Board of Directors Meeting
To be held 19th June 2018
2:30- 5:00pm Boardroom, Museum, Bethlem Royal Hospital

AGENDA: Part 1

Quality Improvement Focus
Presentation by teams about their QI Projects (located at the back of the room) 2:30pm

Opening Matters
94/18 Welcome, apologies for absence & declarations of interest 2:40pm Page 1
95/18 Minutes, Action log review 2:45pm Page 18
96/18 Patient Story - Psychological Medicine & Older Adult Directorate

Quality
97/18 Quality Improvement Update 3:00pm Page 20
98/18 Risk Focus: BAF Risk – 9 Estates 3:20pm Page 37

Performance
99/18 Chief Executive’s Report 3:35pm Page 49
100/18 Cyber Security & GDPR 3:40pm Page 51
101/18 Performance & Finance Report 3:55pm Page 64
102/18 2018/19 Objectives: NEDs & Executive Directors 4:10pm Page 104

Governance
103/18 Board Assurance Framework 4:20pm Page 117
104/18 Terms of Reference – Committees Yearly Update 4:30pm Page 145
105/18 Quality Committee May Update Page 160
106/18 Equalities and Workforce Committee May Update Page 164
107/18 Audit Committee May & June Update Page 166
108/18 Council of Governors Update Page 169
109/18 NHSI Self-Certification Requirements Page 171

For Noting
110/18 Guardian of Safe Working Page 178
111/18 Report from previous Month’s Part II Page 189
112/18 Wrap-up and Next Meeting Page 190
113/18 Meeting Evaluation 4:50pm Verbal

The next Board of Directors Meeting will be held on 24th July 2018
2:30pm, at the ORTUS, Learning Centre, 82-96 Grove Lane, SE5 8SN.
Maudsley Hospital

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

web site: www.slam.nhs.uk
MINUTES OF THE HUNDRED AND EIGHTEENTH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 22 MAY 2018

PRESENT

Roger Paffard Chair
Kristin Dominy Chief Operating Officer
Alan Downey Non-Executive Director
Rachel Evans Director of Corporate Affairs
Mike Franklin Non-Executive Director
Duncan Hames Non-Executive Director
Gus Headfield Chief Financial Officer
Dr Michael Holland Medical Director
Aftaf Kara Director of Strategy and Commercial
Russell Mascarenhas NExT Director
June Mulroy Non-Executive Director
Beverley Murphy Director of Nursing
Dr Matthew Patrick Chief Executive
Sally Storey Interim HR Director
Dr Geraldine Strathdee Non-Executive Director

IN ATTENDANCE

John Adams Liaison FS
Ermias Alemu Governor
Colan Ash Head of Risk and Assurance
Andy Bell Finance Director
Martin Black QI Team
Nicola Byrne Deputy Medical Director
Jenny Cobley Governor
Mike Hammond Communications, SLaM
Graham Hewett AD Quality, Lewisham CCG
Charlotte Hudson Deputy Director of Corporate Affairs
Brian Lumsden Governor
Amanda Pithouse Deputy Director of Nursing
Gabrielle Richards Head of Inclusion, Recovery, OTs / AHPs
Susan Scarsbrook Governor
Gill Sharpe Governor
Sarah Thomas Head of Communications
Adam Ushtensley NExT Director

APOLOGIES

Professor Ian Everall Non-Executive Director
Anna Walker Non-Executive Director

BOD 78/18 WELCOME, APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST & BOARD DECLARATIONS OF INTEREST REGISTER (14.46)

Roger Paffard reflected that the regular slot before the formal Board meeting starts – receiving information about Quality Improvement projects from the staff leading on them – is time well spent. The Board agreed.

Roger Paffard welcomed Russell Mascarenhas, the Trust’s NExT Director, to the table.
It was recognised that this would be Alan Downey’s last Board meeting as a Non-Executive Director. Roger Paffard thanked him for his four years of service and added that he was delighted that the Maudsley Charity will continue to receive the benefit of Alan’s expertise for at least the next eighteen months.

The Board’s Declarations of Interest register was presented for noting; no further declarations were received. Duncan Hames welcomed the transparency observed, and that Board members have not self-filtered for conflicts but rather declared interests very broadly.

**BOD 79/18 MINUTES OF THE PREVIOUS MEETING**

The minutes of the Board held on 24 April 2018 were agreed as an accurate record of the meeting and the Chair was content for the minutes to be regarded as signed by him on this date.

**BOD 80/18 SERIOUS INCIDENT FOCUS (14.50)**

Hilary Williams, Interim Deputy Director, and Dr Rob Harland, Clinical Director for Lambeth and Psychosis Clinical Academic Group (CAG) attended to present this item.

The incident dates back to the CAG structure, and Mr X’s case cut across various services. The new borough structure will hopefully avoid problems such as those encountered in this case becoming entrenched.

Mr X came under the care of the Trust from 2009, via forensic services and then under the care of community services. His contact with community services was often challenging, and the police called. He was discharged in October 2016 and subsequently re-referred by primary care services, firstly to SLaM’s Assessment and Liaison (A&L) team. There was dispute about which team he should be under and delays in referral on. Mr X submitted a complaint to the Trust regarding his discharge, the content of correspondence with his GP and also access to services. A multiagency meeting was convened including the Croydon Recovery and Support team, Community Forensic Team and the Tavistock & Portman NHS Trust to take forward Mr X’s care, but before any further action could be taken, he was found dead in the River Thames.

Upon investigation, three actions were identified for the Trust:

- **Risk assessments and care plans:** Mr X’s risk assessment had not been updated since 2009. He had largely been an outpatient, and outpatient teams do not routinely complete risk assessments. A robust, monthly audit programme to evaluate risk assessment timeliness and quality has been implemented across all teams.

- **Escalation process:** There was no commissioned pathway for the type of treatment Mr X needed and so there was conflict between teams as to where responsibility lay. This will be clearer under the borough structure and an escalation process put in place.

- **Complaints:** Mr X’s complaint was mixed up with his care plan. The governance processes for complaints progress and communication with complainants have been revised and is monitored via weekly reporting via central governance team.

The Board discussed Mr X’s assets and resilience, recognising that he wanted to improve his life and that the focus of his complaints had been that he perceived
barriers to him being able to participate in educational opportunities, or to get a
driving licence, and how frustrated he must have felt. It is clear that communication
should have been better. The challenge was the lack of a clear pathway; none of the
three teams involved with Mr X, or to whom Mr X was referred, were commissioned
to provide care for individuals with his diagnosis.

Mike Franklin focused on the complications inherent with a patient who has been
through the criminal justice system; they are often seen as malingering to get their
sentence reduced, for example. Rob Harland agreed that teams find decisions in this
area complex: whether patients should be treated for a mental disorder or their
behaviour seen as part of their criminality.

The Board thanked the presenters for their openness and honesty.

**BOD 81/18 RISK FOCUS – BAF RISK 1 (WORKFORCE) (15.05)**

Sally Storey, Interim Director of Human Resources, presented this item, the second
in-depth review into one of the risks on the Board Assurance Framework. Risk 1 is
stated as: “If the Trust cannot attract, recruit and retain enough highly skilled staff, in
the right settings with the ability to respond to organisational change, the risk is that
the quality of care may not be acceptable or consistent across services.”

She gave an overview of the current labour market by way of context. Recruiting and
retaining staff is one of the biggest challenges faced by the NHS. The NHS faces
skills shortages, compounded by the effects of Brexit and the removal of the bursary,
and Trusts in London face particular difficulties because of the higher cost of living.

Trust staff work in a difficult environment and this impacts on staff engagement and
morale. The acuity of service users has escalated. Some Trust premises are not
ideal and the IT infrastructure does not always support efficient and effective working

In the past, the Trust has depended on its name, reputation and development offer to
recruit and retain a strong workforce, but it was recognised during 2017 that this was
beginning to change, as turnover rose. A step change in recruitment activity went
some way to address the gaps, and a step change in the Trust’s ability to retain staff
was planned through a package of interventions over a three-year period to improve
the offer to staff.

There have been some improvements over the past year. The number of leavers
has gone down by 4%, new starters have gone up by 7%, and the reported vacancy
levels have gone down from 21% to 13%.

The impact of these interventions, however, are in danger of being offset by the
Trust’s two separate but significant change programmes: the borough reorganisation,
and the large-scale Quality Improvement programme – iCare, which includes a
reassessment of how SLaM delivers community-based care. The borough
reorganisation has capacity to impact on the Trust’s ability to recruit and retain. The
iCare QI Programme should improve the ability to recruit and retain but could, if not
well-handled or confused with the borough reconfiguration, have the opposite impact.

A review of this risk that started with the Senior Management Team a couple of
weeks ago, and was endorsed at the Board’s awayday, has resulted in a proposal to
increase the rating of this risk, raising the likelihood to 5, and the consequence to 4,
giving an overall rating of 20. A further gap in control was flagged, namely the lack of
a robust and fully representative staff side bringing trade union and professional association scrutiny to what the Trust does.

The risk appetite for workforce risks is ‘cautious’, between 3 and 8.

The risk target has been re-assessed as 8. With the controls in place, and gaps in controls addressed, it is expected that the aim should be to reduce the likelihood to 2. The consequence remains at 4.

Altaf Kara sought assurance from Sally Storey that the plan in place is the right one, and that there is sufficient investment in it for an impact to be felt. Sally Storey felt that the plan is comprehensive, bringing together a number of strategies already agreed by the Board e.g. staff engagement, workforce race equality, and wellbeing. There are a raft of actions and initiatives where there has already been an impact. In terms of resources, more would always be welcome, but this is not the only priority area the Trust faces.

Duncan Hames felt that these are risks faced by every NHS Trust in London and beyond, and queried what benchmarking data is available. Sally Storey explained that it had been limited but is now available as SLaM is part of the second cohort of NHSI’s retention programme, so it has access to data. The learning from that benchmarking is that the Trust sits somewhere in the middle. However, the Trust is undergoing a data cleanse, so it should be clearer soon. The Trust’s strategies have been tested against the highest-performing Trusts and there is nothing that SLaM hasn’t considered or already started.

Matthew Patrick added another aspect to the risks associated with the borough reorganisation: how a judgement can be reached as to whether (and when) the risk has subsided. Sally Storey felt that the hard data will show – if the mitigating actions are properly undertaken – a fall in turnover and a reduction in sickness absence (particularly relating to stress). She is liaising with the annual survey provider to extend the Friends & Family test, so that staff are asked on a quarterly basis whether they would recommend the Trust as a place to work, plus other questions, with a view to identifying on a borough (and potentially team) basis where there are improvements.

Matthew Patrick queried whether it would be worth also sending out some quick surveys in-between to target certain areas; this was considered a good idea.

Russell Mascarenhas asked whether the management information will help understand where the risks are particularly acute. Sally Storey explained that the data cleanse will help the Trust get accurate information out its current systems, but that in terms of finding hot spots, there is plenty of information from the staff survey and a heatmap has been developed, RAG (Red / Amber / Green) rated across teams and departments.

Beverley Murphy added that she and Matthew Patrick both attend the London Mental Health Workforce Board, and she is part of a Nursing Workforce Board, where learning and initiatives are shared. SLaM’s Darzi Fellow has been commissioned to undertake a piece of work, surveying 350 nurses to better understand how to improve engagement and the main message is that a clear career pathway is important. The nursing development programme in conjunction with the South London Mental Health and Community Partnership should assist with that. Beverley Murphy has also heard, during leadership visits, that more flexibility in working patterns would help, so she is looking at the shift system to identify improvements.
Mike Franklin suggested that the Trust could do better in engaging in collective bargaining and trade union staff engagement. Agenda for Change is also a blocker to any Trust working more imaginatively with staff. Housing is an ongoing problem. He felt that SLaM should be looking at reward options for staff and ways in which it can set its own standards instead of looking at other Trusts.

Roger Paffard noted that a number of ideas and suggestions had been made, but nothing had been raised that challenged the assessment of the risk. This was agreed.

**BOD 82/18 DEVELOPMENT OF TRUST DATA FRAMEWORK (15.23)**

Nicola Byrne, Deputy Medical Director and Clinical Chief Information Officer, and Martin Black, Quality Improvement Information Development, attended to present this item.

In March 2018, the proposals for conceptualisation and visualisation of the data framework were approved by the Board and the development of the framework is on track for launch in July, albeit without Statistical Process Control (SPC) functionality. This will not, however, be too problematic as no-one would know how to use that tool immediately, and a good start can be made with run charts.

The difficulty in recruiting to the Business Information (BI) team has been a challenge to the development. The Board recommended contacting Kings College London and Kings College University. June Mulroy suggested focusing on the information part of the role, not the tech side. There are non-technology focused agencies who could assist.

Duncan Hames asked who the prototype data framework has been tested on; there has been initial scoping work with Clinical Directors and Service Directors. Further testing will take place in June with a broader set of internal stakeholders.

The Board recognised that this work is a crucial development for the organisation in its use of data and informatics. The need for improvements in that area were flagged during the Board’s annual review. Geraldine Strathdee added that the Quality Committee will benefit enormously from the framework but queried how the metrics to be collected can be prioritised, given that there will be significant demand.

The Board acknowledged the importance of embedding use of the framework and dashboards into day-to-day practice, and that this will require cultural change.

**BOD 83/18 LEARNING FROM DEATHS Q4 (15.31)**

Michael Holland presented this report. The Mortality Review Group continues to review the learning from each CAG’s mortality reviews and an extraordinary meeting of the Group will be held on 23 May to review governance under the new borough structure.

The Royal College of Psychiatrists is currently developing the standardised mortality review tool for mental health and SLaM has agreed to take part in the pilot that will be starting on 1 June.

The Board was asked to note the learning as presented in the report and endorse SLaM’s participation in the Royal College’s pilot. Endorsement was given.
Russell Mascarenhas asked if there is more to be said about interagency communications with GPs, which can be challenging. Michael Holland that the Trust does report where there are concerns about primary care and also, about a month post-discharge from SLaM to primary services, GPs are asked to flag if there have been any issues about the Trust’s care.

Matthew Patrick noted that many deaths are from natural causes and queried whether - in line with the physical healthcare strategy – data should be tracked to see if there are any changes over time to see if interventions have made a difference. Michael Holland said that an annual mortality audit is undertaken and has been for three years. He will bring that to the Board. Some of the learning is from natural deaths, not just unnatural deaths, and SLaM looks at all deaths which goes beyond the requirements of the current guidance.

Beverley Murphy reminded the Board that the long-term aim of the physical healthcare strategy is for the mortality of people who use SLaM’s services not being different to the general population. The Physical Health Committee is therefore linking up to the Mortality Committee as learning from one sets conditions for the delivery of the other.

Geraldine Strathdee noted that this paper had also gone to Quality Committee where it had been well received. She wondered whether the Royal College of Psychiatrists has indicated its intention to change the terminology from “natural” deaths to, say, “physical” deaths. Michael Holland said that the new guidance was due for publication on 23 May and that they would know then.

Kristin Dominy expressed concern at data showing adolescents dying from natural causes. Michael Holland explained that this relates to a specialist neurodevelopmental service where it is natural to see young deaths.

Kristin Dominy sought assurance that where the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) rating is below satisfactory, action is being taken to address that. Michael Holland explained that these cases are fed into the Trust’s Serious Incident processes.

**BOD 84/18 LESSONS LEARNED Q4 (15.43)**

Amanda Pithouse, Deputy Director of Nursing, presented this item.

During this period there have been no new themes of risks or incidents identified, however four Blue Light Bulletins were disseminated across services in response to learning including reports of an increase in self-harm by ingestion.

Complaints in Q4 highlighted concerns from service users that they do not always find it clear how to make a complaint; the PEDIC survey also showed that 30% of service users didn’t know. Working with service users, all PALS (Patient and Liaison Services) information has been updated to address this and improved PEDIC scores should demonstrate whether these actions have had an effect. Roger Paffard asked that progress is reported in the next quarterly report.

The Trust has commissioned an expert in human factors and patient safety to provide a detailed analysis of lessons learned from a sample of 150 incidents. This is due for completion in June.
Gus Heafield referred to the part of the report which points to 25 serious incident investigations submitted to commissioners in Q4, and the 86 actions arising from them. How is the Board sighted on progress on those actions and assured that they are local issues and not more widespread? Amanda Pithouse explained that they tend to be recommendations which show that there needs to be more process / protocol on a specific team. The Trust and the commissioners track actions through the learning review group. Beverley Murphy added that a lot of the learning is about getting into the habit of asking why existing protocols and processes are not understood or adhered to. Without drilling down, the root cause won't be found and addressed.

Mike Franklin asked about the amount of time it takes to resolve a complaint; as demonstrated by the presentation received earlier, making a complaint can be a source of great distress. Amanda Pithouse explained that this data is usually included in the report, and that it will be in the next one.

Beverley Murphy reported that, in relation to the completion of risk assessments and care plans, this is clearly a concern as demonstrated through complaints data, serious incidents, MHA inspections and CQC reports. There is too great a variation across the Trust in terms of compliance and quality. Teams that routinely complete high-quality risk assessments and care plans have good service user involvement. A new risk assessment audit tool has been introduced and there has been consistent improvement in some areas e.g. CAMHS since October. Quality standards are considered with Service and Clinical Directors on a monthly basis. Every service user has a right to an up-to-date to date risk assessment that they have been involved in.

**BOD 85/18 QUALITY PRIORITIES – MEASUREMENT (15.54)**

Beverley Murphy presented this item and a supporting paper was tabled. At its last meeting, the Board had approved the direction of travel of the Quality Priorities for 2018-19, but delegated responsibility to agree metrics for measurement to a smaller group. Beverley Murphy, Michael Holland, Anna Walker, Geraldine Strathdee, Martin Black and Mary O'Donovan (Head of Quality) have subsequently met and discussed what indicators would track and measure the delivery of the priorities. She added that she and Anna Walker had discussed separately whether to track bed occupancy and out of area placements under the “Right Care, Right Time” priority; they agreed that because these are already tracked elsewhere, they won’t be included but will be reported on monthly in the performance report.

Beverley Murphy sought approval of the metrics for inclusion in the Quality Report.

Mike Franklin queried why the aspiration would be to reduce restraint over three years, and not one or even less, especially prone restraint.

Geraldine Strathdee stressed that it is not intended for the reduction to be incremental, but that a realistic target is set. Quality Committee has seen that some teams / directorates can achieve this very quickly. Beverley Murphy concurred, adding that the Four Steps to Safety initiative is showing results but for some it will take some time.

Matthew Patrick raised a question about whether a reduction to 0% is realistic for prone restraint in the absence of a reduction in overall restraints to zero, although the ambition is clearly the right one. Beverley Murphy reported an additional piece of national work that is ongoing and looking at the definitions for restraint, but before
that is completed it is up to the Trust to self-define. She would be feel uncomfortable setting a target for prone restraint which tolerates more than 0%.

Matthew Patrick queried whether it makes more sense to have a target of no restraint of any type; Michael Holland felt that this would not be well-received by staff who would lose confidence. Beverley Murphy added that it will involve a lot of change and staff have to feel supported in achieving it. Additional training and reduced bed occupancy will assist.

Roger Paffard suggested that the phrasing of the Quality Priority is clear that the Trust aspires to no prone restraint in the fastest time possible.

Duncan Hames welcomed the effort to secure baseline data for some of the new indicators but noted that some baselines and targets have still not been set according to the paper. Beverley Murphy explained that some Priorities e.g. reduction in the time from referral to assessment, will have different targets in different services and therefore could not be quantified succinctly in this document. Some e.g. service user and carer involvement, need more work to develop reliable metrics, including working with service users and carers. Once developed, they will be reported on and tracked at the Quality Committee.

The Board approved the metrics for the new Quality Priorities.

**BOD 86/18 PHYSICAL HEALTHCARE & HEALTHY LIFESTYLE STRATEGY (16.13)**

In February, the Board approved the Physical Healthcare Strategy, and in April it approved the implementation plan. There was, however, a lack of enthusiasm from the Board about how the plan would be communicated to staff and patients in terms of its benefits. A very clear one-page information sheet setting out the Trust’s immediate commitments regarding physical health care to people who use its services was requested, and this was presented to the meeting.

It was agreed that this summary met the brief given.

It was queried how the Trust will measure the activity and its impact on physical healthcare, as well as how the performance will be reported; Beverley Murphy explained that impact has been measured as part of the Trust’s CQUIN for quite a while (Commissioning for Quality and Innovation; a system designed make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of care). However, the long-term ambition of the strategy (to reduce premature mortality of people who use SLaM’s services) will take some years to achieve but will be tracked very closely.

**BOD 87/18 LAMBETH LIVING WELL NETWORK ALLIANCE (16.17)**

Neil Robertson, Managing Director of the Lambeth Living Well Network Alliance, and Andy Bell, Director of Finance presented this item.

The Board’s attention was drawn to the appendix of the paper provided, which showed the outcomes of the most up-to-date red lines assessment. The appendices also included Integrated Support and Assurance Process (ISAP) documentation that the Board must approve / self-certify before submission. This consisted of a Board statement, a response to the ISAP statement and a corporate governance statement.
Alan Downey felt that the report did not clearly set out who is “in charge” of the Lambeth Alliance. Neil Robertson explained that, as Interim Managing Director, he is responsible for delivery of the transformation and to lead the Alliance management team. He reports to the Alliance Board, setting the agenda with the independent Alliance Chair.

June Mulroy noted that the term of the Alliance is articulated as seven + three years, whereas it had previously been referred to as a ten-year term. Andy Bell explained that it had always been a seven + three-year term but had possibly not been expressed well.

June Mulroy also queried the exit strategy for the Alliance; Andy Bell explained that an exit strategy has been explored at length by NHS Improvement and NHS England as part of the checkpoint process. If there are significant challenges, there are a number of things that can happen. There is an escalation process, but ultimately SLaM can revert to its standard NHS contract. The CCG and the regulator can also trigger an exit if certain criteria in the escalation process are met.

Matthew Patrick asked where in the Alliance the risk lies should there be a demographic shift i.e. meeting the Mental Health Investment Standard (MHIS) and resourcing over time should demand change. Andy Bell explained that these concerns have been raised and a form of words has been agreed as follows:

“The contract will be adjusted as agreed as applicable to take account of any national settlements for Mental Health (including but not limited to the Mental Health Investment Standard). The CCG has a commitment to meeting the Mental Health Investment Standard across Mental Health services in Lambeth for as long as it is applicable nationally. This may be subject to change should the financial position of the CCG deteriorate such that this is no longer sustainable, but this would be subject to Governing Body approval and agreement with the relevant regulators. The CCG will undertake an annual review of the contract once the Planning Guidance/Operating Framework is released to ensure any changes to national settlements are applied. This will form part of the ongoing management of the Alliance contract between the alliance partners.”

There is a commitment that the commissioners will meet the MHIS for as long as it exists alongside any other annual changes as per the national framework for planning. Kristin Dominy added that it is built into the agreement that where there are population changes, this will trigger a contract re-opening discussion across the board.

Roger Paffard noted an assumption that the bed base that supports Lambeth will reduce in the medium-term and queried whether that is realistic in the current climate of excess bed usage and occupancy; Kristin Dominy thought that keeping people well in the community for longer is a good ambition, but that whether it can be achieved in the timescale is still up for debate. Neil Robertson added that a reduction is predicated on safe alternatives to admission and that all partners are agreed that a reduction in beds will only proceed if those are in place. A reduction was always expected, even under a standard contract agreement.

Geraldine Strathdee asked about the availability of information that shows why those currently using beds have been detained and why they may be relapsing. Neil Robertson felt that with borough-based business units, that sort of deep dive for information can be undertaken and the learning taken from it, also helping to better understand and address delayed discharges.
Roger Paffard reflected on a conversation at Business Development and Investment Committee about not triggering reductions in beds until there is 85% occupancy; approval may be conditional on that. Kristin Dominy said that partners are very clear that SLaM will not agree to do anything unsafe.

The Board gave its approval to a letter from the Chair to state that “the Board is satisfied that there is clear accountability for quality of care throughout The Living Well Network Alliance in Lambeth including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the South London and Maudsley Board where appropriate.”

The Board agreed that the ISAP domain requirements have been met.

The Board approved the corporate governance statement.

It was noted that SLaM is engaged in a high level due diligence process with RSM Tenon on behalf of Lambeth CCG. Whilst this is useful, it is not required by ISAP self-certification process.

Matthew Patrick thanked everyone involved in this robust process. There is a lot invested in this strategically, and it has been well done. Kristin Dominy added that the Alliance is new and innovative and it is a good opportunity to showcase something different and for the good of the population.

**BOD 88/18 CHIEF EXECUTIVE’S REPORT (16.40)**

Matthew Patrick reflected on recent Leadership Walkarounds, where he had been delighted to see some freshly decorated estates. He did, however, want to ensure that redecoration does not mean that the therapeutic benefits of artwork in clinical areas were lost. He pointed to the mural created by local artists at the Tony Hillis Unit at Lambeth, which is energising and inspiring, and restores a sense of humanity to clinical environments.

The Chief Executive stressed the importance of communication during the current reorganisation of the Trust from a Clinical Academic Group (CAG) to a matrix of CAG and borough structure. Leaders within the Trust must be visible, listening to staff and sharing information. Getting full teams in place is a priority. As mentioned earlier in the meeting by Robert Harland, moving to a borough structure will make interface issues feel more manageable.

Matthew Patrick alerted the Board to his role on a steering committee for the Royal Foundation which is working on an initiative spearheaded by the Duchess of Cambridge. The next six to nine months will be spent on shaping what its programme of work should focus on, but it will fit in with SLaM’s ambitions around children and young people.

**BOD 89/18 COUNCIL OF GOVERNORS’ UPDATE (16.46)**

Lead Governor Jenny Cobley thanked all the Non-Executive Directors and Executive Directors who take the time to attend Governor working groups, and Beverley Murphy was thanked in particular. There have been some excellent meetings in the last month. Thanks were also extended to Alan Downey for his service.
Jenny Cobley was encouraged by the earlier discussion regarding workforce issues as Governors are currently concerned about staff morale.

Governors also have reservations about the slow take-up by GPs to join the Lambeth Alliance, and by GP training in the field of mental health more generally. They are usually the first point of call for people feeling unwell and Governors fear that they do not have sufficient understanding of mental health issues.

As part of their lobbying activity, a group of Governors met Neil Coyle MP (Bermondsey and Old Southwark) the previous week, and he offered his support. Another group are due to meet Sarah Jones MP (Croydon Central). A meeting has also been set up with Lewisham CCG.

**BOD 90/18 MENTAL HEALTH LAW COMMITTEE MAY UPDATE (16.48)**

Beverley Murphy told that Board that the Committee is developing a strategy to ensure that the Trust is delivering to CQC regulations and legal requirements in respect of compliance with mental health law compliance. Attendance by carer governors to agree an action plan has been very helpful. A human rights approach is being adopted.

There have been a number of meetings outside the Committee to develop a dashboard to assist the monitoring of compliance and to better understand where there are delays in the system, how people can be supported and where breaches may occur. This will also increase understanding of the reasons why people are detained under the Mental Health Act.

Duncan Hames expressed concern about the volume of Mental Health Act Assessments being cancelled and the reasons for them, including the availability of beds. Beverley Murphy explained that those concerns are shared, and that a multi-agency meeting the previous week had looked closely at cancellations with a view to unblocking the system. The Approved Medical Practitioners (AMPs), who approve detentions under the Act, have been commissioned to prepare a policy. It is anticipated that a move to 85% bed occupancy will assist with rapid access to beds, but it has been stressed that assessments should not be cancelled owing to bed pressures; if someone needs a bed then the Trust will find one.

**BOD 91/18 PERFORMANCE AND FINANCE REPORT (16.54)**

On the Finance side, Gus Heafield reported that there have been some pressures in Month 1, mainly relating to use of overspill beds, and work is underway to map the trajectory and potential financial implications.

The Annual Accounts are almost ready to be signed off by the Auditors and have been approved by the Audit Committee (with delegated authority from the Board), with any minor changes to be agreed between the CFO and auditors and anything more significant to be agreed by Chair of the Audit Committee.

**BOD 92/18 WRAP UP, NEXT MEETING DATE**

The Board welcomed a deep dive into BAF Risk 2 (Estates) at the next meeting, which will be held at the Bethlem Royal Hospital.
BOD 93/18 MEETING EVALUATION 16.58

This item had not been prepared for and was therefore not taken.

The date of the next meeting will be:
19 June 2018, 14.30 – 17.00, Boardroom, Museum of the Mind, Bethlem Hospital

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)
REPORT TO THE TRUST BOARD: PUBLIC
22 May 2018
Note: this paper was tabled at the meeting and added to the online Board pack retrospectively

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<tbody>
<tr>
<td>Author</td>
<td>Beverley Murphy, Director of Nursing</td>
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<td>Responsible Director</td>
<td>Beverley Murphy, Director of Nursing</td>
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Purpose of the report
To consider and approve the Quality Priority indicators being measured across 2018 – 19.

Executive summary
The Board received and approved a draft of the Quality Report 2018 at the April 2018 Board meeting. Approval was given, pending a more detailed review of how the indicators selected for 2018–2019 would be measured. That review was undertaken on 15 May 2018, between:
- Beverley Murphy: Director of Nursing
- Dr Michael Holland: Medical Director
- Anna Walker: Non-Executive Director and Chair of the Quality Committee
- Dr Geraldine Strathdee: Non-Executive Director and Chair of the Mental Health Law Committee
- Mary O’Donovan: Head of Quality
- Martin Black: Quality Improvement Team

The table sets out the agreed Quality Priorities, the indicators for each priority and the summary detail about the source of the data and baselines.

The Board is asked to consider and approve the indicators for measurement.

Risks and issues for escalation
Quality Priorities
The table will finalise the measures for all Quality Priorities 2018-19.

Board Assurance Framework
BAF 1 high quality staffing;
BAF 2 operational structures and care pathways;
BAF 3 informatics as an enabler;
BAF 5 listening to service users;
BAF 7 improving quality;
BAF 11 impact and embedding of Quality Improvement;
BAF 13 well trained staff.

No new risks or issues have been identified for escalation.
A meeting was convened to discuss the indicators and the data sources. It was attended by Anna Walker, Dr Geraldine Strathdee, Dr Michael Holland, Martin Black, Mary O’Donovan and Beverley Murphy.

<table>
<thead>
<tr>
<th>Committees where this item has been considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>15 May 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reducing Violence by 50% over 3 years</th>
<th>Services Applicable to</th>
<th>NHSI Indicator</th>
<th>Baseline and Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Violence by 50% over 3 years</td>
<td>All clinical Pathways</td>
<td>Patient Safety &amp; Patient Experience</td>
<td>Measure all incidents of violence and aggression. Baseline 2017/18: 4158 Source: DATIX Monitoring frequency: monthly</td>
</tr>
<tr>
<td>Reduction in restraint by 50% in over 3 years</td>
<td>All clinical pathways</td>
<td>Patient Safety &amp; Patient Experience</td>
<td>Measure all incidences of restraint. Baseline 2017/18: 1716 Source: DATIX Monitoring frequency: monthly</td>
</tr>
<tr>
<td>Reduction in the use of rapid tranquillisation in 3 years</td>
<td>All clinical pathways</td>
<td>Patient Safety &amp; Patient Experience</td>
<td>Measure all incidents of Rapid Tranquilisation Baseline 2017/18: 840 Source: DATIX Monitoring frequency: monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Right Care, Right time in appropriate setting</th>
<th>Services Applicable to</th>
<th>NHSI Indicator</th>
<th>Definition of Measure, Baseline and Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in the amount of time waiting from referral to first assessment.</td>
<td>Community</td>
<td>Clinical Effectiveness</td>
<td>Measure the amount of time from referral to first appointment across all community settings. Baseline: will be established in Q1. Source: Trust Dashboard (SQL feed) Monitoring frequency: monthly</td>
</tr>
</tbody>
</table>
| **Reduction in crisis readmissions** | Trustwide | Clinical Effectiveness | Measure the number of Readmissions within 30 days of discharge.  
Baseline: 2017/18: 311  
Source: BI Production Cube  
Monitoring frequency: monthly |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service User and Carers Involvement</strong></td>
<td>Services Applicable to</td>
<td>NHSI Indicator</td>
<td>Definition of Measure, Baseline and Data Source</td>
</tr>
</tbody>
</table>
| **Increase number of identified carers/friends/family for person in receipt of care.** | Trustwide | Patient experience | Measure the numbers of identified carers / friends / family  
Baseline: Reliable measure being developed Q1  
Source: TBC  
Monitoring frequency: monthly |
| **Increase in the number of care plans over the next three years that have been devised collaboratively with the service user and that the contents have been shared with them.** | Inpatient first year. To include Community Services second year once new care plan rolled out | Clinical Effectiveness /Patient Experience | Measure the number of care plans that have been devised collaboratively with the service user and that the contents have been shared with them.  
Baseline: 54.3%  
Source: SNAP audit  
Monitoring frequency: Monthly |
| **Increase the number of positive responses to 90% over the next three years regarding patients recommending the service to friends and family if they needed similar care or treatment?** | Trustwide | Patient experience | Measure the number of positive responses over the next three years regarding patients recommending the service to friends and family if they needed similar care or treatment?  
Baseline: 2017/18- 85%  
Source: Friends and Family Test; National Indicator for patient experience  
Monitoring frequency: Monthly |
| **Staff Experience** | Services Applicable | NHSI Indicator | Definition of Measure, Baseline and Data Source |
| Reduce turnover of staff by 10% in a rolling year over next 3 years | Trustwide | Staff Experience | To measure the turnover of staff in a rolling year  
Baseline: 18.6% (Rolling Year) March 2018  
Source: HR Monthly report  
Monitoring frequency: Monthly |
| Increase the number of positive responses to 75% over the next three years of the number of staff SLaM would recommend as a place to work | Trustwide | Staff Experience | To measure the number of staff who positively to recommending SLaM as a place to work.  
Baseline: 60%  
Source: Staff annual survey  
Monitoring frequency: Quarterly Staff Friends and Family Test |
## Public Board meeting 19 June 2018 – 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>
</tr>
</thead>
<tbody>
<tr>
<td>40/18</td>
<td>Staff Survey 2017 Summary Report</td>
<td>Update on the conclusions drawn from the 2017 Staff Survey, suggestions for improvement and target aspirations to return to a future Board meeting.</td>
<td>SS</td>
<td>July 18</td>
<td>Not yet due</td>
<td></td>
</tr>
</tbody>
</table>

Key:
- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule
Mr RB is a service user in Croydon. He has experienced periods of mental health problems for many years. In 2012 he was referred to Croydon Older Adults Community mental health team (CMHT). He was under the care of Dr G between 2012 and 2017. During this time there was excellent treatment from Heavers CMHT. The family was well looked after and offered family counselling. This helped. The community psychiatric nurse (CPN) would drop in and make sure all was well, or phone and check on RB. This reassured the family.

In early February 2017 RB was referred to St George’s Hospital for ear surgery and was taken off lithium in the hospital. RB and his wife believe that this was the start of a period of bad mental health including what they now refer to as a breakdown.

RB also had other physical health problems during his hospital admission and has been struggling to eat since then. There were some problems with the dosing of his lithium which might have contributed to him losing weight in hospital - from 90kg to 75kg.

RB was subsequently referred back to Croydon University Hospital and was re-integrated with the mental health system. At some point in this process, RB was discharged from the Croydon CMHT service but the discharge letter never reached RB or his general practitioner (GP). It appeared to have been sent to the wrong doctor, so the family were unaware that RB was discharged.

On February 16th, 2018, RB felt mentally unwell; his wife was out of the house. He phoned Croydon CMHT and duty staff stated that he was discharged and his records archived. He could only return to the service via a GP referral. He was extremely distressed by this situation and by the apparent lack of signposting to any other service, except to say that he had to go back to GP for re-referral into the service. The following week he went to the GP and was referred back to Dr G. It took a further ten weeks before RB had an appointment with Dr G. Dr G stated that due to cutbacks the service was not allowed keep people on file. RB and his wife had to fill in all the forms again to be referred back to the service. Since then CMHT are involved and are giving great re-assurance which is appreciated. The nurse (G) is now monitoring RB including medication as it needs to stay within a recommended level.

RB is concerned that the service is not seeing the whole person. He thinks physical and mental health services have to join up and be appreciative of the whole person and all the stresses they are experiencing. There were no questions from Croydon CMHT about physical health issues, weight loss, and no acknowledgement that RB has skin cancer or referral to any cancer support or counselling agencies. Also, MB, who is the wife of RB, was never offered support as a carer, a meeting alone, a carers’ assessment, or a Carers Engagement and Support Plan. They were not asked what they thought of the service they were receiving from SLaM. At no point do they remember being given a form to give their views on their experiences of the service, Patient Experience Data Information Centre (PEDIC).
What we did well

RB and his family received excellent care from Croydon CMHT between 2012-2017. The nurse knew them and checked up on them regularly.

The counselling and support they got during that time was very helpful to the family.

