Academic Groups. Each director is responsible for appropriate delegation within his/her directorate/Clinical Academic Group. He/she should produce a scheme of delegation for matters within his/her directorate/Clinical Academic Group. In particular, that scheme of delegation should include how budgets and procedures for approval of expenditure are delegated.

2.2.3 Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the Chief Executive.

2.2.4 Excellence Awards for Consultant Medical Staff. The Chair of the Board has sole discretion on behalf of the Board, in consultation with the Chief Executive, in supporting the merit awards recommended each year.
South London and Maudsley NHS Foundation Trust (‘SLaM’ or ‘the Trust’)
Detailed Scheme of Delegation (‘Detailed Scheme’)

The Detailed Scheme and its place in SLaM’s framework of requirements
1. Section 4 of SLaM’s Standing Orders allows the Board of Directors (‘BoD’) to delegate its functions to a committee, sub-committee, director or officer of the Trust. This is subject to SLaM’s Constitution and Terms of Authorisation, and to such conditions as may be set by the Independent Regulator of Foundation Trusts (‘Monitor’) and/or set by the BoD itself.

2. Certain of the BoD’s functions are so delegated by provisions included within SLaM’s Standing Orders, Standing Financial Instructions or other documents comprising the framework of requirements within which SLaM operates such as the NHS Foundation Trust Accounting Officer Memorandum and the NHS Foundation Trust Code of Governance. Typically these are high level delegations to committees, the Chief Executive or to executive directors.

3. This Detailed Scheme sets out other more detailed delegations, typically set at levels below that of executive director. For each such detailed delegated, where relevant the Detailed Scheme refers to the ‘source’ provision which allows or contains that delegation.

General rules to follow when applying this Detailed Scheme
4. Delegated matters in respect of decisions that may have a far-reaching effect must be reported to the Chief Executive.

5. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other senior officers as appropriate.

6. All matters concerning Finance must be carried out in accordance with Standing Financial Instructions (‘SFIs’) and Standing Orders (‘SOs’).

In the table below a delegated authority in the form:
- ‘X or Y’ means that X or Y can duly exercise the authority individually without reference to the other; and
- ‘X and Y’ means that the delegated authority can only be duly exercised by X and Y acting together.
<table>
<thead>
<tr>
<th>Subject matter</th>
<th>Authority delegated to</th>
<th>Source / reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gifts, hospitality and sponsorship</td>
<td>All Trust staff have a responsibility to declare</td>
<td>SFI 19; Standing Orders; Standard of Business Conduct; Gifts, hospitality and sponsorship policies and procedures</td>
</tr>
<tr>
<td>1a. Maintenance of directorate's section of Trust Register of gifts, hospitality and sponsorship.</td>
<td>1a. Relevant Directors</td>
<td></td>
</tr>
<tr>
<td>1b. Annual review of Trust Register</td>
<td>1b. Trust Director of Corporate Affairs</td>
<td></td>
</tr>
<tr>
<td>1c. Approval of acceptance of certain gifts, hospitality and sponsorship by individual SLaM personnel.</td>
<td>1c. Relevant Directors</td>
<td></td>
</tr>
<tr>
<td>2. Engagement of temporary staff not on the establishment (subject to available funding)</td>
<td>2a. Clinical Director</td>
<td>SFI 9</td>
</tr>
<tr>
<td>2a. Medical staff</td>
<td>2b. Budget holder or team leader</td>
<td></td>
</tr>
<tr>
<td>2b. Nursing and other clinical staff</td>
<td>2c. Director review panel</td>
<td></td>
</tr>
<tr>
<td>2c. Administrative and ancillary staff</td>
<td>2d. Relevant director</td>
<td></td>
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<tr>
<td>2d. Non-medical consultants &lt; £50k</td>
<td>2e. Chief Executive (may require approval of NHS Improvement)</td>
<td></td>
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<tr>
<td>2e. Non-medical consultants &gt; £50k</td>
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<tr>
<td>3. Personnel and pay</td>
<td>3a. Budget holder or team leader</td>
<td>SFI 9</td>
</tr>
<tr>
<td>3a. Authority to fill funded post on the establishment with permanent staff.</td>
<td>3b. Director of HR and CFO</td>
<td></td>
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<tr>
<td>3b. Authority to appoint staff to post not on the formal establishment.</td>
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<tr>
<td>3c. Upgrading and regrading. All requests for upgrading or regrading shall be dealt with in accordance with Trust Procedure.</td>
<td>3c. Director of Human Resources</td>
<td>SFI 9</td>
</tr>
<tr>
<td>3d. Pay</td>
<td>3d(i) Budget holder</td>
<td>Trust Policies SFIs Section 9</td>
</tr>
<tr>
<td>(i) Authority to complete standing data forms affecting pay, new starters, variations and leavers.</td>
<td>3d(ii) Budget holder</td>
<td></td>
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<tr>
<td>(ii) Authority to complete and authorise positive reporting forms</td>
<td>3d(iii) Budget holder or team leader</td>
<td></td>
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<tr>
<td>(iii) Authority to authorise overtime</td>
<td>3d(iv) Budget holder or team leader</td>
<td></td>
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<tr>
<td>(iv) Authority to authorise electronic manpower forms including overtime</td>
<td>3d(v) Budget holder or team leader</td>
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<td>(v) Authority to authorise travel and subsistence expenses</td>
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<tr>
<td>3e. Leave</td>
<td>3e(i) Line manager</td>
<td></td>
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<tr>
<td>(i) Approval of annual leave</td>
<td>3e(ii) Line manager</td>
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<tr>
<td>(ii) Annual leave carry forward: approval up to maximum of 5 days</td>
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<tr>
<td>Subject matter</td>
<td>Authority delegated to</td>
<td>Source / reference</td>
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<tr>
<td>(iii) Annual leave carry forward: approval in excess of 5 days is possible only where the Trust has cancelled annual leave</td>
<td>3e(iii) Relevant Director</td>
<td>Trust Policy</td>
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<tr>
<td>(iv) Compassionate leave</td>
<td>As per Trust Policy</td>
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<td>(v) Leave without pay</td>
<td>3e(iv) Line manager</td>
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<td>(vi) Time off in lieu</td>
<td>3e(v) Line manager</td>
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<tr>
<td>(vii) Maternity leave: paid and unpaid</td>
<td>3e(vii) Budget Holder or Team Leader</td>
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<tr>
<td><strong>3f. Sick Leave</strong></td>
<td><strong>As per Trust Policy</strong></td>
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<tr>
<td>(i) Return to work part-time on full pay to assist recovery</td>
<td>3f(i) Budget Holder</td>
<td>Trust Policy</td>
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<tr>
<td>(ii) Extension of sick leave on half pay for up to 3 months</td>
<td>3f(ii) Budget holder and Director of Human Resources</td>
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<tr>
<td>(iii) Extension of sick leave on full pay</td>
<td>3f(iii) Budget holder and Director of Human Resources</td>
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<tr>
<td><strong>3g. Study leave</strong></td>
<td><strong>As per Trust Policy</strong></td>
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<tr>
<td>(i) Study leave and financial support</td>
<td>3g(i) As per Trust Policy</td>
<td>Trust Policy</td>
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<td>(ii) Courses and conferences</td>
<td>3g(ii) Budget holder</td>
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<tr>
<td>(iii) Study leave, courses and conferences outside the UK</td>
<td>3g(iii) Director of Human Resources and CFO</td>
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<td>3h. Renewal of fixed term contract</td>
<td>3h. Budget holder</td>
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<tr>
<td>3i. <strong>Grievance procedure.</strong> All grievance cases must be dealt with strictly in accordance with the Grievance Procedure.</td>
<td>3i. Director of Human Resources</td>
<td>Trust policy</td>
</tr>
<tr>
<td><strong>3j. Relocation expenses</strong></td>
<td><strong>All employment compensation payments require prior Treasury (Department of Health) approval</strong></td>
<td>Remuneration Committee terms of reference</td>
</tr>
<tr>
<td>(i) Relocation expenses up to £5,000</td>
<td>3j(i) Relevant director</td>
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<tr>
<td>(ii) Relocation expenses over £5,000</td>
<td>3j(ii) Chief Executive and CFO</td>
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<tr>
<td>Subject matter</td>
<td>Authority delegated to</td>
<td>Source / reference</td>
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<tr>
<td><strong>5. Management and control of IT systems and facilities</strong></td>
<td></td>
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<tr>
<td>5a. Overall control</td>
<td>5a. Chief Information Officer</td>
<td></td>
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<tr>
<td>5b. Add/amend/delete user roles</td>
<td>5b. Relevant heads of department</td>
<td>5c. SFI 16.1</td>
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<tr>
<td>5c. Review the Trust's compliance with Data Protection legislation</td>
<td>5c. Chief Information Officer</td>
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<tr>
<td><strong>6. Planning and budgetary control</strong></td>
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<td>SFIs Section 3</td>
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<tr>
<td>6a. Prepare and submit an Annual Plan to Board and NHS Improvement</td>
<td>6a. Chief Executive</td>
<td></td>
</tr>
<tr>
<td>6b. Prepare and submit a financial plan to Board and NHS Improvement</td>
<td>6b. Chief Executive and CFO</td>
<td></td>
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<tr>
<td>6c. Delegation of budget management</td>
<td>6c. Chief Executive</td>
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<tr>
<td><strong>Budget responsibility</strong></td>
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<tr>
<td>6d. For totality of services</td>
<td>6d. Chief Executive</td>
<td></td>
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<tr>
<td>6e. At Directorate / CAG level</td>
<td>6e. Relevant Director</td>
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<tr>
<td>6f. At individual cost centre budget level</td>
<td>6f. Budget holder</td>
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<tr>
<td><strong>Budget Virements</strong></td>
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<tr>
<td>6g. Up to £50,000 per request</td>
<td>6g. Budget holder</td>
<td></td>
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<tr>
<td>6h. Up to £250,000 per request</td>
<td>6h. Relevant Director</td>
<td></td>
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<tr>
<td>6i. Over £250,000 per request</td>
<td>6i. CFO or Chief Executive</td>
<td></td>
</tr>
<tr>
<td><strong>7. Non-pay expenditure (revenue and capital)</strong></td>
<td></td>
<td>SFIs Section 10</td>
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<tr>
<td>7a. Overall responsibility for requisitioning and ordering of goods and services</td>
<td>7a. CFO</td>
<td></td>
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<tr>
<td>7b. Specific delegated approval limits as per authorized signatory list</td>
<td>7b. Director and CFO</td>
<td></td>
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<tr>
<td>7c. Authorisation of order/expenditure</td>
<td>7c. See Appendix A of this document (shows all Procurement Policy limits)</td>
<td></td>
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<tr>
<td>7d. Authorisation of expenditure from Clients Monies</td>
<td></td>
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<tr>
<td>(i) up to £2,500</td>
<td>7d(i) Appointee (only where appointee)</td>
<td></td>
</tr>
<tr>
<td>(ii) between £2,500 and £20,000</td>
<td>7d(ii) Appointee and Service Director</td>
<td></td>
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<tr>
<td>(iii) over £20,000</td>
<td>7d(iii) Appointee and Chief Financial Officer</td>
<td></td>
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<tr>
<td>7e. Purchase card expenditure</td>
<td>7e. Purchase card holder</td>
<td></td>
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<tr>
<td>7f. Drugs</td>
<td>7f. Head of Pharmacy</td>
<td></td>
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<tr>
<td>7g. Authorisation of invoices</td>
<td>7g. As per authorised signatory list</td>
<td></td>
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<tr>
<td><strong>8. Capital schemes (<em>see also 29 for more detail on granting certain leases</em>)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8a. Prepare and submit annual capital expenditure and financing plan (part of Annual Financial Plan)</td>
<td>8a. CFO and Director of Estates</td>
<td></td>
</tr>
<tr>
<td>8b. Approval of business cases</td>
<td>8b. Capital Review Group (operating to</td>
<td></td>
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<tr>
<td><strong>Authorised signatory list</strong></td>
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<tr>
<td><strong>SFIs Section 13 and SOs Section 9</strong></td>
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<tr>
<td>Subject matter</td>
<td>Authority delegated to</td>
<td>Source / reference</td>
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<tr>
<td>8c. Selection of architects, quantity surveyors, consultant engineer and other professional advisers within EU regulations</td>
<td>Appendix A limits) 8c. Head of Capital Planning (subject to Appendix A) 8d. ADoF (Associate Director of Financial Services (from June 2017)</td>
<td>NHSI guidance</td>
</tr>
<tr>
<td>8d. Financial monitoring and reporting on all capital scheme expenditure</td>
<td>8c. Chief Executive or CFO 8d. Chief Executive and CFO 8e. Use the limits applicable to a ‘single tender/quote’ in Appendix A of this document 8f. Senior Management Team</td>
<td></td>
</tr>
<tr>
<td>Subject to consideration of terms of provider licence for commissioner requested services; 8c. Granting*, taking out or termination of leases with annual rent £50,000 or less 8d. Granting*, taking out or termination of leases with annual rent more than £50,000 8e. Acquisition, disposal and writing down of fixed assets (in any one instance)</td>
<td>8c. Chief Executive or CFO 8d. Chief Executive and CFO 8e. Use the limits applicable to a ‘single tender/quote’ in Appendix A of this document 8f. Senior Management Team</td>
<td></td>
</tr>
<tr>
<td>8f. Change of use of land and/or buildings provided use remains within stated purpose of the Trust</td>
<td>8c. Chief Executive or CFO 8d. Chief Executive and CFO 8e. Use the limits applicable to a ‘single tender/quote’ in Appendix A of this document 8f. Senior Management Team</td>
<td></td>
</tr>
<tr>
<td>9. Condemning and disposal Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively 9a. Disposal of IT equipment</td>
<td>9a. Chief Information Officer with advice from Head of Procurement 9b. Director of Estates with advice from Head of Procurement 9c. CFO 9d. Budget Holder with advice from Head of Procurement 9e. Service Director with advice from Head of Procurement</td>
<td>SFIs Section 15 Procurement policy states CFO is responsible for preparation of detailed procedures on disposals</td>
</tr>
<tr>
<td>9b. Disposal of mechanical and engineering plant (subject to estimated income of £5,000 or less per sale) 9c. Disposal of mechanical and engineering plant (subject to estimated income exceeding £5,000 per sale) 9d. Disposal of other items with current or estimated purchase price £1,000 or less 9e. Disposal of other items with current or estimated purchase price above £1,000</td>
<td>9a. Chief Information Officer with advice from Head of Procurement 9b. Director of Estates with advice from Head of Procurement 9c. CFO 9d. Budget Holder with advice from Head of Procurement 9e. Service Director with advice from Head of Procurement</td>
<td>SFIs Section 15 Procurement policy states CFO is responsible for preparation of detailed procedures on disposals</td>
</tr>
<tr>
<td>10. Losses, write-offs and compensations</td>
<td>Report items to the next Losses and Special Payments Group meeting (which reports annually to the Audit Committee) 10a. Director of Corporate Affairs 10b. CFO 10c. Chief Executive and CFO</td>
<td>SFIs Section 15 Losses and Special Payments Group and Audit Committee practice</td>
</tr>
<tr>
<td>10a. Maintenance of register of losses</td>
<td>Report items to the next Losses and Special Payments Group meeting (which reports annually to the Audit Committee) 10a. Director of Corporate Affairs 10b. CFO 10c. Chief Executive and CFO</td>
<td>SFIs Section 15 Losses and Special Payments Group and Audit Committee practice</td>
</tr>
<tr>
<td>10b. Write-off of losses of property and cash due to theft, fraud, overpayment and other causes: £50,000 or less</td>
<td>Report items to the next Losses and Special Payments Group meeting (which reports annually to the Audit Committee) 10a. Director of Corporate Affairs 10b. CFO 10c. Chief Executive and CFO</td>
<td>SFIs Section 15 Losses and Special Payments Group and Audit Committee practice</td>
</tr>
<tr>
<td>10c. Write-off of losses of property and cash due to theft, fraud, overpayment and other causes: more than £50,000</td>
<td>Report items to the next Losses and Special Payments Group meeting (which reports annually to the Audit Committee) 10a. Director of Corporate Affairs 10b. CFO 10c. Chief Executive and CFO</td>
<td>SFIs Section 15 Losses and Special Payments Group and Audit Committee practice</td>
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<tr>
<td>Subject matter</td>
<td>Authority delegated to</td>
<td>Source / reference</td>
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<tr>
<td>10d. Fruitless payments (including abandoned capital schemes) of £250,000 or less</td>
<td>10d. Chief Executive and CFO</td>
<td></td>
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<tr>
<td>10e. Fruitless payments (including abandoned capital schemes) of more than £250,000</td>
<td>10e. Trust Board</td>
<td></td>
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<tr>
<td>10f. Compensation payments made under legal obligation</td>
<td>10f. Chief Executive and CFO</td>
<td></td>
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<tr>
<td>10g. Extra-contractual payments to contractors up to £50,000</td>
<td>10g. Chief Executive and CFO</td>
<td></td>
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<tr>
<td>10h. Extra-contractual payments to contractors over £50,000</td>
<td>10h. Trust Board</td>
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<tr>
<td><strong>Ex-gratia payments</strong></td>
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<tr>
<td>10i. Patients and staff for loss of personal effects: £2,500 or less</td>
<td>10i. Relevant director</td>
<td></td>
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<tr>
<td>10j. Patients and staff for loss of personal effects: more than £2,500</td>
<td>10j. CFO</td>
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<tr>
<td>10k. For personal injury claims involving negligence where legal advice has been obtained and guidance applied: up to £50,000 (including plaintiff's costs)</td>
<td>10k. CFO</td>
<td></td>
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<tr>
<td>10l. For personal injury claims involving negligence where legal advice has been obtained and guidance applied: up to £1,000,000 (including plaintiff's costs)</td>
<td>10l. Chief Executive and CFO</td>
<td></td>
</tr>
<tr>
<td>10m. Clinical negligence claims up to £1,000,000 (negotiated settlements) where legal advice has been obtained and guidance followed</td>
<td>10m. Chief Executive and CFO</td>
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<tr>
<td><strong>Debt Write Off</strong></td>
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<tr>
<td>10n. Write-off of NHS and non-NHS debtors up to £10,000</td>
<td>10n. Associate Director or Director of Finance</td>
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<tr>
<td>10o. Write-off of NHS and non-NHS debtors over £10,000</td>
<td>10o. CFO</td>
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<tr>
<td><strong>Invoice cancellation (not written-off)</strong></td>
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<tr>
<td>10p. Items up to £10,000</td>
<td>10p. Sales Ledger Manager</td>
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</tr>
<tr>
<td>10q. Items over £10,000</td>
<td>10q. Associate Director of Finance</td>
<td></td>
</tr>
<tr>
<td><strong>11. Reporting of incidents to the Police</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11a. Where a criminal offence is suspected (not fraud)</td>
<td>11a. Relevant director or nominated deputy</td>
<td>SFIs Sections 2 and 15</td>
</tr>
<tr>
<td>11b. Where a fraud is involved</td>
<td>11b. Local Counter Fraud Service or CFO</td>
<td></td>
</tr>
<tr>
<td><strong>12. Implementation of internal audit and external audit recommendations</strong></td>
<td>12. Relevant directors (with CFO reporting overall progress to Audit Committee)</td>
<td>SFIs Section 2</td>
</tr>
<tr>
<td><strong>13. Maintenance and update of Trust financial procedures</strong></td>
<td>13. CFO</td>
<td>SFIs</td>
</tr>
<tr>
<td><strong>14. Investment of funds</strong></td>
<td>14. CFO</td>
<td>SFIs Sections 11, 18</td>
</tr>
<tr>
<td><strong>Treasury Management Policy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>15. Not used</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>16. Bank/OPG Accounts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject matter</td>
<td>Authority delegated to</td>
<td>Source / reference</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>16a. Setting up a bank account</td>
<td>16a. Chair and Chief Executive</td>
<td>SFIs Section 5</td>
</tr>
<tr>
<td>16b. Closing a bank account</td>
<td>16b. 2 x 1st Signatory</td>
<td></td>
</tr>
<tr>
<td>16c. Application to National Loans Fund (investment)</td>
<td>16c. 2 x 1st Signatory</td>
<td></td>
</tr>
<tr>
<td>16d. Changing Bank mandates</td>
<td>16d. 2 x 1st Signatory</td>
<td></td>
</tr>
<tr>
<td>16e. Setting up a cash facility (receipt and collection of cash)</td>
<td>16e. Senior Financial Accountant</td>
<td></td>
</tr>
<tr>
<td>16f. Purchase Card Approval</td>
<td>16f. 2 x 1st Signatory</td>
<td></td>
</tr>
<tr>
<td>16g. working capital facility</td>
<td>16g. CFO</td>
<td></td>
</tr>
<tr>
<td>16h. Loan</td>
<td>16h. CFO</td>
<td></td>
</tr>
<tr>
<td>16i. Setting up a petty cash float and amendments thereafter</td>
<td>16i. Senior Financial Accountant</td>
<td></td>
</tr>
<tr>
<td>16j. PDC application</td>
<td>16j. 2 x 1st Signatory</td>
<td></td>
</tr>
<tr>
<td>16k. PDC repayment</td>
<td>16k. CFO</td>
<td></td>
</tr>
<tr>
<td>17. Petty cash disbursements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17a. Expenditure up to £25 per item</td>
<td>17a. Petty cash holder or cashier</td>
<td></td>
</tr>
<tr>
<td>17b. Expenditure over £25 per item</td>
<td>17b. Cashiers manager</td>
<td></td>
</tr>
<tr>
<td>17c. Cash advances up to £100</td>
<td>17c. Cashiers manager</td>
<td></td>
</tr>
<tr>
<td>17d. Cash advances over £100</td>
<td>17d. Senior Finance Accountant</td>
<td></td>
</tr>
<tr>
<td>17e. Reimbursement of patients’ monies up to £100</td>
<td>17e. Senior member of staff on duty</td>
<td></td>
</tr>
<tr>
<td>17f. Reimbursement of patients’ monies over £100</td>
<td>17f. Relevant director</td>
<td></td>
</tr>
<tr>
<td>17g. Reimbursement of patients fares</td>
<td>17g. Outpatient manager or cashiers’ manager</td>
<td></td>
</tr>
<tr>
<td>17h. Issue of bus saver tickets for patients fares</td>
<td>17h. Outpatient manager</td>
<td></td>
</tr>
<tr>
<td>18. Setting of fees and charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18a. Service agreements for the provision of commissioner requested services</td>
<td>18a. Chief Executive and CFO</td>
<td>SFIs Section 6 and 7</td>
</tr>
<tr>
<td>18b. Price of all NHS contracts</td>
<td>18a. CFO or nominated deputy</td>
<td></td>
</tr>
<tr>
<td>18c. Private patient, overseas visitors, trading agency, income generation and other patient-related services. 18d. Any other fees/charges</td>
<td>18c. CFO or nominated deputy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18d. CFO or nominated deputy</td>
<td></td>
</tr>
<tr>
<td>19. Raising an invoice</td>
<td>19. Budget holder, nominated deputy or Senior Directorate Accountant</td>
<td>SFIs Section 6</td>
</tr>
<tr>
<td>20. Cheque payments and CHAPS/BACS payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20a. Authorisation for payroll and non-pay payment runs</td>
<td>20a. Designated 1&lt;sup&gt;st&lt;/sup&gt; and 2&lt;sup&gt;nd&lt;/sup&gt; signatories</td>
<td>SFIs and Trust Procedures</td>
</tr>
<tr>
<td>20b. Authorisation of cheque schedules</td>
<td>20b. Designated 1&lt;sup&gt;st&lt;/sup&gt; and 2&lt;sup&gt;nd&lt;/sup&gt; signatories</td>
<td></td>
</tr>
<tr>
<td>20c. Transmission of non-pay BACS file and supplementary payroll file</td>
<td>20c. 1&lt;sup&gt;st&lt;/sup&gt; signatory</td>
<td></td>
</tr>
<tr>
<td>20d. Transmission of payroll BACS file</td>
<td>20d. IBM</td>
<td></td>
</tr>
<tr>
<td>20e. CHAPS authorisation</td>
<td>20e. Designated 1&lt;sup&gt;st&lt;/sup&gt; and 2&lt;sup&gt;nd&lt;/sup&gt; signatories</td>
<td></td>
</tr>
<tr>
<td>Subject matter</td>
<td>Authority delegated to</td>
<td>Source / reference</td>
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</tr>
<tr>
<td>20f. Bank drafts/foreign drafts authorisation</td>
<td>20f. Designated 1st and 2nd signatories</td>
<td></td>
</tr>
<tr>
<td>20g. Cancelling a cheque/CHAPS payment</td>
<td>20g. Associate Director of Financial Services or nominated deputy</td>
<td></td>
</tr>
<tr>
<td>20h. Cancel BACS</td>
<td>20h. Associate Director of Financial Services or nominated deputy</td>
<td></td>
</tr>
<tr>
<td>21. Not used</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Authorisation of journals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22a. Accruals</td>
<td>22a. Senior Directorate Accountants or Senior Financial Accountants</td>
<td>SFI's and Trust Procedures</td>
</tr>
<tr>
<td>22b. Permanent</td>
<td>22b. Senior Directorate Accountants or Senior Financial Accountants</td>
<td></td>
</tr>
<tr>
<td>22c. Budget</td>
<td>22c. Senior Directorate Accountants</td>
<td></td>
</tr>
<tr>
<td>23. Tax and Pension payments and returns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23a. VAT return</td>
<td>23a. Senior Financial Accountant (Control)</td>
<td>SFI's and Trust Procedures</td>
</tr>
<tr>
<td>23b. Construction Industry Tax return</td>
<td>23b. Creditor Payments Manager</td>
<td></td>
</tr>
<tr>
<td>23c. PAYE and national insurance returns</td>
<td>23c. Payroll manager</td>
<td></td>
</tr>
<tr>
<td>24. Payroll</td>
<td>24d. Payroll manager and Sales Ledger Manager (involve LCFS if fraud)</td>
<td></td>
</tr>
<tr>
<td>24a. Authorisation of lease car application</td>
<td>24a. Associate Director of Finance</td>
<td>SFI's and Trust Procedures</td>
</tr>
<tr>
<td>24b. Authorisation of requests for posts to be authorised as mobile phone users</td>
<td>24b. Associate Director of Finance</td>
<td></td>
</tr>
<tr>
<td>24c. Payment cancellation</td>
<td>24c. Payroll Manager</td>
<td></td>
</tr>
<tr>
<td>24d. Resolving an overpayment</td>
<td>24d. Payroll Manager and Sales Ledger Manager (involve LCFS if fraud)</td>
<td></td>
</tr>
<tr>
<td>24e. Agreement of recovery terms</td>
<td>24e. Payroll Manager and Sales Ledger Manager (involve LCFS if fraud)</td>
<td></td>
</tr>
<tr>
<td>25. Insurance policies and risk management</td>
<td>25. Chief Executive, Director of Nursing and CFO</td>
<td>SFI's Section 21 Risk Management Committee</td>
</tr>
<tr>
<td>26. Retention of records: setting of policy and monitoring of compliance</td>
<td>26. Chief Executive and Director of Corporate Affairs</td>
<td>SFI's Section 20 DH policy</td>
</tr>
<tr>
<td>27. Monitor proposals for healthcare contractual arrangements between the Trust and outside bodies</td>
<td>27. CFO and Chief Operating Officer</td>
<td></td>
</tr>
<tr>
<td>28. Review of the Trust's compliance with the Code of Practice for handling</td>
<td>28. Medical Director</td>
<td></td>
</tr>
<tr>
<td>Subject matter</td>
<td>Authority delegated to</td>
<td>Source / reference</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>---------------------------------</td>
</tr>
<tr>
<td>confidential information in the contracting environment and the compliance with ‘safe haven’ per EL (92)/60 and HSC 1999(012)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 29. Lease agreements and licences where SLaM acts as lessor or licensor (see 8 above)  
29a. Preparation and signature of all tenancy agreements and/or licences for all staff subject to Trust policy on accommodation for staff  
29b. Extensions to existing leases  
29c. Letting of premises to other organisations or agencies  
29d. Approval of rent based on professional assessment  
29e. Rental of equipment to other organisations                                                                                                                                                                                                 | 29a. Head of Capital Planning  
29b. CFO  
29c. Chief Executive, Director of Estates and Facilities and CFO  
29d. CFO  
29e. CFO                                                                                                                                                                                                                                          |                                 |
| 30. Authorisation of the use of new drugs  
30a. Estimated total yearly cost up to £25,000  
30b. Estimated total yearly cost above £25,000                                                                                                                                                                                                                 | 30a. Medical Director with advice from Chief Pharmacist  
30b. Medical Director and CFO with advice from Chief Pharmacist                                                                                                                                                                                                                                       | Monitor guidance                |
| 31. Authorisation of sponsorship deals                                                                                                                                                                                                                           | 31. Chief Executive, Medical Director and CFO                                                                                                                                                                                                                                                           |                                 |
| 32. Authorisation of research projects                                                                                                                                                                                                                           | 32. Chief Executive or Medical Director                                                                                                                                                                                                                                                              | R&D policy                      |
| 33. Authorisation of clinical trials                                                                                                                                                                                                                              | 33. Chief Executive and Medical Director                                                                                                                                                                                                                                                            | R&D policy                      |
| 34. Patients’ and relatives’ complaints  
34a. Overall responsibility for ensuring all complaints are dealt with effectively  
34b. Responsibility for ensuring complaints relating to a directorate are investigated thoroughly  
34c. Co-ordination of the management of medico-legal complaints                                                                                                                                                                                          | 34a. Chief Executive  
34b. Director of Nursing  
34c. Director of Nursing                                                                                                                                                                                                                                                                                 | Complaints policy  
Risk management policy |
| 35. Media and relationships with the Press  
35a. Enquiries (general or emergency) within hours  
35b. Enquiries (general or emergency) outside of hours                                                                                                                                                                                                         | 35a. Head of Communications  
35b. On-call manager with advice from head of communications                                                                                                                                                                                                                                         |                                 |
| 36. Infectious diseases and notifiable outbreaks                                                                                                                                                                                                                  | 36. Medical Director                                                                                                                                                                                                                                                                                     |                                 |
| 37. Extended role activities  
37a. Approval of staff to undertake duties extended professional roles                                                                                                                                                                                          | 37a. Medical Director or Director of Nursing or appropriate Head of Profession                                                                                                                                                                                                                    | Professional organisations and regulatory bodies |
<p>| 38. Patient services                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                 |</p>
<table>
<thead>
<tr>
<th>Subject matter</th>
<th>Authority delegated to</th>
<th>Source / reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>38a. Introduction or discontinuation of patient services with greater than £1m annual turnover</td>
<td>38a. Trust Board</td>
<td>Monitor license and Commissioner Request Services and contracts</td>
</tr>
<tr>
<td>38b. Introduction or discontinuation of patient services with less than £1m annual turnover</td>
<td>38b. Chief Executive</td>
<td></td>
</tr>
<tr>
<td>38c. Variation of clinic sessions within existing numbers</td>
<td>38c. Chief Operating Officer</td>
<td></td>
</tr>
<tr>
<td>38d. Variation of clinic sessions to alter existing numbers</td>
<td>38d. Chief Operating Officer</td>
<td></td>
</tr>
<tr>
<td>38e. Proposed changes in bed allocation and use (temporary)</td>
<td>38e. Chief Operating Officer</td>
<td></td>
</tr>
<tr>
<td>38f. Proposed changes in bed allocation and use (permanent)</td>
<td>38f. Chief Executive</td>
<td></td>
</tr>
<tr>
<td>39. Facilities for staff not employed by the Trust to gain practical experience</td>
<td>39a. Director of Human Resources</td>
<td></td>
</tr>
<tr>
<td>39a. Includes professional recognition, honorary contracts, insurance of medical staff and engagement of work experience students</td>
<td>39b. Director of Human Resources</td>
<td></td>
</tr>
<tr>
<td>39b. Work experience students</td>
<td>39c. Director of Human Resources</td>
<td></td>
</tr>
<tr>
<td>39c. Volunteers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Review of fire precautions</td>
<td>40. Head of Estates and Facilities</td>
<td>Relevant legislation</td>
</tr>
<tr>
<td>41. Review of all statutory compliance legislation and Health and Safety requirements including control of substances hazardous to health regulations</td>
<td>41. Chief Executive</td>
<td>Relevant legislation</td>
</tr>
<tr>
<td>42. Review of Medicines Inspectorate regulations</td>
<td>42. Medical Director with advice from Chief Pharmacist</td>
<td></td>
</tr>
<tr>
<td>43. Review of compliance with environmental regulations (including those relating to clean air and waste disposal)</td>
<td>43. Head of Estates and Facilities</td>
<td>Relevant legislation</td>
</tr>
<tr>
<td>44. Review the Trust’s compliance with ‘Access to Health Records’ Act</td>
<td>44. Chief Information Officer</td>
<td>Relevant legislation</td>
</tr>
<tr>
<td>45. Maintain register of declarations of interests</td>
<td>45. Director of Corporate Affairs</td>
<td>SO 6</td>
</tr>
<tr>
<td>46. Documents required to be ‘signed and sealed’</td>
<td>46a. Director of Corporate Affairs</td>
<td>SO 10</td>
</tr>
<tr>
<td>46a. Sealing of relevant documents</td>
<td>46b. Director of Corporate Affairs</td>
<td></td>
</tr>
<tr>
<td>46b. Maintenance of register of signed and sealed documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Clinical governance and audit</td>
<td>47. Medical Director and Director of Nursing</td>
<td></td>
</tr>
<tr>
<td>48. Nominated Fire Director</td>
<td>48a. Nominated Director</td>
<td>Relevant legislation</td>
</tr>
<tr>
<td>48a. within hours</td>
<td>48b. On-call Director</td>
<td>Trust Freedom of Information Policy</td>
</tr>
<tr>
<td>48b. out of hours</td>
<td></td>
<td>Risk Management policy</td>
</tr>
<tr>
<td>49. Compliance with Freedom of Information requests</td>
<td>49. Chief Information Officer</td>
<td></td>
</tr>
<tr>
<td>50. Serious Untoward Incident Reporting</td>
<td>50. Director of Nursing</td>
<td></td>
</tr>
<tr>
<td>51. Management of medical devices</td>
<td>51. Director of Nursing</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX A: SUMMARY OF EXPENDITURE PROCUREMENT LIMITS AND RELATED PROCEDURES FOR TENDERS AND QUOTES