RB joined the MHOAD service user clinical academic group (SUCAG) in Autumn 2016. This was recommended as he was finding it difficult to motivate himself to get out of the house. This was helpful to him as it gave him a broader understanding of the South London and Maudsley (SLaM).

Once the referral was received and accepted on the 17th April, Mr RB was seen quickly having an appointment with Nurse G on 1st May and by Dr G on the 14th May.

Since RB has been referred and accepted back into the service things are going well and he and his family feel re-assured and supported by the service. They are glad to have the support of nurse G.

What we did not do well

The patient was discharged from the service without any discharge planning or informing him. The GP letter was sent to the correct practice but not the GP Mr RB usually sees.

RB was unable to self-refer in early February 2018 or be accepted back immediately. The referral process meant he wasn’t seen for 10 weeks after making contact first of all.

The Discharge Plan should have been considered within the multidisciplinary team in the presence of the link psychologist as the psychologist was actively involved with the family especially RB and MB.

At no time was Mrs MB offered a carers assessment or Carers Engagement and Support Plan (CESP).

At no point was the family offered a patient experience form (PEDIC) to say what they thought of the service.

What we will do now

The Operational Policy has been refreshed and provides explicit guidance on the management of self-referrals. This has been shared and emphasised with the team. The Team Manager has also emphasised the need to discuss all referrals with the Duty Senior Clinican.

All discharges will be planned with service users and their families/carers. They will be sent a copy of the discharge letter. The letter will go to the GP referring the patient.

Ensure that Carers Engagement and Support Plans are understood by all practitioners and they are offered to carers/relatives who are in a caring role. Nurse G has now offered this to Mr B’s wife.

The Directorate lead for carers will deliver a session to the team regarding the engagement and support plan and there is a group planning how to improve support to carers across the service.

Know and refer to local support agencies such as in this instance – Croydon Carers. A library of resources is being developed as part of the working group regarding carers support.

Always give service users an opportunity to comment confidentially on the services they are receiving. (PEDIC)

Care Coordinators have been reminded of responsibilities and will be included in appraisal objectives.

For outpatients, the receptionist is passing out paper questionnaires and will also have the tablet at the desk for online submissions.

The Team Manager is providing individual feedback to the clinicians involved and the Service Manager is facilitating a learning session to the whole team on the 15th June.
Purpose of the paper

This paper is a regular update on the QI work with a focus on evaluation and Return on Investment (ROI).

The Board is invited to note the updates and discuss and agree the approach presented here for ROI for the QI work across the Trust. In particular, to –
- Endorse the first 4 outcomes for ROI in Section 6 (page 5-6);
- Agree that the next 4 outcomes for ROI in Section 6 (page 5-6) are the correct priority; and
- Help the QI team consider how we balance the tension of reactive and proactive work.

Executive summary

The QI team has continued to focus its efforts on enabling leaders/managers and teams to progress the quality improvements in their local areas and across the Trust. It has also supported Oxleas NHS Foundation Trust in its development and delivery of its first foundation QI skills development. The development of six operational directorates provides an opportunity to improve the focus of QI work and ensure that there is more robust governance in place. The team has used an a widely adopted evaluation framework to assess the outcomes of QI at four levels. The evaluation to date is presented here along with an approach to ROI.

The paper describes:
1. Changes to the QI team
2. The SMT leadership walkarounds
3. Icare- Inpatient care process model development and development and update on community improvements phase one- gaining insight
4. Inpatient and community safety QI- review of 4 steps and progress with community safety
5. Changes being tested in QI training
6. Return on investment (ROI)

Risks / issues for escalation

Relates to all BAF risks, but in particular to Risk 11 - There is a risk that the significant time, resource and money that the trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.
1. Changes in the QI team

The QI team is working more closely with Slam partners, specifically with evaluation, team development, coaching and leadership development. We have a new statistician in post who is supporting the development of measurement tools for evaluation of QI, dashboard development and research.

2. SMT walk arounds

SMT have now carried out a total of 74 Leadership walkarounds since 15th January 2018. This has been to a variety of clinical and non-clinical teams across the Trust. There has been a significant increase in April and May with multiple teams being visited in sites which hold several different teams.

Themes so far continue to show that majority of concerns raised are around environment, such as patient, staff and communal areas, and IT which was similar to last year. There is a bigger focus on security of people and buildings, such as no lighting and poor visibility at entrances and unsecured windows. In relation to IT, the themes coming through relate to broken equipment and not having the right equipment i.e. for mobile working. A schedule for replacement of IT equipment is being rolled out and the schedule will be regularly updated and communicated to teams.

Feedback from current participants is positive with staff reporting that they felt able to speak openly and honestly and believing that their safety concerns were being taken seriously and any actions would be carried through.

![Number of Walkarounds - Weekly](image-url)
3. Improving care and outcomes (I-Care) in general adult services

I-Care

This work focuses on the improvement work across general adult inpatient and community services. After a bumpy start in May 2017, the work has progressed in the autumn with acute wards, the aim being to provide the highest quality care in adult mental health services so that care is received in the right place at the right time and that the service is sustainably run. The outcome measures are:

- **10% Reduction in admissions**
- **35% reduction in length of stay (LOS)**
- **50% reduction in violent incidents**

To improve flow, the discharge co-ordination form to reduce delayed discharges tested in Lambeth is being extended to Southwark and Croydon and a flow tool (Red2Green bed days) test will start this month (one ward in each borough). We are co-producing an inpatient operational care process model (OCPM) so that there are clear goals for a patients’ admission and the same quality of assessment, treatment and care is provided in all wards. This includes patients following the most appropriate clinical care pathway to meet their needs. This will be tested in a borough in early July 2018 before scaling up and spreading.

**Progress**

The Trust is not yet showing improvements in the outcome measures for LOS and in admissions (see appendix one)

For improvements in safety please see section 4

**Community I-Care (crisis care and staying well at home)**

We are currently in the “diagnostic phase” gathering data on the population, Trust activity data from previous work with PPI leads and clinical teams and considering local contexts and developments. We have facilitated three engagement events involving staff, service users, carers and partners over the last three months. On July 13th we will feedback the data and involve a large group to agree next steps. It is likely that we will develop an I-Care network so that each borough can improve and develop services within their local contexts using agreed developed standards for access, assessment, treatment and ongoing support. We will at this event develop the improvement aim and outcome measures.
4. Trust wide violence reduction QI: 4 Steps to safety for inpatient and community services

The 4 Steps to Safety Programme was implemented in January 2016 and within a two-year time span, the QI team have been supporting inpatient teams across the trust with their improvement to reduce violence and aggression. The QI team facilitated an inpatient review across each CAG from January 2018 to April 2018 involving service leads, staff and service users to understand what is working well and what is not. The findings from the review were presented and discussed at an Inpatient Safety Learning event on May 25th, 2018. There has been reduction in violence on some wards as shown in Appendix 2.

Wards in boroughs with the highest violence and aggression will be supported by the QI team to implement interventions on the 4 steps and will be encouraged to develop other change ideas. Modern Matrons within adult services are also working in collaboration with the QI team by supporting 11 wards to progress the implementation of 4 Steps. The QI team have had discussions with the Modern Matron in CAMHS to gain their support as well as BDP senior leads, MHOA and PMIC.

Improving safety in the community

A review of Datix found that approximately 30 reports of violence and aggression by patients in community settings were reported per month in 2017, with CMHT receptions areas highlighted as a flashpoint for aggression. Eight staff events were held across Croydon, Lewisham, Lambeth and Southwark in February and March. Twenty-five people attended from a range of professional groups. The QI Team also attended MHOA, PMIC and Psychosis service user and carer groups.

The following themes were identified as being important in reducing the likelihood of incidents:

- Good relationships with service users and carers
- Smaller teams with shared knowledge of caseloads
- Thorough risk assessments
- A consistently implemented lone-working policy
- Patient-centred care planning

Areas that were highlighted as problematic included:

- Under-reporting on Datix
- Managing increasingly unwell patients in the community due to lack of beds
- Delays and the reception area environment
- Staff misinterpreting patient anxiety/fear as aggression
- Means of effectively accessing support when required
- Inconsistent responses when incidents do occur

Change ideas being tested from June 2018: safer reception environments, Sky Guard personal alarms, simulation training and developing clear agreements/expectations (compact).

5. Changes being tested in QI training

The QI team have agreed a different method of supporting operational directorates and corporate services to focus their QI efforts (see appendix Three). This is being tested to provide more robust governance and oversight of QI ideas and projects.

The QI team are testing a modified method for delivering foundation training through two methods:
1. a learning collaborative model to support specific QI initiatives e.g. working with Lambeth and Croydon community teams to improve care plans.

2. 4 half day learning sessions over 4 weeks so that teams have the opportunity to put learning into practice in-between session. Two cohorts of 30 people will be tested in September 2018.

We are also planning to test the use of QI surgeries in the local boroughs from the end of June 2018. The purpose of these will be to provide timely help for people for people to explore potential QI ideas and support people during their QI work.

We are in the process of training more QI coaches who are people in services who will have a role to support local teams in their QI work and we have people learning together from SLaM, OXLEAS and Southwark LCN.

6. Return on investment (ROI)

This section will define ROI in quality improvement and provide an example of ROI for reduction in violence. It will also highlight challenges/risks and make recommendations for next steps. Through speaking with peers at other Trusts and the IHI, measuring ROI for QI in a systematic way is largely unchartered territory. The financial values represent a range of possible outcomes and theoretical ‘top end’ financial envelopes. Due to the fundamental nature of the improvements being explored there will be multiple factors and dependencies that will impact the opportunity and scale of any financial benefit realisation. Our approach therefore is to define ROI for SLaM, evaluate QI outcomes at four levels using the widely adopted Kirkpatrick model for evaluation and measure ROI for the investment in QI starting with 4 measures that are easily accessible and focus on cost avoidance and cost improvement.

1. 50% Reduction in violence and aggression across the trust for inpatient services (value £117k pa)
2. Icare QI initiative: potential 35% Reduction of LOS for acute inpatients, nil overspill (saving £2.4 m for sustained no overspill and potentially further value over 3 years on reduced LOS)
3. Reduction of wait time for assessment in community proxy measure 10% reduction in admission (potential value of £280,000 pa on reduced admissions per year)
4. Increase in staff retention by reducing staff turnover by 1% (saving minimum of £113,000 pa on reduced agency usage)

We intend to extend these measures before the end of 2018 to:

5. Reduction in violence and aggression across the trust for community services
6. Icare QI initiative: reduction of wait time for treatment in community
7. Increase in patient satisfaction
8. Decrease in staff sickness

(NB we need to agree with the board if 5-8 are the correct next set of measures)

ROI for quality improvement in SLaM is defined as:

measuring the extent to which the investment in QI has contributed to the trust achieving its strategic objectives to improve the lives of people and the communities we serve,. This means improving safety, patient satisfaction and outcomes, staff satisfaction, reducing unwarranted variation and waste and having balanced budgets.
## Actual costs of QI in SLaM from April 2016- end of March 2018

<table>
<thead>
<tr>
<th>Actual costs</th>
<th>2016-2017</th>
<th>2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central QI team for SLaM (pay)</td>
<td>385,2056</td>
<td>515,449</td>
</tr>
<tr>
<td>Additional funding agreed with board e.g. for service user involvement</td>
<td></td>
<td>77,000</td>
</tr>
<tr>
<td>IHI</td>
<td>363,545</td>
<td>462061</td>
</tr>
<tr>
<td>Total</td>
<td>748,601</td>
<td>1,054,510</td>
</tr>
</tbody>
</table>


## Evaluation of QI July 2016 - end of March 2018* note most activity started in January 2017

<table>
<thead>
<tr>
<th>Kirkpatrick level</th>
<th>evaluation description and characteristics</th>
<th>Activity</th>
<th>Outcomes</th>
<th>Improvements to make in evaluation methods from July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 reaction</td>
<td>how people felt about QI learning experience</td>
<td>QI training (leadership, Introductory level Foundation level,</td>
<td>Feedback from evaluations overwhelmingly positive with score 95%, scoring 4 or 5/5 for experience and learning</td>
<td>Improved recording of outcomes on workplan</td>
</tr>
<tr>
<td>2 learning</td>
<td>the measurement of the increase in knowledge</td>
<td>Leadership walkarounds 224 QI projects started, and 780 members of staff and service users attended introductory or foundation level courses Intermediate level training (QI coach) for 12 with a further 20 in training Trained QI experts in coaching Data for improvement training</td>
<td>- No clear recording in 2017 - 2018 78 leadership safety and quality walkarounds 107 current projects linked to quality priorities (see chart). Local - Process improvements in risk assessments, care planning, engagement, reducing delayed discharges, improving patient &amp; staff satisfaction - Work documented on Life QI QI coaches trained are supporting a minimum 2 team per week Supervising /supporting QI coaches demonstrated in work Business managers using in practice</td>
<td>Need to improve structure and process for sharing learning Improve method of data collection</td>
</tr>
<tr>
<td>3 behaviour</td>
<td>the extent of applied learning back on the job</td>
<td>- Teams being coached demonstrate understanding of use of data and improvement science tools in their team - Teams Demonstrating use of tools in practice through improvement projects</td>
<td>Teams change in behaviour to use intervention examples of 4 steps to safety, increase in access to smoking cessation clinics Development of team and Trust dashboards Presentations, learning shared from successes and failures</td>
<td>QI team note all dates for QI coaching we need to collate this to measure impact Better recording and method of shared learning will be put in place by September 2018</td>
</tr>
<tr>
<td>4 results</td>
<td>The effect on the business or environment</td>
<td>Safety reduce violence by 50%, Icare reduce LOS by 35%, Nil overspill X% reduction in wait time for assessment in community</td>
<td>Showing an improvement in violence and cost reduction (see charts below under violence reduction example)</td>
<td>Need to improve routine collation of data and find a method of transferring data from Life QI</td>
</tr>
</tbody>
</table>
Example: ROI with QI work in violence and aggression

We have used data from the Flood and Bowers work (2008) which calculates the cost of violence and aggression incidents and data from Finance and ESR to calculate the change in costs and days before QI commenced and afterwards for six wards showing a reduction in violence and aggression (see appendix Four for detail). We cannot state a causal link between 4 steps and the improvements. The data shows that at the time of violence reduction, staff sickness reduced on 5/6 wards and agency spend reduced on 3/6 wards.

<table>
<thead>
<tr>
<th>Total for Six wards</th>
<th>6 months pre-shift</th>
<th>6 months post-shift</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of incidents</td>
<td>£23,605.08</td>
<td>£10,639.89</td>
<td>-54.93%</td>
</tr>
<tr>
<td></td>
<td>Range between £2005.57-£6267.52</td>
<td>Range between £842.29-£4155.48</td>
<td></td>
</tr>
<tr>
<td>Total calendar days lost to sickness</td>
<td>1880 days Range between 119-552</td>
<td>1442 days Range between 44-581</td>
<td>-23.30%</td>
</tr>
<tr>
<td>Agency spend</td>
<td>£159,015.49</td>
<td>£104,3053</td>
<td>-34.41%</td>
</tr>
<tr>
<td></td>
<td>Range between £1,500.96-£80,046.47</td>
<td>Range between £578.19-£67,021.12</td>
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</tbody>
</table>

The next step is to develop a framework that enables us to routinely report on the other measures at team borough and directorate and trust level.

Challenges and Risks

As highlighted earlier measuring ROI for QI is complex. The development of the Trust dashboard will provide more timely data to enable teams to measure changes in some metrics. Inevitably there are of challenges and risks:

- **Engagement**: Where there is clinical leadership involvement and presence team are more likely to engage and be supported to follow through. Conversely where there is poor or absent clinical leadership Qi projects have failed to progress
- **Learning**: Within the pressurised environment people need time to learn and we need to develop a more robust methodology to share learning across services
- **Pace**: cultural change requires time and a tension between delivering with speed, demonstrating improvements in outcomes and measures for ROI for the Trust The risk of not doing this soon is that we may disengage key stakeholders
- **Time**: staff need time within their working week to do QI. This is variable and has created delays for some QI projects which then potentially reduces the ROI. The risk is that we do not follow through on some projects and lose the learning.
- **Data for improvement**: this links with pace and time to have up and running the Trust dashboard from board to team so that data is readily available and reliable
- **Expertise** required to support the QI team to develop clear framework/model for assessing and reporting on ROI for each QI initiative from team level upwards. This would help us be realistic about the length of time it takes to generate a return on investment for different improvements.
- **Focus for** the central QI. The first two years have been focussed on building the will and letting “a thousand flowers bloom”. We now need to take a more focussed approach. There is a risk that we
disengage staff who want to undertake QI projects that may not be perceived as a priority. The QI team is working to maintain a balance of proactive and reactive work.

The new structure of operational directorates and the quality management centre provides an opportunity to manage these challenges and risks more robustly through the governance functions and structures.

Recommendations

The board

- Agree/ endorse the first 4 outcomes for ROI in Section 6 (page 5-6)
- Agree that the next 4 outcomes for ROI in Section 6 (page 5-6) are the correct priority
- Help the QI team consider how we balance the tension of reactive and proactive work.
Run Chart: Croydon Admissions per week

- Trend
- Shift (not sustained)

Run Chart: Croydon Re-Admissions within 30 days

- Median: 1

Run Chart: Croydon Hospital Length of Stay (Closed Episodes)

- Trend
- Median: 43
Run Chart: Private Overspill Admissions per week

Shift (to see if sustained)

Daily Time Series: Private Overspill – Patients per day (Calculated by OBD excl. leave)
NB: The measure is the count of violent incidents. The data reported includes all grades (A-E) and incidents be it by patient, other or staff. This includes assault, sexual assault, homicide (if applicable) and applies to reported incidents regardless of whether it was actual, threatened or alleged.

Data source: Datix, run 21st May 2018
Appendix Three

Proposal for QI project form completed and sent to:

*Insert QI coordinator for operational directorate*

Form reviewed within relevant borough/division meeting to ensure the project fits in with the trust quality priorities which are:

- Reducing violence
- Well cared for staff, who are motivated with the right skills
- Right treatment without delays in the right setting
- Working proactively with service users and carers as partners

Or that the project will help address our CQC actions.

And that project is appropriate for QI.

Operational directorate agree next steps

- Ready to go ahead
- Needs further work to clarify project

Sponsorship sought from the relevant clinical/managerial lead

Application form for foundation training forwarded to Trust QI team

QI Project lead meets with relevant QI coordinator in service

Progress monitored via service quality meeting

Feedback provided to applicant and could use QI surgery to discuss or contact borough/division link person

Trust QI team borough/division link person responds within 2 working days:

- If foundation course place available QI team will be in touch to discuss project.
- If no foundation places available, QI team will send next available dates for:
  - Foundation courses
  - QI surgery
- QI team will agree with team doing the QI work
REPORT TO THE TRUST BOARD: PUBLIC

June 19, 2018

Title | Deep dive on BAF Risk – 9: Estates
--- | ---
Author | Altaf Kara
Accountable Director | Altaf Kara

Purpose of the paper

This paper presents a discussion on Principal Risk 9 on Estates as part of the Board’s commitment to look in depth at one of the risks on the Board Assurance Framework at each Board meeting. It was also discussed at the recent Board Development session.

Its purpose is firstly to provide sufficient context for the Board to consider more deeply than it was able to at the recent Board development session the recommendation to revise the overall risk score and the risk target for Principal Risk 9.

The second purpose of the paper is to provide visibility of actions underway and controls in place to manage the distance between risk appetite and actual risk as we continue with the turnaround of the estates function and as we make progress with our modernisation strategy.

Executive summary

Our estate and how we run it directly affects the quality and safety of care we can deliver to our patients and service users, the morale of our staff who have to work from it and our ability to deliver our financial plan.

SLaM’s estate is mostly over 30 years old and in some cases well over 50 years old. It is generally inefficient, not ideal for running mental health services and in need of modernisation. In addition, the estates function is undergoing a turnaround that started in April 2017. Whilst it is bearing fruit, there is much to do. Lastly, the organisation has started executing its Estates Strategy which includes significant development (£175m capital development) over the next 5 years.

In recognition of the development programme, this paper recommends changing the description of the risk with the underlined sentence:

‘The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years, services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget.’

This paper further recognises that the condition of our estate and the strength of the Capital and Estates Function (CEF function) still represent a significant risk to the organisation, and argues that the overall risk scoring lies between 16 and 12 because the grading for consequence lies between the current level of 4 and 3 as predicted by the strict application of the consequence criteria.
Although there are a number of considerations to take into account, this paper recommends leaving the consequence score at 4 and the overall risk score at 16.

- The definitions for the scoring levels are well accepted and SLaM should use them. Not doing so means that the organisation inadvertently introduces unnecessary subjectivity into our judgement and management of risk or inappropriately allocates resources. Most would give a consequence score of 3, but adverse financial variance on smaller, individual project capital budgets could exceed 1%, morale as a result of estate and within Estates itself is low and the function is now taking on larger developments – although new capability is being brought on to support their development.

- Management grip, controls and assurance have improved and this mean that risks which do come to pass can be surfaced and managed before they worsen and become major or catastrophic. The move to a borough-based organisation will reinforce closer focus too. The significant increase in refurbishment requests since the inception of new work processes and controls since June 2017 is evidence of this.

- Day to day response to urgent issues of maintenance is the strongest part of the estates function and, whilst it could improve, provides further support for this consequence score.

- We are sighted on the areas of our estate where risks are largest and have mitigation plans in place. The National Autism Unit and The Ladywell Unit are two of three such places and we are investing significantly in the fabric of both and developing plans for rebuild. The third area is the c 25 buildings that house community teams, where we are ‘the tenant’ and where we are building increasing understanding of issues and grip on contracts. These areas of risk need to be judged strategically for organisation impact.

- We have brought on board an estates director and senior programme management officer, both of whom are experienced in large scale developments and consider that whilst these schemes are ambitious, risk consequence – particularly in the current planning phase – are rightly judged as moderate. They have been co-ordinated through the Capital Steering Group that meets monthly and has done so since mid-2017 and is chaired by the Chief Executive. Another mitigation of potential negative impact is the approach to procurement we have used and intend to use for our major developments: P21/P22 framework. This requires that a guaranteed maximum price is agreed by the supplier for an agreed specification.

Whilst an item by item analysis off the criteria for moderate consequence (3) and major consequence (4) would say that on most measures we are at 3, this paper recommends a consequence score of (4) to remain in place given the early stage of turnaround, the risks still present and large new developments that have come on stream.

Given the condition of the estate, the turnaround we are under-going, and the time to make a significant improvement to both, the paper argues for an increase in the risk target to 9 from 8. This is because the original likelihood score of 2 was felt to be too low and has been increased to 3, and the original consequence score felt to be too high at 4 and has been moved down to 3 – in line with the discussion above. The risk appetite remains unchanged within the 3-8 range for regulation and compliance.

A number of updates and revisions to controls and assurances have been made, including the recommendation that the Chairs of the Finance and Performance Committee (FPC), the Quality and Safety Committee (QSC) and the Audit Committee (AC) meet every 6 months to ensure the QSC and AC chairs are adequately sighted on estates risks that are particularly relevant to the terms of reference of these committees.

Risks / issues for escalation
Whilst BAF Risk 9 is at issue, the Estates risk affects several other risk areas as shown below:

**BAF Risk 9:** The Trust estate strategy will be delivered over the next 5 years and is dependant of significant capital investment. During the five years some services will continue to be delivered from poor buildings and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised.

BAF Risk 1: If the Trust cannot attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change the risk is that the quality of care may not be acceptable or consistent across services.

BAF Risk 2: If the trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.

BAF Risk 5: If the Trust fails to listen to the experience of people that use services there is a risk that services will not learn and not improve safety and the experience for all.

BAF Risk 7: In the context of significant demand and change there is a potential risk that the Trust will fail to deliver the necessary quality improvements identified by the CQC or meet our other statutory duties and therefore create a risk of breaching regulation.

BAF Risk 11: There is a risk that the significant time, resource and money that the Trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.

BAF Risk 12: If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage the need for inpatient beds within the Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which prompt intervention by the Regulators

Went through Business development and Investment Committee on 12-06-18

**Introduction**

Our estate and how we run it directly affect the quality and safety of care we can deliver to our patients and service users, the morale of our staff who have to work from it and our ability to deliver our financial plan.

SLaM’s estate is mostly over 30 years old (typical useful life of buildings) and in some cases well over 50 years old. It is very spread out (4 inpatient sites and c 90 community buildings), generally inefficient for running modern mental health services and badly in need of modernisation.

What is more, the estates function has until recently lacked strong director-level leadership for several years and is still functioning today with several gaps – particularly in the capital projects and portfolio management areas – which we are supplementing with external support. This is gradually being phased out, except where specialist skills are needed.

Estates is undergoing a turnaround that started in April 2017 that is now slowly bearing fruit though there is clearly much to do. There are also pockets where we perform well such as the River House facility (a modern efficient facility), some of our newer refurbishments have been recognised for best practice (e.g. the sensory room on ES1) and we have been successful at making some complex disposals (e.g. the disposal of Woodlands and Master’s House where The Cinema Museum were tenants).

It is in this context that that the paper looks more closely at the risk to the organisation posed by the Estate and the Estates function; controls in place; and mechanisms to provide assurance on controls in place. The rest of the paper is structured in the following sections:
Description of BAF Risk 9 and Context of the Turnaround

A slightly altered BAF risk description was signed off at the recent Board Development Session, setting out the risk posed by Estates. This has been expanded to cover the large developments planned over the next 5 years. It now reads as (change underlined):

‘The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years, services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget’

The timeline for the turnaround is shown below:

Estates turnaround timeline

Key steps so far have been:

- Agreeing vision and strategy April 2017
- Implementing new work processes – particularly the Capital Review Group (CRG - chaired by Director of Strategy and Commercial on which sit the CFO, Director of Nursing and the COO to ensure capital schemes are approved and tracked with the input of these key functions) and the Capital Steering Group (CSG – chaired by the CEO where oversight of large scale developments e.g. Douglas Bennett House (DBH) takes place
- Appointing an Estates Director and agreeing a new organization structure
- Agreeing, implementing and tracking the implementation of KPIs and measures of Estates performance
- Establishing a new budgeting process, rebasing the operating budget and establishing a 24-month rolling capital plan that is based on an appraisal of our estate from three sources:
  - Key priorities as expressed by our service and clinical leads
• A six-facet survey for buildings we own
• An analysis of other buildings where we are tenants or landlords
• Strengthening communications and work processes across Estates and Operations, and
• Making changes in project managers and suppliers and appointing to vacancies to strengthen the Estates function including:
  o Introducing new frameworks that have been introduced under which project managers are being procured
  o Recruiting to vacancies where we are benefiting from the synergies arising from one Director of Estates for SLaM and South West London St. George’s
  o Appointing an experienced and senior programme manager for major developments

We have also made progress with the large capital development schemes planned to open in the next 5 years and a key part of our modernisation strategy, at an investment of c £175m.

**Significant capital schemes (selected benefits of this indicated in the Appendix)**
- Douglas Bennett House (DBH)
- The Children and Young People’s Centre (CYP)
- Rebuild of the National Autism Unit

And progressed urgent, large scale refurbishments at the:
- Ladywell Unit
- Bridge House
- Eating Disorder Unit

This is in addition to regular refurbishment and planned maintenance on community and inpatient sites.

Finally, the original estates strategy is undergoing a refresh to focus particularly on:
- How we can accelerate the achievement of our community hub strategy
- Obtaining a more detailed understanding of value potential from proposed disposals and developments, taking account of massing and planning issues – including at the Bethlem
- Understanding the commercial options to structure developments and disposals.

**Risk ownership and Board committee oversight**

The Board has agreed that the Director of Strategy and Commercial will assume full ownership and responsibility for this risk with the CEO being deleted as the owner. The board also agreed that the Finance and Performance Committee (FPC) would have specific and holistic oversight of the BAF risk. It was also acknowledged that the Quality and Safety Committee (QSC) needed to take a keen interest in Estates where the current functioning of estates or future plans impacts the quality of services. It is envisaged that this will continue to be done on an issue by issue basis through submitted papers, verbal briefings and attendance of the Director of Estates and/or the Director of Strategy and Commercial at the Quality Committee as was done recently on the issues related to and focus on community estate.

The same is true of the Audit Committee (AC) which has recently commissioned an internal audit review of our two large capital schemes (DBH and CYP) and reviewed a report on CEF work processes and actions taken at its last meeting.

Because of the nature of interdependencies with other risks, **a recommendation is made that twice a year there is a formal discussion held between the chairs of FPC, QSC and AC to ensure issues surfaced at FPC meetings regarding estates facilitates this process.**

**Key Drivers, Causes and Consequences**

**Drivers**
The drivers of estates risks are briefly recapped below; many have already been touched upon:

- The age of the estate
- Backlog maintenance that is high in absolute and relative terms
- The highly distributed nature of the estate (4 large inpatient sites and c 90 community buildings we operate from) makes establishing grip difficult, but does mean there is limited concentration of risk in community centres
- Weaknesses in some core work processes both within estates and across the Estates-Operations boundary that are now being addressed
- Until recently, lack of a robust estates strategy and regular refreshment thereof
- Until recently, experienced and skilled, director-level leadership
- Until recently, limited corporate experience of managing large scale development

This has given rise to the causes and consequences below.

**Causes**

The original causes were still considered to be broadly accurate, but additions were made to reflect large developments in train, specific issues related to the community estate and improving skills in capital projects:

- The capital funding allocated through the plan will not allow us to make sufficient improvements to all parts of the estate that need it urgently quickly enough
- We do not prioritise effectively, which is impacted on further by a lack of clinical and operational engagement
- We may be unaware of risks that materialise as these are not reported through to the estates team – particularly in the community estate where we are tenants
- Improvements we make are poorly executed or exacerbate further some of the existing problems/issues with the building environment
- We are unable to execute the strategy of moving to integrated community hubs
- We do not strengthen the capital projects team sufficiently or quickly enough
- We do execute large developments successfully including the increased requirements for engagement (staff, service user, community, partner and regulatory), communication and financial modelling

**Consequences**

The original consequences were judged accurate and relevant and an addition was made relating to our large-scale developments:

- The patient experience is poor in buildings that are not fit for purpose and/or have poor environments.
- Health and safety issues raised both internally and externally if not dealt with could impact on our staff, patients and carers, and potentially cause harm.
- The number of health and safety issues raised could cause the estates and facilities teams to work in a reactive manner and thereby threaten sustained effectiveness
- The Trust receives a “Regulatory Action” from the CQC or other statutory bodies for those properties where serious concerns over the environment have been raised
- Staff morale is further affected by delays or poor developments, rather than being lifted by improvement and the successful execution of an ambitious strategy
• Delays or mismanagement of large developments gives rise to new developments that are unfit for purpose, causes delays to moving to new, better environments, negative financial impact and has a further detrimental impact on morale

Risk Rating

The current risk rating is 16 (likelihood 4 x consequence 4). The key descriptors for identified consequences are shown below:

<table>
<thead>
<tr>
<th>Domains</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service/business interruption</td>
<td>Loss/interruption of &gt;1 hour</td>
<td>Loss/interruption of &gt;8 hours</td>
<td>Loss/interruption of &gt;1 day</td>
<td>Loss/interruption of &gt;1 week</td>
<td>Permanent loss of service or facility</td>
</tr>
<tr>
<td>Finance including claims</td>
<td>Small loss</td>
<td>Loss of 0.1–0.25 per cent of budget</td>
<td>Loss of 0.25–0.5 per cent of budget</td>
<td>Loss of 0.5–1.0 per cent of budget</td>
<td>Loss of &gt;1 per cent of budget</td>
</tr>
<tr>
<td></td>
<td>Risk of claim remote</td>
<td>Claim less than £10,000</td>
<td>Claim(s) between £10,000 and £100,000</td>
<td>Claim(s) between £100,000 and £1 million</td>
<td>Claim(s) &gt;£1 million</td>
</tr>
<tr>
<td>Human resources/organisational development/staffing/competence</td>
<td>No or minimal impact or breech of guidance/statutory duty</td>
<td>Breach of statutory legislation</td>
<td>Single breech in statutory duty</td>
<td>Multiple breeches in statutory duty</td>
<td>Multiple breeches in statutory duty</td>
</tr>
<tr>
<td>Statutory duty/inspections</td>
<td></td>
<td></td>
<td></td>
<td>Enforcement action = improvement notices</td>
<td>Enforcement action - Prosecution</td>
</tr>
<tr>
<td>Impact on the safety of patients, staff or public (physical/psychological harm)</td>
<td>Minimal injury requiring no/minimal intervention or treatment. No time off work</td>
<td>Minor injury or illness, requiring minor intervention</td>
<td>Moderate injury requiring professional intervention</td>
<td>Major injury leading to long-term incapacity/disability</td>
<td>Incident leading to death</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Requiring time off work for &gt;3 days</td>
<td>Requiring time off work for 4-14 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Increase in length of hospital stay by 1-3 days</td>
<td>Increase in length of hospital stay by 4-15 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RIDDOR/agency reportable incident</td>
<td>An event which impacts on a small number of patients</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Likelihood

The likelihood of 4 (will probably happen/recur but it is not a persisting issue) is considered accurate given the current position and the financial restrictions on estate development and no change is recommended.

Consequences

The consequence level of 4 is a significant consequence of multiple breeches in statutory duty, service disruption of >1 week, likely enforcement action, injury resulting in long-term incapacity/disability, time off work for >14 days.

It is recommended that the consequence level should remain at 4. At the heart of the question of whether 4 or 3 is appropriate for consequence is whether, at this time, the consequences of the risk coming to pass would be moderate or major. Whilst the fact that our estates risk is distributed, capability is on an upward
trajectory, visibility of key risks is getting better and attracting investment and we have not had catastrophic incidents in the recent past (3 years), 4 is nevertheless proposed as the current score because of the early stages of the turnaround, noted levels of variance to budget on some capital projects and because of the risk posed by the significant new developments we have taken on.

This would maintain the overall risk score at 16.

The arguments in more detail are:

- The definitions for the scoring levels are well accepted and SLaM should use them. Not doing so means that the organisation inadvertently introduces unnecessary subjectivity into our judgement and management of risk or inappropriately allocates resources. Most would give a consequence score of 3, but adverse financial variance on smaller, individual project capital budgets could exceed 1%, morale as a result of estate and within Estates itself is low and the function is now taking on larger developments – although new capability is being brought on to support their development.

- Management grip, controls and assurance have improved and this mean that risks which do come to pass can be surfaced and managed before they worsen and become major or catastrophic. The move to a borough-based organisation will reinforce closer focus too. The significant increase in refurbishment requests since the inception of new work processes and controls since June 2017 is evidence of this.

- Day to day response to urgent issues of maintenance is the strongest part of the estates function and, whilst it could improve, provides further support for this consequence score.

- We are sighted on the areas of our estate where risks are largest and have mitigation plans in place. The National Autism Unit and The Ladywell Unit are two of three such places and we are investing significantly in the fabric of both and developing plans for rebuild. The third area is the c 25 buildings that house community teams, where we are ‘the tenant’ and where we are building increasing understanding of issues and grip on contracts. These areas of risk need to be judged strategically for organisation impact.

- We have brought on board an estates director and senior programme management officer, both of whom are experienced in large scale developments and consider that whilst these schemes are ambitious, risk consequence – particularly in the current planning phase – are rightly judged as moderate. They have been co-ordinated through the Capital Steering Group that meets monthly and has done so since mid-2017 and is chaired by the Chief Executive. Another mitigation of potential negative impact is the approach to procurement we have used and intend to use for our major developments: P21/P22 framework. This requires that a guaranteed maximum price is agreed by the supplier for an agreed specification.

Whilst an item by item analysis off the criteria for moderate consequence (3) and major consequence (4) would say that on most measures we are at 3, this paper recommends a consequence score of (4) to remain in place given the early stage of turnaround, the risks still present and large new developments that have come on stream.

Risk Target and Appetite

Risk Target

The risk target is currently set at 8 (likelihood 2, consequence 4).
It was considered that a likelihood of 2 (do not expect it to happen/recur but it is possible it may do so) is unrealistic in the short to medium term given the age of the estates, the financial environment and the reasons set out above. It is recommended therefore that this should be raised to a 3 (might happen or recur occasionally).

However, for the reasons listed above, it is recommended that the consequence level can be reduced to 3. Accordingly, this would mean a slight increase in the overall target risk rating to a more realistic 9 (likelihood 3, consequence 3).

Risk Appetite

The risk appetite category for this BAF risk is currently regulation and compliance, with a nominal risk rating range of 3-8, which is consistent with the Boards view for risk appetite for finance risk category.

However, this would mean that the risk target is outside of the indicative risk rating range for a regulation and compliance risk, and it will therefore be critical to ensure deteriorating local estates risks are escalated to Operational Directorate level and into the Corporate Risk Register as necessary.

To strengthen escalation processes several actions have been completed and others are in progress:

- New work processes that pick up from the point that issues occur have been introduced at the Operations Executive and shared with Service and Clinical Directors
- The Director of Estates and the COO have agreed the role description and will soon advertise for a senior executive within Operations to act as a primary link with estates
- The Deputy Estates Director has adopted a new protocol for close and regular communication with Service Directors on requirements
- Full visibility of statutory compliance and outstanding maintenance issues pertaining to buildings where we are tenants is partly developed and being completed
- Leadership walkarounds that were introduced as part of the Quality Improvement initiative have brought much greater focus on estates issues and risks

To strengthen capital expenditure and large-scale capital build problems escalating we have instituted the

- Capital Review Group as previously mentioned to review, approve and track capital allocation, and
- The Capital Steering Group to steer the development of large scale developments, surface issues and ensure their follow up

The work of both these escalation mechanisms is being followed through into corporate risk registers.

Controls and Gaps in Control

Controls

The existing controls listed have been updated and now read as:

- Monitoring of achievement against demanding targets for responsiveness – particularly for statutory and urgent needs and progress on capital and strategic projects in the CEF Executive meeting with the Director of Strategy and Commercial
- Six facet survey on maintenance needs identifies the areas of concern and those areas to be prioritised for works for owned estate
- The Estates Team ensure robust systems and processes are in place to monitor the condition of the estate and reportable incidents (Planet FM; Datix).
- Follow through of escalation processes into corporate risk registers
- Continuous health and safety workplace assessments, including for those buildings where the service is occupying a building under third party ownership
• Reports on the implementation of the action plan from the SLAM Internal audit reports of estate and property and capital processes.
• Ligature anchor point assessment and associated work plan implemented and regularly assessed in conjunction with operational and clinical colleagues.
• A formal, monthly contract management meeting with ISS, our key cleaning and catering service provider
• An enhanced capital project management process that enables works to be signed off both technically and clinically at the appropriate points in the project lifecycle.
• A capital works programme which is informed and prioritised by clinical need, signed off and monitored in the Capital Review Group – CRG (chaired by the Director of Strategy and Commercial whose membership includes the Chief Financial Officer, Director of Nursing and Chief Operating Officer) and which meets monthly
• A strategic developments forum, The Capital Steering Group - CSG (chaired by the Chief Executive whose membership includes the Chief Financial Officer, DON, COO, DSC) to oversee large scale capital developments such as Douglas Bennett House.

Gaps in controls

Gaps in control have also been updated and now read as:

• Completion of a matrix of condition reporting on the condition, management and issues pertaining to all unowned estate where we are tenants (expected to be completed within 60 days)
• The Director of Capital, Estates and Facilities has commissioned independent advice to provide the assurance around the estates and facilities adherence to statutory requirements (asbestos, legionella etc.) – regular reports awaited (first one expected in 45 days)
• More robust change management procedures for capital projects – a more robust process is being implemented and will be applied by operations and estates and embedded through CRG (within 45 days)
• Clinical team awareness and management of environmental risks with a designated responsible person appointed, in operations, with a specific estates focus (c 120 days)

Assurance and Gaps in Assurance

Assurance

The following schedule is an update of the original:
• Quarterly reports around the performance of the Estates and Facilities team will be provided to the Finance and Performance Committee and the Trust Board.
• Issue based updates to the Quality Committee on specific concerns relating to services or functions
• Topic based updates to the Audit Committee based on commissioned reports

Gaps in Assurance

The following changes are recommended:
• Because of the nature of interdependencies with other risks, there should be a twice yearly formal discussion held between the chairs of FPC, QSC and AC to ensure QSC and AC chairs are appropriately sighted on issues surfaced at FPC, regarding estates

Conclusion

The Board is asked to support the following recommendations:
• Accept the change in the description of the estates risk as two major developments are now in the planning stage
• Overall risk level to stay at 16 (likelihood 4 and consequence 4)
• Risk target moves to 9 from 8
  o Currently 8 comprised of (likelihood 2, consequence 4)
  o Recommended 9 (Likelihood 3, Consequence 3)
• Risk appetite remains in the 3-8 range
• Note the updates to gaps and assurances including formal, 6 monthly meetings between the chairs of FPC, QSC and AC
Appendix 1

Significant modernisation of our inpatient environment over the next 5 years will arise from our two key capital schemes: Douglas Bennett House (DBH) and the Children and Young People’s Centre. The impact of DBH is shown below in terms of key metrics against external benchmarks in Charts 1 and 2 below.

Chart 1

Gap analysis: recap current estate performance

<table>
<thead>
<tr>
<th>Performance measure</th>
<th>Current Performance</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Now</td>
<td>New DBH</td>
</tr>
<tr>
<td>% beds in single rooms with ensuite accommodation</td>
<td>26%</td>
<td>42%</td>
</tr>
<tr>
<td>% bedroom of an area in line with recommended guidelines</td>
<td>36%</td>
<td>51%</td>
</tr>
<tr>
<td>% inpatient units with direct access to safe therapeutic outdoor space</td>
<td>50%</td>
<td>66%</td>
</tr>
<tr>
<td>% of estate by area dedicated to non-clinical use</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>Risk Adjusted backlog £/m²</td>
<td>£18/m²</td>
<td>-</td>
</tr>
<tr>
<td>% of hospital estate by area ranked at Condition B or higher</td>
<td>35%</td>
<td>43%</td>
</tr>
<tr>
<td>Consulting room utilisation: patient contacts per room</td>
<td>~955</td>
<td>-</td>
</tr>
<tr>
<td>Agile working: % reduction of workstations</td>
<td>2,700 staff occupy 2,600 desks</td>
<td>-</td>
</tr>
</tbody>
</table>

Chart 2

Benchmark performance: Some Mental Health hospitals

<table>
<thead>
<tr>
<th>Mental Health Trust</th>
<th>% Area Clinical</th>
<th>% Area Non-clinical</th>
<th>% Single Bedrooms with ensuite</th>
<th>% Single Bedrooms without ensuite</th>
<th>Risk Adjusted Backlog £/sqm</th>
</tr>
</thead>
<tbody>
<tr>
<td>South London and Maudsley NHS FT</td>
<td>66%</td>
<td>34%</td>
<td>25%</td>
<td>75%</td>
<td>£18/sqm</td>
</tr>
<tr>
<td>Odeas NHS FT</td>
<td>66%</td>
<td>34%</td>
<td>67%</td>
<td>33%</td>
<td>£0/sqm</td>
</tr>
<tr>
<td>South West London and St George’s Mental Health NHS T</td>
<td>55%</td>
<td>45%</td>
<td>22%</td>
<td>78%</td>
<td>£141/sqm</td>
</tr>
<tr>
<td>Northumberland, Tyne and Wear NHS FT</td>
<td>60%</td>
<td>40%</td>
<td>80%</td>
<td>20%</td>
<td>£3/sqm</td>
</tr>
</tbody>
</table>

ERIC returns data 2015/16, combined Trust’s hospital sites
To inform the Board about significant issues affecting the Trust.

1. **South London Mental Health and Community Partnership**

Our thriving partnership with South-West London and St George’s and Oxleas has now reached its first full year of operation. By working in partnership, we have been able to deliver impressive progress across a range of work-streams, including:

- The Forensics New Model of Care which has exceeded all expectations and has resulted in dozens of forensic patients now being cared for closer to home, to the benefit of their recovery and their families and friends. There has also been a sharp reduction in the number of out-of-area placements into the independent sector and the delivery of significant financial savings.
- Reducing out-of-area placements for children and adolescent service users;
- Making progress with almost all CCGs in relation to the difficult ‘complex care’ cases;
- The successful Nursing Development Programme, now entering its second year. It will build on successes such as 70 staff moving up onto a new Band 4 development programme and standardised job descriptions for Band 2-7 across all Trusts, to support and invest in career development.

2. **Care Quality Commission**

As we expected, the Care Quality Commission (CQC) has announced that it will inspect our services starting on Monday 2 July this year. The visit will take place over two weeks, ending on Friday 13 July.

We are expecting inspections to the following services, although this might change. There will also be some unannounced visits.

- Acute inpatient services
- Health based place of safety
- Home treatment teams
- Community services for older people
- Eating disorders inpatient services and step down service
- All four PICUs
- River House forensic services
The Trust will also be assessed against its leadership, governance, management and culture – this is known as a well-led inspection. Inspectors will also consider any improvements and changes since their last visit. The well-led inspection will consist of interviews with the Trust Board, and inspectors will draw on their wider knowledge of quality in the Trust at all levels. This will take place on 14, 15 and 16 August 2018. They are likely to want to meet with some of our Governors and we will provide more information on this as soon as we have it.

We know that CQC inspections can be a stressful time for staff. As a Trust, we are committed to doing everything we can to support our teams and to help them showcase the excellent work that they do as well as to talk about the areas where they are driving improvements. We have excellent staff working across the length and breadth of the Trust and I know that their commitment, skill and warmth will shine through.

3. The Royal Foundation

As a Trust, we are committed to seizing all opportunities to support the mental health of children and young adults. As such, I was delighted to be invited to join a steering group, convened by The Duchess of Cambridge and The Royal Foundation, to explore what can be done to make a positive difference to the lives of children, by focussing on their earliest stage of life, from pre-birth to infancy.

The steering group, which met for the first time last month, is being asked to consider how The Royal Foundation can best support the achievement of better outcomes looking at preparation for parenthood, pregnancy, and a child’s early years. The group is expected to consider issues such as perinatal and maternal mental health, support and advice for mothers and families, attachment and parent-child interaction, and support and training for teachers and other professionals working in the field – all interventions that could make a significant difference.

4. King’s Health Partners Annual Conference

The King’s Health Partners Annual Conference is taking place on 5th June. The event is open to staff from all four partners - SLaM, King’s College Hospital, Guys and St Thomas’s Hospital and King’s College London and from all the 22 Clinical Academic Groups. The event will provide an opportunity to hear about progress and achievements over the last year, as well as to explore our collective priorities, opportunities and challenges for the year ahead.

We are pleased to have the opportunity on the day to present on the exciting proposals for new Centre for Young Persons’ Mental Health on the Maudsley site. This is an issue on which we would like to actively engage the Council of Governors – both so that Governors are fully sighted on the plans and to get Governors actively involved.

Dr Matthew Patrick
REPORT TO THE TRUST BOARD: PUBLIC
19 June 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>GDPR and Cyber Security</th>
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<tbody>
<tr>
<td>Author</td>
<td>Murat Soncul – Head of Information Governance&lt;br&gt;Stephen Docherty – Chief Information Officer</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Gus Heapfield</td>
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Purpose of the paper

To inform the Trust Board of the activities and initiatives that Digital Services have been undertaking to ensure compliance with GDPR and to continuously improve our cyber defences.

Executive summary

The General Data Protection Regulation (GDPR) came into effect on 25th May 2018 as part of the new Data Protection Bill 2018.

Additionally, there is an ever-increasing focus on cyber resilience across the NHS (and all sectors), which is a result of well reported cyber-attacks, including the Wannacry global attack which affected many NHS organisations in May 2017.

**GDPR**
- What GDPR means and key differences from the Data Protection Act 1998
- How we have prepared, including staff awareness
- How we monitor compliance

**Cyber Security**
- How Digital Services have worked with NHS Digital as early adopters of cyber programmes
- How we monitor cyber security
- Staff awareness

Risks / issues for escalation

Although GDPR and Cyber Security relate to BAF Risks 3 & 10, there are no risks or issues for escalation.

BAF Risk 3: Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.

BAF Risk 10: If we do not work in a way that protects the reputation of the Trust there is a risk that we will find it difficult to recruit staff, service users will report adverse experience, we will not be an attractive business partner and we will attract undue attention of our regulators.
The General Data Protection Regulation and Cyber Security

Update to the Trust Board

19 June 2018

Stephen Docherty
Chief Information Officer & SIRO

Murat Soncul
Head of Information Governance & DPO
What is the General Data Protection Regulation?

What is new
• New definition of “personal identifiable data”
• Improved transparency and accountability
• Improved data subject rights
• Bigger sanctions

• The GDPR is the EU-wide new data protection law that replaced the existing Data Protection Act on 25 May 2018.
• The GDPR applies in the UK. The Data Protection Bill, which enshrines the GDPR to English statute is currently making its way through Parliamentary hearings and will eventually be the new Data Protection Act 2018
• As health and social care organisations process personal data, care professionals need to be aware of their responsibilities under the new law.
How the Trust has prepared

- Clear and thorough public privacy notices,
- Privacy-by-design and DPIAs,
- Policy reviews,
- Data sharing arrangements and agreements,
- Data subject rights management,
- Data inventories and flow maps,
- Data retention and minimisation,
- Training of staff and partners.
Privacy-by-design

**Privacy risk mitigation**
- A process to design and develop all new systems, apps, services, policies, procedures with individuals’ privacy and protection of their data at the forefront.
- **The Data Protection and Privacy Impact Assessments** assess data security and privacy risk and build the best information governance arrangements at the outset.

**Secure data flows**
- A rolling review of all personal data the Trust processes ensuring the processing is lawful,
- Mapping of personal data flows; i.e. where such data comes from and whom it is shared with.

**Consistent compliance**
- A data sharing framework to manage and monitor effective and lawful data sharing with partners
- **The SE London Data Sharing Framework** provides a simplified consolidated framework of data sharing agreements to enable secure and lawful data sharing to support direct care and secondary uses like research and service planning.

**Regulator sanctions**
- Monetary fines to negligent data breaches as high as £20M or 4% of annual turnover

**Data Protection Officer oversight**
- The new Data Protection Officer role is to inform and advise their organisation(s) about all issues in relation to GDPR compliance and will also be responsible for monitoring the organisation(s) compliance with the GDPR.
- SE London DPO Council aims to pool expertise, skills and strengths locally available.
Cyber Security

- Secure email
- NHS Digital’s careCERT Assure and careCERT Alert
- Raising awareness
- Monitoring compliance
  - Information Security Committee, the SIRO and the DPO
  - Monthly Digital Services Cyber Dashboard
  - The IT audit programme
  - The DSP Toolkit
  - Cyber security dashboard
  - SLaM Digital Services Information Governance Model
Secure email
@slam.nhs.uk

- Certified conformance with **NHS Digital Secure Email Standard DCB 1596** (formerly SCCI 1596) on 28 September 2017
- Implemented **Data Loss Prevention (DLP)** policy to encrypt all personal identifiable data content on O365 email transfers and secure storage on OneDrive
- Updated **information security policy** with clear and simple guidance on cyber security and data privacy
- **Informed** health and care partners, commissioners and workforce
NHS Digital Cyber Security Programme
careCERT

SLaM is an early-adopter

• Live data security centre cyber threat alerts
• Independent cyber security assurance
• Specialist network of expertise (HCISPP)
Raising awareness

Meet the Caldicott Guardian
Dr Nicole Byrne, one of the newly appointed Deputy Medical Directors is taking over the Caldicott Guardian role on 1 July 2017. Let’s meet Dr Byrne and the IG team, and remember the role of the Caldicott Guardian in the NHS.

Caldicott Guardians derive their name and inspiration from the Government Review of Patient-Identifiable Information, chaired by Dame Fiona Caldicott, which reported in December 1997.

One of its recommendations was that a senior person, preferably a health professional, should be nominated in each health organisation to act as a guardian, responsible for safeguarding the confidentiality of patient information.

For further information on guidance about confidential data sharing, please contact:
CaldicottGuardian@slam.nhs.uk

The Caldicott Principles have been set out in this report for determining when and how confidential patient information should be used:
1. Justify the purpose(s).
2. Don’t use personal confidential data unless it is absolutely necessary.
3. Use the minimum necessary personal confidential data.
4. Access to personal confidential data should be on a strict need-to知道自己 basis.
5. Everyone with access to personal confidential data should be aware of their responsibilities.
6. Comply with the law.
7. The duty to share information can be as important as the duty to protect patient confidentiality.

The Caldicott Guardian with the support of the IG Team ensure that the trust satisfies the highest practical standards for handling person-identifiable information.

Our main concern is information relating to patients and their care, but the need for confidentiality extends to other individuals, including their relatives, staff and others.

Dr Byrne, who is a consultant psychiatrist in Lambeth Hospital, has also taken over the role of the Chief Clinical Information Officer in her capacity as the Deputy Medical Director for informatics.

Countdown to GDPR
Are you starting a new project, process or service?

The GDPR introduces a new mandatory obligation to conduct a Data Protection Impact Assessment before carrying out data processing which is likely to result in a high risk to individuals' interests. We have now updated our existing process of conducting Privacy Impact Assessments to make sure we comply with this change.

At a glance
- A Data protection impact assessment (DPIA) is a process to help us identify and minimise the data protection risks of a project, service, audit, or process.
- A DPIA should be used for certain kinds of data processing, or other processing that is likely to result in a high risk to individuals' interests. It is also good practice to do a DPIA for any other major project which requires the processing of personal data.

A DPIA usually:
- describe the nature, scope, context and purposes of the processing,
- assess necessity, proportionality and compliance measures,
- identify and assess risks to individuals,
- and identify any additional measures to mitigate those risks.

To assess the level of risk, we must consider both the likelihood and the severity of any impact on individuals.

If we identify a high risk and you cannot mitigate that risk, you must consult the ICO before starting the processing.

For further details please contact: informationmanagement@slam.nhs.uk

Information Governance Department

The General Data Protection Regulation
A guide for care professionals

Understanding Patient Data

360° documentary on 21st century privacy: how did the concept of privacy develop in history? Do you know your digital footprint? How dark is your digital mind? Why don't we like USB sticks? What happens if you are too late to consider data privacy? Are we ready for smart homes/hospitals? Not for the faint hearted but informative...
Monitoring compliance

- **careCERT** Cyber Security Programme
- Monthly Digital Services **Cyber Security Dashboard** and progress updates to the **Information Security Committee** chaired by the SIRO and the **Caldicott Committee** chaired by the Caldicott Guardian
- **The Data Protection Officer** role
- **Benchmarking and collaborative working** with NHS Digital, London Digital Programme (HLP) and SE London STP IG Group
- **Data Security and Protection Toolkit** 2018-19
## Roles and responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CIO / Senior Information Risk Officer</td>
<td>They are the most senior lead accountable for data related risk</td>
</tr>
<tr>
<td>Caldicott Guardian</td>
<td>They are the local senior clinical lead for confidentiality</td>
</tr>
<tr>
<td>Chief Clinical Information Officer</td>
<td>They are the local senior clinical lead for better use of clinical data</td>
</tr>
<tr>
<td>Data Protection Officer</td>
<td>They are the most senior accountable lead for GDPR compliance</td>
</tr>
<tr>
<td>Clinical Safety Officer</td>
<td>They are responsible for clinical safety</td>
</tr>
</tbody>
</table>

-Every health and care organisation needs one

-This role can be **shared between organisations**

-This role can be **shared between organisations**
## Data Security and Protection Toolkit

<table>
<thead>
<tr>
<th>NDG standard 1</th>
<th>NDG standard 2</th>
<th>NDG standard 3</th>
<th>NDG standard 4</th>
<th>NDG standard 5</th>
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<tr>
<td>Senior ownership of data security and protection</td>
<td>Clear understanding of personal data held</td>
<td>Data security and protection training</td>
<td>Lawful access to personal data with a need-to-know</td>
<td>Policy and process reviews</td>
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<th>NDG standard 8</th>
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<td>Business continuity</td>
<td>IT software updates</td>
<td>IT network updates</td>
<td>Supplier/contract management</td>
</tr>
<tr>
<td>Whole-system coordination and testing</td>
<td></td>
<td></td>
<td>Supplier contract reviews</td>
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**Benchmark submission on 11 May 2018** — Fully compliant with 8/10, partially compliant with 2/10

**Next annual submission on 31 March 2019**
Titel: Performance and Finance Report

Author: Harold Bennison, Director of Performance, Contracts and Operational Assurance

Accountable Director: Kristin Dominy, Chief Operating Officer

**Purpose of the paper**

To report the Trust’s operational performance against a range of key national indicators and identify and analyse under-performance and report action plans. The report provides an update regarding the Performance Management Framework review meetings, noting the plans to reflect the new borough delivery structure.

To report on current contractual matters arising and the 18/19 Programme Management Office plans (QIPP and CQUIN).

To report on emergency preparedness status and current actions.

**Executive Summary:**

The NHS Improvement Single Oversight Framework indicators were achieved in April 2018 except IAPT Recovery (49.87% vs 50% target). 7-day follow-up performance was also marginally below the target (94.8% vs 95%).

Pressures across the adult acute pathway (inpatient and community) are resulting in continued usage of external overspill inpatient beds.

The Programme Management Office is ensuring all operational changes agreed in 18/19 contract variations are set out and appropriate implementation plans are in place (for both investments and savings). There is an agreed approach with commissioners to evaluate their investment plans and the Five Year Forward View transformation trajectories.

We continue to work with both Southwark Local Authority and CCG to evaluate the impact of the proposed changes by the Local Authority regarding CAMHS services and section 75. The risk from the reduction in placements budget by Southwark Local Authority is being assessed.

Continued progress is evident with our emergency preparedness.

**Risks / issues for escalation**

BAF Risk 2: If the trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.

BAF Risk 3: Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.

BAF Risk 5: If the Trust fails to listen to the experience of people that use services there is a risk that services will not learn and not improve safety and the experience for all.
BAF Risk 6: If the Trust does not have the capacity and the commitment to work with external partners there is a risk that it would be more difficult to deliver / bid for services that meet service user need thereby undermining the sustainability of the Trust

BAF Risk 7: In the context of significant demand and change there is a potential risk that the Trust will fail to deliver the necessary quality improvements identified by the CQC or meet our other statutory duties and therefore create a risk of breaching regulation.

BAF Risk 8: If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high-quality clinical care there is a risk that the Trust will not be able to provide timely access to safe high-quality services across all boroughs and care pathways.

BAF Risk 10: If we do not work in a way that protects the reputation of the Trust there is a risk that we will find it difficult to recruit staff, service users will report adverse experience, we will not be an attractive business partner and we will attract undue attention of our regulators.

BAF Risk 11: There is a risk that the significant time, resource and money that the Trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.

BAF Risk 12: If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage the need for inpatient beds within the Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which prompt intervention by the Regulators.

BAF Risk 13: If the Trust fails to meet its mandatory training compliance targets as a result of poor local management oversight, data quality or availability of courses, there is a risk to staff and patient safety and of breaching regulation of the local training gaps with a risk to the safety of staff and patients.

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
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<tbody>
<tr>
<td>12 June 18</td>
<td>Finance &amp; Performance Committee</td>
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PERFORMANCE AND FINANCE REPORT

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      2.1.1 Home Treatment Team Gatekeeping
      2.1.2 Early Intervention in Psychosis 2-week standard
      2.1.3 IAPT Waiting Times
      2.1.4 IAPT Recovery
      2.1.5 IAPT Payment By Results
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3 Operational Performance and Activity
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6. Programme Management Office (PMO)
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7. Finance
   7.1 Financial Performance

8. Emergency Planning

9. Conclusion

Appendix 1 - Glossary

Appendix A – April Performance Dashboard
Appendix B – April Quality Committee Dashboard
1. Report Summary
The following areas of the report contain noteworthy risks:

- NHSI indicators – IAPT Recovery (April performance) and 7-day Follow-up performance
- Pressure being experienced in adult acute inpatient activity
- Growth in A&E Liaison presentations
- Community activity – A&L, HTT and EI caseloads

The report summarises the agreements reached with commissioners to evaluate the national transformation expectations and the available investment funding agreed for 18/19 and notes the transition arrangements being developed for our performance management system to reflect the new borough delivery model.

2. NHS Improvement Indicators
NHS Improvement indicators for the Single Oversight Framework are detailed below, in addition to being reported to the Finance and Performance committee (Access and Effectiveness indicators) and the Quality Committee (Quality indicators). Performance for May is being validated at the time of writing. The next report will provide greater detail on the new IAPT payment process.

The key risks identified for these indicators is:

- 7-day follow-up performance

2.1 NHSI Indicators: Access, Effectiveness and Quality

2.1.1 Home Treatment Team Gatekeeping

Fig. 1 NHSI Indicators: HTT Gatekeeping.

The Trust has consistently achieved in excess of the 95% HTT Gatekeeping target since April 2018. Recent misses reflected in the chart above have been reviewed and are in fact due to data recording. HTT staff are working on amending these records with ePJS support where necessary.
2.1.2 Early Intervention in Psychosis 2-week standard

Fig. 2 NHSI Indicators: Early Intervention in Psychosis

The Trust has consistently achieved in excess of the 50% target since April 2018. As has been reported previously, the service is reviewing the impact of growth in referrals and caseloads alongside evaluating other factors influencing team workload.

It is anticipated that the data submission process for Early Intervention will switch from Unify 2 to the Mental Health Services Data Set (see 2.2.1). The SLaM reporting process is ready for the change.

2.1.3 IAPT Waiting Times

Fig. 3 NHSI Indicators: IAPT 18 week Waiting Time Standard

The Trust has consistently achieved the 18 week standard across all four boroughs through 2017/18. The Trust is judged by its regulators and NHS England based upon information produced by NHS Digital as opposed to the locally reported information. NHS Digital figures are represented by the green line in the chart, the most recent data being January 2018. Local figures (in blue) are a snapshot
of the live system and there will always be minor variation due to rounding practices used by NHS Digital. Another source of variation is late data entry and changes to data by clinical services – these additional charts have highlighted areas where this could be addressed with the intention of assisting teams to reduce this source of variation. This additional cross-monitoring will continue to be reported.

Fig. 4 NHSI Indicators: IAPT 6 week Waiting Time Standard – aggregate and detail

Whilst the Trust has achieved in excess of the 6 week standard at an aggregated level, there is significant variation between the four boroughs. Therefore the individual performance is also reported
in Fig. 4, alongside the equivalent NHS Digital published data (red line) for each borough through to January.

The IAPT service has been reviewed by the internal audit team and the report was issued in March. The investigation noted the on-going discussion started by London IAPT services with NHS England to further clarify what determines treatment and therefore the recorded wait time. IAPT policy and guidance documents will be developed as part of the action plan.

Additional risks (which have been communicated previously) associated with access to the IAPT service are:

- Croydon CCG has now commissioned the 18/19 IAPT service from SLaM with an agreed trajectory to meet the national access target by March 2019.
- The Lewisham IAPT service has changed its structure as a result of the 2017/18 QIPP. The 6 week standard has not been met in Lewisham since July 2017. The team has specifically restructured to increase step 2 intervention and continued improvements are now seen in adherence to the 6 week target. Additional investment has been agreed as part of the 2018/19 refresh given the increasing access requirements.

2.1.4 IAPT Recovery

![IAPT Recovery Rate Graph]

![Croydon Local vs Published data and Lambeth Local vs Published data Graphs]
The IAPT recovery rate exceeded the 50% target in March 2018 whilst falling marginally short of the target in April 2018.

The local charts show the most recent NHS Digital information (the red line, updated to January 2018). Lewisham, Lambeth and Croydon services are generally delivering a recovery rate around 50% whilst Southwark performance has been significantly lower, although the data for the final three months of the year shows a steady increase with the team meeting the 50% target from March.

The improvement in the Southwark IAPT service results from the on-going focus through 2017, with the recovery rate being a particular theme. The thirteen point action plan confirmed in November 2017 continues to be monitored on a weekly basis jointly by the PM&IC CAG and Southwark CCG. This action plan also includes recommendations from the NHSI review in August. Actions that focus on recovery include increased recovery focused supervision of staff, with no service user being discharged when non recovered without senior agreement. Additionally there have been improved governance processes to ensure data is being entered and reported in a consistent way; a review of patient pathways and inclusion / exclusion criteria for IAPT services (and provision for people with complex needs). Other actions that focus on maintaining and improving access include increasing workforce for wider modalities (DIT) and improving communication and marketing of IAPT services in Southwark. The detailed action plan has been shared with the Quality Committee. There has also been a change of Service lead for the Southwark IAPT service.

To ensure that there is no effect from the upcoming SLaM borough reorganisation, IAPT services will not change operational management until October 2018.

2.1.5 IAPT Payment By Results

There is a national initiative to change the mechanism by which IAPT services will receive income from April 2018. Commissioners agreed to the SLaM proposal to design a simple process for 2018/19 and to use the learning throughout the year to inform any longer term changes. There is a combination of block payment for activity with an outcomes payment attached to the contract which will be reported on in future reports.
2.1.6 7 Day Follow Up

![Graph showing CPA follow up within 7 days of discharge]

**Fig. 6 NHSI Quality Account Indicator: 7 Day Follow Up**

The Trust consistently achieved in excess of 95% in 2017/18 whilst marginally dropping below the target in March and April 2018. This reduction in performance has been escalated to all Service Directors and is being reviewed across all community teams as well as through data assurance processes.

Whilst Seven Day follow-up is no longer has a national target in the SOF, it remains a mandated component of the 2016/17 and 2017/18 Quality Account. Given the importance of the measure, it continues to be monitored and reported to the Board.

2.1.7 Improving Physical Healthcare

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

2.2 Business Intelligence and Trust Information Developments

The development of the Trust data framework using Quality Improvement principles continues with the aim of providing better access to data through visualisation. The overarching Trust dashboard has been demonstrated and is currently being shared for broader feedback. It will be updated in June to reflect the new operational structure for the Trust. The dashboard allows directorates to “click through” to access local data and additional secondary measures are being developed. The current focus for the Community QuESTT dashboard is to make sure it is actually useful for the operational teams and this work will continue to be shared with the Quality Committee. A decision can then be made how both the Trust and the Community QuESTT dashboards are used and access made as simple as possible.

The Business Intelligence team and Quality Improvement team are continuing to explore the ability to automate the production of Statistical Process Control (SPC) charts through Power BI. Microsoft do not have a plan to develop this and a number of partners have been contacted. Very early
prototypes have been developed and are being reviewed to inform a more formal procurement exercise.

The heritage InSight information system has now been retired, although is still available. InSight will be completely defunct once the electronic patient system (ePJS) is moved to the cloud and the plan continues to aim to take Insight out of service as early as possible. All Insight reports being used are now available through Power BI.

System owners are meeting monthly to review all data held and produced within the Trust. This joined up approach will enable analysis of interdependencies across the systems and identify weaknesses and areas of improvement. Priorities will be agreed to ensure the information provided (both for internal and external use) is relevant, accurate and meaningful in order to support improvement and assurance as well as transformation and research. Progress is being made with the review and assurance of workforce data and reconciliation between the four distinct sources, including finance systems. The Trust data warehouse can now access DATIX which will enable central reporting from that system.

The Business Intelligence team is supporting the necessary adjustments to reporting to reflect the developments in the Trust operational model. The existing reports by CAG will continue to be available and also developed to better reflect the new borough structure. The work done in recent months to develop our Service Directory is enabling this work and the changes made will be assured by the operational teams to ensure data continue to be robust. A specific assurance process will be developed and included in the standard assurance reports.

All staff members have now been given access to the Microsoft Power BI dashboards and reporting systems following the recent procurement of bulk Power BI Premium licences. This change requires a new approach to storing and accessing our information and this is being undertaken in June. The increased access has great potential to revolutionise the way data is analysed and utilised within the Trust: the use of dashboards and dynamic reports can actively assist in monitoring and identifying patient trends and improve on KPIs and data quality on a daily basis. Subsequent developments will see new data domains introduced, which will allow users to see finance, Datix and ePJS data all in one place. The change has

The BI team are currently investigating a number of different avenues on how best to promote this latest integrated reporting development solution to all grades of staff. One method under consideration is to train a number of staff to be ‘Power BI champions’ across the Trust. These champions could then in turn offer training and guidance to other groups of staff on the ground.

2.2.1 Data Quality for Mental Health Services Data Set submissions
The Mental Health Services Data Set (MHSDS) v3.0 mandates data collection from 1st April 2018 and data submission will commence from 1 June 2018. A gap analysis has highlighted a number of changes required to the ePJS system which are planned in the next upgrade. We continue to work with CCGs to review the SLaM position and agree timescales.

Test submissions are planned to start in May. Data quality reports will be developed, using the Microsoft Power BI platform, to ensure that data is valid, accurate and complete. This early testing phase will enable the data extract mechanism to be finely tuned.

The approach used will continue to develop a suite of reports and dashboards to clinical services which will allow the Trust to look ahead and determine national figures before publication as has been developed for our current EI and IAPT reporting. This should reinforce our ability to keep the focus on improving clinical services rather than discussing the data.
It is worth noting that NHS digital are actively trying to understand the accuracy of the national MHSDS submissions by carrying out validation exercises for Early Intervention, Children and Young People and general Data Quality indicators. The BI Team has already started to work more closely with the commissioners to validate and share key data quality and performance indicators. This joint initiative is leading to a development of a shared catalogue of key reporting items which can be then be jointly tracked and discussed with the aim of improving confidence, assurance and overall governance. This process will be supported by a series of dashboards based on the MHSDS version 3 data submissions.

3 Operational Performance and Activity

3.1 In-Patient Activity and Performance
In order to improve the tracking of performance against contract, the following five run charts show the performance of the adult acute inpatient services for LSLC patients against the LSLC contract values. In order to enable monthly comparison, the charts show the average number of occupied beds during the month. There are 340 beds across all adult acute wards (EI, triage, acute, PICU), with approximately 20 beds being filled with non-LSLC inpatients.

The charts show LSLC performance on a monthly basis from April 2017 to April 2018 with the contract trajectory included through to March 2019. It can be seen that the contracted level of activity was revised upwards in October / November 2017 as part of the contract refresh negotiations with Lambeth and Lewisham. Figures include foreign patients for which a further accounting adjustment is made (usually reducing the activity by c. 2%). The data excludes leave and includes all overspill.

Whilst starting from a relatively high base, the Croydon improvement has been a highlight and can be seen to be the key driver in the overall Trust position. Conversely, there has been continued pressure in Lambeth and also Southwark. To support comparison, the y-axis scale for the four individual CCG charts have the same range (50 – 110 equivalent beds per month).
Fig. 7 – LSLC Acute, Triage, PICU and EI performance against commissioned trajectory

In addition to the variance against contract, external overspill adds an additional cost pressure to the Trust. Eliminating external overspill aligns closely to the Mental Health Five Year Forward View target and the Crisp report recommendation to eliminate out of area placements; as such, there is a national focus on Out of Area Placements (OAPs). Both the SEL and SWL STPs are reporting the Trust status for OAPs based on the definition of external overspill (i.e only counting those patients in non-SLaM beds) and there has been no feedback regarding an alternative national definition based on borough boundaries within the SLaM LSLC system.

The following chart shows the overall position from April 2017- May 2018 and the increased, on-going pressure is evident. The colours represent the split between Acute (green) and PICU (grey) beds.
A more comprehensive report on the Quality improvement initiative, Improving Care and Outcomes (I-care) is being developed in line with the new borough delivery model. Community teams and inpatient wards in each of the four boroughs have developed ideas for improvement projects in collaboration with service users and carers, working towards the overall aims of keeping people well in the community to reduce avoidable admissions, length of stay, violent incidents and to improve patient experience. In addition to projects taking place within individual teams, the five main strands of work are:

- Safety in the community
- Safety in inpatient services
- Crisis care and relapse prevention
- Care process models
- Community improvements (redesign)
3.1.1 Length of Stay: Acute Care Pathway

Figure 9 clusters the inpatient cohort within the acute care pathway (wk1, June) by their length of stay at that point. The first colour is 0-30 days, then 31-60 days etc. and the final group is >180 days. The commissioners are in alphabetical order: Croydon, Lambeth, Lewisham, Southwark and “other”.

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. Lambeth CCG can be seen to have the highest number of inpatients and Croydon has a high proportion of patients with longer lengths of stay.

3.1.2 LSLC Admissions

The following charts show the admissions by CCG for each month Apr 17 – Apr 18 with planned levels through to March 2019. The planned level was based on historical performance in 2016 and was set at a flat, consistent rate. It can be seen that admission levels are broadly consistent.
Fig. 10 – LSLC Admissions by month
3.1.3 Delayed Transfers of Care
The Trust makes a monthly submission to NHS England providing a snapshot of delays and lost bed days. The charts below plot these overall submissions alongside the most recent split across the different boroughs. The reporting is by local authority as the reason for delay can be attributable to NHS or social care.

In April, the Trust recorded 619 bed days being lost to delayed transfers of care. At 2.9%, this is below the 3.5% target set from September 2017 by NHSE. A DToC process has been drawn up to ensure consistency in the process for agreeing and recording DToCs across the Trust. This complements the existing weekly calls where DToCs are discussed.

The DToC processes are being reviewed in June as the ongoing pressure in bed usage does not appear to be a factor of increased admissions which would leave length of stay as the prime contributor. Therefore, the apparently positive position with regards DToC merits being checked.

![Delayed Transfers of Care](image1)

Fig. 11 – Delayed Transfer of Care lost bed days by month

![Lost bed days by Local Authority (April)](image2)
3.2 Community Activity & Performance

Overall, the community picture remains one of increasing pressure in many areas of the system and the next section outlines an approach being developed to capture and report on this pressure routinely.