Sections 7 and 8 of this Detailed Scheme of Delegation refer

This page is an extract from SLaM’s Procurement Policy

**Important.** This is a summary of limits and related procedures. Refer to the body of the Procurement Policy document for the full rules.

<table>
<thead>
<tr>
<th>Contract value (Whole life cost) excluding VAT/£</th>
<th>Addressee and Tender opening.</th>
<th>Minimum number of willing and capable Suppliers asked to compete</th>
<th>Minimum level of advertisement</th>
<th>Acceptance of tender</th>
<th>Waiver (Single tender action) received</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 24,999</td>
<td>Procurement Department</td>
<td>3 written quotations where practical and appropriate</td>
<td>where appropriate through e-quote tool</td>
<td>Budget Holder</td>
<td>n/a</td>
</tr>
<tr>
<td>25,000 to 49,999</td>
<td></td>
<td>3 written quotations</td>
<td>Advertised in accordance with current Public Contract Regulations. Anything above 25,000 must be advertised via contracts finder.</td>
<td>Any relevant Director</td>
<td>(1) A director and two of DDoF, ADoF, Procurement Manager</td>
</tr>
<tr>
<td>50,000 to OJEU Threshold.</td>
<td></td>
<td>4 tenders</td>
<td></td>
<td>Any relevant Director and Chief Financial Officer</td>
<td>(1) A director and two of DDoF, ADoF, Procurement Manager</td>
</tr>
<tr>
<td>OJEU Threshold to 999,999</td>
<td></td>
<td>5 tenders</td>
<td></td>
<td>Any relevant Director and Chief Financial Officer</td>
<td>(1) Chief Executive OR Chief Financial Officer</td>
</tr>
<tr>
<td>1M Plus</td>
<td></td>
<td>5 tenders</td>
<td></td>
<td>(1) BoD 4 sub-group</td>
<td>(1) BoD 4 sub-group</td>
</tr>
</tbody>
</table>

**NOTES/KEY**

(1) Report the matter to the next meeting of the Audit Committee (‘AC’) who will subsequently where appropriate send through to a meeting of the board.

‘Director’ means an Executive Director (‘ED’), a service director or a corporate director

‘Relevant director’ means a director for whom the tender relates to their delegated area of work (and for the purposes of this Appendix constitutes the ‘duly nominated officer’ noted in section 6 of this document)

ED means Executive Director; NED means Non-Executive Director

DDoF means Deputy Director of Finance; ADoF means Assistant Director of Finance

BoD 4 sub-group means a sub-group of the BoD including at least the: Chief Executive; Chief Financial Officer; AC Chair; and one further person (a NED or the Trust Chair)
REPORT TO THE TRUST BOARD:
23rd May 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>South London Partnership</th>
</tr>
</thead>
</table>

Purpose
To note information about the South London Partnership and the attached Draft Terms of Reference and Draft Memorandum of Understanding.

South London Mental Health and Community Partnership Board
Terms of Reference

Committee
South London Mental Health and Community Partnership Board

Key Strategic Objectives
Lead the initiatives of the South London Partnership.
Represent the Trust Boards
Provide Assurance to the Boards

Chair
One of the NEDs, on a rotating basis (six months rotation)

Secretary
Programme Director

Minutes and Administration
PMO Office

Papers will be sent to Board members seven working days in advance of the meeting.

Minutes are due to the chair seven working days after the Board.

Members
1 NED of each Trust
1 CEO of each Trust

Attendees
Programme Director
PMO Office

The Committee may invite any other Trust representative and/or external professional advisors as it deems necessary from time to time.
Frequency
The Partnership Board will meet bi-monthly.

Reporting
The Partnership Board will report to the three Trust Boards and will provide quarterly updates to the Trust Boards.

Quorum
The quorum of the Committee shall be three NEDs and three CEOs so that all three Trusts are represented at all times.

Where a non-executive or executive director is not able to attend the meeting they must send a deputy who is authorised to make decisions on their behalf.

Purpose
This Committee has been established to ensure, on behalf of the three Trust Boards, that there are effective mechanisms and systems in place to deliver the objectives approved by the Boards in relation to the Trusts' collaboration initiatives in the areas of forensic services, clinical pathways and productivity.

Structure

![Diagram showing the structure of the Partnership Board and its operational boards]

Duties
The Partnership Board will

- design and set the level of ambition of the Partnership,
- challenge and monitor the work in progress, and
- hold the Executives to account.
Administration and Reporting

The PMO Office will provide the organisation and administration of all Partnership Board meetings and related activities.

The PMO Office will provide minutes of the Partnership Board meetings. In addition, a summary for public communication will also be produced.

Involvement of (Shadow) Governors and other internal stakeholders

The communications teams will organise stakeholder events every six months at the three Trusts. This will include staff from all areas, governors and staff side representatives. For all matters where it is necessary to work with governors or staff side directly then that will be organised separately.

The Heads of Communications are also planning a monthly newsletter that will be provided to staff, governors and staff side representatives.

A sharepoint site has been set up to enable project teams to collaborate. The public (to the three Trusts) area of the site will store all programme documentations that has been provided to internal stakeholders as well as project plans and governance documentation.

Communication with External Stakeholders

The three Heads of Communications are working with the workstream SROs and project managers to create a proactive external communications plan to include (among others) regulators, professional groups, commissioners, NHS Mental Health and Acute Trusts outside the Partnership and Local Authorities.

Role Definitions

<table>
<thead>
<tr>
<th>Member</th>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Clinical and Productivity Workstream SROs | Key executives to lead, control, facilitate and mediate the programme meetings, and focused on providing clinical assurance within delivery. | • Facilitate discussions at Partnership Board meetings.  
• Accountable for delivery of programme benefits.  
• Determine if a quorum is present for decision making.  
• Provide challenge and resolution to conflicts of interest.  
• Provide direction for achieving programme objectives, including ideas for further collaboration.  
• Review and validate significant decisions during the programme.  
• Provide clinical assurance and oversight of all clinical strategy and work  
• Resolve strategic issues that arise in and between work streams, including those with clinical and enabling work streams. |
| Programme Director | Dedicated senior level individual assigned to lead the entire programme and oversee all work streams. | • Own the day to day delivery for the programme.  
• Review and approve scope, status and results on regular and/or ad-hoc basis.  
• Coordinate the resolution of issues in and between work streams and escalate those requiring SRO approval.  
• Oversee the success of individual programmes / projects.  
• Serve as the liaison between the Board Members and Trust Executive Teams / Project Leads.  
• Direct executive over each of the project managers.  
• Align resources and facilitate cooperation among all teams, third parties and management. |
<table>
<thead>
<tr>
<th><strong>Project SRO / Lead Executive Director</strong></th>
<th>Overall responsible officer for the programme / project within the clinical or productivity workstreams</th>
</tr>
</thead>
</table>
|                                         | • Accountable for delivery of the entire group, including successful implementation and benefits realisation.  
• Maintain a firm understanding of progress within each intervention and specific issues to delivery.  
• Act as a ‘change champion’ communicating with key stakeholders so as to increase buy-in and momentum.  
• Mitigate risks and issues to successful delivery and escalate those which need further decision making.  
• Oversee the project manager and work closely with them to determine the key next steps.  
• Provide insight on delivery from an organisation level.  
• Communicate information disseminated at Operational Board meetings. |
| **Project Manager**                     | Individual assigned to mobilise, manage and control a specific work stream.                       |
|                                         | • Oversight of the entire work stream at organisational and intervention level.                   
• Monitor, track and reports key performance metrics, dependencies within each intervention.  
• Provide SRO with critical risks and issues as they arise.  
• Prepare for the CLG, creating a report that highlights progress, savings delivered, decisions need to be made, key issues, risks and mitigations.  
• Oversee quality control, standard definition and ongoing adherence.  
• Liaise with other work stream project managers to share best practices. |
Memorandum of Understanding

Between

South West London and St George’s Mental Health NHS Trust

and

South London and Maudsley NHS Foundation Trust

and

Oxleas NHS Foundation Trust

‘The South London Mental Health and Community Partnership’

This Memorandum of Understanding (MOU) outlines the terms between the South West London and St George’s Mental Health NHS Trust and South London and Maudsley NHS Foundation Trust and Oxleas NHS Foundation Trust to collaborate both in clinical services and infrastructure / productivity initiatives. The collaboration in forensic services also falls under this partnership.

The MoU is intended to be signed by trust boards to ensure all organisations agree on the principles and objectives of collaboration of this work. It also covers the business rule that lay out how projects will be set up and investments, benefits divided.
Purpose / Rationale / Scope

The South London Mental Health Partnership is the first of its kind in London. By working in partnership, and sharing resources where appropriate, we aim to improve outcomes for our communities in integrated care.