3.2.1 Dementia Diagnosis Rates

The national ambition is for a dementia diagnosis rate of 67% with London CCGs achieving 70.3% in April, albeit with significant variation (58% - 91%). The four rates for SLaM boroughs are:

- Lambeth 75.8%
- Southwark 75.3%
- Lewisham 72.7%
- Croydon 67.4%

The MHOAD CAG has created an action plan which will be monitored each month for progress with a challenge from the COO for 85% for LSL and 75% for Croydon. The difference is based on the funded staffing levels for the services although Croydon has confirmed plans to invest in the service during 2018/19. The CAG has provided an initial plan for this investment to the Croydon Alliance.

There are three broad areas being tackled: data harmonisation, accessing hard-to-reach groups and optimising the memory service diagnostic pathway.

3.2.2 A&E Mental Health Liaison

The number of presentations to A&E Mental Health Liaison teams has been consistently above plan for all four teams. The impact of Core 24 investment and also the CQUIN work to identify very frequent users will need to be incorporated into a refresh of activity plans for 18/19.
Fig. 13 Mental Health Liaison Team Presentations
3.2.3 Community Teams
The community redesign is taking place as part of the new delivery models in boroughs. These monthly snapshots of teams will continue to be provided in this report.

The following graphs repeat the information shared in the last report highlighting growth in the caseload size of our Home Treatment and Early Intervention teams. The updated information to May 2018 is shown in Figs. 14 and 15.

Fig. 14 Adult Home Treatment Team caseload, referrals and discharges Apr 16 – May 18

Fig. 15 Early Intervention caseload, referrals and discharges Apr 16 – May 18
4. 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 remain consistent:

- Adult inpatient pathway pressures; external overspill and Delayed Transfers of Care (DToc) – the full system approach to tackling this has now commenced although significant pressure remains in this area
- Placements (Southwark and Lewisham)
- IAPT performance (noting the improved performance)
- Early Intervention delivery
- 18/19 CIP and QIPP schemes
- Agency expenditure and achieving the NHSI reduction trajectory
- Dementia diagnosis rates
- Mandatory training compliance
- Community waiting times

The Performance Management Framework is being updated to reflect the change to a borough delivery model. The April (month 12) and May (month 1) meetings have been transitional meetings to support the change. The June meeting, reviewing M2 performance will have the first draft of performance information reflecting the new structure.

The existing CAG reporting will continue at least throughout Quarter 1 as a reference for the developing borough-based reports. The Power BI system will support this change and commissioner reporting is already structured for each commissioner.

4.1 Training

4.1.1 Mandatory Training Compliance

Compliance has continued its upward trend and overall compliance is now 84.17%. Tier 1a has moved into the green zone at 85.19% and tier 1b to 81.41% which is pleasing to see. However, these figures should be viewed with caution as this is the first month in which the reporting system has moved from CAG to Borough reporting to align to the Trust’s new structure of Borough reporting. Although it is believed that the figures quoted are a true reflection of compliance, we would need to see consistent improvement over subsequent months to ensure any anomalies in the data during the transition period are identified and resolved.

The Education and Development Department are experiencing an increase in uptake of mandatory training which is frequently the case during appraisal season.
4.1.2 Appraisals – effect on compliance reports
As mentioned last month, compliance in Risk Management and Health and Safety for Managers is expected to show a drop during the appraisal period. This will be due to appraising staff having their training profile temporarily changed on LEAP to show them as managers in order that they may access the management appraisal documentation. Once the appraisal period is complete, staff training profiles will revert back to their pre-appraisal status.

4.1.3 ASCOM Training
Compliance for this topic is still poor at 62.10% and it is not expected to improve until the eLearning package, currently being developed, is available for staff to access. It is anticipated that the eLearning package will be completed by the end of June 2018.

4.1.4 PSTS
It would appear that PSTS teamwork has improved from last month and is now showing at 85.03%. However, 106 staff are currently non-compliant and this remains a concern as it can pose a risk to patient and staff safety. We continue to remind non-compliant staff of the need to refresh training and will be putting on additional training spaces from July 2018 as we begin to move this training from the Trust’s venue at Bishopsgate Training Centre to a larger external venue.

The recent directive that staff who are not fully compliant with PSTS training requirements, permanently or temporarily, can no longer work within in-patient services to safeguard patient and staff safety is also slowly impacting on compliance as exempt staff are identified and encouraged to complete training where possible.
PMOA
Lewisham Directorate
Grand Total

Fig. 17 – PSTS Teamwork compliance

1 day disengagement training, although improved, is still well below satisfactory compliance. We continue to offer additional training two Saturdays per month and although the uptake was initially good, with sessions being almost full, this seems to have slowed down.

<table>
<thead>
<tr>
<th>CAG / Corporate</th>
<th>Staff Count</th>
<th>Compliant</th>
<th>% Target 85%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Adolescent Services</td>
<td>387</td>
<td>271</td>
<td>70.03%</td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>456</td>
<td>315</td>
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</tr>
<tr>
<td>Lambeth Directorate</td>
<td>234</td>
<td>147</td>
<td>62.82%</td>
</tr>
<tr>
<td>Croydon Directorate</td>
<td>396</td>
<td>286</td>
<td>72.22%</td>
</tr>
<tr>
<td>Southwark Directorate</td>
<td>349</td>
<td>249</td>
<td>71.35%</td>
</tr>
<tr>
<td>PMOA</td>
<td>331</td>
<td>239</td>
<td>72.21%</td>
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<tr>
<td>Lewisham Directorate</td>
<td>248</td>
<td>181</td>
<td>72.98%</td>
</tr>
<tr>
<td>Clinical Support Services L2</td>
<td>64</td>
<td>40</td>
<td>62.50%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>2465</strong></td>
<td><strong>1728</strong></td>
<td><strong>70.10%</strong></td>
</tr>
</tbody>
</table>

Fig. 18 – PSTS 1 day disengagement compliance

From July 2018 we will be moving disengagement training to the Ortus Training Centre, to use their larger training rooms to enable a greater number of delegate spaces to be offered.

4.1.5 Basic Life Support (Clinical Staff)
Additional Basic Life Support courses have been put on to improve compliance.

<table>
<thead>
<tr>
<th>CAG / Corporate</th>
<th>Staff Count</th>
<th>Compliant</th>
<th>% Target 85%</th>
</tr>
</thead>
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<td>PMOA</td>
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<td>Lewisham Directorate</td>
<td>290</td>
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<tr>
<td>Clinical Support Services</td>
<td>35</td>
<td>28</td>
<td>80.00%</td>
</tr>
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<td><strong>Grand Total</strong></td>
<td><strong>2469</strong></td>
<td><strong>1752</strong></td>
<td><strong>70.96%</strong></td>
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</table>

Fig. 19 – Basic Life Support compliance
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<tr>
<th>Tier 1 Level B</th>
<th>3 Years Clinical Risk</th>
<th>Tier 1 Level B</th>
<th>Once Only Clinical Supervision</th>
<th>Tier 1 Level B</th>
<th>3 Years Deprivation of Liberty Safeguards (DoLS)</th>
<th>Tier 1 Level B</th>
<th>Once Only Dual Diagnosis - Level 1</th>
<th>Tier 1 Level B</th>
<th>2 Years Fire Warden</th>
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<tr>
<td>79.51%</td>
<td>89.80%</td>
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<td>91.30%</td>
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<td>84.30%</td>
<td>86.90%</td>
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<td>86.90%</td>
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<td>84.30%</td>
<td>86.90%</td>
<td>72.30%</td>
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<td>87.23%</td>
<td>80.45%</td>
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<td>79.63%</td>
<td>84.30%</td>
<td>86.90%</td>
<td>72.30%</td>
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<tr>
<td>81.41%</td>
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<td>87.23%</td>
<td>80.11%</td>
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<td>85.19%</td>
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<td>84.30%</td>
<td>86.90%</td>
<td>72.30%</td>
</tr>
<tr>
<td>Tier Level B</td>
<td>Once Only</td>
<td>Risk Management for Senior Managers</td>
<td>47.35%</td>
<td>56.32%</td>
<td>63.01%</td>
<td>64.94%</td>
<td>66.38%</td>
<td>51.69%</td>
<td>72.32%</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>Tier Level A</td>
<td>3 Years</td>
<td>Safeguarding Adults Alerters</td>
<td>85.08%</td>
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<td>88.29%</td>
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<td>Safeguarding Adults Plus</td>
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<td>88.85%</td>
<td>87.62%</td>
<td>87.58%</td>
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<td>89.66%</td>
<td>88.70%</td>
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<tr>
<td>Tier Level A</td>
<td>Once Only</td>
<td>Safeguarding Children level 1 and 2</td>
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<td>96.85%</td>
<td>95.79%</td>
<td>95.55%</td>
<td>95.60%</td>
<td>95.92%</td>
<td>93.60%</td>
</tr>
<tr>
<td>Tier Level A</td>
<td>3 Years</td>
<td>Safeguarding Children level 3</td>
<td>84.69%</td>
<td>87.62%</td>
<td>86.10%</td>
<td>85.01%</td>
<td>85.77%</td>
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<td>1 Year</td>
<td>Smoking Cessation Level 1</td>
<td>70.36%</td>
<td>70.15%</td>
<td>59.50%</td>
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<td>70.96%</td>
<td>70.33%</td>
<td>70.94%</td>
</tr>
<tr>
<td>Tier Level B</td>
<td>Once Only</td>
<td>Smoking Cessation Level 2</td>
<td>85.95%</td>
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<td>73.68%</td>
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<td>77.88%</td>
<td>78.74%</td>
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<td></td>
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<td>80.50%</td>
<td>81.67%</td>
<td>81.47%</td>
<td>82.64%</td>
<td>79.68%</td>
<td>79.15%</td>
</tr>
</tbody>
</table>

Fig. 20  Mandatory Training Tier 1 Levels A & B, May 17 to May 18
5. Commissioning

The Programme Management Office is ensuring that all QIPP and investment schemes have clear implementation schemes and expected outcomes. Each commissioner will work with its respective borough team at SLaM to set out the borough status for Five Year Forward View transformation initiatives and cross-reference current performance, challenges and change plans. The workforce plan submitted to both SEL and SWL STPs in March will form the basis of the initial discussions across LSLC.

Adult acute inpatient service capacity continues to be a major discussion point given the ongoing heat in the system. Commissioners have confirmed their commitment to maintain the bed base in 2018/19 and to plan to commission at 85% bed capacity utilisation. The ICare programme to reduce length of stay (with flat admissions) continues to be a major focus in 2018 for commissioners as there is an expectation that a ward closure should be planned early in 2019/20 which is based on SLAM activity trajectories and ICare plan. A system risk share is being reviewed for the inpatient system and this includes the allocation of future QIPPs (although this review is likely to be delayed until the system is more stable and potentially a revised trajectory agreed).

There is an on-going discussion with Southwark CCG and local authority regarding their plans for CAMHS services and adult placements (section 75). The CAMHS review is due to report in the summer. Southwark local authority have reduced their placement budget in 2018/19 by £1 million to £2.1 million, putting the Trust at risk of non payment of invoices once this level of expenditure is exceeded. The Trust will need to work with the local authority to discuss this late decision to withdraw funding.

5.1 Lambeth and Croydon Alliances

The start date for the Lambeth Alliance continues to be July 2018 and a separate paper has been presented to the Board.

The MHOAD CAG are reviewing the agreed investment plans from Croydon for the Alliance and following the April Croydon Mental Health Programme Board, detailed plans for recruitment are being confirmed.

5.2 Ann Moss Unit

Ann Moss is a specialist care unit for older adults with complex mental health needs and dementia which is based in Southwark. Following an engagement process with families and carers, it has been confirmed by Southwark CCG that the unit will close by 31st August 2018. Alternative care settings are being identified for patients and an appropriate staff consultation is taking place.

5.3 Commissioner-related Quality Impact Assessments (QIAs)

The Programme Management Office (PMO) undertakes the assurance and governance processes for QIAs. QIAs have been developed for most CIP schemes and are either approved or in draft for approval. There are currently no schemes in delivery that do not have an approved QIA. As new schemes are developed, they will be put through the rigour of the QIA process.
### 5.4 Commissioning Programmes 2017-18

2018-19 QIPP and CQUIN schemes are being managed using the PMO principles.

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

QIPP has been rated into four categories:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Definition</th>
<th>£’000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Requires significant work</td>
<td>1,517</td>
</tr>
<tr>
<td>Amber</td>
<td>Requires some work</td>
<td>2,566</td>
</tr>
<tr>
<td>Green</td>
<td>Requires little work</td>
<td>4,421</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8,504</td>
</tr>
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</table>

The QIPP risk dashboard is below:

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<thead>
<tr>
<th>QIPP Ref</th>
<th>CCG</th>
<th>QIPP plan</th>
<th>Progress</th>
<th>Value (£)</th>
<th>RAG</th>
<th>Forecast (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAM-1819-005-Q</td>
<td>Lambeth</td>
<td>Lambeth Adult inpatient - baseline as per 17/18</td>
<td>QIPP offset by investment.</td>
<td>835</td>
<td>70</td>
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<tr>
<td>STH-1819-003-Q</td>
<td>Southwark</td>
<td>Swk Adult inpatient - baseline as per 17/18</td>
<td>QIPP offset by investment.</td>
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<td>44</td>
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<tr>
<td>LEW-1819-006-Q</td>
<td>Lewisham</td>
<td>ERT staffing budget reduction</td>
<td>Ongoing discussion to agree plan</td>
<td>150</td>
<td>13</td>
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<td>LAM-1819-004-Q</td>
<td>Lambeth</td>
<td>SHARP M1 variance of £33k</td>
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<td>PMOA-1819-010-Q</td>
<td>Southwark</td>
<td>Ann Moss Way</td>
<td>Service improvement</td>
<td>893</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>STH-1819-002-Q</td>
<td>Southwark</td>
<td>Southwark Placements - CCG</td>
<td>Action plans being drafted</td>
<td>472</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>STH-1819-004-Q</td>
<td>Southwark</td>
<td>QIPP gap - initiatives to be identified</td>
<td>Initiatives to be identified</td>
<td>559</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>LEW-1819-012-Q</td>
<td>Lewisham</td>
<td>FYE - Lewisham Community Teams - A&amp;L Team</td>
<td>Community teams budget (£42k) is in the baseline budget. Budgets will be monitored to track spend</td>
<td>42</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>LEW-1819-005-Q</td>
<td>Lewisham</td>
<td>QIPP Triage savings</td>
<td>Implementation in June 18</td>
<td>200</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>LAM-1819-006-Q</td>
<td>Lambeth</td>
<td>ASD &amp; ADHD C&amp;V expenditure</td>
<td>QIPP being achieved subject to CCG confirmation.</td>
<td>150</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>PMOA-1819-011-Q</td>
<td>Lambeth</td>
<td>Greenvale - reduction in beds</td>
<td>QIPP being achieved</td>
<td>666</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>LEW-1819-007-Q</td>
<td>Lewisham</td>
<td>FYE - IAPT (15% reduction)</td>
<td>QIPP being achieved</td>
<td>93</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>LEW-1819-011-Q</td>
<td>Lewisham</td>
<td>FYE - LITT Team - move from Psychosis to primary (PMIC link)</td>
<td>QIPP being achieved</td>
<td>43</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CRY-1819-010-Q</td>
<td>Croydon</td>
<td>Croydon Adult inpatient - baseline as per 17/18</td>
<td>OBD are within the plan and QIPP should be achieved (based M1 performance)</td>
<td>2,333</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CEN-1819-017-Q</td>
<td>NHSE</td>
<td>NHSE Specialist Contracts</td>
<td>QIPP offset by investment - 17/18 baseline has therefore been retained</td>
<td>1,136</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>8,504</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Fig. 21 QIPP dashboard**

The QIPP position at month 1 is as follows;

All QIPPs that have not been delivered in 18/19 (and where there is no agreement to reduce the baseline) have been captured in the 18/19 business planning cycle with ongoing discussions in monthly performance management meetings to address the gap.

The majority of the QIPPs identified for 18/19 have robust plans that will be monitored in the monthly performance management meetings. All QIPPs are mapped to the new organisational structure and were discussed in the April / May PACMAN performance meetings.

**QIPP Red risks**

- **Southwark Adult inpatient (baseline as per 17/18). Value £532k.** QIPP offset by investment. This QIPP is red as although the baseline is reinstated, the Trust is over performing (more activity than income) against occupied bed day (OBD) baseline. Please note this is not a direct financial risk to the plan of £532k as the baseline funding reflects over
performance and has been offset by additional CCG investment. However, the QIPP is noted as red given the requirement to achieve 85% bed occupancy and the potential financial impact on cost overall due to high bed occupancy.

- **Lambeth Adult inpatient (baseline as per 17/18). Value £835k.** QIPP has been offset by investment. This QIPP is red as although the baseline is reinstated, the Trust is over performing (more activity than income) against occupied bed day (OBD) baseline. Please note this is not a direct financial risk to the plan of £835k as the baseline funding reflects over performance and has been offset by additional CCG investment. However, the QIPP is noted as red given the requirement to achieve 85% bed occupancy and the potential financial impact on cost overall due to high bed occupancy.

- **ERT staffing budget reduction. Value £150k.** This is a QIPP based on service improvement. The trust is not clear how this is to be achieved. A meeting is being scheduled shortly between Donna Hayward-Sussex, Service Director for Lewisham, Kenny Gregory from Lewisham CCG and Tim Greenwood from Finance to determine how this will be achieved.

### Amber Risks

- **SHARP. Value £400k.** SHARP team has been disestablished and displaced staff have been placed within other teams, except for one post where plans are being drafted to place this member of staff in an appropriate team with vacancies.

- **Ann Moss Way. Value £893k.** Implementation delayed by a month, from August to September due to slippage in decision making by Southwark CCG. Financial impact of the delay should be recoverable from the CCG. Operational team on track to deliver this QIPP in September.

- **Southwark Placements. Value £472k.** This is being managed via Southwark PACMAN where performance is tracked and remedial initiatives are being identified. Although there is no overspend in M1, this QIPP is amber due to overspent budget and high spend placements trend from 17/18. Action plan is being drafted by the new Service Director for Southwark.

- **QIPP gap - initiatives to be identified. Value £559k.** Southwark CCG has not identified any initiative for this value. New initiatives have been proposed by the Trust, to the CCG in May and the Trust are awaiting response.

- **FYE - Lewisham Community Teams - A&L Team. Value £42k.** This is an outstanding issue that will be picked up as part of the borough restructure programme. This is amber due to an overspend of £10k in M1.

- **QIPP Triage savings. Value £200k.** This QIPP is amber because Implementation of this initiative has moved from May to early June, which is due to delay in seeking QIA approval.

### 5.4.2 Commissioning for Quality and Innovation (CQUIN) Schemes

The majority of the 2018/19 CQUIN schemes are a continuation of the 17/18 programme. Local details are being finalised where necessary. Final payment decisions for 2017/18 are being confirmed.

The PMO Programme Director continues to work with the Performance & Contracts team and the Trust leads to review project management support and capability across the rest of the CQUIN programme to identify where additional support will be beneficial.
6. Programme Management Office (PMO)

6.1 Cost Improvement Programme (CIP)

Fig. 22 Trust April CIP position

The chart above shows the summary of the Trust CIP schemes broken down by Operational Delivery Unit (ODU) and by risk as at M1. The table shows that of the 66 schemes at £16.4m in the Trust plan, £3.7m are at high risk. This is driven primarily by bed costs (overspill). £5.9m is rated medium for risk, driven primarily by overspends in inpatient nursing. The remaining £6.8m is rated as low risk of which £0.27m has been delivered. Full financial details will be included in the next update.
7. Finance

The early overall position is as planned and the Trust expects to meet its control total. A more comprehensive understanding of the position will be available for the end of quarter 1. However, significant challenges around inpatient demand is driving up overspill and ward nursing costs. There will need to be significant improvement in the very near future to return to a sustainable position. The Trust is working with its commissioners and alliance partners in Lambeth to agree collective solutions which could include prioritising funds to these areas. The proceeds from the disposal of the Woodlands Unit has been received one month ahead of plan causing a £5.1m favourable variance which will be corrected in Month 3. Excluding disposals the Trust is £0.3m ahead of plan YTD at Month 2. It should be noted that as this is the early part of the financial year some areas of the budget are being normalised especially in corporate areas (e.g. Occupational Health funding in HR and Utilities cost inflation in Estates) This is reflected in the larger than expected overspends in infrastructure.

Key areas driving overspend operationally YTD are:
- Overspill
- Ward Nursing Costs
- Kent CAMHS

Key areas driving overspend corporately YTD are:
- Estates (capital planning)
- HR (training income and advertising spend)
- Reduction in R&D income (late changes in DH allocation)

Some existing overspends (e.g. Occupational Health and CAMHS prior year non recurrent savings) will be resolved using central provisions.

Key Risks not reflected in the YTD position:
- A large proportion of CIP delivery is focused in the last 6 months of the year (e.g. transformation related savings for SLP and Borough reconfiguration).
- There is a risk around significant underfunding of Southwark Local Authority based placements (circa £1m reduction)
- The Trust has now largely committed its £1.8m general reserve to essential infrastructure and CQC related service developments

7.1 Financial Performance

At Month 2 YTD the Trust made a surplus of £3.9m, a favourable variance of £5.4m against the new control total. The position was impacted this month by the earlier than planned sale of the Woodlands Unit. This has resulted in £5.1m of the favourable variance being attributable to the sale and will reverse out in month 3 when the sale proceeds were planned to occur. If the sale is stripped out of the position, the underlying variance at month 2 was a £0.3m favourable variance from plan. The phasing of the plan is such that the NHS Improvement (NHSI) target surplus of £2.5m is largely delivered in the second half of the year. 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 the main variances are occurring. The main adverse position is in ACP where acute inpatient activity and ward nursing costs are above plan. This position has deteriorated further in month 2 as bed usage continues to increase. The CAMHS directorate are also facing significant financial pressures with Kent services not in balance (low activity and high cost of staffing), adolescent ward pay costs higher than plan and outpatient income/activity below plan.
The Trust was notified on the 23rd May of a £0.52m reduction in its Research and Capability funding (RCF). There had been no previous indication that this would occur and its reduction has not been built into the annual plan. There is little scope to develop a corresponding cost reduction and the impact is now showing within the R&D directorate as a £0.1m overspend at month 2. The Trust has informed NHSI and will be taking up the late notification issue with the Department of Health and how they intend to address it.

The Trust has been remapping its services in line with the new borough structures. Whilst there are still some issues to be worked through, including the allocation of management, medical budget/costs and overspill, a provisional analysis of month 2 would indicate the following financial positions:
The position is being impacted by key cost risks:

- **Acute overspill** - overall 18 overspill beds were used by the Trust in May, an increase of 13 from the previous month. This number excludes local CCG patients overspilling into Trust beds that were planned to be funded by NCA activity (non contracted activity – primarily overseas and cross boundary flow patients). The net financial impact of overspill and loss of NCA income is £565k ytd. Overspill numbers continued to increase through May and as at 8/6/18 were standing at 32. Given the Plan only allowed for limited overspill of 2-3 beds it will be important that the new Borough directorates continue to focus on this high risk area. Based on month 1 figures, the main areas of concern are Lambeth (19% above contract) and Southwark (8% above contract).

- **Complex placements** – placements are currently in balance largely achieved through a combination of additional income (Southwark CCG) and changes to budget as allowed for in the Annual Plan. However there remains a risk on Southwark local authority placements where funding is no longer being routed through the CCG contract under a Section 75 agreement. Previously this provided the Trust with some certainty as the CCG effectively underwrote any issues that the CCG had with the Local Authority as regards recovery of funding. The Trust must now invoice the Local Authority direct in order to recover costs which last year overspent by £0.8m against a baseline budget of £3.1m. As at month 2 the LA element of placements has cost £0.65m with zero recovery as yet from Southwark Council.

- **Use of agency staff** – the ytd position is now £0.4m outside the NHSI ceiling set for the year to spend no more than £15.1m on all agency staff. The deterioration in the position is due to a combination of backdated agency costs (late booking of staff on to the NHSP system) and increase in agency use. The increase was particularly in medical costs. Agency cost reductions form part of the annual plan and rely upon meeting the NHSI ceiling. As at month 2 ytd the Trust had incurred an additional expense of c£0.5m above the cost of employing permanent SLaM staff, assuming a 20% agency premium.
• **Ward nursing costs** – a reduction from month 1 but continue to remain stubbornly high at £366k overspent ytd (£10k higher than the 17/18 average). The majority of these overspends are being incurred in ACP and CAMHS with the main outliers being 3 out of the 4 Adult PICUs, Lewisham Triage where its conversion to an acute ward is still pending and the CAMHS adolescent units.

• **Variable Income** – income targets are not being met in Psychosis, PMIC and CAMHS. Some of these positions are similar to 2017/18. Of particular note are income/activity shortfalls on the Psychosis Unit and in various outpatient services in PMIC and CAMHS. Some of these shortfalls are being offset by corresponding pay underspends but it will be important to take swift action if these positions are not to drift again over the coming year.

A forecast will be undertaken at Q1. This will have allowed for any budget or cost anomalies/changes coming through in the first month whilst picking up any developing trends.

8. Emergency Planning

The Trust’s Accountable Emergency Officer and Emergency Planning Manager continue to attend monthly meetings with NHSE(London) to formulate the action plan to address non-compliant areas of the NHSE (London) annual EPRR assurance process from November 2017.

Following staff absences, the Trust is now continuing with Business Continuity exercising, along with the on-going work with NHSE(London), and the LAS (London Ambulance Service), to develop a Hazardous Materials (HazMat) and Chemical Biological Radiological Nuclear and explosives (CBRNe) ‘train the trainer’ course, specifically aimed at Mental Health Trusts.

In response to the 2017 ransomware / cyber security incident that affected a substantial proportion of NHS organisations, a SLaM Information and Communication Technology (ICT) ‘task and finish’ group has been set up with a plan to meet imminently. This group is to be chaired by the Chief Operating Officer.

9. Conclusion

The Trust continues to meet the majority of NHS Improvement Single Oversight Framework indicators for April 2018 although IAPT Recovery and 7-day follow-up targets were missed. There are a number of risks and associated actions set out in the report.

Pressure across the adult acute pathway (inpatient and community) has increased and is resulting in continued usage of external overspill inpatient beds.

The Programme Management Office is ensuring all operational changes agreed in 18/19 contract variations are set out and appropriate implementation plans are in place (for both investments and savings). There is an agreed approach with commissioners to evaluate their investment plans and the Five Year Forward View transformation trajectories.

We continue to work with both Southwark Local Authority and CCG to evaluate the impact of the proposed changes by the Local Authority regarding CAMHS services and section 75. The risk from the reduction in placements budget by Southwark Local Authority is being assessed.

The Performance Management Framework is being reviewed as part of the development of the borough operational delivery model.

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEP</td>
<td>Accountable Emergency Officer</td>
</tr>
<tr>
<td>Ascom</td>
<td>Alarm / communications system supplied by Ascom UK, a telecommunications company</td>
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<tr>
<td>CAG</td>
<td>Clinical Academic Group – bringing together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy (CBTp is CBT of psychosis)</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CHS</td>
<td>Croydon Health Services NHS Trust</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation: A fund where payment is contingent on delivery on quality improvements and meeting milestones agreed with commissioners.</td>
</tr>
<tr>
<td>CYP</td>
<td>Children &amp; Young People</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>DTOC</td>
<td>Delayed Transfers of Care</td>
</tr>
<tr>
<td>EI</td>
<td>Early Intervention: First Episode Psychosis</td>
</tr>
<tr>
<td>ePJS</td>
<td>Electronic Patient Journey System: Clinical records system</td>
</tr>
<tr>
<td>EPM</td>
<td>Emergency Planning Manager</td>
</tr>
<tr>
<td>EPRR</td>
<td>Emergency Preparedness, Resilience and Response</td>
</tr>
<tr>
<td>GSTT</td>
<td>Guys &amp; ST Thomas’ NHS Foundation Trust</td>
</tr>
<tr>
<td>HTT</td>
<td>Home Treatment Team</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>JOSC</td>
<td>Joint Overview and Scrutiny Committee</td>
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<tr>
<td>LoS</td>
<td>Length of Stay. The duration of an inpatient stay, usually measured in days. Can include or exclude leave and can focus on a stay on a particular ward or the full hospital admission.</td>
</tr>
<tr>
<td>LSLC</td>
<td>Lambeth, Southwark, Lewisham &amp; Croydon (CGGs)</td>
</tr>
<tr>
<td>MHOAD</td>
<td>Mental Health of Older Adults and Dementia</td>
</tr>
<tr>
<td>MHSDS</td>
<td>Mental Health Services Data Set: National dataset submitted to NHS Digital (formerly known as the Health &amp; Social Care Information Centre)</td>
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<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSE(L)</td>
<td>NHS England (London)</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement: the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>NHSP</td>
<td>NHS Professionals</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence: provides national guidance and advice to improve health and social care</td>
</tr>
<tr>
<td>OAP</td>
<td>Out of Area Placement</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>PMF</td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td>PMO</td>
<td>Programme Management Office</td>
</tr>
<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help enhance services and improve their cost effectiveness</td>
</tr>
<tr>
<td>QuESTT</td>
<td>Quality, Effectiveness and Safety Trigger Tool. An inpatient self-audit which enables pressures in inpatient wards to be quantified. In 2018 a simple community equivalent is being developed and introduced at SLaM.</td>
</tr>
<tr>
<td>SEL</td>
<td>South East London</td>
</tr>
<tr>
<td>SLP</td>
<td>South London Mental Health and Community Partnership. A partnership of SLaM, Oxleas and SWLSiG formed in 2015</td>
</tr>
<tr>
<td>SOF</td>
<td>Single Oversight Framework: NHSI assurance and performance mechanism</td>
</tr>
<tr>
<td>SPC</td>
<td>Statistical Process Control</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
</tr>
<tr>
<td>SWL</td>
<td>South West London</td>
</tr>
<tr>
<td>SWLSiG</td>
<td>South West London and St George’s Mental Health NHS Trust</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
Appendix A Performance Management Framework Trust Summary

Please refer to Board Finance Report

Workforce

Agency Cost (Phased NHSI Ceiling)

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

All Staff - Annual Leave Planning

Sickness (in arrears)

Delayed Discharges - Days Lost

Adult OBD Against Monitor Plan (excl. Private Overspill)

Acute CAG overspill (April - March)
Appendix A Performance Management Framework Trust Summary

7 Day Follow Up (Target 95%)
- Achieved: 7
- Missed: 128

CPA 12 Month review
- Patients with valid review: 224
- Patients with overdue review: 0

HTT Gatekeeping (Target 95%)
- Total Achieved: 8
- Total Missed: 180

Delayed Discharges Target Below 7.5%
- Days Not Loaded: 919
- Trust Days Lost: 20,749

Early Intervention in First Episode Psychosis
Completed Pathways (50% target) by Month
- Completion %: Average 86%
- Lambeth %: Average 5%
- Lewisham %: Average 2%
- Southwark %: Average 9%
- % Total: Average 83%

IAPT Waiting Time (6 Weeks)
- Previous Month: 0%
- Current Month: 0%

IAPT Waiting Time (18 Weeks)
- Previous Month: 0%
- Current Month: 0%

Compliance and reporting of Full Risk Screen is being developed in line with new reporting
- Variation to the previous month: 0.0%

Customer (Patient & Commissioners)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Achieved</th>
<th>Missed</th>
<th>Variation to the previous month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Risk Screen (CPA Patients)</td>
<td>5676</td>
<td>123</td>
<td>0.0%</td>
</tr>
<tr>
<td>Child Need Risk Screen (CPA Patients)</td>
<td>6127</td>
<td>245</td>
<td>0.0%</td>
</tr>
<tr>
<td>Employment Recording (CPA Patients)</td>
<td>5954</td>
<td>95</td>
<td>0.0%</td>
</tr>
<tr>
<td>Accommodation Recording (CPA Patients)</td>
<td>5532</td>
<td>37</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Friends and Family
- Patient Surveys (PEDIC)
  - Do you feel involved in your care? (%)
  - Early Intervention in First Episode Psychosis: 86%
  - IAPT Waiting Time (6 Weeks): 0%
  - IAPT Waiting Time (18 Weeks): 0%

Learning and Growth

Mandatory Training
- Mandatory Training Tier 1A
- Mandatory Training Tier 1B
- Clinical Risk
- Target
**QC Quality Dashboard**

Period: April (Month 1) 2018  
Circulation: Board Circulation June

**Introduction**

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

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

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

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

**Exception reporting:**

IAPT Recovery Rate is reported in the main body of the Chief Operating Officer’s Quality report to the QC. The low level of Mandatory Training courses falling into the Red rating has been maintained and the number of courses falling into the green rating has increased.

Unauthorised Absences data unavailable at time of production - measure under development.

Seven Day Followup remains low at 94.8%

Staff Sickness and Total Training Completions unavailable at time of publication

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<table>
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<tr>
<th>Safe</th>
<th>Level 0 (Score = 9 or less)</th>
<th>Level 1 (Score = 10 – 16)</th>
<th>Level 2 (Score = 17 – 23)</th>
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**Total QUESTT Scores by Ward, April 2018**

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<tr>
<th>Ward</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
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<tbody>
<tr>
<td>Chaffinch</td>
<td></td>
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<td>Brook</td>
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<td></td>
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<tr>
<td>Thames</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Acorn Lodge</td>
<td></td>
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<tr>
<td>Lambeth Ht</td>
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<tr>
<td>FM2</td>
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<td>CAMHS PICU</td>
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**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, Planned annual appraisals not performed
6. Planned clinical supervision sessions not performed,
7. No formal feedback obtained from patients during the month (e.g. questionnaires or surveys)
8. 2 or more formal complaints in a month,
9. No evidence of resolution to recurring themes,
10. Unusual demands on service exceeding capacity to deliver,
11. Number of hours of enhanced levels of observation exceed 120,
12. Ward/department appears untidy/disrepair,
13. No evidence of effective multidisciplinary/multi-professional team working,
14. On-going investigation or disciplinary investigation
The LEAP system for training and learning was introduced in December 2016. For the core skills framework subjects a total of 25 tailored training courses are provided dependent on staff type and including skills refresh. The updated RAG rating has been applied whereby below 70% = Red, 71-84% = Amber, above 85% = Green (except IG which is 95%). Total training completions data not available at time of production.

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Title
NED OBJECTIVES & COMPETENCY FRAMEWORK
& CHIEF EXECUTIVE / SENIOR MANAGEMENT TEAM OBJECTIVES
2018 / 19

Author
Rachel Evans

Purpose of the paper
To inform the Board about the proposed high level objectives and role descriptions for the Chief Executive, Senior Management Team and the Non-Executive Directors (NEDs). The NED objectives were presented to the Nominations Committee in May and this version includes their changes.

The Senior Management Team will continue to develop detailed metrics to measure progress against agreed objectives.

Risks / issues for escalation
This paper relates to all the BAF risks.

Committees where this item has been considered

<table>
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<th>Date</th>
<th>Committee / Meeting</th>
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<tr>
<td>23/05/18</td>
<td>Nominations Committee</td>
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<tr>
<td>11/06/18</td>
<td>Senior Management Team</td>
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1. **NED Competency Framework 2018 / 19**

**Personal Motivation**

- Committed to enhancing mental health and well-being and services within our local communities.
- Enthusiastic about change and the strategic opportunities facing the Trust.
- Committed to, and demonstrates, the Nolan principles of public life.

**Strategic direction**

- Able to play a strong role on the Board, balancing stewardship, strategic thinking, scrutiny and support.
- Able to look ahead and work with others to develop practical but ambitious plans.
- Ensures that the Board acts in the best interests of services users, their family, carers and the wider public.

**Influencing and Communication**

- A sharp and clear thinker who can weigh up other people’s ideas and have good ideas of their own.
- Able to gain respect through a personal empowering style supported by effective communication and influencing skills

**Team Working**

- Able to build constructive relationships and work effectively with our Governors, our Executive team and our wider stakeholders.
- Able to build constructive relationships and work effectively in a team of people and be able to let others take forward the executive operational work
- Robust enough to hold others to account for their performance and to be open to being held to account for their own performance.

**Demonstrates commitment**

- Regularly attends Board meetings, Governor meetings and relevant Committee meetings
- Prepares effectively for meetings by reading the papers closely and preparing thoughts and ideas in advance.
- Stays up to date with developments in the sector understands the Trust’s position in the local healthcare economy, and undertakes relevant training.
2. NED objectives 2018 / 19

ROGER PAFFARD
Chair, Chair of the Council of Governors & Governors governance working group, Vice Chair KHP board, Chair Nominations committee, Member of FPC & Quality Committee

A. To be a high-performing Chair of the Trust, including by -
   a. providing strong and effective leadership and strategic direction to the Board;
   b. providing support and challenge to the Chief Executive, ensuring that the Chief Executive and his team are held to account for the delivery of the Trust’s plans and strategies;
   c. providing strong and effective leadership as Chair of the Council of Governors and building constructive relations with Governors;
   e. staying fully up to date with developments in the sector;
   f. acting as an ambassador for the trust and building strong partnerships across the healthcare economy;
   g. ensuring that the Board acts in the best interests of services users, their family, carers and the wider public.

B. To support and monitor the Trust’s plans, with a focus on:

1) BME inclusion

Championing the work to deliver a step change in the treatment of BME staff within the Trust, including by providing scrutiny and support to the Chief Executive and his team with regards to a package of measures to deliver marked improvements to –

   a) the number of BME staff at senior grades,
   b) the staff survey measures on satisfaction, career opportunities and discrimination amongst BME staff, 
   c) the number of BME staff being mentored, in secondments or acting up, and 
   d) a reduction in the number of disciplinary proceedings being brought against BME staff.

2) QI

   a) Acting as a champion for the QI programme and ensure that the NEDs each play a part in the leadership walkarounds.
   b) Supporting and challenging the Chief Executive and his team in their work to ensure that the QI programme is recognised as having delivered tangible improvements to the quality, culture and service-user/carer engagement and co-production across the Trust.
3) Finances & Strategy

To support the Chief Executive to:

a) Deliver the budget and control totals agreed with NHSI in 2018/9;

b) Secure a sound & sustainable financial platform for the Trust over the coming year and future planning cycles;

c) Champion the Changing Lives strategy, enabling the Trust to be an internationally outstanding mental health provider fuelled by our unique strengths in research and development, with a highly engaged and supported workforce.

C. Equalities and Workforce Committee

a) Chairing the Equalities and Workforce Committee to provide assurance to the Board on the recruitment, retention, management and development of the Trust’s workforce and the development of an equalities strategy addressing both workforce and service provision.

b) Holding the Executive team to account for the provision of high-quality information, reports and papers to the Committee.

D. Partnerships

a) To Chair the Centre for Young People’s Mental Health with a view to delivering transformation of our CAMHS services.

b) Supporting and championing the work of the South London Partnership to ensure that the opportunities for effective collaboration and co-ordination across South London are seized.

E. Board Development

a) Reviewing the performance of the Board, including by gathering evidence from Board members, participants and observers, to inform a package of improvements to enable the Board to operate as a high performing and continuously improving Board, e.g. the improved use of data at the Board.

b) Providing leadership to the Board on working in effective partnership with the South London MHC Partnership, the Kings Health Partnership, our CCGs, STPs and others.

F. Supporting the Trust’s corporate objectives

Championing and supporting –

- the Changing Lives strategy and associated priorities
- the Quality Improvement programme
- the Chair and the Chief Executive’s ambitions to deliver a step change in the engagement of all staff in general and of BME staff in particular within the Trust;
- effective learning from serious incidents and deaths; and
- effective partnership working with the South London Partnership, the Kings Health Partnership, the South London STPs, our CCGs and local authorities.

ALAN DOWNEY

Chair of the new Maudsley Charity, Member of BDIC & FPC

To support and monitor the Trust’s plans, with a focus on:

1) Charity Committee and the Maudsley Charity
Supporting the Chief Executive of the Charity in providing leadership for the newly independent Charity as it starts in as a new entity.

2) BDIC & Commercial

Providing support and scrutiny to the new alliance contracting models and international venturing.

Supporting June Mulroy as the Chair of BDIC and FPC.

3) Supporting the Trust's corporate objectives

Championing and supporting –
- the Changing Lives strategy and associated priorities
- the Quality Improvement programme
- the Chair and the Chief Executive’s ambitions to deliver a step change in the engagement of all staff in general and of BME staff in particular within the Trust;
- effective learning from serious incidents and deaths; and
- effective partnership working with the South London Partnership, the Kings Health Partnership, the South London STPs, our CCGs and local authorities.

MIKE FRANKLIN

Support for Governors Membership and Involvement Working Group, Member of the Equalities and Workforce Committee

To support and monitor the Trust's plans, with a focus on:

1) Membership and Involvement Working Group

Supporting the Governors in developing and involving the membership of the Trust and improving its communication with different constituencies, including overseeing and promoting the involvement and social responsibility activities of the membership.

2) Equalities and Workforce

Working with the Chair, the CEO and the Snowy White Peaks group to develop and monitor a strategy that delivers a step change in our treatment of BME staff.

Supporting the Freedom to Speak Up champion to deliver a culture where staff feel better able to raise concerns and challenges.

3) Stakeholder Engagement

Supporting the Director of Strategy & Commercial in the development of public engagement and communications strategies.

4) Supporting the Trust's corporate objectives

Championing and supporting –
- the Changing Lives strategy and associated priorities
- the Quality Improvement programme
- the Chair and the Chief Executive’s ambitions to deliver a step change in the engagement of all staff in general and of BME staff in particular within the Trust;
DUNCAN HAMES

Senior Independent Director, Chair of Audit Committee, NED representative for SLAM at the South London Partnership Board

To support and monitor the Trust’s plans, with a focus on:

1) Audit Committee
   a) Chairing the work of the committee in seeking assurance as to the integrity of financial reporting, and the adequacy of financial controls including counter-fraud measures.
   b) Keep under review the operation of the Board Assurance Framework, and management of corporate risks.
   c) Overseeing the Trust’s compliance with NHS Improvement’s financial and governance reporting, and
   d) Holding the Executive team to account for the provision of high-quality information, reports and papers to the Committee.

2) Senior Independent Director
   Building profile amongst the Governors and other Trust executives, with a view to being suitably accessible as Senior Independent Director.

3) South London Partnership Board
   Playing an active part in the governance of the South London Partnership with a view to ensuring that the opportunities for effective collaboration and co-ordination across South London are seized and delivered.

4) Supporting the Trust’s corporate objectives

   Championing and supporting –
   - the Changing Lives strategy and associated priorities
   - the Quality Improvement programme
   - the Chair and the Chief Executive’s ambitions to deliver a step change in the engagement of all staff in general and of BME staff in particular within the Trust;
   - effective learning from serious incidents and deaths; and
   - effective partnership working with the South London Partnership, the Kings Health Partnership, the South London STPs, our CCGs and local authorities.

JUNE MULROY

Deputy Chair, Chair of FPC, Chair of BDIC, Member of Audit Committee, Board of the new Maudsley Charity

To support and monitor the Trust's plans, with focus on:

1) FPC & BDIC
Ensuring effective join-up between the work of the Finance and Performance Committee and the Business Development and Investment Committee. Also integrating Estates into FPC and BDIC

Supporting the Executive team to provide effective scrutiny of new models of alliance contracting and international venturing.

Supporting the CFO in developing the Trust’s capacity to deliver the significant infrastructure & efficiency targets in the budget and bringing to the board’s attention any need for remedial or recovery action as early as possible.

Holding the Executive team to account for the provision of high-quality information, reports and papers to the Committee

2) NHSI

Supporting the Executive team in their delivery of the NHSI performance targets and control totals.

3) Supporting the Trust’s corporate objectives

Championing and supporting –

- the Changing Lives strategy and associated priorities
- the Quality Improvement programme
- the Chair and the Chief Executive’s ambitions to deliver a step change in the engagement of all staff in general and of BME staff in particular within the Trust;
- effective learning from serious incidents and deaths; and
- effective partnership working with the South London Partnership, the Kings Health Partnership, the South London STPs, our CCGs and local authorities.

GERALDINE STRATHDEE

Chair of Mental Health Law committee, Member of Quality Committee.

To support and monitor the Trust’s plans, with a focus on:

1) Trust-wide Mental Health Law Committee

Chairing the Trust-wide Mental Health Law Committee and reviewing the strategic direction, Terms of Reference and routine information reports of the Committee. This is with a view to ensuring that the use of Mental Health Act, Mental Capacity Act & Deprivation of Liberty Safeguards are monitored within SLaM to meet the legal and regulatory standards and support human rights, population health, quality improvement and the reduction of inequalities and restrictive practices.

Supporting the Trust to get the best out of our Associate Hospital Managers, including appraising the Lead Associate Hospital Managers and identifying any deficiencies in performance that need to be addressed.

2) Clinical expertise

Drawing on expertise in population health, physical healthcare, Research and Development, informatics, digital and service transformation to help shape the Trust’s strategic direction and to provide effective challenge and support to the executive team at the Board and at Committees.

3) Induction
Building and capturing understanding about the difference between the Non-Executive and Executive Director roles and their roles in well led governance with a view to providing guidance and support to new SLaM Non-Executive Directors in the future.

4) **Supporting the Trust’s corporate objectives**

Championing and supporting –

- the Changing Lives strategy and associated priorities
- the Quality Improvement programme
- the Chair and the Chief Executive’s ambitions to deliver a step change in the engagement of all staff in general and of BME staff in particular within the Trust;
- effective learning from serious incidents and deaths; and
- effective partnership working with the South London Partnership, the Kings Health Partnership, the South London STPs, our CCGs and local authorities.

**ANNA WALKER**

*Chair of Quality Committee, Member of Audit Committee, Support to Governors Quality Committee*

To support and monitor the Trust’s plans, with a focus on:

1) **Quality Committee**

   a) Chairing the Quality Committee to ensure effective oversight of quality, workforce (if appropriate) & assurance improvement;
   b) Improving the processes, membership, reporting methods and discussion at the Committee.
   c) Holding the Executive team to account for the provision of high-quality information, reports and papers to the Committee;
   d) Ensuring the Committee focusses on the key quality issues and those attending it find it helpful;
   e) Working with the Governors Quality working group to improve constructive challenge and dialogue and focus on key issues.

2) **CQC and Francis Report**

In conjunction with the Deputy Chair, scrutinising the delivery of the CQC and other action plans and support the Director of Nursing & Medical Director and executive team in achieving this.

3) **Risk Assurance Framework**

   In conjunction with the Chair of Audit, monitoring the development of the Board Assurance Framework and management of Quality and staffing risks where those remain the responsibility of the Quality Committee.

4) **Supporting the Trust’s corporate objectives**

Championing and supporting –

- the Changing Lives strategy and associated priorities
- the Quality Improvement programme
- the Chair and the Chief Executive’s ambitions to deliver a step change in the engagement of all staff in general and of BME staff in particular within the Trust;
- effective learning from serious incidents and deaths; and
- effective partnership working with the South London Partnership, the Kings Health Partnership, the South London STPs, our CCGs and local authorities.

PROFESSOR IAN EVERALL

To support and monitor the Trust’s plans, with focus on:

1) **Commercial**
   
a) To support and scrutinise the development of an International strategy, and the priorities for commercial opportunities.
   
b) To support and scrutinise the development of a commercial Maudsley education and training business ensuring clarity of interfaces within Kings Health Partners

2) **Research**

To support the Board in understanding the role, opportunities and KHP interfaces for Research within SLaMs “Changing Lives” Strategy.

3) **Centre for Young Peoples Mental Health (CYP)**

a) To lead the development and agreement of strategic and business plans as joint senior responsible director (with the chief executive) to achieve a new centre on schedule.

b) To support the SLaM Board and the CYP programme Board to understand the opportunities and interfaces to make this initiative a success.

4) **Supporting the Trust’s corporate objectives**

Championing and supporting –

- the Changing Lives strategy and associated priorities
- the Quality Improvement programme
- the Chair and the Chief Executive’s ambitions to deliver a step change in the engagement of all staff in general and of BME staff in particular within the Trust;
- effective learning from serious incidents and deaths; and
- effective partnership working with the South London Partnership, the Kings Health Partnership, the South London STPs, our CCGs and local authorities.
3. CEO & SMT Objectives

Chief Executive & Senior Management Team – key objectives for 2018 / 19

1. Deliver outstanding care and experience every day from high-quality estate, placing quality improvement at the heart of everything we do

Key priorities will include:

   a. All patients having access to the **right care, at the right time, in the right setting** – measured by reductions in the waiting time from referral to first assessment and reduction in crises readmissions by 10% by April 2019. (Quality Priority)
   b. A **reduction in violence** by 50% over three years with the aim of reducing all types of restrictive practices. (Quality Priority)
   c. **Quality Improvement** delivering tangible improvements by April 2019 on Length of Stay (both Community and Inpatient), Violence Reduction and Recruitment and Retention.
   d. To deliver improvements to the quality of our **estates** by building capability and refreshing the estates strategy.

2. Partnership Working with our service users, their families and carers in the development and delivery of services

Key priorities will include:

   a. Increasing number of **identified carers/friends/family** for person in receipt of care – measured through the Quality Priorities measurement strategy (Quality Priority)
   b. Increasing the **number of care plans that have been devised collaboratively** with the service user and that the contents have been shared with them – measured through the Quality Priorities measurement strategy. (Quality Priority)
   c. Increasing the number of positive responses to 90% over the next three years regarding patients recommending the service to friends and family if they needed similar care or treatment. (Quality Priority)

3. Improve how we value, develop, involve and empower our staff

Key priorities will include:

   a. Ensuring that the ambitions of the Trust in relation to the treatment of BME staff in the Trust are prioritised and deliver effective results in relation to:
      - Making linear progress towards achieving that the representation of BME staff at bands 7 and above by Spring 2021, by increasing the number of BME staff at Band 7 and above to 373 persons by April 2019.
• Eliminating the over-representation of BME staff in disciplinary proceedings, with a view to reducing the over-representation of BME staff in disciplinary proceedings from 3.5 times to less than 2.0 times (and to eradicate completely if possible) by April 2019.

Achieving a substantial improvement to the career development offer to BME staff by the publication of the Staff Survey results, such that the gap between white and BME staff responding to the career development questions in the Staff Survey 2018 survey is markedly narrowed. (WRES priorities)

b. To successfully deliver the iCare programme in a way that improves patient outcomes and models a new and structured approach to engagement in which all affected staff, service users and carers report that they have been given an opportunity to shape and develop the plans.

4. **Move to whole-population contracts in all our Boroughs, based on better population outcomes starting with the Lambeth Alliance**

Key priorities include:

a. The successful delivery of the new **Borough structures and the Quality Centre** in a way that improves the interface with our boroughs, increases the focus on Quality and empowers our senior leaders.

b. To ensure the successful delivery of the **Lambeth Alliance contract** taking opportunities to maximise the benefits of this new approach in the other three boroughs over the coming year.

c. To ensure the successful development of the Partnership Southwark project.

5. **Work with our partners in Oxleas and South West London and St George's to improve the delivery of our national and specialist services**

Priorities for the next year include:

- Launching a Forensics CAMHS service
- Expanding CAMHS Crisis Care services
- Increasing community Dialectic Behaviour Therapies interventions for children and young people, particular in south east London
- Starting to take on commissioning and support for Complex Care patients
- Piloting new Band 5 community nursing roles
- Achieving momentum in relation to ‘back-office’ functions

6. **Improve translation of research into clinical practice – including physical and mental health, & develop a successful fundraising campaign including CYP**

Key priorities include:
a. To deliver the SOC for the Centre by summer 2018 and maintain the momentum this year for an earliest opening date of May 2022. To launch a robust fundraising proposition for the concept, and engage and excite staff, stakeholders and local communities by January 2019.

b. To develop clear CAG work plans to demonstrate delivery of evidence base and latest research findings into clinical practice.

7. **Ensure we are financially sustainable and governed to the highest possible standards**

   Key priorities include:
   
   a. Continue the focus on getting the (brilliant) **basics** right, including on care planning, risk assessments and bed management.
   
   b. Maintaining financial stability and the delivery of the 2018 / 19 **control total**.

8. **Deliver profitable commercial ventures that will enable us to further support and invest in our local services**

   To drive **Maudsley Health** and other commercial opportunities to maximise the benefits for local services, including identifying additional international commercial opportunities by April 2019.

   To launch a strategy for **Maudsley Learning** by December 2018.

9. **Ensure we enable staff to make the best use of information with reliable IT infrastructure and applications**

   To ensure that **WiFi and connectivity** is improved across all sites in the Trust and that staff are equipped with the technology they need to do the job, demonstrated by a fall in the number of IMT issues raised at Leadership Walkarounds by April 2019.
4. Detailed SMT objectives

**Trust priorities**

- Relentless focus on quality of care, experience, and outcomes.
- Supporting broader communities as well as individuals.
- Enabling staff to make full use of research, development, and innovation.
- Making the best use of our money and supporting vital information infrastructure.

**SMT objectives**

- Drive the delivery of right care, right time in right setting [Beverley & All]
- Transform culture so QI at its heart [Michael & All]
- Reduce violence & prevalence of restraint, prone restraint & seclusion [Beverley & Michael]
- Deliver new iCare community care model [Beverley & Michael]
- Refresh Estates strategy & improve capability [Altaf]
- Establish capacity & flow as devolved responsibilities [Kris]
- Deliver new site management approach [Kris]

- Increase number of identified carers / friends / family for person receiving care [Beverley, Michael]
- Increase number of care plans that have been devised collaboratively [Beverley, Michael]
- Increased positive responses re patients recommending services to friends and family [Beverley, Michael]
- Improve BMi experience by delivering WRES plan [Sally]
- Deliver new iCare community care modelling good engagement model [Beverley & Michael]
- Deliver robust workforce [Kris & Sally]
- Refresh Recruitment & Retention strategy [Sally]
- Improve staff engagement & staff experience [Rachel & Sally]
- Workforce strategy [Sally]
- Improve retention of Band 5 – 7 nurses [Beverley]

- Embed new Borough management structures [Kris]
- Deliver Lambeth Alliance [Kris]
- Develop Partnership Southwark [Kris]
- Financial modelling and strategy for CCG contract currencies and alliances [Gus]
- External partners’ engagement and communications strategy [Altaf]
- Deliver Housing strategy and strategic housing framework [Kris]

- Move to whole population contracts in all our boroughs, to deliver better population outcomes, starting with the Lambeth Alliance
- Work with our partners in Deelas and SWLTG to improve the delivery and reach of our national and specialist services
- Develop CYP case and fundraising proposals [Altaf]
- Successfully launch Maudsley learning [Altaf]
- Increase research activity and align financial incomes to activity [Michael]
- Obtain full benefit of R&D investment [Michael]

- Ensure we are financially sustainable and governed to the highest possible standards
- 3 – 5 Year Finance Strategy [Gus]
- Transform internal financial reporting and BI to support transparency on key ventures [Gus]
- SLAM delivery against contractual and regulatory targets [Gus]
- Reduce Agency spend for doctors [Michael]
- To deliver a high-performing Board, CoCo and SMT [Rachel]

- Enable staff to make the best use of information with reliable IT infrastructure and applications
- Gain Board alignment to new Commercial structure [Altaf]
- Drive Maudsley Health & other commercial opportunities [Altaf]
- Ensure WiFi and connectivity is improved and staff have technology they need [Gus]
- Ensure IT and operational delivery are aligned [Kris]
- Ensuring Informatics support clinical development [Michael]

- To support the continuous improvement of the mental health outcomes for the people and communities we serve whilst maintaining financial stability
Title | Board Assurance Framework
---|---
Author | Colan Ash, Head or Risk and Assurance
Accountable Director | Beverley Murphy, Director of Nursing

Purpose of the paper

The purpose of the paper is to provide a review of the Board Assurance Framework (BAF) and an overview of the next steps being taken to provide assurance that agreed actions are progressing.

Executive summary

Since the last Board BAF review March 2018, the Board has received risk focus reports for BAF risks 1 & 2 and held a detailed review of all BAF risks at the Board development day 22nd May 2018.

This paper presents a summary of these reviews and proposes an updated BAF with 1 new risk, 2 risks recommended for closure, 1 risk recommended for de-escalation to the Corporate Risk Register (CRR) and changes to individual risk rating and details to all other BAF risks.

This paper also summarises changes to the Corporate Risk Register (CRR) and risk escalation procedures and advises the Board of the outcome of an Internal Audit of the Trust's BAF and risk management which has given substantial assurance.

Committees where this item has been considered

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<th>Date</th>
<th>Committee / Meeting</th>
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<tr>
<td>05 June 2018</td>
<td>Audit Committee</td>
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1. Introduction

1.1 This report presents the Board Assurance Framework (BAF) for June 2018 as part of the agreed oversight and governance arrangements.

1.2 Since the last update in March 2018, the Board has received risk focus reports for BAF risks 1 & 2 and held a detailed review of all BAF risks at the Board development day 22nd May 2018.

1.3 The proposed updates and changes to the BAF have been highlighted in this report for approval.

1.4 The Trust has also received substantial assurance of the effectiveness of the BAF and risk management from internal audit and the key findings are summarised in this report.

1.5 This report also provides an update on the Corporate Risk Register (CRR) and risk escalation procedures within the Trust.

2. BAF update

2.1 The full revised BAF is attached as appendix 1.

2.2 Each BAF risk has been critically reviewed by the assigned responsible Executive Director and update recommendations presented to the Board at the Board development day 22nd May 2018. The significant changes to the BAF are set out below.

2.3 **BAF risk 13.** This is a new risk to provide oversight and assurance of risk associated with mandatory training compliance. The Director of Human Resources is the assigned responsible Executive Director with oversight at the Equalities and Workforce Committee Board.

2.4 **BAF risk 4.** This risk is recommend for closure following a review, led by the Medical Director that concluded the agreed and shared objectives between SLaM and IoPPN and other mitigations had reduced the risk to an acceptable level.

2.5 **BAF risk 10.** This risk is also recommended for closure following a review, led by the Director of Strategy and Commercial. The review confirmed that reputational risks are intrinsic to and being addressed individually in all BAF risks. It was therefore colluded that there is minimal additional oversight and assurance being provided to the Board from this separate BAF risk.

2.6 **BAF risk 6.** The likelihood of the risk has been reduced to 3 to reflect the control and assurances the “Lambeth alliance red lines” process has provided to contract negotiations. With the consequence remaining at 3, the overall risk has therefore reduced to 9, the risk target level. Following further consideration (notably at the Audit Committee (5th June 2018), it is judged that this no longer represents a significant strategic risk and therefore recommended for de-escalation to the Corporate Risk Register for continued monitoring at the operational level.

2.7 **BAF risk 1.** The Board considered the detailed rationale in the Board paper (22nd May 2018) to reflect the heightened risk as we embark on the major change programmes and approved the increase to the likelihood to 5, consequence to 4 and therefore the overall risk to 20. The board also approved the re-setting of the risk target to 8 with a reduction of the likelihood to 2 and consequence remaining at 4 and updates to the BAF text have been made.

2.8 **BAF risk 2.** The Board considered the detailed rationale provided in the Board paper (16th April 2018) and approved the reduction of the likelihood of the risk from 5 to 4, retention of the consequence rating at 4 and therefore an overall risk rating reduction from 20 to 16. The BAF risk target has also been reduced to 6 (likelihood 2, consequence 3) and updates to the BAF text have been made.
2.9 **BAF risk 3 & 5.** No changes have been made to the risk rating and risk targets as they are considered to continue to accurately reflect the level of risk although updates to the BAF text have been made.

2.10 **BAF risk 7.** No changes have been made to the risk rating and risk targets as they are considered to continue to accurately reflect the level of risk although the risk description has been amended to more accurately reflect the wider application of the risk to all regulatory duties on the Trust and updates to the BAF text have been made.

2.11 **BAF risk 8.** The likelihood of the risk has been maintained at 3 but the consequence re-assessed at 4 giving a reduction in the overall risk to 12. The risk target likelihood has been increased to 3 to reflect a more realistic and achievable level increasing the risk target to 3 and updates to the BAF text have been made.

2.12 **BAF risk 9.** The overall risk rating has been maintained at 16. The risk target likelihood level of 2 was felt to be too low and has been increased to 3, increasing the overall risk target to 9 and updates to the BAF text have been made.

2.13 **BAF risk 11.** One of the major aims of the iCare QI programme is to improve bed availability and placements but is unlikely to deliver results until later in the year. Given that we are currently experiencing significant bed pressures and despite having implemented additional interim control measures, it is felt the consequence risk rating should be increased to 4 reflect this elevated risk, increasing the overall risk rating to 12. The risk target likelihood level of 2 was felt to be too low and has been increased to 3, increasing the overall risk target to 6 and updates to the BAF text have been made.

2.14 **BAF risk 12.** The likelihood of the risk has been maintained at 3 but the consequence re-assessed at 4 giving a reduction in the overall risk to 12. The risk target likelihood has been increased to 3 to reflect a more realistic and achievable level increasing the risk target to 3 but with the consequence maintained at 4 gives an overall risk target of 12 which is currently above the risk appetite. The Audit Committee will need to ensure continued close monitoring of the key financial tolerance limits to ensure early warning of deteriorating financial control.

2.15 Overall the BAF now contains 10 principal risks and the graph below shows these by nature of risk.

![Graph 1 showing BAF principle risks by risk category type](image)

2.16 There are now 3 red rated risks (down from 4) and 7 amber rated risks (down from 8). The graph below shows the risk rating level changes over time.
3. Internal audit of BAF and risk management arrangements

3.1 An internal audit was undertaken on the Trust BAF and risk management arrangements and the final report received on 15th May 2018. The report provides a substantial assurance rating and improvement of the previous Internal Audit review that provided a limited assurance rating.

3.2 The report made just three recommendations:-
   - The Trust’s strategic objectives recorded on the BAF disagreed with those recorded on the Trust’s website - the website should be updated to include the latest strategic objectives.
   - Some BAF risks were considered to have gaps in key controls, assurance or effectiveness of key controls. The reviews of the BAF risks and the updated BAF referenced in this Board paper have now addressed this weakness.
   - The BAF does not currently include any action plans to address gaps in controls or assurance. See item 6

4. Oversight and governance

4.1 As part of the BAF oversight and governance arrangements each BAF risk has been assigned to a responsible Executive Director and a Board level committee for oversight of each risk and its controls.

4.2 Since the last BAF update, the relevant board level committees have considered issues, controls and assurance monitoring associated with the BAF principle risks, summarised in the table 1 below.

<table>
<thead>
<tr>
<th>Board Level Committee</th>
<th>BAF related agenda items</th>
<th>BAF risk addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Committee 13/3/18</td>
<td>Quality Priorities: Progress and 2017/2018 Draft Quality Accounts version 1</td>
<td>1,3,5,7,9,11</td>
</tr>
<tr>
<td>Quality Committee Terms of Reference</td>
<td>1,2,5,7,11</td>
<td></td>
</tr>
<tr>
<td>Community Quality, Effectiveness &amp; Safety Trigger Tool (QuESTT)</td>
<td>2,3</td>
<td></td>
</tr>
<tr>
<td>Lambeth Living Well Alliance</td>
<td>2,3,5,6,7,8,11,12</td>
<td></td>
</tr>
<tr>
<td>Acute Care CAG- Progress CQC Report</td>
<td>1,3,5,7,9,11</td>
<td></td>
</tr>
<tr>
<td>e-Ob Project Update</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Key Priorities Update Report</td>
<td>2,3,5,6,7</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Key Priorities Update Report</td>
<td>2,5,6,7</td>
<td></td>
</tr>
<tr>
<td>IAPT Recovery Rate Report</td>
<td>2,3,6,8</td>
<td></td>
</tr>
<tr>
<td>Trust-wide Mental Health Law Committee escalation report</td>
<td>2,7,11</td>
<td></td>
</tr>
<tr>
<td>Mandatory Training Review</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Ligature Anchor Point Annual Review</td>
<td>7,9</td>
<td></td>
</tr>
<tr>
<td>Staff Survey 2017 – summary report</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Board Assurance Framework review</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>Risk Management strategy 2018-2021</td>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>
5. Risk escalation & CRR

5.1 A revised risk escalation process has been approved by SMT (See appendix 2).

5.2 All risks on Operational and Corporate Directorate risk registers haven been reviewed against the new risk escalation criteria and the Corporate Risk Register (CRR) refreshed.

5.3 There are now 30 risks on the CRR (including the 13 BAF risks). The graph below shows the range of these risks.
6. BAF reporting Template development

6.1 The BAF does not currently include details of action plans to address gaps in controls or assurance.

6.2 However to include the various action plans in place for each BAF risk would overload the BAF report with detail that may reduce the effectiveness of the BAF and potentially allow a significant issue to be missed amongst the mass of information.

6.3 It is therefore proposed to implement a pragmatic approach that enables the Board to receive appropriate assurance in the BAF that can be examined in detail response where a particular concern is identified or in deep dive reports.

6.4 Each BAF risk will be logged on the Datix risk management module as part of the CRR where the detailed action plans can uploaded and updated on the system and be accessible to the Board and senior management for closer inspection and interrogation as desired.

6.5 A line will be added to the gaps in control and gaps in assurance sections of the BAF template which the assigned responsible Executive Director will be required to provide a status level for the relevant action plan(s) to provide the Board with assurance using a red amber green rating, where

- Green will mean the plans are on target for delivery by due date
- Amber will mean good progress is being made but there may be some slippage towards delivery by the due date
- Red will mean poor progress is being made and delivery is unlikely to be achieved by the due date unless remedial actions are taken.

7. Action

The Board is requested to:-

a) Approve the new BAF risk (BAF 13) and the closure of BAF risks 4 & 10.

b) Note and approve the changes to risk ratings and/or text to the remaining BAF risks and the revised BAF.

c) Note the substantial assurance rating from internal audit and the recommendations made.

d) Note the revised escalation procedure and the CRR.

e) Approve the proposed approach to providing BAF action plan progress assurance and the revision to the BAF template.

Colan Ash
Head of Risk and Assurance
25/5/18
Appendix 2 – Diagram showing risk escalation, de-escalation, oversight and reporting procedure

Operational Directorate monthly risk register review identifies risk(s) for escalation

Corporate Directorate’s monthly risk registers review identifies risk(s) for escalation

SMT review escalated risk

COO via PACMAN

Executive Director

Escalation accepted

Escalation rejected

BAF & CRR summary reports

Audit Committee

Board

Corporate Risk Register

Quality Committee

FPC

BDIC

Allocated lead ED

Key
- Escalating risk
- De-escalating risk
- Risk oversight
- Reporting route
The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but wherever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, mainly through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.
<table>
<thead>
<tr>
<th>Lead Director</th>
<th>Ref No.</th>
<th>Principal Risk</th>
<th>Initial score</th>
<th>Trend</th>
<th>Target score</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRD 1</td>
<td>If the trust can not attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change the risk is that the quality of care may not be acceptable or consistent across services.</td>
<td>12 12 12 12 20</td>
<td>↑</td>
<td>8 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KD 2</td>
<td>If the trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.</td>
<td>16 16 16 20 16</td>
<td>↓</td>
<td>6 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>KD 3</td>
<td>Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.</td>
<td>12 12 12 12 12</td>
<td>↔</td>
<td>6 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH 4</td>
<td>If the Trust and IoPPN do not have aligned objectives there is a risk that the outcome of research will not focus on developments in practice that make a difference to our service users and the effective delivery of services.</td>
<td>9 9 9 9 6 6</td>
<td>↓</td>
<td>4 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BM 5</td>
<td>If the Trust fail to listen to the experience of people that use services there is a risk that services will not learn and not improve safety and the experience for all.</td>
<td>15 12 12 12 12</td>
<td>↔</td>
<td>6 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK 6</td>
<td>If the Trust does not have the capacity and the commitment to work with external partners or have adequate contract development/control mechanisms, there is a risk that it would be more difficult to deliver / bid for services that meet service user need thereby undermining the sustainability of the trust</td>
<td>20 12 12 12 9</td>
<td>De-escalated to CRR</td>
<td>9 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BM 7</td>
<td>In the context of significant demand, change and unpredictable clinical situations there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do's) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation.</td>
<td>12 8 8 8 8</td>
<td>↔</td>
<td>6 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GH 8</td>
<td>If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high quality clinical care there is a risk that the trust will not be able to provide timely access to safe high quality services across all Boroughs and care pathways</td>
<td>15 15 15 15 12</td>
<td>↓</td>
<td>9 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK 9</td>
<td>The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years some services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised</td>
<td>20 16 16 16 16</td>
<td>↔</td>
<td>9 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AK 10</td>
<td>If we do not work in a way that protects the reputation of the trust there is a risk that we will find it difficult to recruit staff, service users will report adverse experience, we will not be an attractive business partner and we will attract undue attention of our regulators.</td>
<td>16 12 12 12 6 6</td>
<td>Closed</td>
<td>8 -2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH 11</td>
<td>There is a risk that the significant time, resource and money that the trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.</td>
<td>9 9 9 9 12 12</td>
<td>↑</td>
<td>6 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GH 12</td>
<td>If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINS and if we do not manage within Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which will prompt intervention by the Regulators.</td>
<td>15 15 15 15 12</td>
<td>↓</td>
<td>12 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HRD 13</td>
<td>If the Trust fails to meet its mandatory training compliance targets as a result of poor local management oversight, data quality or availability of courses, there is a risk to staff and patient safety and of breaching regulation of the local training gaps with a risk to the safety of staff and patients</td>
<td>20 12 12 12</td>
<td>New risk</td>
<td>4 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consequence score</td>
<td>1 Negligible</td>
<td>2 Minor</td>
<td>3 Moderate</td>
<td>4 Major</td>
<td>5 Catastrophic</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
<td>---------</td>
<td>------------</td>
<td>---------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
<td></td>
</tr>
<tr>
<td>Current BAF risk - the number relates to the principal risk number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New BAF risk - the number relates to the principal risk number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Priorities and objectives for 2018 / 2019

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To support the continuous improvement of the mental health outcomes for the people and communities we serve whilst maintaining financial stability</td>
<td>Relentless focus on quality of care, experience and outcomes.</td>
<td>CL1: Deliver outstanding care and experience every day from high-quality estate, placing quality improvement at the heart of everything we do.</td>
<td>All patients will have access to the right care, at the right time, in the appropriate setting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CL2: Partnership working with our service users, their families and carers in the development and delivery of services</td>
<td>We will reduce violence by 50% over 3 years with the aim of reducing all types of restrictive practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CL3: Improve how we value, develop, involve and empower our staff</td>
<td>Within 3 years we will routinely involve service users and carers in (a) all aspects of service design, improvement and governance, and (b) all aspects of the planning and delivery of their loved ones’ care</td>
</tr>
<tr>
<td></td>
<td>Supporting broader communities as well as individuals</td>
<td>CL4: Move to whole population contracts in all our boroughs, to deliver better population outcomes, starting with the Lambeth Alliance</td>
<td>Over the next 3 years, we will enable staff to enjoy improved satisfaction and joy at work</td>
</tr>
<tr>
<td></td>
<td>Enabling staff to make full use of research, development and innovation</td>
<td>CL5: Work with our partners in Oxleas and SWLStG to improve the delivery and reach of our national and specialist services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Making the best use of our money, and supporting vital information infrastructure</td>
<td>CL6: Improve the translation of research into clinical practice – including physical and mental health – and develop a successful fundraising campaign, including CYP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CL7: Ensure we are financially sustainable and governed to the highest possible standards</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CL8: Develop profitable commercial ventures that will enable us to further support and invest in our local services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CL9: Enable staff to make the best use of information with reliable IT infrastructure and applications</td>
<td></td>
</tr>
</tbody>
</table>
“The Board of Directors has developed and agreed the principles of risk that the Trust is prepared to accept, deal and tolerate whilst in pursuit of its objectives. The Board has a broadly cautious to open approach to risk but actively encourages well-managed and defined risk management, in alignment with its risk strategy, acknowledging that service development, innovation and improvements in quality require a level of risk taking.

Our lowest risk appetite relates to regulatory compliance but we have greater risk appetite for innovation, commercial and partnership strategies. This means that we will ensure we prioritise the minimisation of risks relating to our legal obligations whilst seeking opportunities to develop and enhance the quality and efficiency of our service delivery.”

The following draft principles outline the Board’s appetite for risk further:

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Specific risk appetite statement</th>
<th>Risk Appetite level[1]</th>
<th>Indicative risk rating range for the risk appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (patient safety, experience &amp; clinical outcomes)</td>
<td>The Board is committed to delivering outstanding care and services including achieving CQC ‘Outstanding’ and will adopt a cautious approach to risk where the benefits are justifiable and the potential for mitigating actions are strong.</td>
<td>Cautious</td>
<td>3 - 8</td>
</tr>
<tr>
<td>Finance</td>
<td>The Board has a cautious risk appetite for risk that may affect our aim to be financially sustainable and governed to the highest possible standards. However, we have an open risk appetite to investing or allocating resources that may capitalise on opportunities for generating longer term return.</td>
<td>Cautious to open</td>
<td>3 - 10</td>
</tr>
<tr>
<td>Operational performance</td>
<td>The Board is committed to maintaining and improving performance against core standards and will adopt a cautious approach to risks that may adversely affect this aim.</td>
<td>Cautious</td>
<td>3 - 8</td>
</tr>
<tr>
<td>Strategic change &amp; innovation</td>
<td>The Board has a high risk appetite for strategic change, innovation, partnerships and commercial ventures that will develop our clinical &amp; operational service delivery.</td>
<td>Open-seeking</td>
<td>6 - 15</td>
</tr>
<tr>
<td>Regulation &amp; Compliance</td>
<td>The Board has a minimal to cautious risk appetite when it comes to compliance and regulatory issues (including financial obligations). The Board will make every effort to meet statutory regulations and standards, unless there is compelling evidence or argument to challenge them.</td>
<td>Minimal-Cautious</td>
<td>1 - 8</td>
</tr>
<tr>
<td>Workforce</td>
<td>The Board has a cautious approach to risks that may affect our commitment to value, develop, involve and empower our staff.</td>
<td>Cautious</td>
<td>3 - 8</td>
</tr>
<tr>
<td>Reputational</td>
<td>The Board has a cautious to open approach for risks that may affect the Trust’s reputation. On occasions we may be accept risks where there are potential benefits to delivering our quality priorities.</td>
<td>Cautious - open</td>
<td>3 - 10</td>
</tr>
</tbody>
</table>

Principal Risk 1: If the trust cannot attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change, the risk is that the quality of care may not be acceptable or consistent across services.