The South London Mental Health Partnership does not replace any organisations’ structures or governance arrangements.

The programme is intended to run on an ongoing basis and will be reviewed every three years.

The scale of ambition is significant and comparable to the South East and South West London STPs.

Objectives

The objectives of the partnership are to

- Increase population health
- Significantly decrease the gap between years of life
- Agree best practice approaches across the partnership and roll them out using QI methodology
- Ensure no one will be sent out of area by 2020
- Ensure everyone has access to care in good time
- Deliver savings by working in partnership

The above goals will be accomplished by undertaking a number of joint projects. This includes forensic services.
Governance Structure

Resources

The Trusts have agreed to jointly fund the Programme Director.

Additional project / admin resource, investments (eg in joint systems), external financial or capacity modeling, external resource for process reviews, funding for restructuring or similar may be necessary.

However, this MOU is not a commitment of funds and each funding request needs to be authorised separately by all Trusts.
Authorisation

The signing of this MOU is not a formal undertaking. It implies that the signatories will strive to reach the objectives stated in the MOU, to the best of their ability. Agreed projects will have binding contracts and terms and conditions will be set out in the business rules.

Duration

This MOU shall become effective upon signature by the authorised officials from the Trusts and will remain in effect until modified or terminated by any one of the partners by mutual consent.

_______________________ Date:
(Partner signature)
(Partner name, organization, position)

_______________________ Date:
(Partner signature)
(Partner name, organization, position)

_______________________ Date:
(Partner signature)
(Partner name, organization, position)
Appendix: Business Rules

Key Principles

- The overriding principle is fairness between all three Trusts.
- A project can be undertaken by two of the three Trusts as part of this programme.
- The Partnership initiatives will take priority, however, where beneficial the Trusts can jointly decide whether to pursue certain STP / other local / London wide initiatives.
- The Partnership will work in a ‘governance light and objective heavy way’. This will mean that each project will have clear, well defined and detailed milestones and targets that will enable project managers to stay on track and allow the trusts to monitor progress. The governance will be kept as light as possible to enable teams to focus on the actual project work. It will be key to ensure that appropriate leadership is in place for each initiative to ensure this approach is successful.
- These rules will be reviewed annually by the Partnership Steering Group as well as Trust boards.
- Disputes will ideally be resolved internally. Should this not be possible in a particular situation then the escalation route is
  1. the CEOs.
  2. the NEDs on the Steering Committee and the Chairs
  3. an external mediator as the last resort.
- All decisions need to be unanimous.

Return on Investment Principles

- Each new project must be more beneficial to each partner Trust than the status quo or the model needs to be re-worked. Alternatively, the partners commit to make a compensation payment to ensure no Trust loses out financially if there is a clear benefit to the partnership as a whole.
- All three partners would agree to the compensation payment and the length of time this would be paid. The payment would be the difference between the agreed trust baseline and the new partnership model for an initiative.
- Projects with a quality / patient experience benefit are expected to be cost neutral at worst, unless separately agreed by the Partnership Board.
- Budget is the starting baseline, however, due to the way current budgets had to be set, each trust will have the chance to set the baseline. Direct costs only are to be included, but include direct element of estates (only the space used / a rental agreement) can also be shown. Each Trust then signs up to this baseline (revenue gross margin / direct cost) and it will not be changed during the project work.
• Payback periods will be looked at on a case by case basis, but should not be longer than three years. Ideally they should be shorter than two years.
• Each project must meet the Trusts’ internal return requirements and / or clinical quality standards. A higher than standard return (5%) will be required unless the project is very large.
• Each initiative will be supported by a standard business case. Trust Boards will continue to have overall oversight.
  • The Partnership Board can take decisions in the range of £250k-£750k. this equates the level of the Executive Team at Oxleas. Oxleas have the lowest cut offs for decision making and have therefore been chosen as the benchmark.
  • The Operational Boards can take decisions up to £250k.

Benefits, Cost and Risk Share

• Trusts agree to share benefits, costs and risk equally regardless of size of the individual team / service.
• Capital / other investment / running costs / set up costs / restructuring costs / stranded costs etc are shared in the same proportion agreed above, regardless of costs actually taken out in each Trust. For example, redundancies could all come out of one trust’s team, but the cost would be shared by all. The test must always be that the individual trust returns are greater with the project than before.
• All risks (financial and non financial) are shared in the same proportion.
• Over and underspends (not due to local mismanagement defined as the variance of actuals to the agreed baseline) and other changes to the baseline are also shared in the above proportion.
• After a period of one year a standard cost will then be implemented across all Trusts. For example, if the savings of joining up payroll teams is £100k in year one, then the Trusts will split that in the proportion agreed. From year two onwards a standard price per payslip will be implemented.
• There needs to be a collective decision about reinvesting funds into each service and a reserve for each may need to be built up. This will be decided by the Partnership Board on a case by case basis. The teams will have first call on reinvesting any benefits.
• Share of local efficiencies after go-live will be decided on a case by case basis. This needs to be reasonable and allow local providers to meet individual CIP after the initial benefit is taken (ie from year 3 onwards).
• The Trusts will give each collaborative service a CIP target for their shares, which will be added to the return requirements from year 2 onwards of the initiative.
• Clinical quality and governance to be responsibility of the specific provider (this may create situations of conflict with resources being managed by the partnership). Minimum / standard levels of governance across the partnership need to be agreed upfront by the trust boards.
• Changes to services are to be agreed jointly

Projects with Shared Revenue

• A host will be decided for each project – eg Oxleas for Forensic Services
• All gains, deficits and risks sit with the Partnership and will be shared based on
KPIs (an agreed operating model) and that drive the desired behaviours.
• All service changes need to be agreed by all Trusts and benefits / investments as well as potential overspends will be shared as previously agreed.
• The Partnership agrees a total budget for the whole service.
• There will be rental / service level agreements for estates or other services used by one or more of the partner trusts.
• The existing income block budgets will be the starting point for allocating out shared income. A mechanism to vary the budget based on certain operational criteria will be added to that until there is enough information to set up new contracts and define new shares.
• The host / commissioning hub will be in charge of drawing up agreements with the partner trusts of what is bought by each trust
• If there is a financial or non financial risk to being (or not) a host, then there needs to be an upfront agreement of how that needs to be reflected in a risk / reward premium.
• The individual projects will not be ringfenced into separate entities initially, but this may follow later.

Benefits and Risk Share with External Partners

• NHSE / other commissioners will not form part of the partnership but will have a separate agreement with the partnership.
• Current contracts with NHSE should be replicated, eg a block with a mechanism to share the QIPP. Every six months there is a check on actual performance and contracts can then be varied accordingly.
• There is an intention to incentivise good behavior. In the set up phase stability and information are most important though, with incentives coming in in the second phase. These incentives will depend on the nature of the project and will support the aims of the partnership, not individual trusts. Since the project has been accepted this means that that will best serve the interests of the partnership.
• In the first year, established contracts are in place for existing activity and will be used. All new activity, new bed capacity, staffing, etc will go through the host from the start date of the initiative.
• All decisions must be taken unanimously and the partnership needs to have one position with external partners.
• The trusts will have a joint agreement with NHSE, which is separate from the trusts’ internal agreement.
• A risk share model / indemnities will be negotiated upfront for each project based on the dataset available at the beginning of the shadow period.
• Contracts with NHSE and other commissioners must be compatible with internal partnership mechanisms to deliver those contracts.
• For the trial period, NHSE will keep their existing contract mechanisms for services that existed pre partnership (e.g., 95% occupancy) with 50% marginal rates and 5% tolerance.
• During the shadow period, all risk needs to be borne by the commissioners or have a 50/50 gain share (e.g., new wards).
• The CIP should be delivered by activity gains / reductions prior to the surplus / deficit share between the organisations. [difficult to expect services to deliver CIPs whilst they are undergoing a transformation in how they deliver services]
• Contract length following the trial will not follow national commissioning timelines, but we should break the mold and aim for longer term contracts where possible.
• Any required investments signed off in the business case will form part of the contract negotiation.

Assets and Liabilities

• The host has delegated authority for assets that serve all three trusts to run joint assets on behalf of the partnership. There will be annual true ups to ensure costs paid by each trust are based on real data. Additional agreements to share the risks and costs need to be made between trusts based on the previously agreed principles.
• The trusts jointly bear the risk of supplier insolvency / price increases and this will form part of the annual review.

Contracts and Venture Form

• Contracts are set up to be long enough to make a venture worthwhile, but with break clauses to enable trusts to leave should their circumstances change. Contract length is five years, with benefits review / true up after one year and three years and a break clause after three years.
• Initial projects will work as a contractual JV to enable a speedy set up. However, modeling and legal work will be completed to ensure that the most cost effective solution is found and implemented in the medium term (contractual JV, full JV, outsourced service)
• There will be quarterly performance reviews.
Project Assessment

- A robust sign-off process for due diligence will be in place, with scrutiny by relevant directors, the Partnership Board and the individual Boards. This will be in line with the delegated authority granted to the partnership board.
- Standardised systematic approach to benchmarking costs, benchmarking service models and input resources (such as staffing), and maintaining quality, common outcome measures, clearly described and documented pathways. This will be agreed by the CFOs and the operational boards on a case by case basis.

Project Review / Ongoing Management

- Annually based on initial KPIs. Bigger review after year 1 and if there are major changes to the service (e.g., new external contract)
- Project changes that lead to growth or different ways of working will be proposed by the project leadership and be decided on by the CEO Steering group.
- When a project falls short of its agreed KPIs it will be performance reviewed and the project lead will need to provide and manage against a turnaround plan.
- Should it not be possible to turn around a project then it will be dissolved and the previous structures will be reintroduced. Any related costs will be borne by the trusts in the same proportions of the project related benefits share.
- Consistent reporting tools and data management will be implemented.
- ‘Lessons learnt’ from each project will be implemented.

Termination / Resignation of Partner Trust

- Notice period for a partner to leave is twelve months
- The leaving Trust will then leave individual projects at the review date and must ensure appropriate handover processes are in place, e.g., if the leaving trust was the lead on a particular project.
- Each individual project needs to determine individual processes as part of its setup
- The leaving Trust will remain on all committees with voting rights until the end of the notice period, but not after the notice period is finished even if some projects are still ongoing. It can be agreed by the remaining trusts that the leaving trust is no longer part of any discussions that may be commercially sensitive.
- Expulsion of a Trust from the partnership would need to be agreed by two other partners. Reasons for expulsion could include financial bankruptcy or a rating of ‘inadequate’ for a trust.
- If it remains in the partnership then the affected trust would not be able to participate in new bids until the situation was resolved.
- All risk and benefit share in that situation would transfer to the two other trusts.
• Neither Partner may transfer, sell, assign or otherwise dispose of all or any part of its interest in the Partnership without the partnership agreeing.
• Liquidation of the partnership would be carried out on a project by project basis

New Partners / Clients

• Possible new members to the partnership need to be approved by all partners.
• Partner trusts will decide on a case by case basis what the terms of an expanded partnership are and whether they are willing to dilute their shares in the interest of participating in a larger group.
• The partnership accepts external clients. They will pay a fee for service and any risks / rewards are shared among the partners in the normal way. The partnership will sell high and low margin services:
  • Commissioning or similar can be sold at a higher price
  • Back office services will be sold on efficiency – low margin
REPORT TO THE TRUST BOARD:
23rd May 2017

Title
Haematology Institute – Strategic Outline Case, Final Version, Cover Note April 2017

Purpose
To note information about the Haematology Institute – Strategic Outline Case, provided by Kings Health Partners.

1. Introduction

This briefing paper summarises the key points of the Haematology Institute Strategic Outline Case (SOC) Final Version, details what has changed from the first version submitted, and sets out the conclusions and recommended next steps.

The first version of the Haematology Institute Strategic Outline Case (SOC) was submitted to the KHP Joint Boards at the end of March 2016, which confirmed approval to submit to partner organisation sub-committees and Boards. The SOC has been presented to, and discussed in detail, at the following:

- GSTT – Cancer committee, Commercial board, Cancer CAG, TME, Board in Committee
- KCH – Executive committee, Consultants Committee, KCH Charity, Board strategy seminar, KCH Board
- KCL – Health Faculties Executive
- SLaM – Business Development & Investment Committee
- KHP – Operational Executive, Chief Executive Action Group, Directors of Finance meetings

Overall the SOC has been acknowledged as a compelling document and is supported throughout KHP. The following areas were specifically requested to be updated/ included in the final version of the SOC in order to be ready for approval to progress to outline business case (OBC). The final version of the SOC has been approved for submission by the Haematology Leaders Group and the Haematology Programme Board, Chaired by Lord Kerslake (Chairman of Kings College Hospital).

<table>
<thead>
<tr>
<th>Tasks for SOC</th>
<th>Action</th>
<th>Summary outcome</th>
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| Refine the financials – does it really cost that much to build an institute? | Provide sensitivity analysis on various factors within the finance case, such as PP income, activity growth and marginal rates. This will address the ‘optimistic’ view on the financials and give ranges on potential costs.  
OUTPUT: updated the commercial and financial cases to test and validate further ranges | Sensitivity analysis shows conservative assumptions have been used in the case on pay and non-pay marginal rates, private patient margin and interest rates on borrowed funds. This means that varying these factors still results in a |
| Demonstrate thinking on the potential sources of funds | Provide update on developments with potential commercial and philanthropic partners. Fundraising plans. Trust estate plans. Be clear the case is predicated on borrowing the capital funds and ability to service the associated debt. **OUTPUT:** updated the financial case; funding sources section | Commercial partnership with Celgene in discussion for £20.4m (including £6m contribution to capital); Elimination of Leukaemia Fund (ELF) proposal in discussion to fund mind and body service; Detailed site strategy for KCH analyses benefit of released space on business case; Fundraising propositions in development |
| Develop the KHP partnership model | Through the Impact and Risk workshops, develop options for acceptable business models for the partner organisations **OUTPUT:** worked example of acceptable options of partnership models from the Impact and Risk workshops | Risk and impact work highlighted examples of partnership models which some of the partners are already involved in and which may be adapted to meet the needs of the Institute, for example the Francis Crick Model. See appendix for detailed outputs. |
| Further develop the network model and benefits | No drafting revision in SOC V2 – OBC work will further define the network as set out in the next stage plans. **OUTPUT:** Produced a detailed network summary | See appendix for detailed network analysis from pre-OBC work. |
| Phase the plan to SOC v2 and OBC, resource and financial requirements | Demonstrate steps to OBC gateway and throughout OBC to phase deliverables and control cost – initially focussing on network implementation, benefits and investment needed, followed by build activities. **OUTPUT:** updated the management case | OBC phase 1 – develop the clinical academic network OBC phase 2 – Integration creating ‘one team’ for Haematology across KHP OBC phase 3 – capital case for the Institute hub build |
| Provide organisation impact assessments and responses to the questions raised (which aren’t covered by the above) | Provide an organisation specific narrative to address individual questions/ points raised (as detailed in the slides included here) around impact to organisations and appreciation of other initiatives which may impact. Individual organisations to lead the response. **OUTPUT:** addendum to the SOC, organisational impact assessment and responses to specific questions. You said; we listened. | All questions have been logged and responses given. See appendix for detail. |

2. **Executive Summary**

**Haematology across KHP today**

The Departments of Haematological Medicine at King’s College Hospital NHS Foundation Trust (KCH) and Guy’s and St. Thomas’ NHS Foundation Trust (GSTT) are the largest in the UK and have an extensive referral base within south London, Kent, Sussex and Surrey, with more than 75% of regional referrals for specialised
services coming to KCH and GSTT. Thus high quality haematological services are provided through a highly networked model. All clinical aspects of haematological medicine are underpinned by academic excellence, incorporating strong basic and translational scientific programmes, with both national and international collaboration.