<table>
<thead>
<tr>
<th>Owner:</th>
<th>HR Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee:</td>
<td>Equalities &amp; Workforce Committee</td>
</tr>
<tr>
<td>Proximity:</td>
<td>Immediate</td>
</tr>
<tr>
<td>Risk Category:</td>
<td>Workforce</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Cautious (nominal range 3-8)</td>
</tr>
</tbody>
</table>

### Potential Causes (links to the CRR)
National shortage of suitably qualified staff and numbers reducing in some key staff groups. High cost of living in London. Several years of pay restraint. Brexit. Increasing pressure of work. Staff not always attracted into this area of work. Staff morale & retention negatively impacted by Borough re-structure. Staff engagement negatively impacted by implementation of iCare. Escalating patient acuity negatively impacts on staff morale.

### Key Controls
Retention and recruitment strategy actions including getting the basics right, improving recruitment processes, improving staff engagement, enhancing the development and training offer and redesigning roles. Talent management programme, targeted recruitment campaigns. SLP nurse development and workforce programme. BME development and support network strategy. Guaranteed job offers for student nurses. Working Race Equalities Scheme and Equalities and Workforce Action Plan. Increased support for development opportunities. Addition of new roles for workforce. Staff engagement plan. Borough restructure and iCare implementation risk mitigation plan. Positive outcomes from the implementation of iCare. Trust wide preceptorship scheme. Improvements to e-appraisal. Leadership engagement plan. Participation in NHSI retention initiative.

### Sources of Assurance
Quarterly workforce & equalities action plan progress report. Recruitment and retention KPIs, annual national staff survey, quarterly staff friends and family test. Deep dive reports eg to CCG. Quarterly workforce & equalities action plan progress report.

### Assurance on the effectiveness of Controls
SMT will ensure assurance is maintained during the critical phase of the change management programme by taking every opportunity to engage with staff during the planned quality visits and review weekly as part of the Monday morning SMT QI meeting.

### Potential Consequences
Patient care affected by staff shortages, poor patient experience, poor staff experience, higher bank usage and higher agency spend.

### Gaps in Control
Operational impacts from lack of vacancy data at ward level. High and continuous agency staff usage in some areas eg CPNs. Lack of robust housing strategy. Impacts of aligning agency rates to NHS pay levels yet to be assessed. Talent management programme labour intensive and pilot yet to deliver desired outcomes. Developments in supervision. Lack of a robust and fully representative staff side bringing trade union and professional association scrutiny to what we do.

### Gaps in Assurance
Recruitment & retention KPIs currently limited to CAG level.

### Request for Closure
No
Principal Risk 2: If the trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.

<table>
<thead>
<tr>
<th>Owner: KD / COO; BM / DoN: MH / MD</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee: Quality committee / Finance and Performance Committee</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Proximity: Immediate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Category: Operational Performance</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Risk Appetite: Cautious to open (nominal range 3-10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last reviewed: Apr-18</td>
<td>Next review</td>
<td>Jun-18</td>
<td></td>
</tr>
</tbody>
</table>

Potential Consequences

Board to Ward decision-making can therefore be protracted reducing the effectiveness of the operational structure. Patients experience can be impacted by hand-offs between teams.

Performance across boroughs, services and teams differs and quality can be inconsistent. Delays are caused as a result of the lack of a standardised approach.

Impact on quality and safety in services delivered through alliance contracts, and reputational risk for the Trust.

Gaps in Control

As the Trust re-structures to a borough model, the mitigation measures to ensure quality is not adversely affected have not been tested nor is evidence available to prove improvements to effective decision-making have been realised. In relation to iCare, the engagement plan is yet to be formalised and will need to be reviewed in May.

Gaps in Assurance

QI Programme and Performance Management systems are not yet integrated and fully aligned.

Request for Closure

No

---

The iCare QI programme is designed to reduce variation in operational practices, improve patient outcomes and experience, enhance staff experience and also improve interfaces with external stakeholders. A restructure to a Borough based model has been developed and planned for implementation from 1st April 2018. Development of community QUESTT as a tool to enable performance monitoring and pre-emptive corrective action.

Key Controls

The iCare QI programme is designed to reduce variation in operational practices, improve patient outcomes and experience, enhance staff experience and also improve interfaces with external stakeholders. A restructure to a Borough based model has been developed and planned for implementation from 1st April 2018. Development of community QUESTT as a tool to enable performance monitoring and pre-emptive corrective action.

Sources of Assurance

Performance monitoring KPIs through PACMAN (including DToC, LoS and other throughput and quality measures such as patient experience). CQC Review. Clinical governance framework, monitoring and assurance processes built into Alliance contract with clear governance and assurance route to SLaM.

Assurance on the effectiveness of Controls

Reports will be made available to QSC and FPC for assurance and discussion.
Principal Risk 3: Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.

<table>
<thead>
<tr>
<th>Owner</th>
<th>KD / COO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee</td>
<td>Finance and Performance Committee</td>
</tr>
<tr>
<td>Proximity</td>
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</tr>
<tr>
<td>Risk Category</td>
<td>Strategic change &amp; innovation</td>
</tr>
<tr>
<td>Risk Appetite</td>
<td>Open to seeking (nominal range 6 - 15)</td>
</tr>
<tr>
<td>Likelihood</td>
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</tr>
<tr>
<td>Consequence</td>
<td>Level: 12, Trend: 6</td>
</tr>
<tr>
<td>Last reviewed</td>
<td>Mar-18, Next review: Jun-18</td>
</tr>
</tbody>
</table>

Potential Causes (links to the CRR)

There are currently numerous independent systems responsible for different types of information across the Trust (workforce, clinical, financial, incidents, training etc.). Integrated reports are achieved through extensive manual manipulation and presentation of data and therefore there is variation between source data and reported data which is not reconciled.

A small number of systems are run from obsolete systems (Windows XP). The Power BI system cannot currently support statistical process control (SPC) reporting and a work around is being defined.

Increasingly, integrated care and partnership working is requiring information systems to cross organisational boundaries. There is discussion at STP level but not co-ordinated for LSLC.

Novel contracts have collapsed in other CCG areas due to poor data leading to unexpected financial risk.

The Trust informatics systems may not be accessible by all staff.

Key Controls

The independent systems all have differing reporting capabilities. The Power BI tool is being developed to be a single point of access for relevant information across the Trust. The implementation of Power BI enables all staff to have access to the information.

In February 2018, system owners met, chaired by COO and DoN, together to set out priorities to address the frustrations experienced by staff and therefore this risk. This forum has continued to meet on a monthly basis and it has enabled improved communication and agreement around priorities. Additionally, a central record of systems, their owners and inter-connections is being compiled.

Weekly information development meetings are led by the Deputy Medical Director for Informatics and Quality Improvement.

A new Service Directory has been designed to provide co-ordination and cross-referencing between systems to enable automatic reports to be produced without manual interference.

Potential Consequences

Production of inconsistent or irreconcilable data will damage the reputation of the organisation if challenged by external organisations and may also incorrectly reflect the clinical and quality standards being achieved. Incorrect information may also result in inferior decision-making for quality improvement initiatives.

Capital investment will be required to replace or eliminate systems at risk. Obsolete systems must be isolated to manage risk of cyber-attack. STP discussions to consider LSLC co-working.

There is a risk that initially the increased usage and closer scrutiny will highlight new problems with data sources and mapping. The focus on developing assurance and governance processes will support the rapid resolution of emerging problems.

Adopting cloud-based solutions reduces risk from local technical infrastructure outages. Digital Services needs work with BI to ensure accessibility throughout the organisation.

SPC remains as an outstanding need to allow the organisation understand its clinical variability.

Gaps in Control

The new monthly meeting of system owners will be formalised alongside the assurance reporting processes.

The governance processes for the Service Directory are being developed and documented.

Formal information controls are not yet in place with the various owners of data sources: Finance, HR, Estates & Facilities, BI and Digital Services. This is being addressed May / June 2018.
<table>
<thead>
<tr>
<th>Sources of Assurance</th>
<th>Gaps in Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A quarterly BI assurance report has been developed between the Head of Business</td>
<td>Close monitoring of the introduced information governance process will identify potential gaps.</td>
</tr>
<tr>
<td>Intelligence and the Head of Information Governance. This will be extended in 2018</td>
<td></td>
</tr>
<tr>
<td>to all systems and include data assurance and system support and management. QC</td>
<td></td>
</tr>
<tr>
<td>oversight of IT development s &amp; impacts on quality data collection.</td>
<td></td>
</tr>
<tr>
<td>Assurance on the effectiveness of Controls</td>
<td></td>
</tr>
<tr>
<td>Reports will be made available to the Global Digital Exemplar / Quality Improvement</td>
<td></td>
</tr>
<tr>
<td>Programme Board and also Finance and Performance Committee for assurance and</td>
<td></td>
</tr>
<tr>
<td>discussion.</td>
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</tbody>
</table>
### Principal Risk 4: If the Trust and IoPPN do not have aligned objectives there is a risk that the outcome of research will not focus on developments in practice that make a difference to our service users and the effective delivery of services.

<table>
<thead>
<tr>
<th>Owner: MH / MD</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
<th>Trend</th>
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<tbody>
<tr>
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<td>2</td>
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<tr>
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<td>Risk Appetite: Open to seeking (nominal range 6 - 15)</td>
<td>Sep-17</td>
<td>Next review</td>
<td>Jun-18</td>
<td></td>
</tr>
</tbody>
</table>

#### Potential Causes (links to the CRR)
None

#### Potential Consequences
None

#### Key Controls
1. CEO and SMT members working closely with the new Dean of the IoPPN and with the Director of the BRC to ensure alignment. 2. Formation of CTI binding research and informatics imperatives.

#### Sources of Assurance
Updates at SMT and R&D committee, feeding into BoD via R&D and QI reports

#### Assurance on the effectiveness of Controls
Controls are effective and the risk is being reduced to an acceptable level

#### Gaps in Control
None

#### Gaps in Assurance
None

#### Request for Closure
Yes recommend for closure
Principal Risk 5: If the Trust fail to listen to the experience of people that use services and / or fail to implement the learning from all sources of adverse incidents there is a risk that services will not learn, not improve safety and present unacceptable risks for people that use services.

<table>
<thead>
<tr>
<th>Owner:</th>
<th>BM / DoN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee:</td>
<td>Quality committee</td>
</tr>
<tr>
<td>Proximity:</td>
<td>Immediate</td>
</tr>
<tr>
<td>Risk Category:</td>
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<td>Risk Appetite:</td>
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### Likelihood

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### Consequence

<table>
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<th>Dec 17</th>
<th>Mar 18</th>
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### Level

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### Last reviewed

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<th>Immediate</th>
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<tbody>
<tr>
<td>Quality (patient safety, experience &amp; clinical outcomes)</td>
<td>Quality (patient safety, experience &amp; clinical outcomes)</td>
</tr>
</tbody>
</table>

### Potential Causes (links to the CRR)

- Culture that does not value engagement with people who use services. Lack of structure / framework to support user engagement. Lack of confidence to move into co production with service users and carers. Reporting structures that are not open, failure to be open. Lack of analysis and reporting of adverse incidents. Information that is presented in a format that is difficult to use. QI methodology not applied. Delays in receiving conclusions of SI investigations. Delays in receiving conclusions of homicide reviews.

### Potential Consequences

- Failure to learn leading to unacceptable risks to safety for people that use services and a poor staff and service user experience. People who use, commission or regulate our service have a lack of confidence in the safety of our service.

### Key Controls

- Implementation of Patient and Public Involvement policy and plans with measurable outcomes across Trust services. Significant Involvement of service users and carers in Operational Directorate governance. Adherence to ‘Being Open’. Monitoring of the quality of complaints and SI reports is overseen by senior CAG Operational and Executive Directors. Monthly Operational Directorate Quality Governance Compliance meeting embedded and includes PPI. Risk management strategy and incident reporting structure in place. Action plans developed and monitored to implement learning from adverse incidents. Trust wide SI panel to ensure learning is shared. Trust audit programme. Safety bulletins, events and Operational Directorate briefings. Quality priorities consultation with service user and carers. Patient voice at Board.

### Sources of Assurance

- Learning lessons report to QSC and Board. Practice changes (locally and trust wide) as a result of adverse incidents. Reports on PPI strategy by CAGs into the trust wide involvement committee. Oversight of the level 2 serious incident reports by the Medical and Nursing Director, closure of all SI reports by the CCGs. Oversight of CEO level complaint responses by Director of nursing. Oversight of all reported incidents by Service and Clinical Directors. Monthly quality compliance committees with Operational Directorates. External oversight via CRQG, deep dives by CCGs and NHSE oversight of delivery of homicide plans. Delivery and monitoring of action plans in relation to PFDS (rule 28). Care plan and risk assessment audits. Trust wide SI meeting and reports to Quality Committee and the Board detailing incidents of all kinds, where they happen, what the nature is and the level of investigation as well as an investigation progress status update.

### Assurance on the effectiveness of Controls

- Combination of oversight of PPI implementation plans at trust wide level; Clinical Directors being held to account for delivery of improvement plans internally and by the CCG; clear escalation framework for all incidents reported and closure of complaints offers reasonable assurance.

### Gaps in Control

- The risk will be better managed if all CAGs and corporate services move from involvement to consistently co producing with people who use services. Additional rigor needed to ensure timeliness and accountability of delivery of action. Inequitable governance resources in existing CAG structures to be balanced in the Borough restructure. Consistency of learning across Trust.

### Gaps in Assurance

- Services respond to risks and challenges on a daily basis, unless there is actual harm the near miss is not always reported and therefore shared as learning. Trends in learning need to be better understood and more effectively communicated in order to support change. QI methodology being used routinely. Not all CAGs have an embedded service user and carer involvement methodology. Weak performance levels for offering Carer Engagement and Support plans.

### Request for Closure

- NO
Principal Risk 6: If the Trust does not have the capacity and the commitment to work with external partners or have adequate contract development/control mechanisms, there is a risk that it would be more difficult to deliver / bid for services that meet service user need thereby undermining the sustainability of the trust

<table>
<thead>
<tr>
<th>Owner: AK / DoS&amp;C</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
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<tr>
<td>Risk Category: Strategic change &amp; innovation</td>
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<td>Likelihood</td>
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<tr>
<td>Consequence</td>
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<td>Level</td>
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<tr>
<td>Last reviewed</td>
<td>Mar-18</td>
<td>Next review</td>
<td>Jun-18</td>
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Potential Causes (links to the CRR)
Lack of clarity of partnership objectives and gap. Insufficient effective operators used to forming and managing partnerships below SMT, SD and CD level. Insufficient scrutiny of how partnership objectives are being progressed.

Potential Consequences
Newly forming Borough partnerships formed and operated poorly leading to sub-optimal performance. Inability to form equitable or workable contracts. SLaM being a at the periphery of strategic discussions where partnership working is key. “SLaM reputation harmed by partners governance/operational failings”.

Key Controls
Track in SMT against objectives. Ensure there are clear owners of key relationships. Red lines and monitoring/approval process via BDIC. Board final contract proposals sign off.

Sources of Assurance
Updates at Audit Committee and Board. BDIC oversight of contract negotiations, assessment and development.

Assurance on the effectiveness of Controls
The contract development processes (eg “red lines” process) and Board oversight arrangements have improved and the overall risk is now considered to be lower and within the acceptable risk appetite range. Accordingly the Board can be reasonably assured that the Trust is well placed to manage this risk of contract unknowns, changing landscape and new relationships.

Gaps in Control
Gap of experience of working in this way - SMT does not track relationship management formally yet. Partnership strategy not fully developed (NB AK is leading the development with a target of end of July). Untested processes to assess and manage the potential impacts on other services not part of a partnership/contract.

Gaps in Assurance
Independent Advisory Group (IAG) consultation not fully embedded in SLaM strategy development. Board external stakeholders’ portfolios.

Request for Closure
Yes close from BAF but retain on CRR.
Principal Risk 7: In the context of significant demand, change and unpredictable clinical situations there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do’s) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.

<table>
<thead>
<tr>
<th>Owner:</th>
<th>BM / DoN</th>
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</thead>
<tbody>
<tr>
<td>Committee:</td>
<td>Quality committee</td>
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<tr>
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</tr>
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<td>Risk Appetite</td>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Likelyhood</th>
<th>Initial</th>
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</tr>
<tr>
<td>Level</td>
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<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

| Last reviewed | Mar-18 | Next review | Jun-18 |

Potential Causes (links to the CRR)
The context of consistent delivery of mental health services across four London Boroughs; significant need and deprivation; a time of unprecedented NHS financial challenge; current levels of funding is amongst the lowest in the country; the transformation of services creates significant pressure for people leading services and people delivering services. This challenges the capacity and capability of an organisation to make change and improvements.

Key Controls
Internal: Established, well led Board of Directors, experienced Service and Clinical Directors, clear operational and professional structure, quality governance, operational performance management, recruitment of sufficient high quality staff. Good knowledge or regulatory standards. CQC PID, action plan and core planning meeting in place. Monthly Operational Directorate Quality Governance Compliance meeting embedded. Risk management strategy and incident reporting structure in place. Established health safety and fire management procedures and governance arrangements. Ligature anchor point audit and management procedures and annual risk reduction programme. CQC preparation meetings. Borough Directors (fresh set of eyes) full site visits. SMT quality visits (to all sites within the year). External: established relationships with commissioners, full engagement with alliance boards, engagement / leadership of transformation programmes (locally and nationally). CQRG clinical quality review group chaired by CCG

Sources of Assurance
COO Quality report, Learning lessons reports, compliance reports, CQUINN reports, progress reports of delivery of CQC inspection improvement actions, QUEST scores, safer staffing reviews, QI progress reports, reported progress on delivery of strategy, monthly quality compliance committees with Operational Directorates embedded and Quality matters governance meetings embedded.

Assurance on the effectiveness of Controls
CQC compliance inspection reports provide good assurance that controls are effective however the staff survey results 16 - 17 and the changes in quality governance processes that will need time to embed reduce this to reasonable assurance.

Gaps in Control
Short of staff in some areas (e.g. CPNs). The potential of the alliance model to deliver transformational change is currently unknown. Lack of access to acute beds compromises ability to be responsive and safe. Not all Boroughs have recruited a full senior management team. CAMHS, Southwark & Lewisham Head of Nursing not yet recruited

Gaps in Assurance
QI methodology is starting to build however the approach is new and will take time to embed. Data Quality, compatibility & integrated report issues being addressed by data summit. Transition of quality governance information into a format reflecting the new borough structures not yet completed.

Request for Closure
NO
**Principal Risk 8: If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high quality clinical care there is a risk that the trust will not be able to provide timely access to safe high quality services across all Boroughs and care pathways**

<table>
<thead>
<tr>
<th>Owner: GH / CFO</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
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</thead>
<tbody>
<tr>
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<td></td>
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<tr>
<td>Last reviewed</td>
<td>Mar-18</td>
<td>Next review</td>
<td>Jun-18</td>
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</table>

**Potential Causes (links to the CRR)**

There is a risk that due to the on-going and severe financial pressures in the NHS, South London Health Economy and SEL STP contract values will be offered and set at levels that would put patient care at risk. Currently, the key CCGs for SLaM (Lambeth, Southwark, Lewisham and Croydon) are all funded in the lowest quartile in terms of spend per weighted population. This inequity in funding increases the likelihood of suboptimal financial settlements. Additional risk will also stem from the variability of financial health across the key commissioning boroughs (with Croydon as a particular concern). Significant risk will also stem from the uncertainty around the development of new commissioning arrangements (e.g. alliances) in which SLaM will need to increasingly compete to maintain a fair financial settlement for its service users. Similar uncertainty around risk / opportunity will also be reflected whilst the SLP finalises the financial arrangements around forensics, CAMHs and any other future partnership programmes.

**Potential Consequences**

Quality: Material financial reductions in the Trust’s contracts will have a number of impacts that will directly impact patient care, experience and safety. Access/Activity: Reduced funding will limit the number of patients the Trust can treat and/or the quality of care that can be provided. Indeed, to avoid patient safety issues the trust may be forced to withdraw from services altogether reducing access to the local population. Capacity (Clinical): Staffing as resources (especially clinical and nursing staffing) would be severely constrained if funding is limited. Capacity (Management): Increasing financial constraints will also consume managerial capacity within the trust and limit the focus on maximising quality. Financial: Limited funding will have a negative impact on the trust’s cash position and would constrain its ability to invest in estate, equipment and technology to ensure they remain fit for purpose and offer the best value for money.

**Key Controls**

Dedicated and focused contracting and finance resource to assess financial sustainability implications and terms. Clear quality assurance procedures (e.g. QIAs) to assess and validate impact of any new contracts on patient care. Contracts to be sanctioned by FPC, SMT and the Board. The trust has an established QI process and PMO function in order to ensure a focus remains on delivering maximum value for patients to ensure limited funds are spent effectively and strengthening the Trust’s bargaining position. The Trust has developed a “Red Lines” analysis to assess material projects including alliances. There is a specific section relating to financial matters. Failure to score 6 out of 10 flags the issue as a ‘red line’ and if not mitigated would stop the project from progressing.

**Gaps in Control**

The pace of change and breadth of scope of the new contracting and commissioning arrangements coupled with the uncertainty and complexity of new models will create capacity pressures across all the relevant control mechanisms in the Trust. Challenging regulator deadlines create additional pressure and limit development time. The Trust will need to develop new finance and activity models to help mitigate these risks. A 3 to 5 year model is in development but is not yet complete. This will allow the Board to more readily assess the future state scenarios for the Trust. Any new contracts will require detailed risk share and escalation protocols in order to mitigate the risks to patient care. The Trust will need to influence the wider health system to ensure underfunding in our key boroughs and parity of esteem remain high up on the agenda at NHSI and the DH assurance. Lack of established communication routes with CCG to raise concerns of funding reductions on caseload and quality.
### Sources of Assurance

Contract settlements that align with STP and Trust based business planning requirements. FPC and SMT scrutiny of key contract arrangements and changes. Clear quality impact assessments detailing the implications and mitigations of any contract changes. Internal assurance is provided via audit and benchmarking to ensure SLaM offers excellent Value for Money. This would include; reference costs, Model Hospital, NHS Benchmarking and the trust’s internal ‘Red Lines’ analysis. The Trust has secured agreement on the Mental Health Investment Standard in 2018/19 with all Commissioners. There is still moderate risk as how the additional funding will be spent is still to be determined in some cases. The Trust has established Risk shares in place around inpatient bed days. £1.5m (net) additional funding has been secured from Southwark around Complex placements based on projected outturn. However, there remains some risk related to Southwark CCG no longer underwriting Placements funded by Southwark council. QIPPs requiring specific cost reductions have been limited to circa £1.5m in 2018/19 (as opposed to circa £10m in 2017/18). In addition, none of these QIPPs are related to bed reductions. The South London Mental Health Partnership has continued to develop New Models of Care yielding benefits in Forensics and Tier 4 CAMHS. Significant progress has been made in mitigating the financial and governance risks of the Lambeth Living Well Network Alliance and this is due to go live 1st July 2018. (see also BAF Risk 6 on Alliances).

### Gaps in Assurance

The pace of change and breadth of scope of the new contracting and commissioning arrangements coupled with the uncertainty and complexity of new models will create capacity pressures across all the relevant assurance mechanisms in the Trust. Comparators and Benchmarks around performance and best practice are limited or unavailable (e.g. the Model Hospital is still in development). Financial Modelling of new contractual models and impact of individual Borough approaches including partnership collaborative agreements need to be completed and assessed including Lambeth Living Well Network and Croydon Alliance.

### Assurance on the effectiveness of Controls

Clear contracting and business planning procedures assured by internal audit and NHSI sign off as the regulator. FPC, SMT and Board scrutiny and sign off of any new contracts. ISAP process for Alliance agreements conducted by NHSI / NHSE.

### Request for Closure

no
## Principal Risk 9: The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years some services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised

<table>
<thead>
<tr>
<th>Owner: AK / DoSC</th>
<th>Committee: Finance and Performance Committee; SMT</th>
<th>Proximity: Immediate</th>
<th>Risk Category: Regulation &amp; Compliance</th>
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<td><strong>Proximity</strong></td>
<td><strong>Risk Category</strong></td>
<td><strong>Risk Appetite</strong></td>
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<tr>
<td><strong>Initial</strong></td>
<td><strong>Likelihood</strong></td>
<td><strong>Consequence</strong></td>
<td><strong>Level</strong></td>
<td><strong>Cautious (nominal range 3-8)</strong></td>
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<td><strong>Current</strong></td>
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<td><strong>Trend</strong></td>
<td><strong>Level</strong></td>
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<td><strong>Jun-18</strong></td>
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</table>

### Potential Causes (links to the CRR)

The capital funding allocated through the plan will not allow us to make sufficient improvements to all estate that needs it. We do not prioritise effectively, which is impacted on further by a lack of clinical and operational engagement. Improvements we make are poorly executed or exacerbate further some of the existing problems/issues with the building environment. We may be unaware of risks that materialise as these are not reported through to the estates team.

### Key Controls

Six facet survey on maintenance needs identifies the areas of concern and those areas to be prioritised for works. The Estates Team ensure robust systems and processes are in place to monitor the condition of the estate and reportable incidents (Planet FM; Datix). Achievement of demanding targets for responsiveness - particularly for statutory and urgent needs. Assurance around all estates and facilities processes to be independently verified by the Director of Capital, Estates and Facilities. An enhanced capital project management process that enables works to be signed off both technically and clinically at the appropriate points in the project lifecycle. A capital works programme which is informed and prioritised by clinical need at the Capital Review Group (CRG) (whose membership includes the Director of Nursing and Chief Operating Officer) and at subsequent (monthly) review meetings.

### Sources of Assurance

Reports on the implementation of the action plan from the SLAM internal audit reports of estate and property and capital processes. Oversight and scrutiny of all projects and programmes provided by the CRG that includes; the Director of Strategy, the Director of Nursing, the Chief Operating Officer and the Director of Finance. Quarterly reports around the performance of the Estates and Facilities team will be provided to the Finance and Performance Committee and the Trust Board. Continuous health and safety workplace assessments, including for those buildings where the service is occupying a building under third party ownership. Ligature anchor point assessment and associated work plan implemented and regularly assessed in conjunction with operational and clinical colleagues. Clinical team awareness and management of environmental risks with a designated responsible person from the service for building and risk management.

### Assurance on the effectiveness of Controls

Internal audit reports of estate and property and capital processes commissioned by the Director of Capital, Estates and Facilities.

**Potential Consequences**

The patient experience is poor in buildings that are not fit for purpose and/or have poor environments. A number of health and safety issues raised both internally and externally, causing the estates and facilities teams to work within a reactive manner. These health and safety issues could impact on our staff, patients and carers, and potentially cause harm. The Trust receives a “Regulatory Action” from the CQC for those properties where serious concerns over the environment have been raised.

### Gaps in Control

The Director of Capital, Estates and Facilities to employ independent advice to provide the assurance around the estates and facilities processes. There are new processes for managing capital projects and a new process is being implemented around change management.

### Gaps in Assurance

Independent audit of the estates and facilities processes

### Request for Closure

NO
### Principal Risk 10: If we do not work in a way that protects the reputation of the trust there is a risk that we will find it difficult to recruit staff, service users will report adverse experience, we will not be an attractive business partner and we will attract undue attention of our regulators.

<table>
<thead>
<tr>
<th>Risk Category:</th>
<th>Reputational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Appetite</td>
<td>Cautious to open (nominal range 3-10)</td>
</tr>
</tbody>
</table>

#### Potential Causes (links to the CRR)
- Insufficient horizon scanning
- Inability to deal with shocks
- Operational silos combined with lack of team to Board engagement

#### Potential Consequences
- 1. Being seen by the system as a 'problem' and a 'laggard' - with resultant diminution of strategic influence
- 2. Erosion of innovation capability leading to poorer care, fewer discoveries, less success raising funding
- 3. Appetite of existing and potential partners cooling

#### Key Controls
1. Effective horizon scanning (for example through Comms update and horizon scanning at the Board)
2. Robust clinical and corporate governance - particularly for unusual risks
3. Trend data on key measures such as use of restraints, mortality, patient experience, staff and patient surveys
4. Financial control data
5. Engaged workforce
6. Implementation of PPI strategy
7. Established and open relationships with commissioners and regulators.

#### Sources of Assurance
- Lead indicators: Chief Executive's report to the Board; Opinion of regulators; Relationships with key partners; Reputation with key opinion formers in mental health.
- Lag indicators: Media coverage; All Board committee reports - particularly Audit committee reports; Auditor's report; All BAF risk consider the inherent reputational associated within the specific risks; All BAF risks consider the inherent reputational associated within the specific risks

#### Assurance on the effectiveness of Controls
- Well led assessment for the Board; staff survey: PEDICs.

#### Request for Closure
- Yes recommend for closure
**Principal Risk 11:** There is a risk that the significant time, resource and money that the trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.

<table>
<thead>
<tr>
<th>Owner: MH/ MD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Committee:</strong></td>
<td>Quality committee</td>
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<tr>
<td><strong>Proximity:</strong></td>
<td>12 months</td>
</tr>
<tr>
<td><strong>Risk Category:</strong></td>
<td>Quality (patient safety, experience &amp; clinical outcomes)</td>
</tr>
<tr>
<td><strong>Risk Appetite:</strong></td>
<td>Cautious (nominal range 3-8)</td>
</tr>
<tr>
<td><strong>Initial</strong></td>
<td><strong>Current</strong></td>
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<td>Level</td>
<td>9</td>
</tr>
<tr>
<td>Last reviewed</td>
<td>Mar-18</td>
</tr>
</tbody>
</table>

**Potential Causes (links to the CRR)**

QI devolves authority to teams to make changes to improve quality of care and relies on teams using data to make improvements through a structured methodology. Lack of clinical engagement. Demand for services reduces time available within clinical teams for QI. Cuts to services reduces resource available for QI. The iCare QI programme fails to deliver improvements in bed pressure.

**Key Controls**

- Investment in a clear methodology, training rolled out, dedicated QI resource. QI team assist and monitor progress with each project. QI Programme Board monitors progress of QI delivery.

**Sources of Assurance**

- Data is collected for each project from inception. The data plan is drawn up individually by project and projects are assigned a project progress score on a monthly basis. SMT members updated bi weekly. Bi-monthly reporting to QSC and Board

**Assurance on the effectiveness of Controls**

- New governance processes are beginning to demonstrate the effectiveness of controls for this programme.

**Potential Consequences**

- No improvements made to quality or efficiency of services. Reputational risk to organisation as known externally to be pursuing QI agenda. Financial risk of negative return with no improvement in quality.
- Disengagement of workforce. Bed pressures remain a significantly challenging issue impacting on quality of care and performance ratings.

**Gaps in Control**

- An effective balance between pursuing increased performance and implementing quality improvements has yet to be achieved. iCare QI programme planned but yet to be rolled out. Value for money assurances.

**Gaps in Assurance**

- Not all the data is available within Business Intelligence for projects at the current time. Therefore a lot of data is collected manually currently.

**Request for Closure**

- No
**Principal Risk 12:** If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage within Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which will prompt intervention by the Regulators.

<table>
<thead>
<tr>
<th>Owner: GH/ CFO</th>
<th>Committee: Finance and Performance Committee</th>
<th>Likelihood</th>
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<td>Risk Appetite: Cautious to open (nominal range 3-10)</td>
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<td>Level</td>
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<td>12</td>
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<td>Last reviewed</td>
<td>Next review</td>
<td>Mar-18</td>
<td>Jun-18</td>
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</table>

**Potential Causes** (links to the CRR)

There is a risk that due to the on-going and severe financial pressures in the NHS, South London Health Economy and SEL STP contract values will be offered and set at levels that would put patient care at risk. Currently, the key CCGs for SLAM (Lambeth, Southwark and Croydon) are all funded in the lowest quartile in terms of spend per weighted population. The Trust has been required to make more than £70m worth of savings in the last 3 financial years and there is a requirement of £16.4m CIP in 2018/19 (4.1% of turnover). Whilst this is seen as achievable it is still a very high requirement over a prolonged time period which is not seen as sustainable. Additional risk will also stem from the variability of financial health across the key commissioning boroughs. The acuity of our patients and demand for services continues to be higher than expected which has driven up average length of stay (bed days) and as such the need for overspill beds which are in excess of budgets and disproportionately expensive. In addition, delayed transfers of care continue to be commonplace due to continued constraints in local government and particularly social care. The Trust has multiple and emergent requirements that need additional financial resource and divert management focus (e.g. Operational reorganisation, developing Alliances, CQC preparation). The Trust has significant challenges recruiting and retaining key staff groups (e.g. Band 6 community nurses) this will continue to ramp up the pressure to utilise agency staff despite a decrease in the Trust’s agency ceiling.

**Key Controls**

Regular Performance meetings (PACMAN) for all Operational Directorates and corporate areas where the financial position are monitored are held monthly and are escalated to a Portfolio board chaired by the CEO. The Trust has been able to step up and down these meetings as required allowing decisions to be made in an agile way. Financial performance (incl. CIP and QIPP) are reported routinely to the FPC, Trust Board, NHSI and SMT. Overspill beds have been managed via an escalation process to Gold and Silver command structures and as a result private bed usage has reduced although it remains a significant downside risk. Quality Impact Assessments are in place for all CIPs to ensure patient care and safety are assured. New Operational delivery units will allow better cost control once they are fully developed. The Trust has a fully staffed PMO that works closely with Finance and Operational teams.

**Potential Consequences**

Quality: Failure to manage the Trust’s costs and deliver savings will have a number of impacts that will directly impact patient care, experience and safety.

Access / Activity: This will limit the number of patients the Trust can treat and/or the quality of care that can be provided. In addition to avoid patient safety issues the trust may be forced to withdraw from services altogether reducing access to the local population.

Capacity (Clinical): This will manifest as resources (especially clinical and nursing staffing) being severely constrained.

Capacity (Management): Increasing financial constraints will also consume managerial capacity within the trust and limit the focus on maximising quality. In addition, non-delivery of financial will increase the likelihood of intervention by NHSI and would likely lead to significant external scrutiny and more extreme action to restore financial balance. In addition, management focus will be limited due to competing priorities e.g. Operational reorganisation, CQC preparation and developing Alliance contracts. Moreover, non-delivery within available resources will have a negative impact on the trust’s cash position and would constrain its ability to invest in estate, equipment and technology to ensure they remain fit for purpose and offer the best value for money.

**Gaps in Control**

QI, value based, programmes are established but still to be fully realised and measuring outcomes in terms of ROI will be a challenge. Delivery of the programmatic approach of PMO, QI Team and SLAM partners are underway. Sustainable processes and procedures for overspill beds and placements will be required to ensure long term delivery.
### Sources of Assurance
Outturn performance in line with monthly reports. Internal audit reviews of systems and processes. External audit review. Review meetings with commissioners. Year to date performance and forecasts are regularly monitored. Further recurrent and one-off opportunities being reviewed to mitigate risks. Mental Health Investment Standard has been agreed with commissioners for 2018/19 although how this will be spent remains subject to negotiation in some cases. QIPPs requiring specific cost reductions have been limited to circa £1.5m in 2018/19 (as opposed to circa £10m in 2017/18). In addition, none of these QIPPs are related to adult acute pathway bed reductions. Planning and Contracts for two-years finalised by 23rd December 2016. Where QIPPs are not being delivered by the CCGs the Trust is challenging and seeking recompense as appropriate. Reports are made to the Finance and Performance Committee and the Trust Board. Agency progress reporting through Finance reports to the FPC and Board. Increased challenge reduced spend in 16/17 and 17/18. However, the challenge in 2018/19 is significant as the ceiling has reduced by more than £2m.

### Gaps in Assurance
A long term financial strategy still to be is being developed with models to underpin it.

Financial Modelling of new contractual models and impact of individual Borough approaches including partnership collaborative agreements need to be completed and assessed including Lambeth Living Well Network and Croydon Alliance.

### Assurance on the effectiveness of Controls
Internal audit programme; Audit Committee review with FPC
Actual performance in line with forecasts.