Despite our collective strength, there are significant challenges to the ongoing sustainability of the service given the challenging financial environment and competitive threats. We therefore need to move at pace with a compelling and achievable vision for change. There are issues to be addressed within current provision, including duplication of services across sites and variability in the services offered to patients as a result.

There are capacity challenges across services such as bone marrow transplantation (BMT) whereby there are long waits for patients due to bed capacity constraints. There is an ageing asset base across haematology, with estates that are of poor quality and in urgent need of modernisation. This limits the productivity of current research activities and hinders the recruitment of additional staff in this area.

In the current and future healthcare climate we cannot afford to work in anything other than the most efficient way to deliver the best outcomes for patients. At the same time, only by adopting, investing in and exploiting radically new approaches to health care delivery and academic excellence, can we bring together our combined strengths to deliver an offering that is greater than the sum of its parts.

**The vision – why an Institute of Haematology?**

Our vision is to develop a King’s Health Partners (KHP) Institute of Haematology that is undeniably top five in the world in terms of clinical outcomes, research output and quality, and education excellence, delivering exceptional outcomes for patients, both locally and globally, by accelerating the adoption of innovation from bedside to bench and back.

The delivery model for the Institute is focussed on clinical care delivered primarily in, or close to, the patient’s home through a highly networked model. Given the highly specialised nature of much of clinical haematology our vision is for a highly efficient tertiary hub, working in seamless partnership with local “spokes” at a range of DGH and local sites.

This model offers the opportunities for super-specialisation, delivering excellence for patients, whilst offering a sustainable proposition for commissioners and an opportunity for collaboration and development across the organisations within the network. The benefits delivered through the creation of an Institute of Haematology are:

<table>
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<tr>
<th>Summary of benefits</th>
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<tr>
<td><strong>Opportunities that can only be realised only through a full clinical academic Institute</strong></td>
<td>Outstanding internationally recognised and leading basic and discovery science in all aspects of haematology.</td>
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<td>Exceptional outcomes for patients delivered through a sustainable clinical model:</td>
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<td></td>
<td>• Transforming patient outcomes by extending transplantation (e.g., BMT in sickle, autoimmune, combined solid and liquid organ transplants, like stem cell and kidney).</td>
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<td>• Creating Comprehensive centres for sickle cell and haemophilia across South London.</td>
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<tr>
<td></td>
<td>• Consolidation across our National services (e.g., such as PNH, BMF, porphyria and red cell).</td>
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**Bedside to bench and back** delivered through truly integrated clinical academic facility, which is internationally distinctive, enabling:

- Ease of transportation of samples to tissue bank.
- Linking clinical and diagnostic research information.
- Highly attractive proposition, strengthening commercial and academic links with pharma companies.

### Improvements in quality of service, patient experience and access

- Care delivered as close to home as possible, through strong relationships with local care networks and a highly integrated clinical academic network across the south east of England.
- Improved quality and enhanced service offering through combined scale ensuring access to the right team and equipment for all patients at all times;
- Greater and more timely access to specialist expertise through greater integration of workforce across provider network;
- Integration of mind and body agenda across clinical academic network, leveraging KHP’s expertise, to ensure a consistent focus on mental health for all patients.

### Benefits that can only be realised through a clinical academic network and institute model

- Vibrant clinical academic network enabled through delivery of new models of care supported by infrastructure investment that releases capacity and efficiencies across the system;
- Critical mass of expertise and staff to provide highly specialised services across the network, improving access for patients whilst reducing costs;
- Increased access to innovative treatment, supported by physical integration of research and clinical service;
- Increased efficiency – use of high cost resources, reduction in A&E attendances and unnecessary admissions, reduction in duplication of activity across multiple site;
- Cash savings through bed reductions across KHP;
- Workforce development – comprehensive offering in education and training that takes advantage of scale and international reputation of haematology within KHP;

*Underpinned by compelling commercial case that ensures world class clinical care within haematology is deliverable and sustainable.*

### Support specialised commissioners and local CCGs deliver population health agendas

- Highly networked population health model will enable KHP to support commissioners in developing innovative models of payment for population outcomes.
- Support specialised commissioners to consolidate high cost resources within a model that ensures a thriving, sustainable provider network across tertiary, secondary, community and primary care.
Options appraised and outcomes

There are three main options tested within the SOC and variations within these options to ensure due diligence has been performed in identifying the preferred option upon which to proceed. The options appraised were:

1. Do nothing
   a. Current baseline of service provision and change nothing;
   b. Current baseline, but lose market share to competition – ‘downside’ of do nothing;

2. Regional clinical academic care network
   a. Create a virtual network with no capital build as a ‘hub’;
   b. Create the virtual network, and in addition create a Private Patient offering;
   c. Create the virtual network, and in addition create a Training & Education offering;
   d. Create the virtual network, and in addition create a Research offering;

3. Full Clinical academic Institute
   a. Create the full Institute vision including a capital build;
   b. Create the full Institute vision including a capital build, but reducing the research investment;

The benefits to be realised by the institute were categorised into the following areas, against which the options were appraised:

1. International brand
2. Delivering world leading performance sustainably
3. Clinical academic network – population health model
4. Research excellence from bedside to bench and back
5. Compelling and comprehensive education offering
6. Efficient use of resources
7. Viable commercial offer (economic test)

The options appraisal (including the financial appraisal of the options) has concluded that the only option that can deliver all the benefits identified and create a financially sustainable future model for haematology is the Full Clinical Academic Institute (option 3a). The clinical academic network will be scoped, and its implementation outlined, as a precursor to full institute delivery in order to realise benefits by creating efficiencies and standardisation where possible in the short term.

Financial risk in developing institute business case:

The decision to invest significant case development effort and up-front funding requires some confidence that the direction of travel will produce a successful result and an understanding of the factors that will be critical for delivering it.

The next stage of the programme, OBC, has been phased to manage financial risk and to focus on the delivery of benefits early in the programme, with build activities coming in a later phase. The phasing of the OBC is as follows:

OBC phase 1 – develop the clinical academic network
OBC phase 2 – integration creating ‘one team’ for Haematology across KHP
OBC phase 3 – capital case for the Institute hub build

Financial viability of the preferred option
The preferred option of a full Clinical Academic Haematology Institute, including a capital build, is estimated (at the upper range of space and cost) to cost a total of £200m, and have the following financial profile:

- **£200m**
  - **£30m** Philanthropy and fundraising
  - **£20m** Commercial and other third party
  - **£150m** KHP Partner organisations

KHP Haematology Institute financial case has been developed based on capital investment to deliver:
- Highly integrated clinical academic care network across the South East of England.
- Specialist clinical academic facility delivering quaternary / tertiary clinical service integrated with basic and translational research supported by dedicated education and training facilities.

To support this development, the KHP Haematology Institute will need to attract third party investment through both traditional and non-traditional sources, as well as build a compelling commercial proposition that can deliver the revenue requirements to support the investment.

The financial model is based on the Institute being able to repay a £150m loan.

The preferred option of a full Clinical Academic Haematology Institute, including a capital build, is shown to be financially viable (with both upper and lower ranges of capital investment) by meeting the following tests:

1. Positive NPV forty years after investment; and
2. EBITDA of 10% ten years after investment; and
3. Undiscounted payback period of less than thirty years.

Key elements driving the viability are:
- Private patient offering, supporting 25 beds (of 125) for private patients and the provision of private patient outpatient facilities;
- Increasing NHS market share of highly specialist work through the Institute proposition;
- Education models, underpinned by a strong brand, to attract international students with high value MSc, postgraduate and short courses;
- Drug development capabilities to build on our basic science and comprehensive trials portfolio (phases I – IV);
- Commercial partnerships, acting as a strategic education and training partner for industry and big pharma companies.
- Strong proposition to generate philanthropic fundraising

**Governance**

In order to proceed at pace with the business case programme and to facilitate decision making, a governance structure has been outlined which sees the creation of a **Haematology Institute Programme Board**, which is accountable to the individual local partner organisation boards within the Kings Health Partners AHSC. The Haematology Institute Board will be Chaired by the Chairman of Kings College Hospital.
An Executive Senior Responsible Officer (SRO) has been appointed to provide leadership within the Board and to hold accountability on behalf of the programme. The Institute Board is the key governance body within the programme structure that is responsible for decision making and managing business issues that are essential to delivery of the programme. This board will manage the budget, monitor and manage risks escalated by the Leaders Group, make policy and resourcing decisions and assess any required change of scope for the programme.

The Haematology Institute Leaders Group, Chaired by Professor Ghulam Mufti, will be accountable to the Institute Programme Board and for the delivery of successful business cases and will feed into a sub-group, the Haematology Institute Steering Group, which will define the clinical academic operating model of the Institute.

A Programme Team will be set up which will be responsible for the delivery of all products/outputs from the programme, including the business case and the network design. This team will plan, manage and coordinate the activities of the programme.

A KHP Institute Commissioner Steering Group will most likely be set up by the Commissioners for them to endorse the programme’s strategic developments, to support and drive service re-design, lead on public consultation processes, provide assistance in securing ongoing service commissioning, regularly report to other NHSE/Commissioning Boards on programme performance and developments and to act as advocates for the programme.

The Cancer Clinical Academic Group (CAG) and the KHP Joint Boards will continue to provide an assurance and oversight function to the programme.

Organisational Form

The Institute of Haematology will require an organisational form that allows it to deliver the vision, clinical model, research and education offering set out in the SOC. The next phase of business case development will need to consider this further, seeking to design an organisational model that delivers the following:

- Clinicians, academics and managers are able to work as “one team” to deliver the required outcomes and feel like they are part of one organisation;
- Bringing rigour to the model that cements buy-in from partner organisations, shares risk and liability as well as gains and benefit;
- Simpler governance that delivers:
  - Simple, robust, internal structures to allow appropriate decision making;
  - Contracts managed in one place – simple for commissioners;
  - Decisions can be made through the haematology lens, rather than corporate lens of each organisation;
  - Each partner board appropriate oversight of the organisation;
- The model can be regulated appropriately and regulators (i.e., OFT, Monitor, HEFCE, NHS England) are content with plans;
- Financial framework that delivers capital management and decision making, as well as meeting tax needs across the system.

The best organisational form to meet the needs of the Institute will be further worked up during the OBC phase. Initial consideration of organisation forms has taken place based on the requirements set out in the SOC. A working group, led by Alan Goldsman, has Finance Directors within its membership and is reviewing the potential options for organisational form and considering the associated impact and risks for each partner organisation. Initial documentation and findings from this group is included in the SOC appendices.

Delivering the Institute vision will require system-level integration to create the underpinning network. The potential for KHP to provide policy and system leadership is significant and the SOC sets out some initial
thoughts on the proposition to organisations outside of KHP across the network and the benefits this will bring.

**Programme Delivery**
A provisional programme plan is detailed in the SOC, below are the key decision making milestones:

<table>
<thead>
<tr>
<th>Milestone</th>
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<tr>
<td>SOC approval (to commence OBC)</td>
<td>March 2017 – May 2017</td>
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<tr>
<td>OBC phase 1 – network configuration and planning</td>
<td>June 2017 – May 2018</td>
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<tr>
<td>OBC phase 2 – One Team Institute integration</td>
<td>July 2017 – May 2018</td>
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<tr>
<td>OBC phase 3 – build planning</td>
<td>September 2017 – May 2018</td>
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<tr>
<td>OBC approval (to proceed to FBC)</td>
<td>April 2018 – May 2018</td>
</tr>
<tr>
<td>FBC approval to commence build</td>
<td>June 2019 – Aug 2019</td>
</tr>
</tbody>
</table>

The programme resource requirement and structure to deliver the business cases is outlined in the SOC. A breakdown of costs to OBC is below:

<table>
<thead>
<tr>
<th>OBC Item</th>
<th>Summary</th>
<th>Cost to OBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Core Team</td>
<td>Programme Director, Programme Managers and Administrator</td>
<td>£316,938</td>
</tr>
<tr>
<td>Network Delivery &amp; Integration Team</td>
<td>Network Lead, Clinical backfill and dedicated resource</td>
<td>£534,505</td>
</tr>
<tr>
<td>Build Team &amp; Specialist support</td>
<td>Capital build related activities — RIBA Stage 1 &amp; RIBA Stage 2* External Economic, Consulting and Financial support</td>
<td>£1,790,000</td>
</tr>
<tr>
<td>Integration Investment Fund</td>
<td>Investment Fund to support integration activities</td>
<td>£100,000</td>
</tr>
<tr>
<td><strong>Total (excl VAT)</strong></td>
<td></td>
<td><strong>£2,741,443</strong></td>
</tr>
</tbody>
</table>

*An option to further reduce these costs would be to delay the build team and RIBA stages to later in the programme, however this is not advised as it is likely to incur additional costs overall as timescales will be extended and OBC cannot be completed with sufficient detail to allow a decision to proceed, without these stages included.