### Request for Closure
no
## Principal Risk 13: If the Trust fails to meet its mandatory training compliance targets as a result of poor local management oversight, data quality or availability of courses, there is a risk to staff

<table>
<thead>
<tr>
<th>Owner: HRD</th>
<th>Committee: Equalities &amp; Workforce Committee</th>
<th>Likelyhood: 5</th>
<th>Current: 4</th>
<th>Target: 2</th>
<th>Trend: new risk</th>
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<tr>
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<td>Level: 20</td>
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<tr>
<td>Risk Appetite: Minimal-Cautious (nominal range 1-8)</td>
<td>Last reviewed: new risk Jun-18</td>
<td>Next review: Sep-18</td>
<td></td>
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</tr>
</tbody>
</table>

### Key Controls
- Mandatory training policy. Mandatory and service specific training (inc. e-learning). LEAP. Mandatory training compliance linked to individual appraisals. Report of Trust’s statutory and mandatory training to align our requirements with those of our SLP partners and reduce the burden of training.

### Sources of Assurance

### Assurance on the effectiveness of Controls
- Actions and controls introduced over the last 12 months have produced a steady improvement in overall Trust-wide levels of mandatory training, from 76% in April 2017 to 81% in March 2018 but this is still short of the Trust’s target of 85%.

### Potential Causes (links to the CRR)
- An increasing list of training topics deemed as mandatory. Training requirements potentially over-specified for some groups of staff. Training capacity issues, both in terms of trainer and venue availability. Challenges with the new learning management system (LEAP). Slower development of e-learning alternatives than would be ideal. Wide variation in line manager’s oversight and direction of local staff attendance.

### Potential Consequences
- Difficulty in releasing staff for training, loss of faith in the data LEAP holds and lack of management oversight leading to poor mandatory training compliance rates. Lower mandatory training rates could lead to patient care and staff safety and well-being compromised an extreme cases the Trust could be liable for failing to meet its own and external standards including enforcement action.

### Gaps in Control
- Inaccuracy with training data as ESR out of line with LEAP. Inherent weakness of manual workarounds whilst LEAP issues addressed. Management actions to address non compliance with key training (PSTS, BLS and ILS training) yet to embed. Statutory and mandatory training review report assessment and action plan

### Gaps in Assurance
- LEAP data accuracy concerns.

### Request for Closure
- Open as new risk
Title | Audit Committee (‘the Committee’) Terms of Reference
---|---
Author | Steven Thomas (Audit Committee Secretary)
Accountable Director | Duncan Hames (Audit Committee Chair)

**Purpose of the paper**

Under the Standing Orders of the Board of Directors, only the Board shall determine the Terms of Reference (ToR) of any of its Committees.

The Audit Committee concluded a review of its ToR at its meeting on 21 May 2018, and a final draft is offered for consideration and ratification by the Board.

**Executive summary**

At its meeting on 21 May 2018, as part of its annual review process, the Audit Committee undertook an appraisal of its terms of reference. To assist, the Audit Committee was equipped with:

- The results of a survey undertaken in March/April, seeking views on the Committee’s effectiveness;
- A breakdown of how the Committee has spent its time over the period 1 April 2017 – 31 March 2018;
- An analysis of the extent to which the Committee considered issues relating to Board Assurance Framework risks during that period;
- Information about attendance levels;
- Information on how the Committee has interacted with other Board Committees;
- A template Terms of Reference, specifying areas already identified as requiring update; and
- Important specific confirmations for 2017/18 required by the Audit Committee’s current Terms of Reference

**Conclusions**

The review indicated that, overall, the Committee is operating effectively with some possible points for improvement for the Committee to discuss as regards: effective use of data by the Audit Committee; the clarity/focus of agenda papers received by the Audit Committee; increasing the duration of Committee meetings; and clarifying/publicising the Committee’s role of ‘prime oversight’.

The Committee considered that, given the proposal to reinforce the Committee’s role of ‘prime oversight’, arguably BAF risk 6 (external partner working) should be re-allocated to the Business Development and Investment Committee (‘BDIC’). The BDIC has already played a material role in the oversight of new partnership ‘alliance’ arrangements in the boroughs. This would ensure that each BAF risk is owned elsewhere in the first instance, and that the Audit Committee’s role is more clearly one of prime oversight. **Note: the latest BAF iteration shows that BAF risk 6 has subsequently been re-allocated to the BDIC.**

The Board is asked to approve the Terms of Reference as set out in this paper.

**Committees where this item has been considered**

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 May 2018</td>
<td>Audit Committee</td>
</tr>
</tbody>
</table>
The Audit Committee agreed a revised version of its current terms of reference at its May 2018 meeting. This has been re-analysed to follow the latest template required to be used for all Board Committees. The references [in square brackets] below show the derivation paragraphs in the revised version agreed by the Audit Committee or show that the paragraph derived from the template. These references will be removed in the final document. Track changes show changes to the current terms of reference as agreed by the Audit Committee at its May 2018 meeting.

AUDIT COMMITTEE TERMS OF REFERENCE

1. PURPOSE

The overall purpose of the Committee is to support the Board in effective implementation of Board strategy, by promoting the efficient and effective management of risk and excellent financial management and governance within SLaM, and by acting as the committee with prime oversight of these matters. It will do this by putting in place arrangements:

(a) generally to review and periodically report to the Board on the adequacy of the Assurance Framework and the associated systems and procedures which support it. Each Board committee is allocated specific areas of the Assurance Framework for ongoing review, and the Audit Committee considers this work when itself reporting to the Board; and

(b) specifically to monitor, review and periodically report to the Board on the adequacy of the financial systems and procedures used within SLaM. [2.1]

2. DUTIES

General

In carrying out its role, the Audit Committee will:

- Prepare a forward workplan and keep track of actions arising.
- Monitor Trust risks allocated to the Committee by way of the Board Assurance Framework, focussing on the key risks and mitigating actions, and report to the Board
- Undertake, every 6 months, a detailed review of the Board Assurance Framework risks that the Committee has the delegated oversight responsibility for.
- Have due regard to all risk connected to the objectives of the Committee, focussing on key risks, mitigating actions and escalating issues to the Board as appropriate. [Template]

Operation of the Committee

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

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

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

The Chief Financial Officer will be responsible for ensuring that the Committee is kept informed of all significant financial risks, predicted changes in risk status and any significant weakness in SLaM’s financial management arrangements. [5.4]
The Committee may obtain outside legal or other independent professional advice and may secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. [5.5]

**Board Assurance Framework**

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

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

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

**Financial Assurance**

The Committee shall have specific responsibility for ensuring that the principal systems and processes associated with financial management and financial governance within SLaM are efficient, effective and fit for purpose. These shall include:

(a) internal control including arrangements for the prevention and detection of fraud and corruption;
(b) internal audit;
(c) external audit; and
(d) financial management arrangements associated with resource planning, accounting, control, reporting and compliance. [4.1]

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

**Internal Control and Risk Management**

The Committee shall review the establishment and maintenance of systems and procedures associated with the management and control of SLaM’s financial assets and liabilities in order to ensure that:

(a) those systems and procedures are efficient, effective and compliant with current legislative and national standards;
(b) those systems promote the detection and prevention of error, fraud or corruption; and
(c) financial regulations and procedures are current, relevant and complied with. [6.1]

**Internal Audit**

The Committee will:

(a) in conjunction with the Chief Financial Officer determine the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal;
(b) review and approve the internal audit programme, consider the major findings of internal audit investigations and the adequacy of the management response. The Committee shall receive regular reports updating the Committee on the extent to which recommended changes have been implemented;
(c) ensure that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
(d) annually assess the independence, objectivity, efficiency and effectiveness of the internal audit function. [7.1]

Counter Fraud function
The Committee will:
(a) in conjunction with the Chief Financial Officer determine the appointment of the counter fraud service, the fee and any questions of resignation and dismissal;
(b) consider and comment on counter fraud’s proposed work programme (produced to meet mandated requirements), consider progress reports from the counter fraud function and the adequacy of the management response;
(c) ensure that the counter fraud function is adequately resourced and has appropriate standing within the organisation; and
(d) annually assess the independence, objectivity, efficiency and effectiveness of the counter fraud function. [8.1]

External Audit
The Committee will:
(a) annually report to the Council of Governors as to the performance of the external auditor (including details such as the quality and value of the work, and the timeliness of reporting and fees) to enable the Council of Governors to consider whether or not to reappoint the external auditor. The Committee will also make recommendations to the Council of Governors as to the appointment, reappointment, termination of appointment and fees of the external auditor and (if the Council of Governors rejects the Committee’s recommendations) prepare an appropriate statement for the Board to include in the Annual Report;
(b) review the annual audit programme in conjunction with the external auditor and the Chief Financial Officer;
(c) review external audit reports, including value for money reports and management letters, together with the management response, and the annual governance report (or equivalent);
(d) develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance on this matter; and
(e) annually assess the independence, objectivity, efficiency and effectiveness of the external audit function. [9.1]

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

‘Whistleblowing’ arrangements
The Committee should review arrangements by which SLaM’s staff may raise, in confidence, concerns about possible improprieties in matters of: financial reporting and control; clinical quality; patient safety; or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. [11.1]

3. CONSTITUTION, MEMBERSHIP AND PROCEDURE

3.1 Members

The Committee is a standing committee of the Board and is responsible to the Board. The Committee’s members are appointed by the Board from its non executive members. The Committee shall consist of at least three members of which one shall have relevant financial experience. The Board or the Chair of the Board will also appoint the Committee’s Chair. [1.1]

All Committee members are expected to attend each Committee meeting. The Chief Financial Officer, the Chief Operating Officer, the Head of Internal Audit, the Local Counter Fraud Specialist (‘LCFS’) or a nominated representative and a representative of the external auditors shall normally attend meetings. Other members of the Board may attend if they
A representative of the Council of Governors will attend as an observer. No other party may attend without the Committee’s specific invitation. The Committee has the overriding authority to restrict attendance at a meeting if the Committee considers this to be appropriate in the specific circumstances of that meeting. [15.1]

A record of attendance shall be kept. Other Trust staff will be required to attend to address specific issues as they arise. [Template]

3.2 Accountability

The Audit Committee is responsible to the Trust Board of Directors. As a minimum, the Audit Committee will: provide a briefing note, escalating key issues, to the Board after each of its meetings; escalate concerns to the Board; present areas of specific interest or concern at the request of the Board as required and provide an Annual Report. [Template]

The Committee’s Chair will report to the Council of Governors: annually on the Committee’s work; and (if and as the Committee considers it necessary) on matters needing action or improvement, and the corrective steps to be taken. [15.3]

3.3 Working between the Board and its Committees

In order for the Audit Committee to provide assurance for the Board on the efficient and effective management of risk and oversight of the functioning of the Trust systems of control, there needs to be a very close working relationship between the Audit Committee and:

(a) the Finance and Performance Committee;
(b) the Quality Committee; and
(c) the Business Development and Investment Committee. [5.6]

Each committee will be considering issues of risk and potential decisions on investment which have an impact on quality and finance. [5.6]

The Audit Committee will receive a report at each regular quarterly meeting from the Quality Committee, the Finance and Performance Committee and from the Business Development Committee on key issues arising with a particular focus on risk and where there are concerns over the management of risk or variations and changes to the way risks are being managed. The feedback should cover any significant areas of risk or gaps in controls or assurance. The Audit Committee will consider whether to provide an update specifically for these committees on particular issues where this is not covered by the routine Board escalation reports. [5.7]

Where possible the Board will consider the opportunity for explicit joint membership of the NEDs between these committees. [5.8]

To the extent that joint membership is not possible, the Chairs of each of the sub-committees should consider the need to meet together in order to discuss the escalation reports and issues arising to ensure that there are no gaps in assurance or control emerging which have not been considered appropriately. The Chairs should advise their respective committees of such meetings, and the fact that these meetings have occurred should be recorded in the minutes of the respective committees. [5.9]

The Audit Committee will schedule time at its meetings at least once a year to which the Chairs of the Quality Committee and the Business Development Committee will be invited to discuss common issues and assurances. There will be a standing invitation for the Chair of each committee to attend the meetings of the other committees. [5.10]

Each Board sub-committee will consider the effectiveness of these arrangements as part of their annual review and report to the Board. [5.11]

3.5 Partnership working
The Committee will keep under review the need to obtain and/or provide reports to bodies with which SLaM is involved in partnership working. Such bodies may be NHS Trusts or other bodies engaged in service user pathways. [5.12]

3.5 Roles and Responsibilities

Chair: Non Executive Director
Minutes and administration of meeting: Trust HQ will provide a secretariat function
Key contact in Trust: CFO

[Template]

3.6 Frequency of meetings

Meetings will be held at least four times a year. In addition, the Committee’s Chair or the Board may convene one or more special meetings of the Committee. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. [12.1]

At least once a year the Committee may wish to meet with the external and internal auditors and LCFS without any executive Board director present. This is without prejudice to the unrestricted right of access to the Committee’s Chair by the external auditor and/or the Head of Internal Audit. [15.2]

3.7 Conduct of meetings

All procedural matters in respect of the conduct of meetings shall follow the Trust’s Standing Orders. [Template]

The Chair, Executive Lead and Secretary will review the agenda in advance of meetings and the effectiveness of the committee after each meeting. [Template]

Archives of minutes and papers relating to Audit Committee meetings are kept on the Trust shared drive. [Template]

3.8 Quorum

A quorum shall be two members. [13.1]

3.9 Terms of reference review

The Terms of Reference will be reviewed annually, and any proposed alterations remitted to the Trust Board of Directors for determination. [Template]

Date of next review: April 2019

Revision log

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<th>Date</th>
<th>Version</th>
<th>Comments</th>
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<td>March 2005</td>
<td>V1</td>
<td>Audit Committee Chair Terms of Reference formally adopted by Board (of Directors).</td>
</tr>
<tr>
<td>September 2006</td>
<td>V2</td>
<td>Audit Committee Secretary Terms of Reference updated for recent DH guidance and approved by Audit Committee.</td>
</tr>
<tr>
<td>October 2006</td>
<td>V3</td>
<td>Audit Committee Secretary Terms of Reference reformatted to fit Trust template and approved by Board (of Directors).</td>
</tr>
<tr>
<td>December 2006</td>
<td>V4</td>
<td>Audit Committee Secretary Terms of Reference updated for Foundation Trust status (including Sep 06 Foundation Trust Code of Governance)</td>
</tr>
<tr>
<td>September 2007</td>
<td>V5</td>
<td>Audit Committee Secretary Update for changes in Chair and Members, and for minor style points.</td>
</tr>
<tr>
<td>June/July 2009</td>
<td>V6</td>
<td>Audit Committee Secretary Minor clarification, update and style revision, also reflecting a review against the Foundation Trust Code of Governance and the</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------</td>
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<td>----------</td>
</tr>
</tbody>
</table>
| February 2011 | V7      | Audit Committee Secretary  
Update, reformatting and clarifications, also taking account of the latest current version of the Foundation Trust Code of Governance (March 2010 version) and the Bribery Act 2010. |
| December 2012 | V8      | Audit Committee Secretary  
References to the ‘Board Assurance Framework’ have been replaced with references to the ‘Assurance Framework’ to reflect current nomenclature. The AC meeting of 11 December 2012 considered that no further amendments were required and that the TOR were appropriate for Board approval. |
| March 2014   | V9      | Audit Committee Secretary  
Minor update to reflect current nomenclature. |
| June/July 2014 | V10     | Chief Financial Officer and Audit Committee Secretary  
Update to section covering operations of the Committee to incorporate more specific reference to escalation, communications and close working between the Audit Committee, Business Development and Investment Committee and Quality Committee paragraphs 5.6 to 5.11. New paragraph 3.3 clarifies the reports from SLaM management required by the Committee to enable it to fulfil its role regarding the Assurance Framework. |
| June 2015    | V11     | Audit Committee Secretary  
Minor interim update pending a fuller review of the terms of reference of all SLaM's committees. The interim update includes: the Counter Fraud function (section 8 – the Counter Fraud function has confirmed it is content with this wording); the Governor Observer role (section 15.1); and liaison with the Maudsley Charity (section 15.4). |
| September 2015 | V12    | Audit Committee Secretary  
Interim update to refer to the attendance of the Chief Operating Officer at Audit Committee meetings (paragraph 15.1 refers). The Board’s ratification of this change will be sought as part of the next substantive update of the terms of reference. |
| July 2016    | V13     | Audit Committee Secretary  
No changes are proposed other than ratifying inclusion of the Chief Operating Officer in para 15.1 (as noted above) and inclusion of the Finance and Performance Committee in paras 5.6 and 5.7, as that Committee was formed after the Board most recently approved the Audit Committee’s terms of reference. |
| July 2017    | V14     | Audit Committee Secretary  
No changes proposed (as agreed at the Audit Committee meeting 27 June 2017) |
| May 2018     | V15     | Audit Committee Secretary, agreed by Audit Committee  
Amendments to reflect new template and latest agreed practice |
Title | Finance and Performance Committee ('FPC') Terms of Reference
---|---
Author | Steven Thomas (FPC Secretary)
Accountable Director | June Mulroy (FPC Chair)

Purpose of the paper
Under the Standing Orders of the Board of Directors, only the Board shall determine the Terms of Reference ('ToR') of any of its Committees.

The Finance and Performance Committee concluded a review of its ToR at its meeting on 12 June 2018, and a final draft is offered for consideration and ratification by the Board.

Executive summary
At its meeting on 12 June 2018, as part of its annual review process, the Finance and Performance Committee undertook an appraisal of its terms of reference. To assist, the Committee was equipped with:
- The results of a survey undertaken in March/April, seeking views on the Committee’s effectiveness;
- A breakdown of how the Committee has spent its time over the period 1 April 2017 – 31 March 2018;
- An analysis of the extent to which the Committee considered issues relating to Board Assurance Framework risks during that period;
- Information about attendance levels;
- Information on how the Committee has interacted with other Board Committees; and
- A template Terms of Reference, specifying areas already identified as requiring update

The review indicated that, overall, the Finance and Performance Committee is operating effectively with some points for the FPC to discuss for improvement as regards availability of information in the agenda papers and the clarity/focus of agenda papers.

Key points for Board consideration
The FPC considers that the Trust needs to clarify roles as regards one of the risks currently included in the FPC’s remit for monitoring and review, namely Risk 3 – ‘Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements’.

The FPC notes that it reviews the use made of information available from the various Trust informatics systems but does not consider the systems themselves or technical issues related thereto. Those factors are considered by other Trust groups which report to the Senior Management Team (‘SMT’) and hence to the Board.

With this proviso the FPC is content for risk 3 to remain in its remit

The Board is asked to approve the Terms of Reference as set out in this paper.

The FPC’s current Terms of Reference have been put into the format of the latest template for the Trust’s Committee Terms of Reference and revised. Tracked changes indicate the main changes as compared with the latest template and the current Terms of reference.

Committees where this item has been considered
<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 June 2018</td>
<td>Finance and Performance Committee</td>
</tr>
</tbody>
</table>
1. PURPOSE

The overall purpose of the Finance and Performance Committee is to monitor the Trust’s operational and financial performance, and to provide assurance to the Board about the delivery and sustainability of performance and delivery against operational and financial plans and in delivery of the Trust strategy and financial strategy.

2. DUTIES

Each year the Finance and Performance Committee will establish its priorities for the year ahead and will agree these with the Board before the start of the year.

In carrying out its role, the Finance and Performance Committee will:

- prepare a forward workplan and keep track of actions arising
- monitor Trust risks allocated to the Committee by way of the Board Assurance Framework, focussing on the key risks and mitigating actions, and report to the Board
- undertake, every 6 months, a detailed review of the Board Assurance Framework risks that the Committee has the delegated oversight responsibility for
- have due regard to all risk connected to the objectives of the Committee, focussing on key risks, mitigating actions and escalating issues to the Board as appropriate

The Finance and Performance Committee will work to:

- provide assurance to the Board on the delivery of efficient and economical financial and operational performance against internal and external targets agreed by the Trust. This will include (where appropriate in parallel with other relevant initiatives) consideration of:
  - benchmarking information, business modelling reports and other information comparing the Trust with other relevant entities; and
  - management arrangements for efficient and effective delivery of Trust programmes
- support the development, implementation and delivery of the Medium Term Financial Plan (MTFP)
- support and promote the efficient use of financial resources by reviewing the Trust’s Financial strategy, performance and business development
- review and endorse the Trust’s annual revenue and capital budgets before they are presented to the Board for approval
- approve the development of financial and contractual reporting in line with best practice.
- provide assurance to the Board on systems and processes, supporting submissions to NHS Improvement
- review and approve submissions to NHS Improvement as delegated by the Board in order to meet external deadlines.

3. CONSTITUTION, MEMBERSHIP AND PROCEDURE

3.1 Members

- Non-Executive Director (Chair)
- Non-Executive Director
- Chief Executive
- Chief Financial Officer (‘CFO’)
Chief Operating Officer (‘COO’)
Director of Strategy and Commercial
Director of Finance

All members are expected to attend every meeting or nominate a named deputy. A record of attendance shall be kept. All Board members are welcome to attend. Other Trust staff will be required to attend to address specific issues as they arise.

3.2 Accountability

The Finance and Performance Committee is responsible to the Trust Board of Directors. As a minimum, the Finance and Performance Committee will: provide a briefing note, escalating key issues, to the Board after each of its meetings; escalate concerns to the Board; present areas of specific interest or concern at the request of the Board as required and provide an Annual Report.

3.3 Working between the Board and its Committees

The Finance and Performance Committee interacts mainly with the Audit Committee.

The Finance and Performance Committee will provide a briefing note, escalating key issues, to the Board after each of its meetings. It will also provide regular reports to the Audit Committee. The Chairs of the Finance and Performance Committee and Audit Committees should meet regularly in order to discuss the escalation reports and gaps in assurance or control. The Chair of the Finance and Performance Committee shall also be a member of Audit Committee.

The Finance and Performance Committee may remit matters to any other Board Committee as the Chair finds appropriate, and vice versa. Minutes of the Finance and Performance Committee will be circulated to other Board Committee Chairs. The Committee will work with other Committees as appropriate.

Each Board Committee will consider the effectiveness of these arrangements as part of their annual review and report to the Board.

3.4 Partnership working

The Committee will keep under review the need to obtain and/or provide reports to bodies with which SLaM is involved in partnership working.

3.5 Roles and Responsibilities

Chair: Non Executive Director
Minutes and administration of meeting: Trust HQ will provide a secretariat function
Key contact in Trust: CFO and COO

3.6 Frequency of meetings

Meetings will be held every two months (approximately six times a year). The Committee Chair may call one or more Extraordinary meetings of the Committee, for example to agree the Annual Plan for the Trust.

3.7 Conduct of meetings

All procedural matters in respect of the conduct of meetings shall follow the Trust’s Standing Orders.

The Chair, Executive Lead and Secretary will review the agenda in advance of meetings and the effectiveness of the committee after each meeting. [Temporary drafting note: this is standard wording in latest template – this review is in addition to any end of meeting evaluation by a Committee member]
3.8 Quorum

A quorum shall be two members to include the following (or their deputy with full delegated authority):
- one Non-Executive member
- one Executive member

3.9 Terms of reference review

The Terms of Reference will be reviewed annually, and any proposed alterations remitted to the Trust Board of Directors for determination.

Date of next review: April 2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2015</td>
<td>V1</td>
<td>Gus Heafield (CFO)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Initial draft of the terms of reference</td>
</tr>
<tr>
<td>February 2016</td>
<td>V2</td>
<td>Steven Thomas (FPC Secretary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revised for points from Board meeting (23/02/2016) approving the document, and minor amendments of consistency/layout</td>
</tr>
<tr>
<td>September 2016</td>
<td>V3</td>
<td>Steven Thomas (FPC Secretary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Administrative amendments (membership section page 1)</td>
</tr>
<tr>
<td>July 2017</td>
<td>V4</td>
<td>Steven Thomas (FPC Secretary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amendments to membership section (page 1)</td>
</tr>
<tr>
<td>May/June 2018</td>
<td>V5</td>
<td>FPC and Steven Thomas (FPC Secretary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amendments to reflect new template and latest agreed practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amendments as to NED membership (3.1) and quoracy (3.8)</td>
</tr>
</tbody>
</table>
REPORT TO THE TRUST BOARD: PUBLIC
19 JUNE 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Business Development &amp; Investment Committee Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Adam Pryce/ Jenn Owen</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Altaf Kara</td>
</tr>
</tbody>
</table>

Purpose of the paper
Under the Standing Orders of the Board of Directors, only the Board shall determine the Terms of Reference (ToR) of any of its Committees.

The Business Development & Investment Committee (BDIC) concluded a review of its ToR at its meeting on 12 June 2018, and a final draft is offered for consideration and ratification by the Board.

Executive summary
In 12th June 2018, as part of its annual review process, the Business Development & Investment Committee undertook an appraisal of its terms of reference. To assist, the Committee was equipped with:
- The results of a survey undertaken in March / April, seeking views on the Committee’s effectiveness;
- A breakdown of how the Committee has spent its time over the period 1 April 2017 – 31 March 2018;
- An analysis of the extent to which the Committee considered issues relating to Board Assurance Framework risks during that period;
- Information about attendance levels;
- Information on how the Committee has interacted with other Board Committees; and
- A template Terms of Reference, specifying areas already identified as requiring update e.g. ownership of BAF risks.

The Committee also sought to illustrate the governance / accountability structures around it.

The Committee proposes changes to membership and quorum sections of the ToR to ensure consistency with other Committees.

The Board is asked to approve the Terms of Reference as set out in this paper.

Committees where this item has been considered
<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/06/2018</td>
<td>Business Development &amp; Investment Committee</td>
</tr>
</tbody>
</table>
BUSINESS DEVELOPMENT AND INVESTMENT COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

The overall purpose of the BDIC is to monitor business development, investment, and commercial strategy and provide assurance to the Board in terms of investment decisions and scrutiny of the trusts commercial activities.

2. DUTIES

In carrying out its role, the BDIC will:

- Provide assurance to the Board over the delivery of the Commercial Strategy for the Trust
- Evaluate and provide assurance to the Board on the identification and appropriate consideration of commercial opportunities based on their business case including particular consideration of appropriate due diligence arrangements
- Evaluate and provide assurance to the Board on the identification and appropriate consideration of high-value tenders for new or existing NHS contracts based on their business case
- Advise the Board on potential options and the best uses of available resources in order to maximise value added
- Evaluate and provide assurance to the Board for the assessment of opportunities and potential strategic partners for the Trust and appropriate models such as joint ventures, partnerships, or alliance contracts
- Review and provide assurance to the Board on the financial and commercial arrangements relating to investments, developments, disinvestments and decommissioning plans. The committee will approve of business cases for major investment and disinvestment decisions within limits delegated to it by the Board.
- Evaluate and provide assurance to the Board over the development and implementation of the commercial strategy, including developing and scrutinising the key financial deliverables for the Trust including appropriate and attractive financial returns.
- Provide advice to the Board on necessary actions or improvements required to address potential issues identified
- Identify and keep under review appropriate arrangements whereby decisions or advice from the committee can be obtained at short notice arising from the specifics of a particular transaction or proposal
- Prepare a forward workplan and keep track of actions arising
- Monitor Trust risks allocated to the Committee by way of the Board Assurance Framework, focussing on the key risks and mitigating actions, and report to the Board
- Undertake, every 6 months, a detailed review of the Board Assurance Framework risks that the Committee has the delegated oversight responsibility for
- Have due regard to all risk connected to the objectives of the Committee, focussing on key risks, mitigating actions and escalating issues to the Board as appropriate
3. CONSTITUTION, MEMBERSHIP AND PROCEDURE

3.1 Members

Chief Executive
Chief Financial Officer
Medical Director (with cover from Director of Nursing if required)
Chief Operating Officer
Director of Strategy and Commercial – Executive lead
Non-Executive Director
Non-Executive Director

All members are expected to attend every meeting or nominate a named deputy. A record of attendance shall be kept. All Board members are welcome to attend. Other Trust staff will be required to attend to address specific issues as they arise.

The Council of Governors will be invited to nominate a Governor observer to attend meetings of the Committee.

3.2 Accountability

The BDIC is responsible to the Trust Board of Directors. As a minimum, the BDIC will:
- provide a briefing note, escalating key issues, to the Board after each of its meetings;
- escalate concerns to the Board; present areas of specific interest or concern at the request of the Board as required and provide an Annual Report.

3.3 Working between the Board and its Committees

The BDIC interacts with the Finance and Performance Committee, the Audit Committee and the Quality Committee.

The BDIC will provide a briefing note, escalating key issues, to the Board after each of its meetings. It will also provide regular reports to the Finance and Performance Committee, the Audit Committee and the Quality Committee. The Chairs of the Finance and Performance Committee, the Audit Committee and the Quality Committees should meet regularly in order to discuss the escalation reports and gaps in assurance or control. The Chair of the Audit Committee shall also be a member of BDIC Committee.

The BDIC may remit matters to any other Board Committee as the Chair finds appropriate, and vice versa. Minutes of the BDIC will be circulated to other Board Committee Chairs. The Committee will work with other Committees as appropriate.

Each Board Committee will consider the effectiveness of these arrangements as part of their annual review and report to the Board.

The BDIC will schedule time at its meetings at least once a year to which the chairs of the Quality and Audit Committees will be invited to discuss common issues and
assurances. There will be a standing invitation for the Chair of each committee to attend the meetings of the other committees.

3.4 Roles and Responsibilities

Chair: Non-Executive Director – June Mulroy
Minutes and administration of meeting: Secretariat support will be provided by the SLaM executive

3.5 Frequency of meetings

Meetings will be held at least six times a year. The Committee Chair may call an Extraordinary meeting of the Committee.

3.6 Conduct of meetings

All procedural matters in respect of the conduct of meetings shall follow the Trust’s Standing Orders.

The Chair, Executive Lead and Secretary will review the agenda in advance of meetings and the effectiveness of the committee after each meeting.

Archives of minutes and papers relating to BDIC meetings are kept on the Trust shared drive.

3.7 Quorum

A quorum shall be three members to include the following (or their deputy):
- 2 Non-Executive Directors
- 1 Executive Director
or, in exceptional cases, if previously agreed by the Chair,
- 1 Non-Executive Director
- 1 Executive Director

3.8 Terms of reference review

The Terms of Reference will be reviewed annually, and any proposed alterations remitted to the Trust Board of Directors for determination.

Date of next review: April 2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/06/2018</td>
<td>1</td>
<td>Small changes to membership and quorum</td>
</tr>
</tbody>
</table>
Title | Quality Committee update
---|---
Non-Executive Director | Anna Walker

**Purpose of the paper**

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

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

The Board is asked to **note** the report which is presented for information and discussion. This report covers meetings of the Quality Committee which took place on 15 May 2018.

## KEY ISSUES SUMMARY

<table>
<thead>
<tr>
<th><strong>Actions proposed to address key issues</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IAPT</strong></td>
</tr>
<tr>
<td><strong>Quality Priorities</strong></td>
</tr>
<tr>
<td><strong>Statutory / mandatory training</strong></td>
</tr>
<tr>
<td><strong>Care plans and risk assessments</strong></td>
</tr>
<tr>
<td>Committee Annual Review</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Mortality report</td>
</tr>
<tr>
<td>Lessons Learned Q4</td>
</tr>
<tr>
<td>Supervision</td>
</tr>
<tr>
<td>Trust Performance dashboard</td>
</tr>
<tr>
<td>CQC inspection of eating disorders services</td>
</tr>
</tbody>
</table>
| **Seclusion facilities and practices** | The Committee received the outcome of a piece of work commissioned by the Director of Nursing to assess all seclusion sites across the Trust against the code of practice. The report is open and honest, highlighting where sites were found to fall short and where seclusion practice is contrary to Trust policy. The Committee welcomed the breadth of the report including all blanket restrictions.

Environmental issues are being addressed and a digital seclusion form is being rolled out, which should help to address variances in the standard of reporting seclusion. While actions are in place to address deficiencies from this review, a full Trust-wide audit of the use of seclusion, the recording of seclusion and staff awareness of seclusion practices will be conducted in 2018-19. |
| **Reducing Restrictive Practice (RRP) and reducing violence** | The Committee received a thorough report, broken down by CAG.

In the past year, there has not been a significant change in performance across the Trust albeit in some areas e.g. CAMHS, there have been noteworthy improvements over a longer period of time. There are some pockets which have got to grips with Four Steps to Safety but it is inconsistent across the Trust.

The focus on RRP and reducing violence continues through the Quality Priorities set for 2018-19. |
| **Thematic review of self-harm** | Self-harm incidents account for 11% of reported incidents across the Trust, second to incidents of violence / aggression / assault. Child & Adolescent Mental Health Services (CAMHS) have the highest overall reports of self-harm. Males aged 31-55 are the demographic category with the highest levels of self-harm. The Trust’s data in respect of self-harm is consistent with national figures, but a discrepancy was identified between the Trust’s data on self-harm amongst Children and Young People (a reduction of c.30% over the last year) when more generally it is reported to be increasing. This may arise by the way that data is categorised or collected. |

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**Key points of assurance**

**Infection control**
The Trust continues to perform well in this area.
Care plans and risk assessments
Deficiencies in the completion of care plans and risk assessments is a common theme found in a number of reports received by the Committee. The Committee continues to track improvements by way of the Quality Priorities; reports from Quality Compliance meetings; updates on EPJS and other electronic tools. IT reports would be available for staff on the number of plans in place and audits would also be carried out of their quality.

Seclusion facilities and practice
The recent review has highlighted environmental and practice issues, which are being addressed. A full Trust-wide audit of the use of seclusion, the recording of seclusion and staff awareness of seclusion practices will be conducted in 2018-19.

Reducing Restrictive Practice (RRP) and reducing violence
The Committee welcomes the commitment demonstrated to implementing Four Steps to Safety in areas where it is not yet embedded and will continue to monitor RRP and reducing violence through the Quality Priorities set for 2018-19.

Key risks to flag
No key risks to flag.

Issues to be brought to the attention of other committees

Statutory / mandatory training (Equalities and Workforce Committee)
The Committee would like to see work on assessing whether the level of statutory / mandatory training is appropriate concluded as soon as possible.

Workforce report (Equalities and Workforce Committee)
The Quality Committee recognises a potential overlap between it and the Equalities and Workforce Committee in terms of receiving a regular workforce report, and does not wish to duplicate effort. However, workforce information can often assist with triangulation of quality performance issues and as such it is desirable to agree the form of a regular workforce report to the QC.
Purpose of the paper

This is a regular report to the Board which sets out:
- the key issues discussed at the Committee meeting and the actions proposed;
- the key points of assurance;
- the key risks that the Chair or the Committee wish to flag; and
- any issues to flag to other Committees.

This paper covers the 10 April 2018 and 15 May 2018 meetings of the Equalities and Workforce Committee.

The Board is asked to note the report which is presented for information and discussion. The Board is asked to consider the distance from our aspirations as shown by the current metrics, whether our aspirations are realistic, and what further action needs to be taken to achieve them.

Key issues summary

<table>
<thead>
<tr>
<th>The April meeting</th>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>of this committee was a deep dive meeting and covered the 2017 Staff Survey, and the two workforce risks on the Trust’s Board Assurance Framework relating to recruitment and retention, and mandatory training compliance. The Committee agreed objectives for 2018-19 and approved a strategy to improve leadership engagement and two-way communication from board to ward and back.</td>
<td>Actions in response to the 2017 Staff Survey are under way. Achievement of objectives for 2018-19 will be tracked quarterly. The leadership engagement strategy will be implemented by the senior leadership in boroughs and corporate directorates.</td>
</tr>
</tbody>
</table>

| The May meeting | Actions outstanding from the 2017-18 action plan that are still a priority will be built into the 2018-19 agenda. Detailed discussion to take place at SMT and Board about the disappointing results so far from the WRES and Snowy White Peaks action plan. This discussion will include how to gain more traction in relation to these ambitions, and the extent to which the ambitions are realistic and achievable in the light of the current metrics, and what action is necessary to make them achievable. Further analysis in relation to disciplinary issues, to increase understanding of the causes and enable targeted action to be taken, will support these |
| was a core/business meeting. The Committee reviewed the Equalities and Workforce Actions in Q4 and approved the Integrated Equalities and Diversity Action Plan for 2018-21. The Committee reviewed a number of metrics that raised concern in relation to the Trust’s progress towards its equalities ambitions. Specific metrics that raised concern included: | | Applications not considered directly in the day to day business of Board meetings. |
A rise in the proportion of BME staff subject to disciplinary action from 65% of cases to 71% of cases in the same period.

On a more positive note the Committee was advised of:

- More starters (1,016) than leavers (895) during 2017-18
- A reduction in vacancies from 21% in March 2017 to 13% in March 2018
- A reduction in turnover from 19.94% to 18.63% in the same period

The Committee agreed that the Trust should expand its ambition in relation to proportionate representation of BME staff in managerial roles to include all posts at band 7 and above. In 2017 there were 969 staff in these bands, and 305 (24%) were BME. In order to achieve this ambition, the Trust would need to increase the number of BME staff in these bands from 305 to 509 over a three year period. Given current 18% average turnover rate this would require about half of posts in these bands to be awarded to BME candidates.

The Committee agreed to start to track equality in grievances.

The Committee considered the Gender Pay Gap information the Trust had published in March on its website, noted issues that have arisen and are being addressed with our Occupational Health Service provider, and considered a report on SafeCare which described developments in the use of e-Rostering to support safe and effective staffing.