Full costs to complete FBC and to gain approval to proceed will be dependent on the OBC Gateway approval through local Boards and commissioner arrangements, and go ahead to a capital build, along with agreement on the procurement methods to be used. The additional sum to **FBC is estimated at £5m to £7m.**

3. **What does it mean for SLaM to approve the SOC?**

Approving the Haematology Institute SOC signals the following from SLaM:

1. Commitment to the **Haematology Institute vision**, strategic intent, benefits and assurance of viability. Agreement to move to the next, more detailed stage of business case planning (OBC);
2. Agreement to proceed with an **OBC for a capital build** and all associated activities, such as planning and design of the new building, in line with KCH and KCL master planning work;

3. Agreement to support planning the Institute **network configuration**, and **one-team integration** to create the foundations of the Haematology Institute. –These plans will detail the clinical model across the clinical academic network and integration plans required to create one Institute team and to realise the benefits of this structure and deliver efficiencies across KHP to secure the viability of Haematology services in the short term, in preparation for the Institute capital build ‘hub’.

A full copy of the SOC and appendix documents can be downloaded at: [https://2020delivery.box.com/v/KHPHaematologySOC](https://2020delivery.box.com/v/KHPHaematologySOC)

The password to access the documents is: **K1ngsHealthPartners**

Professor Ghulam J Mufti OBE
Professor of Haemato-oncology & Head of Department Haematological Medicine
King’s College Hospital NHS Foundation Trust

Kate Barlow
Programme Director
Haematology Institute

24 April 2017
REPORT TO THE TRUST BOARD: PUBLIC

23 May 2017

<table>
<thead>
<tr>
<th>Title:</th>
<th>Combined Performance and Finance 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 report

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

To review change and progress throughout the year and key programmes going forward.

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 (PMO), Finance, Estates & Facilities and SLaM Digital.

To report on emergency preparedness status and current actions.

Recommendations to The Board

To approve the report noting the key issues raised, highlighted risks and remedial actions.

To note the challenges represented, in particular the numerous change schemes planned for 2017/18.

Executive Summary:

The Trust continues to meet the majority of the performance-related NHS Improvement Single Oversight Framework indicators with a number of risks and associated actions noted in the report. The IAPT recovery rate performance continues to be an area of focus.

The pressure in the acute inpatient pathway has not resolved. The existing mitigation actions have been escalated across the system and the plan is being refined to deliver improvements to the ‘full’ system working across all boroughs.

The PMO is now supporting CIP, QIPP and CQUIN change initiatives for 2017/18. Work continues to complete the baseline documentation to ensure robust delivery plans are in place alongside effective monitoring and challenge.

Continued progress is evident with our developments in Estates & Facilities, SLaM Digital and EPRR.
COMBINED PERFORMANCE AND FINANCE REPORT: 23 May 2017

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Glossary

Appendix A: Trust Performance Management Framework Summary
Appendix B: QSC Quality Dashboard
1 NHS Improvement Indicators

The Trust’s performance is detailed in the table below. Provisional performance for April is included where possible. Associated actions will be reviewed through the Performance review process and updates provided to The Board.

1.1 Summary Table NHSI Indicators: Access and Effectiveness

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>April Prov.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admissions had access to crisis resolution / home treatment</td>
<td>95</td>
<td>98.3</td>
</tr>
<tr>
<td>2. Early Intervention in Psychosis 2 week standard</td>
<td>50</td>
<td>Pending</td>
</tr>
<tr>
<td>3. IAPT Waiting Times 6 Week Standard</td>
<td>75</td>
<td>88.6</td>
</tr>
<tr>
<td>4. IAPT Waiting Times 18 Week Standard</td>
<td>95</td>
<td>99.5</td>
</tr>
</tbody>
</table>

For the overall year 2016/17 the Trust performance exceeded all of the national standards.

Early Intervention results were being validated at the time of writing prior to their submission to NHS England.

1.2 Summary Table NHSI Indicators: Quality Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>April Prov.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. CPA follow up within 7 days of discharge</td>
<td>95</td>
<td>96.7</td>
</tr>
<tr>
<td>6. IAPT Recovery Rate</td>
<td>50</td>
<td>49</td>
</tr>
</tbody>
</table>

Seven-day follow up of discharged patients was being validated at the time of writing but provisional information indicates performance over 95%.

NHS Digital (formally Health and Social Care Information Centre) publishes the official statistics for IAPT and the full year statistics and Quarter 4 will be available later in the year. However, Trust data indicates the quarterly target for the IAPT Recovery rate was not met in Quarter 4 (see section 1.3.4).

1.3 Risks and updates

1.3.1 Recovery Trajectories – Home Treatment and Early Intervention In Psychosis

In 2016/17 following failure to achieve the standards in Quarter 1 for Home Treatment Gatekeeping and Early Intervention, recovery plans were developed and circulated to the Board in September 2016 for assurance. Progress against the recovery trajectories was delivered and the national standards exceeded for 2016/17, confirming successful implementation of the recovery plans.
1.3.2 Early Intervention in Psychosis 2 week standard
The Early Intervention in Psychosis Access and Waiting Times standard Part II assesses provision of NICE concordant treatment and care. The self-assessment report arising from the national exercise in 2016/17 was presented to commissioners as planned, highlighting areas of good performance and areas for improvement. The report for 2016/17 is primarily for benchmarking purposes for all Trusts delivering EIP services. Areas of good practice included the waiting time standard, cognitive behavioural therapy for psychosis (CBTp) and vocational interventions. Areas of improvement included Family Intervention, Physical Health and carers support interventions. An action plan has been developed to focus on sustaining areas of good practice and addressing the areas of improvement.

The Trust is participating in the London wide programme led by the Healthy London Partnership (NHS England) and the London Early Intervention in Psychosis (EIP) Clinical Reference Group. This is assessing London providers’ capacity and demand against the requirements of part two of the standard. The Trust has now reported to the South East London Sustainability & Transformation Plan (STP) MH Board our concerns about delivery of part two of the standard; the rising caseloads and the projected 70% total caseload increase over three years. Commissioners have been briefed previously on these risks based on existing CCG investment.

1.3.3 IAPT Standards – waiting times and access
The IAPT waiting time standards were met. Trust provision is affected by the reduced service commissioned by Croydon CCG targeting 10.75% access against the national CCG target of 15% access for population with depression or anxiety disorders.

1.3.4 IAPT Recovery Rate
Trust overall performance was 49% in April compared to 50% in the previous two months.

Chart 1 – IAPT Recovery Rate by CCG

CCG performance is based on the responsible commissioner of patients rather than the location of service.

Lewisham and Lambeth performance continues to deliver over 50% recovery. Southwark performance has fallen in April after significant improvements in the previous two months. Process changes around assessment are being implemented in May and other solutions are being considered including for more specialised provision for this outside the core Southwark IAPT model.

Croydon performance is beneath the target following its under commissioning as part of the implementation of the Croydon affordability bridge in June 2016. The focus for Croydon has been minimizing the impact on access targets and the recovery rate has been affected. This
has been compounded as the Croydon population also has similar complex needs seen in Southwark. Following a further reduction in the finance available for the service in 17/18, the team is subject to further formal staff consultation and the loss of further posts. Croydon CCG plan not to renew the contract at the end of September 2017 and the Trust has to consider whether to bid for the new contract. There is a risk that the CCG plans for a new contract will not be ready and early discussions have commenced regarding this.

1.3.5 Physical Health

Physical health in serious mental illness is a national priority as outlined in the Five Year Forward View for Mental Health; the priority continues to be closely aligned to a national CQUIN. In 2016/17 there were local negotiations and definitions for some aspects of the CQUIN whereas in 2017/18 the full national CQUIN has been agreed. Significant progress was made with improved reporting systems last year and they are being reviewed to ensure alignment with the broader definitions and targets for 2017/18. This will allow for an improved quality of reporting through the organisation to support CAGs in providing focus and also to report on progress and challenges.

1.3.6 Data Quality for Mental Health Services Data Set submissions

The Mental Health Services Data Set (MHSDS) is a defined list of measures used by NHS England and CQC to help inform how mental health providers are performing. There is a requirement to achieve 95% data quality for patient identifier information and 85% for identified priority measures. The priority measures are now ethnicity, employment and accommodation status (for adults only) with ICD10 primary diagnosis coding (all patients) and school attendance (for children and young people only) having been suspended from the definition in early 2017. Based on the revised definition, we are meeting both standards.

This is a national challenge and Trusts are awaiting clarification of the next steps regarding the detailed definitions and requirements. The Business Intelligence Team has continued to work to improve data accuracy and is liaising closely with NHS Digital as the completeness of data impacts on the accuracy of both published statistics and experimental statistics. The work programme includes both technical refinement and educating clinical staff of the importance of entering the information. It is expected that the new operational information available through Power BI will support local teams in addressing this as they record the care they provide.
2 Operational Performance and Activity

A presentation on the development of the new Quality Improvement Dashboards and the development of Chief Operating Officer quality reporting for the Quality Sub-Committee (QSC) was presented to the May QSC. The initial area of focus was MHOAD and community. The presentation introduced the initial concepts, which will be worked up to improve the quality reporting system.

2.1 Inpatient Activity and Performance

2.1.1 Acute Care Pathway Overspill and Out of Area Placements

External overspill aligns closely to the Mental Health Five Year Forward View target and the Crisp report recommendation to eliminate out of area placements.

Performance against the Acute CAG trajectory to reduce external overspill is outlined in chart 2. The Trust trajectory is represented by the green segment, with actual performance represented by the black line.

Chart 2 – External Overspill

Private overspill patients are predominantly Croydon patients and the number of OBDs in the inpatient acute pathway remains high in Croydon and Lambeth. 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.

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.

Whilst the rate of growth has been arrested, there is limited impact in delivering the necessary reduction in external overspill. The mitigation actions are being reviewed and escalated beyond Croydon across the whole system.

2.1.2 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 beds 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.
The Trust recorded 4.9% of bed days (1033) being lost to delayed transfers of care. This is comparable to the previous month with a slight reduction in the snapshot of delays in Croydon. The majority of delays relate to awaiting assessment, followed by availability of nursing home placement.

April results are being validated and also agreed with social care prior to submission to NHS England later this month.

The charts below describe the number of days lost (by patient’s local authority) and a snapshot of the number of patients delayed by CAG. The attribution of responsibility for delays process follows NHS England guidance and attribution agreed in consultation with local authorities.

The Director of Social Care is currently determining the funding allocations to the 4 Local Authorities over 3 years as announced at the Spring budget to understand with them individually whether they have received additional funding and what their spending intentions are for mental health.

**Charts 3 and 4 – March Delayed Transfers of Care**

**2.2 Community Activity & Performance**

The developments in reporting on community information are being co-ordinated with the development of the quality reporting approach to QSC. A number of constraints have been identified and are being addressed (such as the structure of community teams within our reference directories) which will support more effective reporting in the future. Priority developments will be complete during the first quarter.

The inpatient report (section 2.1) has noted the additional focus being placed across the full LSLC system. This enhances the existing work in Croydon teams to develop broader community and inpatient communication and operational standards for Croydon.

**2.2.1 Assessment and Referral Centre (ARC)**

The outcomes of ARC Home Treatment Team (HTT) assessments where admission has been requested are being collated. Data continues to indicate a 5 – 10% avoidance of potential admissions each month with the patient generally either being discharged or receiving home treatment.

**2.2.2 Place of Safety**

The centralised Place of Safety (POS) became operational across all four boroughs in February. POS reporting is being developed in line with the memorandum of understanding
developed with the local authorities and the benchmarking project with NHSE for new Section 136 standards.

2.2.3 A&E Mental Health Liaison
The number of presentations to A&E Mental Health Liaison teams is broadly consistent with indicative activity plans. (April data is included for Lambeth and Lewisham as received early.)

Chart 4 A&E Liaison Mental Health Team Presentations

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 are detailed below:

- Development of new CIP schemes for 17/18
- Agency expenditure and the risk to the NHSI reduction trajectory
- 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
- Development of QIPP plans and other commissioner cost reduction plans in response to commissioned schemes
- LSLC plans for delivering older adult services – a Task & Finish Group has met monthly since 2016 and this is reviewing its plan for 2017/18 to ensure focus and delivery of improvements to the services
- Development of the information infrastructure to support daily operational management – local inpatient and community teams now have relevant operational information available ‘live’ through the new Power BI system. Fortnightly meetings are now held between BI and the CAGs reviewing progress with roll out and also considering how to meet the significant backlog of information requirements.
3.1 Mandatory and Training Compliance

A significant amount of training is delivered around the annual appraisal cycle and this can result in a reducing volume of training being completed later in the year. The picture for compliance with training is more stable: during 2016-17, tier 1a (mandatory) training compliance remained relatively static around the 80% mark; tier 1b (role-specific) training rose from 54% in April 2016 to 65% - 70% for much of the following year.

For both types of training, compliance does fall short of the Trust’s 85% target. The new LEAP system (Learn, Engage, Aspire, Perform) is designed to encourage self-directed learning wherever possible. Individuals and managers have real-time access to training compliance information and self-service allows staff members to undertake e-learning and book face-to-face sessions from the system when they see that a course is due for renewal. However, following feedback from team leaders and concerns about compliance, E&D has reintroduced email notifications to staff and managers to remind individuals when training is due.

An “allocate spaces” option will also be rolled out shortly to allow line managers to book staff onto face-to-face sessions. This is a response to feedback from ward managers who asked for additional functionality to help them balance training release time against the staffing requirements of their wards. This will also support balancing the volume of training across the year.

In order to deliver better compliance with training, the E&D team is continuing work to better reflect the granularity of local training requirements and the vision is for all local training logs to be replaced by extended, role-specific training requirements agreed on a CAG or team basis. This will improve compliance with the wider skills and knowledge framework and will reduce the local administrative burden of maintaining effective logs.

Through April performance reviews, CAGs with a red rating for statutory and mandatory training have been given a 3 month performance improvement requirement which will be monitored monthly.
4 Commissioners and Contracting Update

4.1 Contract Issues

Work continues with commissioners regarding the additional investment plans associated with the Five Year Forward View (5YFV). The bids for Core 24 Liaison Psychiatry services across LSLC were successful. It is felt that the unsuccessful IAPT bids had service specifications, which reflected the constrained financial environment and did not meet the aspirations in the 5YFV. We are working with commissioners to develop a joint understanding of the requirements and to agree our future approach and compliance with the overall plan.

4.2 Contracting Developments 2017-19

Notable contract developments:

- Lambeth Alliance – Lambeth CCG/LA are proposing to commence an Alliance Contract (starting April 2018) for their entire spend on adult mental health. The Prior Information Notice (PIN) for expressions of interest was submitted. This will affect most CAGs and the Programme Management approach is being defined.
- NSHE Forensic – New Models of Care Secure Services - we are working as part of the South London Partnership whilst contractual details are finalised.
- SLaM is confirming the status of the Croydon IAPT plans as there is a potential risk of the CCG not being in a position to transfer to the new provider in October 2017.

Croydon CCG has confirmed a financial envelope requiring a 70% reduction in the use of adult specialist services and a similar reduction for CAMHS services. Whilst these services are paid for on a ‘usage’ basis as opposed to a fixed block payment, the Trust is clarifying the detail behind the plans and undertaking an internal Quality Impact Assessment to support these ongoing discussions with the commissioner.

The Croydon Outcomes Based Commissioning (OBC) contract for older adults was signed on 13 April 2017. One of the key elements of the overall model is the Out of Hospital business case looking at the delivery of community services to adults of all ages. The case has concentrated on physical health initially and the CCG is now developing its approach to preparing the business case for mental health services.

5 Programme Management Office (PMO)

5.1 2017-18 CIP Planning

Assembly of the CIP register is now complete and transferred to the finance tracker for the 2017-18 portfolio, which has been issued to CIP scheme leads for review and agreement.

The SMT has requested that scheme performance will be managed as an element of trust departmental performance tracking. CAG scheme management will be included in the CAG Performance Review meetings, and design principles are being agreed for non-CAG scheme performance management.

5.2 2017-18 QIPP and CQUIN scheme review and audit

The Trust is undertaking a review and evaluation of the 2017-18 QIPP and CQUIN schemes to ensure these are delivered to meet Trust financial plans. Latest findings of the review are:
• **QIPP.** QIPP delivery plans are now in discussion with commissioners. There is currently £1.5M QIPP risk in the Trust Financial plan, however, while some of the QIPP plans are straightforward and offer no risk, many will be challenging and could expose the Trust to more risk, which is currently being analysed. The fundamental aim of the negotiations with commissioners is to ensure the balance of risk remains with the commissioner and not the Trust.

• **CQUIN.** CQUIN this year is calculated on 2.5% of our total commissioned income of £236M, which is an award of £5.9M. 50% of CIP award has been assumed in Trust income and 50% has been placed in reserves (£2.95M).

• Currently the following risks exist in the CQUIN plans:
  o Trust Flu plans are unlikely to meet NHSE targets based on the uptake last year, therefore all £160k of flu award is at risk. This risk is extremely likely to be realised.
  o Trust Physical Health plans are based on current national physical health targets, not the CQUIN targets. This places £80k risk in the plan, however the national physical health committee is attempting to amend the CQUIN which is expected in the third week of May. Therefore, the risk is very unlikely to be realised and the targets will change.
  o STP engagement relies on the performance of all Mental Health and all Acute Trusts in the STP, therefore it is unknown if the targets will be achieved and that £1.92M CQUIN award is at risk. It is recommended that CQUIN planning is raised in the STP to enable the Trust to assure its position.

5.3 Creation of a substantive PMO
Recruitment is underway, with screening for the PMO Assurance System manager completed. Other roles are now being advertised, with assessment scheduled for mid-June. The new teams are planned to start in early summer and to be complete by October 2017.

6 Finance
At Month 1 the Trust made a deficit of £1.5m, an adverse variance of £0.6m against its new surplus control total. The phasing of the plan is such that the NHS Improvement (NHSI) target surplus of £2.2m is largely delivered in the second half of the year with a £2.6m deficit planned for the first half. The change in position is expected to be brought about through the impact of savings plans not scheduled to deliver until later in the year. Clearly these are critical to the delivery of a plan that is back-loaded in terms of cost reductions.

The table below highlights the financial position by service including a brief narrative where adverse variances are occurring. Overall, most services are operating within budget at month 1. However adverse positions are already apparent in the Acute Care Pathway where overspill is £941k above plan and in Psychosis with Southwark placements £240k above plan. Both these variances are before any application of risk shares but these will not substantially alter the current position. Both overspends are impacting on our current use of resource rating which has risen to a 3 (where 1 is best out of a 1-4 range).
6.1 Drivers
The position is being impacted by key cost drivers:

6.1.1 Acute overspill
Acute overspill reduced by 2 beds in April but this is still 41 beds above plan. The use of all acute/PICU beds (internal and external) by LSL&C CCGs is shown in the tables below –
Overall local CCG bed usage dropped in April whilst contracted bed numbers increased. The main exception is in Lambeth where bed usage is up by 13 beds over the last 2 months (a 14% increase). This puts Lambeth 24% above their contracted level of activity. Through the closure of Foxley Lane and Bridge House the Trust has reduced its capacity below contracted levels of activity whilst planning for only a small level of overspill. With activity 22 beds above contract in month 1, the resulting use of overspill has caused a £941k overspend (before application of risk shares).

6.1.2 Complex placements
Complex placements, particularly in Southwark continue to over-perform. The Local Authority did not increase their share of the budget but continue to operate under a 100% risk share arrangement. The CCG by contrast did increase their budget based on the outturn position but then applied a QIPP that has resulted in a net decrease in funding for the year. The CCG are also undertaking a review with the Local Authority and Trust to improve processes and quality of information. This will lead to improvements later in the year but at month 1 the position is a £240k overspend (again before application of risk shares).

6.1.3 Agency Staff
Use of agency staff has fallen compared to month 12 and is closer to the NHSI ceiling set for the year to spend no more than £17.4m on all agency staff. This still means however that the Trust incurred an additional expense of c£0.25m above the cost of employing permanent SLaM staff, assuming a 20% agency premium.

6.1.4 CIPs
In order to deliver on its control total for 17/18, the Trust has set itself a savings target of £27m (16/17 £29.2m). Against this target schemes with an estimated value of £21.7m have been identified, leaving an unidentified savings gap of £5.3m. The value of identified schemes includes £3.9m that has been assessed as high risk. Work is on going to de-risk identified schemes and to identify additional savings. The adjustments for identified schemes have largely now been reflected in live budgets. As one would expect the forecast at month 1 does not differ significantly from the Plan, apart from one exception. Given the comments above as regards the overspill position and the related uncertainty, the month 1 forecast assumes that no overspill reduction savings will be made until Q2. This results in a downgrade in the forecast of £0.8m.
7 Estates & Facilities

The aim is to reduce the number of community properties and related operating costs; the intention is to achieve £20m of capital planned through asset disposal in 2017/18.

7.1 Disposals:
- No new disposals since the previous report.

7.2 Properties for disposal 2017/18
- **Inglemere**: Two potential buyers on the market but if the offers are not on line with the Capital receipt, the plan is to auction the property on 25th May 2017.
- **Woodlands/Masters House**: Pre-application completed. One offer received but decision required on whether to obtain full planning consent to maximise value. A steer is required from the Trust on how to proceed.
- **Foxley Lane**: The plan is to auction the property on 25th May 2017.

7.3 Capital projects achievement against plan:
- **Anti-ligature programme**: Funding approved. Capital planning to appoint a Project Manager.
- **Work hubs**: BRH 1 hub complete
- **ASCOM**: Awaiting Trust decision regarding budget allocation to progress works for phase 2.

7.4 Capital projects progress update against plan:
- **Douglas Bennett House (DBH)**: Pre planning application submitted to Southwark Council March 2017. Council visited site 28th April with view of confirming application for proposed 8 wards. Initial meeting with Town Planners has taken place and first indications were positive. Design Team Meeting to be re-instated week of 15th May. Squatters have occupied DBH which may delay the programme. Estimated Feasibility costs: £53M. Programme Completion: Q3 19/20.
- **Adamson Centre**: The IAPT service has vacated St Thomas’ and moved temporarily to McKenzie Annexe until Stockwell Gardens refurbishment complete in Q2 2017. Estimated Cost: £100K.
- **GSTT**: Have been sent the accommodation required for the Liaison services to remain at St Thomas’. Joint DV appointment to ascertain and negotiate costs for occupation.
- **Jeanette Wallace House** – Contractors completed main works on floors ground to 5th. Proposals for the operation of the lift have been agreed and order placed. Works to be completed by 22nd May. Services from Tamworth Road and Salcot Crescent will move in at end of May. Works to floors 6, 7 and 8 due to complete 18th May 2017 for HR and Finance departments. Estimated Outturn Cost: £750K. Project Completion: Q2 17/18.
- **Refurbishment of Fitzmary 1**: To support female Croydon overspill. Main works complete. Ascom works will be complete on 19th May and ward can open on 22nd May. Project Cost: £325K.
- **Refurbishment of Norbury ward / Bridge House** – plan to decant forensic services being developed. Some enabling works to take place at Bridge House to support the decant. Estimated Cost: Norbury £900K; Bridge House £282K. Project Completion Q3 17/18.
- **ES2 Refurbishment**: Tender due back mid-May. Work to be carried out in situ over 7 phases. Estimated Cost: £1M. Project Completion Q4 17/18.
- **McKenzie ward** – Ward in the Community to relocate from Witley 2 at Bethlem Royal hospital to McKenzie House at Landor Road. Contractor on site. Estimated cost: £165K. Project Completion Q1 17/18.
7.5 Hotel Services Catering and Domestic Tender:

The ISS Mediclean Catering & Domestic contract commenced on 1st May 2017. The current patient menus will continue until August/September when new menus will be introduced following food tastings and feedback from Service Users. Meetings are being scheduled now for a group from all disciplines including Service Users who will work together to produce the new menus.

The retail offering complies with CQUIN 1B requirements with healthy options for all staff. Vending machine facilities will shortly be introduced to provide drinks and snacks 24/7 which will comply with CQUIN 1B.

All cleaning machines have been replaced with new ones along with some portable machines being introduced to enable cleaning of areas not always easy to access.

Feedback from the staff restaurants so far has been mixed, with concern over the price increases for some food items. A positive is the installation of the payment card machines. ISS are in the process of recruiting to some posts and there has been some restructuring of senior management. The Hotel Services Team continues to meet with the ISS Mobilisation Team on a weekly basis and this will continue for some time supported by Procurement and Finance.

8 SLaM Digital

8.1 Initial update re: cyber-attack

SLaM systems remained operational throughout the cyber-attack from Friday 12th May 2017. At the time of writing, services remain on high alert and vigilant with on-going scans for vulnerabilities.

8.2 SLaM named as London’s ‘Global Digital Exemplar’:

NHS England has announced that South London and Maudsley NHS Foundation Trust (SLaM) is one of seven organisations cited as amongst the most advanced IT hospitals in the NHS and SLaM was named as London’s ‘Global Digital Exemplar’. As a global digital exemplar, the Trust will exploit the potential of digital technology to ensure care is more personalised and responsive to patient need, by providing seamless integration across the entire local health and care community. The funding award further strengthens SLaM’s position as one of the leading locations for digital mental health research in the UK.

8.3 SLaM’s IG Toolkit compliance rate reaches a satisfactory 91%:

The trust’s assessment of compliance with the NHS Digital Information Governance Toolkit for 2016-17 has been submitted. The highly satisfactory submission was reviewed independently, which gave a reasonable assurance opinion. The trust improved its compliance with most standards relating to data security and IT governance due to the digital transformation, cyber security programmes and CoBIT alignment work undertaken by SLaM Digital Services.

8.4 SLaM Digital Services have completed important technical tests as early adopters of the NHS Digital cyber security programme:

SLaM Digital Services has signed up to the NHS Digital careCERT Assure Programme. As part of the programme, NHS Digital has undertaken a Cyber Essentials Plus level technical review. The Information Security Committee are overseeing the action plan for completion of the recommendations arising from the technical reviews to further improve the trust’s cyber defences against emerging threats.
8.5 Digital Services – Virtual Desktop access issue:
Following an upgrade to the latest version of the software on 1st May, some users experienced issues when logging on to the virtual desktop. A work-around was put in place whilst Digital Services investigated the underlying problem with the software vendor. Digital Services helpdesk received an unusual spike in calls as a result. A configuration change was applied on the 11th May and the environment is being monitored.

9 Emergency Preparedness, Resilience and Response (EPRR)
Progress has been made in a number of areas, including the lack of training for mitigating the effects of Hazardous Materials (HazMat) and exposure to Chemical Biological Radiological and Nuclear (CBRN) material. NHSE (London) have liaised with the London Ambulance Service (LAS) and recommended potential training support for SLaM through the provision of a ‘train the trainer’ course specifically tailored for Mental Health Trusts. The SLaM Health and Safety function will be taking this forward with LAS.

The recently ratified universal templates for Business Continuity (BC), and Business Impact Analysis (BIA) are being applied across the organisation. The next site based table top BC testing exercise is planned to be held in May 2017.

10 Conclusion
The Trust continues to meet the majority of the performance-related NHS Improvement Single Oversight Framework indicators with a number of risks and associated actions noted in the report. The IAPT recovery rate performance continues to be an area of focus.

The pressure in the acute inpatient pathway has not resolved. The existing mitigation actions have been escalated across the system and the plan is being refined to deliver improvements to the ‘full’ system working across all boroughs.

The PMO is now supporting CIP, QIPP and CQUIN change initiatives for 2017/18. Work continues to complete the baseline documentation to ensure robust delivery plans are in place alongside effective monitoring and challenge.

Continued progress is evident with our developments in Estates & Facilities, SLaM Digital and EPRR.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>Ascom</td>
<td>Alarm / communications system supplied by Ascom UK, a telecommunications company</td>
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<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>
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<td>CBT</td>
<td>Cognitive Behavioural Therapy (CBTp is CBT of psychosis)</td>
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<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
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<td>CIP</td>
<td>Cost Improvement Programme</td>
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<td>CPA</td>
<td>Care Programme Approach</td>
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<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>
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<td>CYP</td>
<td>Children &amp; Young People</td>
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<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
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<td>DTOC</td>
<td>Delayed Transfers of Care</td>
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<td>EI</td>
<td>Early Intervention: First Episode Psychosis</td>
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<td>ePJS</td>
<td>Electronic Patient Journey System: Clinical records system</td>
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<td>EPRR</td>
<td>Emergency Preparedness, Resilience and Response</td>
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<td>GSTT</td>
<td>Guys &amp; ST Thomas’ NHS Foundation Trust</td>
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<td>HTT</td>
<td>Home Treatment Team</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>LSLC</td>
<td>Lambeth, Southwark, Lewisham &amp; Croydon (CCGs)</td>
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<td>MHOA</td>
<td>Mental Health of Older Adults</td>
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<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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<td>NHSE</td>
<td>NHS England</td>
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<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>
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<td>NHSP</td>
<td>NHS Professionals</td>
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<td>NICE</td>
<td>National Institute for Health and Care Excellence: provides national guidance and advice to improve health and social care</td>
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<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>
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<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
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<td>PMF</td>
<td>Performance Management Framework</td>
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<td>PMO</td>
<td>Programme Management Office</td>
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<td>QIA</td>
<td>Quality Impact Assessment</td>
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<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>
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<td>SOF</td>
<td>Single Oversight Framework: NHSI assurance and performance mechanism</td>
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<td>YTD</td>
<td>Year to Date</td>
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Appendix A Performance Management Framework Trust Summary

Finance & CIPs

Workforce

Activity

All Staff - Annual Leave Planning

- please refer to Board Finance Report

All Staff - Annual Leave Planning

- please refer to Board Finance Report

Safer Staffing: Wards Breaching 20% of shifts (YTD)

Quality Priority to reduce to 10 wards

Nursing Vacancies, Bank & Agency WTE Usage (YTD)

Vacancy WTE

Nursing Vacancy (WTE)

Agency Cost (Phased NHSI Ceiling)

Admin Vacancies, Bank & Agency WTE Usage

Admin Vacancy, Bank & Agency WTE Usage

Admin NHSP Bank (WTE)

Admin Agency (WTE)

Admin & Clerical Vacancy (WTE)

Agency Cost (Phased NHSI Ceiling)

Nursing Vacancies, Bank & Agency WTE Usage

Sickness

All Staff - Annual Leave Planning

- please refer to Board Finance Report

Nursing Vacancies, Bank & Agency WTE Usage (YTD)

Nursing Vacancy (WTE)

Vacancy WTE

Trust (total - out of 50)

All Staff - Annual Leave Planning

Admin Vacancies, Bank & Agency WTE Usage

- please refer to Board Finance Report

Admin Vacancy, Bank & Agency WTE Usage

Admin NHSP Bank (WTE)

Admin Agency (WTE)

Admin & Clerical Vacancy (WTE)

Adult OBD Against Monitor Plan (excl. Private Overspill)

- please refer to Board Finance Report

Adult OBD Against Monitor Plan (excl. Private Overspill)

- please refer to Board Finance Report

Nursing Vacancies, Bank & Agency WTE Usage

- please refer to Board Finance Report

Service: Adult OBD overspill & underspill performance against target
Appendix A Performance Management Framework Trust Summary

Mar-17

HTT Gatekeeping (Target 95%)

- Total Achieved
- Total Missed

Early Intervention in First Episode Psychosis
Completed Pathways (50% target) by Month

Delayed Discharges

- Days Not Lost
- Trust Days Lost

IAPT Waiting Time (6 Weeks)

- Copoly %
- Camden %
- Lewisham %
- Southwark %
- % Trust Total

IAPT Waiting Time (18 Weeks)

- Copoly %
- Camden %
- Lewisham %
- Southwark %

Friends and Family

- No. of FFT Responses
- FFT Score (%)

Patient Surveys (PEDIC)

- Do you feel involved in your care? (%)

Learning and Growth

- Mandatory Training Tier 1A (Mandatory for all Trust staff)*
- Mandatory Training Tier 1B (Mandatory to specific staff based on role)
- Clinical Risk

Training Completions

*Previous Month
*Current Month
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 content of the report has been adjusted this month to better reflect the quality priorities and indicators specific to the remit of this committee and also reduce duplication of reporting across sub-committees. IAPT Recovery rate and Safer Staffing ward level breaches (previously reported directly to Board has now been added to the dashboard). The Finance & Performance Committee continues to receive updates on a number of key operational performance indicators (including waiting time standards for IAPT, Early Intervention, Delayed Transfers of Care, Home Treatment Team Gatekeeping and Acute Overspill).

This report also provides written updates on delivery of Commissioning Quality and Innovation (CQUINS) throughout the year and progress against the Trust Quality Priorities.

CQUINS:
2016/17 CQUIN programme
The Trust has submitted year end reports for all CQUINs and is awaiting formal confirmation from commissioners regarding CQUIN achievement and payment.
2017/19 CQUIN programme: LSLC CCGs and SLaM signed off on the national 2017/19 CQUIN indicators on 25 April 2017. All indicators are challenging with particularly ambitious targets for the uptake of flu vaccinations for front line staff, Improving Physical Healthcare and Improving services for people with mental health needs who present to A&E. SLaM CQUIN leads are currently finalising their delivery plans which will be submitted to SMT for approval by the end of May 2017.
National CQUIN indicators:
  • Improving Staff health and well-being
  • Improving Physical Healthcare for people with Serious Mental Illness
  • Improving services for people with mental health needs who present to A&E
  • Transitions out of Children and Young People’s Mental Health Services (CYPMHS)
  • Preventing ill health by risky behaviours – alcohol and tobacco
In addition to this there are 3 local CQUINs being finalised with LSLC commissioners during Q1. NHSE CQUINs are similarly ambitious and cover:
  • Repatriation of London Non secure and CAMHS Patients and Reducing Length of Stay
  • CAMHS Inpatient Transitions
  • Neuro-rehabilitation STP System development
The Forensic CQUIN programme (Repatriation, Recovery College and Reducing Restrictive Practice) will be managed through the South London Partnership.

Exception reporting:

Safer Staffing:
15 wards breached their minimum staffing levels in 20% or more shifts in March. Detail of breaches by ward is provided at the end of this report.

QUESTS:
Of the wards scoring red Bridge house has now closed and NAU’s quality standards are being addressed

IAPT Recovery Rate:
The recovery rate continues to improve month on month as reported in the Performance Board last month. Overall the Quarter 4 target of 50% was not met despite recent improvements. The locally agreed Lewisham plan has successfully delivered sustained improvements in the recovery rate and has exceeded 50% for each month in the quarter. Lambeth has met the target for the quarter having made improvements in February and March. Southwark has also made significant improvements in the most recent two months and the CCG are happy with the progress being made; there is a shared recognition with the CCG of the complexity of a cohort of the patients and solutions are being considered including for more specialised provision for this outside the core Southwark IAPT model. Croydon performance is beneath the target following its under commissioning as part of the implementation of the Croydon affordability bridge in June 2016. The focus for Croydon has been minimizing the impact on access targets and the recovery rate has been affected. This has been compounded as the Croydon population also has similar complex needs seen in Southwark. Following a further reduction in the finance available for the service in 17/18, the team is subject to further formal staff consultation and the loss of further posts. The Croydon IAPT Contract will terminate at the end of September 2017 and the Trust has to consider whether to bid for the new contract.
QUESTT incorporates the following Metrics:

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.
14. No evidence of effective multidisciplinary/multi-professional team working.
15. On-going investigation or disciplinary investigation of patients.
17. New or no Ward Manager in post (within last 6 months).
18. Vacancy rate higher than 7%.
19. Bank shifts is higher than 6%.
20. Sickness absence rate higher than 3%.
21. No monthly MPT review of key quality indicators (e.g. peer review or governance team meetings).
22. Planned annual appraisals not performed.
23. Planned clinical supervision sessions not performed.
24. No formal feedback obtained from patients during the month (e.g. questionnaires or surveys).
25. 2 or more formal complaints in a month.
26. No evidence of resolution to recurring themes.
27. Unusual demands on service exceeding capacity to deliver.
28. Number of hours of enhanced levels of observation exceed 120.
29. Ward/department appears untidy/disrepair.
30. No evidence of effective multidisciplinary/multi-professional team working.
31. On-going investigation or disciplinary investigation.

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### Safer Staffing (Number of Wards Breaching 20% of Shifts)

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### Total QUESTT Scores by Ward, March 2017

#### Seven Day Follow Up

- 94.1% followed up within 7 days of discharge

#### Full Risk Screen (CPA Patients)

- 94.0% of patients had a brief or full risk screen

#### Child Need Risk Screen (CPA Patients)

- 97.9% of patients had a child need risk screen

#### Unauthorised Absences (Detained Patients)

- 105 of 109

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### Unauthorised Absences

- Detained Patients

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### New Serious Incidents

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### All Restraints Incidents

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### Prone Restraints

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<td>Feb-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Safety Continued

### Patient Physical Assault on Patients (All Grades A-E)

- **Graph**: Shows the number of physical assaults on patients over time, categorized by grade (A-E).
- **Data**: Graph data includes the number of assaults, average, upper control limit (UCL), and lower control limit (LCL).

### Patient Physical Assault on Staff (All Grades A-E)

- **Graph**: Demonstrates the number of physical assaults on staff over time, categorized by grade (A-E).
- **Data**: Graph data includes the number of assaults, average, upper control limit (UCL), and lower control limit (LCL).

### Caring

#### Do you Feel Involved in your Care? Quality Priority

- **Graph**: Displays the percentage of patients feeling involved in their care.
- **Data**: Graph data shows the percentage of patients who feel involved, with a time series from April 2015 to March 2017.

#### Friends & Family

- **Graph**: Illustrates the percentage of friends and family members responding.
- **Data**: Graph data includes the number of friends and family responses and the score percentage.

### New Complaints - 2015/16

- **Graph**: Shows the trend of new complaints from April 2015 to March 2016.
- **Data**: Graph data includes new complaints, average, upper control limit (UCL), and lower control limit (LCL).

### New Complaints - 2016/17

- **Graph**: Displays the trend of new complaints from April 2016 to March 2017.
- **Data**: Graph data includes new complaints, average, upper control limit (UCL), and lower control limit (LCL).
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 24 tailored training courses are provided dependent on staff type and including skills refresh. The updated RAG rating has been applied whereby below 70% = Red, 71-84% = Amber, above 85% = Green (except IG which is 95%).

Well Led

Mandatory Training Tier 1 Level A Compliance

Training Completions (All Subjects)

Clinical Risk Training Compliance Tier 1 Level B

Staff Sickness

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 24 tailored training courses are provided dependent on staff type and including skills refresh. The updated RAG rating has been applied whereby below 70% = Red, 71-84% = Amber, above 85% = Green (except IG which is 95%).
Safer Staffing Ward Level Breaches:
This new format attempts to triangulate safer staffing results with vacancies and sickness.

<table>
<thead>
<tr>
<th>Clinical Academic Group Name</th>
<th>Hospital Site</th>
<th>Ward Name</th>
<th>Breach</th>
<th>RMN vacancy %</th>
<th>sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>Maudsley</td>
<td>ES2</td>
<td>25%</td>
<td>19%</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Maudsley</td>
<td>AL3</td>
<td>30%</td>
<td>28%</td>
<td>4.9%</td>
</tr>
<tr>
<td></td>
<td>Lambeth</td>
<td>Bridge House</td>
<td>49%</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem</td>
<td>Croydon PICU</td>
<td>27%</td>
<td>5%</td>
<td>2.1%</td>
</tr>
<tr>
<td></td>
<td>Maudsley</td>
<td>John Dickson</td>
<td>40%</td>
<td>15%</td>
<td>8.8%</td>
</tr>
<tr>
<td></td>
<td>Lewisham</td>
<td>Lewisham Triage</td>
<td>24%</td>
<td>37%</td>
<td>14.3%</td>
</tr>
<tr>
<td></td>
<td>Lambeth</td>
<td>Luther king</td>
<td>24%</td>
<td>29%</td>
<td>4.3%</td>
</tr>
<tr>
<td></td>
<td>Lambeth</td>
<td>Nelson</td>
<td>33%</td>
<td>8%</td>
<td>8.0%</td>
</tr>
<tr>
<td></td>
<td>Lewisham</td>
<td>Johnson PICU</td>
<td>42%</td>
<td>7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Bethlem</td>
<td>Acorn Lodge</td>
<td>72%</td>
<td>55%</td>
<td>2.8%</td>
</tr>
<tr>
<td>B&amp;D</td>
<td>Bethlem</td>
<td>Spring</td>
<td>20%</td>
<td>31%</td>
<td>13.0%</td>
</tr>
<tr>
<td>MHOAD</td>
<td>Bethlem</td>
<td>Chelsham House</td>
<td>22%</td>
<td>0%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Lambeth</td>
<td>Tony Hillis</td>
<td>43%</td>
<td>20%</td>
<td>6.8%</td>
</tr>
<tr>
<td></td>
<td>Bethlem</td>
<td>Fitzmary 2</td>
<td>30%</td>
<td>25%</td>
<td>7.9%</td>
</tr>
<tr>
<td></td>
<td>Lambeth</td>
<td>LEO</td>
<td>41%</td>
<td>26%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

Breaches exceeding 20% of total shift per month are reported to the board.

To note Bridge House closed on 19th March so will not appear in future reports.
### Board of Directors Meeting

**To be held 27th June 2017**  
3:00pm Learning Centre, Maudsley Hospital

#### AGENDA: Part 1

**Opening Matters**

1. Welcome and apologies for absence
2. Minutes, Action log review & Declarations of Interest  
   **3:00pm**
3. Patient Story  
   **Kathryn 3:05pm**
4. Chief Executive’s Report  
   **Presentation**  
   **Rachel 3:15pm**
5. KHP Update  
   **Strategy**  
   **Robert**
6. Estates Strategy  
   **Altaf**
7. Digital Services Update  
   **Quality & Safety**  
   **Stephen**
8. Retention & Recruitment Strategy  
   **Louise**
9. Freedom to Speak up Guardian  
   **Zoe**
10. Policy Ratification Process  
    **Beverley**
11. Mortality Report  
    **Michael**
12. Review of Place of Safety  
    **Governance**  
    **Beverley**
13. Council of Governors Update  
    **Rachel**
14. Quality Committee Update – May  
    **Amanda**
15. Finance & Performance Committee Update – June  
    **Stephen**
16. Business Development & Investment Committee Update - June  
    **For Noting**  
    **Altaf**
17. Endorsement of Proposed Governance & Partnership Arrangements for CBC  
    **Rachel**
18. CCG Lewisham Paper  
    **Performance**  
    **Rachel**
19. Revalidation Annual Report  
    **Michael**
20. Performance Report  
    **Kris**
21. Finance Report  
    **Gus**
22. Wrap-up and Next Meeting  
   **The next Board of Directors Meeting will be held on 25th July 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.