Further analysis of gender pay gap information, along with pay gap information by other protected characteristics, has been proposed.

Work is underway with the new OH provider to speed up referrals.

Key points of assurance

The 2017 Staff Survey Action Plan was presented and noted.

Equalities and workforce achievements in 2017-18 were noted.

The two workforce risks on the BAF, causes, controls, and gaps in assurance and actions to close the gaps were discussed.

Key risks to flag

The two workforce risks on the BAF, causes, controls, and gaps in assurance and actions to close the gaps were discussed. Significant risks are indicated above in relation to the Trust’s ability to deliver its WRES ambitions.

Issues to be brought to the attention of other Committees

BAF risks discussed at the Board awayday in May 2018.
Purpose of the paper

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

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

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

The report covers key issues arising from the Audit Committee’s meetings on:

- **21 May 2018** (special meeting focused on review of the Trust’s draft 2017/18 Accounts, Annual Report and Quality Account. Note that the May 2018 Board meeting delegated the Audit Committee to approve these documents on its behalf; and
- **05 June 2018** (quarterly Audit Committee meeting).

Board Assurance Framework

The Audit Committee is tasked with monitoring **BAF Risk 10 (protecting the Trust’s reputation)**: If we do not work in a way that protects the reputation of the trust there is a risk that we will find it difficult to recruit staff, service users will report adverse experience, we will not be an attractive business partner and we will attract undue attention of our regulators.

The other key risk relevant to the Audit Committee’s work is **BAF Risk 7 (breaching regulations)**: In the context of significant demand, change and unpredictable clinical situations there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do’s) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation.

### KEY ISSUES SUMMARY

<table>
<thead>
<tr>
<th>Audit Committee meeting 21 May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Review of 2017/18 draft Accounts etc.</strong></td>
</tr>
<tr>
<td>The Committee reviewed the Trust’s draft 2017/18 Accounts, Annual Report and Quality Account. Earlier in the year the Committee had reviewed and commented on previous drafts of the Annual Report and Quality Account. The Committee also noted that the Quality Committee, the Board of Directors and a</td>
</tr>
<tr>
<td>Note: these documents have since been finalised and submitted to the regulator.</td>
</tr>
<tr>
<td>After due discussion, the Committee approved these documents on behalf of the Board of Directors, subject to appropriate resolution of points raised at the meeting.</td>
</tr>
</tbody>
</table>
small sub-group nominated by the Board of Directors had also reviewed prior drafts of the Quality Account.

The Committee raised a number of comments, and a note of points affecting the drafting of these documents was circulated to relevant parties on 06 June 2018 to be considered and dealt with.

The main issue noted was that figures in the Accounts may make it appear as if the Trust is cash rich, but in fact Sustainability and Transformation Partnership (‘STP’) funding is unpredictable. The CFO explained that the Trust’s reported surplus for 2017/18 was largely due to 2 non-operating items: release of provisions previously made now deemed unnecessary, and (unpredictable) STP funding. If these factors are adjusted for, the Trust’s underlying operating result is roughly break-even.

<table>
<thead>
<tr>
<th>2. External audit and internal audit reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee reviewed annual reports from external audit and internal audit. This supported the Committee’s review of the Trust’s draft 2017/18 Accounts etc.</td>
</tr>
</tbody>
</table>

The Committee noted that external audit proposed to issue unmodified reports on the 2017/18 Accounts etc.

The Committee noted internal audit’s conclusion for 2017/18 that: “The financial systems and procedures used within SLaM are generally satisfactory for their purpose of financial reporting and control. Internal audit has concluded that the controls in place are adequate and effective. Internal audit’s review reports for 2017/18 on individual areas included 2 limited assurance and one nil assurance report. However none of these relate to core financial systems. The Committee also noted that the CFO and internal audit concurred that there were no significant control issues that needed to be disclosed in the Annual Governance Statement.”

<table>
<thead>
<tr>
<th>3. ‘Data quality (IAPT 6/18 week target)’ internal audit report</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee asked for an update on the key issues discussed at the previous Committee meeting – namely, the criteria used by Trust management to ‘stop the clock’ for the purpose of calculating adherence to the 6/18 week targets, and consistency of these criteria with official guidance.</td>
</tr>
</tbody>
</table>

Internal audit advised that SLaM’s treatment was in line with that of all other London Trusts, and that NHS England had recently revised their guidance to reflect this.

Internal audit also advised that the Trust had now issued written guidance to relevant staff. Internal audit considered that the issue was now resolved. It was confirmed that the Quality Committee would follow up on this at a future meeting.

<table>
<thead>
<tr>
<th>4. Audit Committee Annual Review report 2017/18 and revised Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee reviewed this report and the draft revised Terms of Reference</td>
</tr>
</tbody>
</table>

The Committee has reported separately to the Board on this process.
### 5. Board Assurance Framework (‘BAF’)
The meeting discussed BAF risk 6 (working with external partners) and whether it should be reworded to refer to more measurable outcomes which would aid management, absorbed into another risk eg risk 2 (operational structure), or simply deleted.

The meeting noted the recent ‘substantial assurance’ opinion on the BAF from internal audit, and suggested some further improvements to its content in particular as regards identifying and giving prominence to action plans to mitigate gaps in control and gaps in assurance risk mitigation actions.

The point noted in ‘key risks to flag’ section below also refers.

**The Director of Nursing and Head of Risk and Assurance are asked to review these matters and report proposals to the next Audit Committee meeting.**

### 6. Capital projects
The meeting reviewed this report (dated Nov 2017) from the Trust’s previous internal audit provider – TIAA. The report included 15 recommendations, 8 of which were flagged by TIAA as ‘high priority’.

The Strategy and Commercial Director outlined the position on the recommendations in the report noting that many were now closed and the remainder should be closed by October 2018.

**The next Audit Committee meeting (September 2018) will receive an update on the Trust’s progress in closing recommendations.**

Internal audit will re-audit this area in November 2018.

### Key points of assurance

Points 1, 2, 3, 5 and 6 provide assurance.

### Key risks to flag

Nothing significant

### Issues to be brought to the attention of other Committees

It was confirmed that the Quality Committee would follow up on the point about the ‘Data quality (IAPT 6/18 week target)’ internal audit report (see 3 above) at a future meeting.
REPORT TO THE TRUST BOARD: PUBLIC
19 June 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Council of Governors’ report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Charlotte Hudson, Deputy Director of Corporate Affairs</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
</tr>
</tbody>
</table>

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

**Planning & Strategy Working Group**
The group met on 15 May. The meeting included an update from the Director of Strategy and Commercial on “Changing Lives”, as well as a facilitated break-out session to consider the feedback of the group’s annual review, and a discussion on updating the group’s Terms of Reference. The terms of reference of all Working Groups have been revisited and will be presented to the Council of Governors meeting on 14 June for approval.

A recommendation raised at the PSWG and subsequently discussed by the Lead and Deputy Lead Governors and the Chairs of the Working Groups, is to bring workplans for each group to the Chairs’ meeting in future, so as to identify overlaps or where groups can complement one another. It has been agreed that this will assist collaborative working.

**Care Quality Commission**
The CQC held engagement sessions at both the Maudsley Hospital and the Bethlem Hospital on 14-15 May, and Governors were encouraged to attend and share their views.

On 22 May, before the Trust Board meeting, Director of Nursing Beverley Murphy held a drop-in session for Governors interested in learning more about the upcoming inspection by the Care Quality Commission, and what it involves.

On 24 May, three Governors met two of the Trust’s CQC inspectors to discuss the critical role of carers, especially in community care. The Governors wanted to highlight the importance of engaging carers both when undertaking an inspection and preparing a report, presenting findings from carers as separate to those from service users.

**Council of Governors’ meeting 14 June**
A meeting of the Lead and Deputy Lead Governor, plus Chairs of the Working Groups, was held on 17 May to – amongst other things – finalise the agenda for the Council of Governors meeting on 14 June. Having taken on board feedback at recent Working Group meetings, it was agreed that the main focus of the meeting will be a briefing on the Lambeth Alliance and an opportunity to raise questions with Non-Executive Directors about it. The Governors also want to hear more about how readmissions are managed, as they are concerned that a drive
to reduce bed occupancy and length of stay will result in service users being discharged too early.

The CoG will also receive the recommendations of the Nominations Committee in respect of the appointment of a new Non-Executive Director, as well as the outcomes of the NEDs’ appraisals (including the Chair’s) and objectives for the next year.

Governors will also have an opportunity to assess its own collective performance and its impact on its Trust at the meeting, as it considers the outcomes of its annual review.

Meeting with the Chair

The quarterly meeting between the Lead Governor, Deputy Lead Governor, Chair and Directorate of Corporate Affairs took place on 23 May. Issues discussed included poor attendance by some Governors at CoG meetings, and visits by Governors to sites and services.

Bids Steering Group

The group met on 24 May. This year’s bids scheme has proved as popular as ever and Governors are being recruited to assist with the assessment of the bids. The group used their meeting as an opportunity – just as the other working groups have – to review their performance and effectiveness.

National Governors’ Conference

This was held on 24 May at Congress House, London, and was attended by the Lead and Deputy Lead Governor.

The main theme of the day was Governors working collaboratively in health care systems, particularly STPs and now ICSs (Integrated Care Systems), which were formerly referred to as ACSs (Accountable Care Systems). The Deputy Lead Governor reports that Governors from separate Trusts have been meeting up with each other all around the country, like SLaM has with colleagues in KHP and the South London Mental Health and Community partnership.

Lobbying

Meetings with Neil Coyle MP (Bermondsey and Old Southwark) and Sarah Jones MP (Croydon Central) took place in late May. Sarah Jones mentioned that she used to be a volunteer at the Bethlem Royal Hospital community centre.

A meeting has also been set up with Lewisham CCG.
Title  
NHSI SELF-CERTIFICATION REQUIREMENTS

Author  
Rachel Evans & Gus Heafield

Purpose of the paper

For the Board to approve or make any changes to the proposed content for the NHSI self-certification forms that need to be submitted to NHSI. The proposed forms are set out in Annexes A - C. This is a new requirement this year.

There are three forms. They relate to:

- Corporate Governance
- Governor training
- Availability of Resources

The forms will also be considered by the Council of Governors at their 14 June meeting. Any suggested changes from the Governors at that meeting will be presented orally to the Board for their consideration.

The agreed documents will be submitted to NHSI following the Board.

Risks / issues for escalation

This paper relates to all the BAF risks.

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/06/18</td>
<td>Council of Governors meeting</td>
</tr>
</tbody>
</table>
Context

The Board is invited to approve the NHSI proposed self-certification forms that need to be submitted to NHSI. These self-certification requirements have been introduced this year. Our proposed drafts are at Annex A.

The forms will also be considered by the Council of Governors at their 14 June meeting. Any suggested changes from the Governors at that meeting will be presented orally to the Board for its consideration.

Relevant Licence extracts

Relevant extracts from the Licence are as follows:

Condition G6 – Systems for compliance with licence conditions and related obligations
1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
(a) the Conditions of this Licence,
(b) any requirements imposed on it under the NHS Acts, and
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
(b) regular review of whether those processes and systems have been implemented and of their effectiveness.
3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.
4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Condition CoS7 – Availability of resources
1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
(a) “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”
(b) “After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services”.

(c) “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.

4. The Licensee shall submit to Monitor with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to Monitor in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

Section 5 – Continuity of Services

6. The Licensee shall inform Monitor immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

“distribution” includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;

“Financial Year” means the period of twelve months over which the Licensee normally prepares its accounts;

“Required Resources” means such:

(a) management resources,
(b) financial resources and financial facilities,
(c) personnel,
(d) physical and other assets including rights, licences and consents relating to their use, and
(e) working capital

as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.
### Worksheet "FT4 declaration"

#### Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond “Confirmed” or “Not confirmed” to the following statements, setting out any risks and mitigating actions planned for each one.

<table>
<thead>
<tr>
<th>1 Corporate Governance Statement</th>
<th>Response</th>
<th>Risks and Mitigating actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.</td>
<td><strong>Confirmed</strong></td>
<td>The Trust keeps its systems of corporate governance under regular review. Each Board and Committee undertakes an annual review of its effectiveness, as does the Council of Governors and its Working Groups. We undertake peer reviews and invite external challenge on our performance against the Well-Led criteria.</td>
</tr>
<tr>
<td>2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time</td>
<td><strong>Confirmed</strong></td>
<td>The Board are informed about guidance on good corporate governance where required.</td>
</tr>
<tr>
<td>3 The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.</td>
<td><strong>Confirmed</strong></td>
<td>The existing Boards and Committees are well-established. The Board keeps its Board and Committee structures under regular review. The Terms of Reference are reviewed on an annual basis and this is informed by a review of effectiveness. The outcomes of the Committee discussions are reported to the Board every month, enabling key points to be escalated and risks and areas of assurance to be highlighted. The Board has introduced changes to the Committee structures.</td>
</tr>
<tr>
<td>4 The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee’s operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.</td>
<td><strong>Confirmed</strong></td>
<td>The Board receives information every month about the financial and operational performance of the Trust. This includes reporting against statutory performance requirements. These issues are also discussed at the Finance and Performance Committee and the Quality Committee. The Board Assurance Framework is presented quarterly to the Audit Committee and to the Board. The Board undertakes a ‘deep dive’ into one of the BAF risks at each Board. The whole set of BAF risks are reviewed on an annual basis by the Board and each risk is allocated and monitored by a Board Committee. The Quality Improvement programme reports regularly to the Board, highlighting the quality improvement projects underway and their impact on performance. The Trust is introducing a Trust dashboard to ensure that key performance indicators can be effectively tracked.</td>
</tr>
</tbody>
</table>
The capability and skills of the Board are reviewed regularly at the Nominations Committee and this informs the filling of vacancies. The Board has strong capability on Quality of Care - both at Executive and Non-Executive level. The Board receives detailed reports on all key issues relating to Quality of Care, including the Quality report, learning from incidents reports, learning from deaths reports, Service User and Carer Involvement, Quality Improvement, Care Quality Commission reports and much more. The Quality Committee is responsible for monitoring improvement and providing assurance to the Board on quality matters across the Trust, including the implementation of Quality Improvement. The Trust has an active Patient and Public Involvement Policy and is aiming to involve service users, carers and their families in all that we do.

The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name

Name

The membership of the Board is kept under regular review. There is a programme of succession planning which takes places both within the Executive Team and at the Nominations Committee. The Workforce Strategy is monitored at the Equalities and Workforce Committee and key issues are escalated to the Board.
## Worksheet "Training of governors"

### Certification on training of governors (FTs only)

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.*

### 2 Training of Governors

1. The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

   - **Confirmed**
   - **Not confirmed**

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

<table>
<thead>
<tr>
<th>Signature</th>
<th>Signature</th>
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<th>Capacity</th>
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<tbody>
<tr>
<td>[job title here]</td>
<td>[job title here]</td>
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<th>Date</th>
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Annex 3: Worksheet on General condition 6 and Continuity of Service Condition 7

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors
REPORT TO THE TRUST BOARD: PUBLIC
19 June 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Guardian of Safe Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Michael Holland</td>
</tr>
</tbody>
</table>

Purpose of the paper

For the Board to note the Quarterly Report on Safe Working Hours for Doctors in Postgraduate Training.
Quarterly Report on Safe Working Hours for Doctors in
Postgraduate Training at South London and Maudsley NHS
Foundation Trust – November 2017 to January 2018

Executive summary

This is the fourth quarterly report by the Guardian of Safe Working Hours for South London and Maudsley NHS Foundation Trust, covering the period November 2017 to January 2018.

In this period there have been two immediate safety concerns raised by trainees and the Guardian has levied fines totaling £3944.85 and equating to 32.5 hours of work which breaches the 2016 contract. The immediate safety concerns and fines both relate to the same issue, which are breaches of the requirement for the Junior Doctor to have 8 hours rest in a 24 hours period. These breaches have all been by specialist trainees and all relate to the inherent problem with their periods of on call lasting 16 hours during the week (in addition to their 8 hour working day) and 24 hours at weekends. As a result of these fines and concerns about safe working, the Trust are urgently reviewing the ST doctors on call working arrangement with a view to changing their on calls so that they work for no longer than 12 hours shifts, with a plan to implement changes in time for the next set of rotas in August 2018.

There are ongoing problems with core trainees submitting few exception reports and the Guardian has met with the Core Trainees to promote exception reporting. The Specialist Trainee exception reporting mostly relates to working beyond their estimates hours of work while on call, and the Guardian has collaborated with Medical HR and the Specialist Trainees to adjust their work schedules to address this. The Guardian has implemented a system for ensuring they receive payment for the additional hours they work while on call. There are some borough variations in exception reporting both at core and specialist trainee level though it is unclear if these represent individual factors or systemic factors and will need to be monitored to see if they are sustained over longer periods.

There is now information on locum use coming from NHS professionals and this is showing some positive trends with a reduction in agency locum use and unfilled slots during this quarter. There are significant differences in locum use between boroughs with Lambeth having very low use of locums and Croydon having very high use of locums.

Introduction

The 2016 Junior Doctor Contract has now been in place across the Trust for a year. There have been significant changes brought about by the new contract, most notably the ability for junior doctors to submit exception reports to seek redress where they work beyond their work schedule and the role of the Guardian to collate the exception reports and champion safe working. The new contract has specific contractual requirement around working hours with the Guardian having the power to fine the Trust if these are broken. Over the last quarter there have been a number of breaches of the requirement to have 8 hours rest in a 24 hour period, which is related to the Specialist Trainees on call arrangements. As the position of the Guardian is new, the current Guardian has set up systems within the Trust to ensure
repayment is given to the junior doctors when payment is the agreed outcome for breaches of the work schedule.

**High level data**

Number of doctors / dentists in training (total): 203 (107 CTs, 96 STs)

Number of doctors / dentists in training on 2016 TCS (total): 203

Amount of time in job plan for guardian to do the role: 2 PA per week

Admin support provided to the guardian (if any): Nil

**a) Exception reports (with regard to working hours)**

**EXCEPTION REPORTS BY GRADE**

<table>
<thead>
<tr>
<th>GRADE</th>
<th>Number of exceptions raised</th>
<th>Number of exceptions closed</th>
<th>Number of exceptions outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT1-3</td>
<td>22</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>ST4-6</td>
<td>55</td>
<td>55</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77</strong></td>
<td><strong>77</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**EXCEPTION REPORTS BY SITE/ROTA**

<table>
<thead>
<tr>
<th>SITE</th>
<th>Number of exceptions raised</th>
<th>Number of exceptions closed</th>
<th>Number of exceptions outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth CT</td>
<td>15</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Lambeth ST</td>
<td>9</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Southwark CT</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Southwark ST</td>
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<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Lewisham CT</td>
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<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Lewisham ST</td>
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<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Croydon CT</td>
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<td>0</td>
</tr>
<tr>
<td>Croydon ST</td>
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<td>10</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77</strong></td>
<td><strong>77</strong></td>
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</tr>
</tbody>
</table>

**EXCEPTION REPORTS RESPONSE TIME BY GRADE**

<table>
<thead>
<tr>
<th>GRADE</th>
<th>Addressed within 48 hours</th>
<th>Addressed within 7 days</th>
<th>Addressed in longer than 7 days</th>
<th>Still open</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT1-3</td>
<td>3</td>
<td>1</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>ST4-6</td>
<td>9</td>
<td>3</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>4</strong></td>
<td><strong>61</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**EXCEPTION REPORTS RESPONSE TIME BY SITE/ROTA**

<table>
<thead>
<tr>
<th>SITE</th>
<th>Addressed within 48 hours</th>
<th>Addressed within 7 days</th>
<th>Addressed in longer than 7 days</th>
<th>Still open</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Southwark</td>
<td>3</td>
<td>2</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Lewisham</td>
<td>4</td>
<td>1</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Croydon</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>0</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>4</strong></td>
<td><strong>61</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>
b) Work schedule reviews

There have been three work schedule reviews requested. Two relate to immediate safety concerns and one was requested by the guardian due to persistent breaches of the work schedule.

The two immediate safety concerns were raised by Specialist Trainees and both relate to on call work. On one occasion the Specialist Trainee had to act down and work on site from 9pm to 9am as there was no Core Trainee. In the 24 hour period they had worked a normal day of work (9am to 5pm) worked on call between 5pm and 9pm which involved continuous work, and then had to work on site between 5pm and 9pm, in effect working continuously for 24 hours, though they did have periods of rest during their 9pm to 9am shift. The clinician involved (Consultant on call) responded to the Guardian and felt it was a significant concern though not serious or immediate.

The second immediate safety concern involved a Specialist Trainee having a busy night shift which involved them working beyond the 9am ending of their shift. In total they worked for 10 hours on call, as well as their 8 hours of day time work. The clinician involved (liaison Consultant) responded to the Guardian and felt it was a serious but not immediate concern. As a result a work place review was requested by the Guardian and the outcome of this was no further action.

The other work place review related to a Core Trainee who submitted 13 exception reports including 5 in a 2 week period. A work place review was requested and a result time off in lieu was given for the additional work.

c) Locum bookings

Information on locum booking previously was taken from information supplied by the locum agencies which the Trust used, whereas it is now coming from NHS Professionals as the Trust books locums directly through NHS Professionals. As a result the Guardian suspects the information is likely to be more complete, and also enables better comparison of month-by-month trends.

Locum Booking November 2017

<table>
<thead>
<tr>
<th>LOCUM BOOKING BY DIRECTORATE</th>
<th>Bank</th>
<th>Agency Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>0</td>
<td>111</td>
<td>35</td>
</tr>
<tr>
<td>B&amp;D</td>
<td>1</td>
<td>92</td>
<td>25</td>
</tr>
<tr>
<td>MHOA</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CAMHS</td>
<td>0</td>
<td>54</td>
<td>99</td>
</tr>
<tr>
<td>PMIC</td>
<td>5</td>
<td>93</td>
<td>19</td>
</tr>
<tr>
<td>Acute</td>
<td>33</td>
<td>156</td>
<td>25</td>
</tr>
<tr>
<td>Unspecified</td>
<td>0</td>
<td>44</td>
<td>2</td>
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<td>Total</td>
<td>39</td>
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### LOCUM BOOKING BY GRADE

<table>
<thead>
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<th>Grade</th>
<th>Bookings (Bank and Agency)</th>
<th>Total Requests (Bank, Agency and Unfilled)</th>
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<tbody>
<tr>
<td>Consultant</td>
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<td>309</td>
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<tr>
<td>Associate Specialist</td>
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<td>69</td>
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<tr>
<td>Specialist Trainee/SpR</td>
<td>140</td>
<td>224</td>
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<tr>
<td>Core Trainee/SHO</td>
<td>131</td>
<td>162</td>
</tr>
<tr>
<td>Staff Grade</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>589</td>
<td>794</td>
</tr>
</tbody>
</table>

### LOCUM BOOKING BY BOROUGH

<table>
<thead>
<tr>
<th>Borough</th>
<th>Bookings (Bank and Agency)</th>
<th>Total Requests (Bank, Agency and Unfilled)</th>
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</thead>
<tbody>
<tr>
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<td>Southwark</td>
<td>88</td>
<td>183</td>
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<tr>
<td>Lewisham</td>
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<td>165</td>
</tr>
<tr>
<td>Lambeth</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Kent (CAMHS)</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>589</td>
<td>794</td>
</tr>
</tbody>
</table>

### LOCUM BOOKING BY REASON

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total Requests (Bank, Agency and Unfilled)</th>
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</thead>
<tbody>
<tr>
<td>Vacancy</td>
<td>673</td>
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<td>Sickness</td>
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<td>Extra cover needed</td>
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</tr>
<tr>
<td>Annual Leave</td>
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<td>Compassionate/special leave</td>
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<tr>
<td>Maternity Leave/Pregnant/Paternity Leave</td>
<td>19</td>
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<tr>
<td>No reason given</td>
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<tr>
<td>Other</td>
<td>57</td>
</tr>
<tr>
<td>Total</td>
<td>794</td>
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**Locum Booking December 2017**

### LOCUM BOOKING BY DIRECTORATE

<table>
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<th>Directorate</th>
<th>Bank</th>
<th>Agency Locum</th>
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<tbody>
<tr>
<td>Psychosis</td>
<td>5</td>
<td>122</td>
<td>23</td>
</tr>
<tr>
<td>B&amp;D</td>
<td>1</td>
<td>53</td>
<td>1</td>
</tr>
<tr>
<td>MHOA</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CAMHS</td>
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<td>27</td>
<td>79</td>
</tr>
<tr>
<td>PMIC</td>
<td>6</td>
<td>62</td>
<td>5</td>
</tr>
<tr>
<td>Acute</td>
<td>53</td>
<td>159</td>
<td>30</td>
</tr>
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<td>Unspecified</td>
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<tr>
<td>Total</td>
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## LOCUM BOOKING BY GRADE

<table>
<thead>
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<th>Bookings (Bank and Agency)</th>
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<tbody>
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<tr>
<td>Associate Specialist</td>
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<td>43</td>
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<td>Specialist Trainee/SpR</td>
<td>124</td>
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<td>Core Trainee/SHO</td>
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<td>170</td>
</tr>
<tr>
<td>Staff Grade</td>
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<td>21</td>
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<tr>
<td>Total</td>
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<td>651</td>
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## LOCUM BOOKING BY BOROUGH

<table>
<thead>
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<th>Bookings (Bank and Agency)</th>
<th>Total Requests (Bank, Agency and Unfilled)</th>
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</thead>
<tbody>
<tr>
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<td>Southwark</td>
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<td>Lewisham</td>
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<td>153</td>
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<tr>
<td>Lambeth</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Kent (CAMHS)</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>513</td>
<td>651</td>
</tr>
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</table>

## LOCUM BOOKING BY REASON

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total Requests (Bank, Agency and Unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancy</td>
<td>494</td>
</tr>
<tr>
<td>Sickness</td>
<td>27</td>
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<tr>
<td>Extra cover needed</td>
<td>28</td>
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<tr>
<td>Annual Leave</td>
<td>14</td>
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<tr>
<td>Compassionate/special leave</td>
<td>2</td>
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<tr>
<td>Maternity Leave/Pregnant/Paternity Leave</td>
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</tr>
<tr>
<td>No reason given</td>
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<tr>
<td>Other</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>651</td>
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</table>

Locum Booking January 2018

## LOCUM BOOKING BY DIRECTORATE

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Bank</th>
<th>Agency Locum</th>
<th>Unfilled</th>
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</thead>
<tbody>
<tr>
<td>Psychosis</td>
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<td>130</td>
<td>13</td>
</tr>
<tr>
<td>B&amp;D</td>
<td>0</td>
<td>45</td>
<td>9</td>
</tr>
<tr>
<td>MHOA</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CAMHS</td>
<td>0</td>
<td>17</td>
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</tr>
<tr>
<td>PMIC</td>
<td>1</td>
<td>82</td>
<td>11</td>
</tr>
<tr>
<td>Acute</td>
<td>60</td>
<td>142</td>
<td>56</td>
</tr>
<tr>
<td>Unspecified</td>
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<td>0</td>
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<tr>
<td>Total</td>
<td>63</td>
<td>420</td>
<td>161</td>
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## LOCUM BOOKING BY GRADE

<table>
<thead>
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<th>Bookings (Bank and Agency)</th>
<th>Total Requests (Bank, Agency and Unfilled)</th>
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</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>161</td>
<td>199</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>57</td>
<td>58</td>
</tr>
<tr>
<td>Specialist Trainee/SpR</td>
<td>122</td>
<td>178</td>
</tr>
<tr>
<td>Core Trainee/SHO</td>
<td>143</td>
<td>209</td>
</tr>
<tr>
<td>Staff Grade</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>483</strong></td>
<td><strong>644</strong></td>
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</table>

## LOCUM BOOKING BY BOROUGH

<table>
<thead>
<tr>
<th>Borough</th>
<th>Bookings (Bank and Agency)</th>
<th>Total Requests (Bank, Agency and Unfilled)</th>
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</thead>
<tbody>
<tr>
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<td>310</td>
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<td>Southwark</td>
<td>73</td>
<td>86</td>
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<tr>
<td>Lewisham</td>
<td>88</td>
<td>122</td>
</tr>
<tr>
<td>Lambeth</td>
<td>35</td>
<td>48</td>
</tr>
<tr>
<td>Kent (CAMHS)</td>
<td>7</td>
<td>78</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>483</strong></td>
<td><strong>644</strong></td>
</tr>
</tbody>
</table>

## LOCUM BOOKING BY REASON

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total Requests (Bank, Agency and Unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancy</td>
<td>407</td>
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<tr>
<td>Sickness</td>
<td>59</td>
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<td>Extra cover needed</td>
<td>53</td>
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<tr>
<td>Annual Leave</td>
<td>26</td>
</tr>
<tr>
<td>Compassionate/special leave</td>
<td>1</td>
</tr>
<tr>
<td>Maternity Leave/Pregnant/Paternity Leave</td>
<td>22</td>
</tr>
<tr>
<td>No reason given</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>76</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>644</strong></td>
</tr>
</tbody>
</table>

Below is a graph providing a month-by-month comparison of bank shifts, agency locum shifts and unfilled shifts across the quarter.
d) Rota gaps

Information on rota gaps has been requested from HR and will be included in the next quarterly report.

e) Fines

There have been 32.5 hours of fines applied by the Guardian in this quarter. All of the fines relate to breaches of the rest period per 24 hours being reduced to less than 8 hours. In financial terms, the fines are £3944.85, of which £1831.05 will be paid to the Specialist Trainees whose additional work incurred the fine (they get 1.5x the locum rate), and the remaining £2113.80 goes to the Guardian to be spent on additional training and educational activities for the trainees. As there was no previous system for fines as no fines had been levied by the previous Guardian, the new Guardian has set up a system for levying fines. Due to the delays in doing this, the fines for this quarter were submitted in April 2018.

Qualitative information

The Guardian chaired the Junior Doctor Forum on 10th January 2018. During this meeting it was discussed that there are ongoing issues with few exception reports being submitted by core trainees, despite anecdotal experience of more frequent breaches to the work schedule. It was unclear why this would be though it was felt a sensible step for the Guardian to speak to the core trainees at the Q&A session as part of their MRCPsych course.

There is an issue around Less Than Full Time trainees, working as Specialist Trainees on the on call rota as it is unclear whether they are entitled to a day off in lieu if the day after an on call shift falls on a day in which they do not work. This has been discussed with Medical HR who advised that the LTFT aim to avoid this by
swapping their on call shifts, though it was unclear what would happen if they are unable to do this, and Medical HR would look into the issue.

Issues arising

The following issues have arisen from this quarter of exception reporting and information on locum use:

1) There exception reports continue to be submitted more frequently by the Specialist Trainees than the Core Trainees. The number of exception reports from the Core Trainees appears to be low and may reflect reluctance from the Core Trainees to submit exception reports.

2) The Guardian has set up a system of repayment for the Specialist Trainees and Core Trainees via exception reporting. Payments have been going through to the majority of trainees without problems, though there have been problems with trainees not directly employed by the Trust who are doing on calls, for example doctors undertaking out-of-placement experience who may have other employers such as Kings College London. These trainees have yet to receive payments and the situation needs to be resolved with Medical HR and payroll.

3) The Specialist Trainees on call arrangement (non-resident on call lasting up to 24 hours) has led to two incidents felt to be immediate safety concerns by the specialist trainees. Both these incidents resulted from the Specialist Trainees working above 16 hours in a 24 hour period. In addition shifts in which Specialist Trainees work beyond 16 hours in a 24 hour period incur a fine from the Guardian, and these happen frequently, approximately weekly. It is felt that the current system of on calls for the Specialist Trainee doctors, which involve 16 hour weekday shifts after an 8 hour working day, and 24 hours weekend shifts, will remain vulnerable to persistent breaches of the 2016 contract and will incur regular fines as result.

4) There were more exception reports submitted by Core Trainees in Lambeth than other boroughs, though eleven of the fifteen exception reports were submitted by two trainees and so it is unclear if the variation is due to individual factors rather than systemic factors.

5) There were more exception reports submitted by Specialist Trainees in Lewisham compared with other boroughs. It is unclear why this has happened, though it may be the result of a small number of Specialist Trainees consistently submitting exception reports compared with trainees in other boroughs. It will be worth monitoring this and seeing if this effect is sustained after February when the Specialist Trainees change jobs and they move onto to new rotas.

6) Use of agency locum has been reducing over the last quarter. There has been a small increase in use of bank staff to provide locum cover, and a small reduction in unfilled shifts. The highest use of locums is in the borough of Croydon, and the least is in Lambeth, with a significant difference in locum use. Consultant was the grade of doctor most frequently requiring locum cover, though there has been a downward trend of requests for Consultant locum cover over the last quarter. ‘Vacancy’ is the most frequent reason for a locum request, though this
has been declining over the quarter, though ‘other reason’ and ‘extra cover’ have risen and may particularly account for this. Requests for locums due to sickness have spiked during this quarter which may be related to seasonal factors, such as higher rates of illness over winter.

**Actions taken by SLAM to resolve issues**

1) Following input from the Guardian, Medical HR have now adjusted the prospective estimates of hours worked on call for the Specialist Trainees during their non-resident on call shifts to provide figures which are more reflective of their hours of work, and a system which is much clearer for the Specialist Trainees to understand.

2) Dr Rosalind Ramsay, Deputy Medical Director, is leading on a review of Specialist Trainee on call rotas and is preparing a consultation paper to look at different on call options which may improve safe working and prevent fines from the Guardian.

**Key issues and actions taken by Guardian of Safe Working Hours**

1) The Guardian has now set up a system with payroll and Medical HR of repayment for doctors for whom payment is agreed as a response to their exception report. This mostly occurs due to Specialist Trainees working beyond more than the estimated hours of work while they are on call.

2) The Guardian has discussed the issue of fines with the Medical Director, Finance department and Medical HR in order to determine the correct account for the money to be withdrawn, and for money owed to the Guardian to be kept. This has laid the groundwork so that fines can be levied. The Guardian will submit a summary of his financial accounts each financial year – as there have been no fines submitted until April 2018, the first annual summary will be in April 2019.

3) The Guardian has met with the Core Trainee doctors in January 2018 at the Q&A session as part of the MRCPsych course and discussed exception reporting in order to promote the use of exception reporting amongst the Core Trainee doctors.

4) The Guardian has given a presentation exception reporting at the Trust induction in February 2018 for doctors newly starting in the Trust.

5) The Guardian has been involved in the Specialist Trainee rota review process with Dr Ramsay, including attending meetings between Dr Ramsay and the representatives of the Higher Trainee Committee.

**Summary**

The exception reports highlight similar issues to the last quarterly report. There are few Core Trainee exception reports which is likely reflective of under-reporting and the Guardian is trying to promote exception reporting to the Core Trainees. The Specialist Trainees mostly exception report due to breaches of their work schedule while on call – the Guardian has adjusted their prospective estimates and set up a system for repayment which is largely working well. There are ongoing problems
with Specialist Trainees exception reports breaching the contractual requirement to have 8 hours rest per 24 hours, and this is attracting fines and also raises concerns around safe working for the Specialist Trainees while they are on call. As a result there is significant work being put into a review of the Specialist Trainee on call shifts with a plan to change their on call to shorter 12 hours shifts, ideally in time for the next set of rotas in August 2018.

There have been two safety concerns raised during the period, one was felt to be significant and not serious or immediate, and the other was felt to be serious but not immediate and led to a work schedule review in which no further action was taken. The Guardian has submitted fines for 32.5 hours of breaches which corresponds to a value of £3944.85.

The information on locum bookings is now coming from NHS professionals. The last quarter showed an overall reduction in the number of requests for locums, a reduction in number of agency locum shifts used, a reduction in unfilled shifts and a rise of bank shifts. There is significant variation across boroughs in agency use, with this particularly apparent when comparing Lambeth (low use) and Croydon (high use).

Questions for consideration

The following questions require further consideration:

i) There is a review of the Specialist Trainee on call rota with a move to 12 hour shifts in order to prevent guardian fines and also promote safe working. There are different ways options to do this, including altering the working practices altogether to a shift pattern, or maintaining a non-resident on call model with 12 hour shifts, either with scattered shifts or a block pattern (ie 4 night shifts in a row). There are differing pros and cons to each option and differing financial implications and the Trust will need to consider which option is optimal. A consultant paper is being drawn up to describe each option in detail.

ii) There are significant differences in the rota patterns for Core Trainees with differences in numbers of Core Trainees on the rota for different boroughs. A question to consider is whether there should be a review of Core Trainee on call rotas to make them more equitable across the boroughs, though this may lead to an additional cost.

iii) There are significant differences between boroughs for locum use. The boroughs of particular note are Lambeth which has a very low use of locums, and Croydon which has a high use of locums. It would be worth trying to understand the reasons for this significant variation in order to implement targeted strategies to try to reduce locum use.

Dr Hugh Williams

Guardian of Safe Working Hours

May 2018
REPORT TO THE TRUST BOARD: PUBLIC
19 June 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Report from previous month’s Part II meeting</th>
</tr>
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<tbody>
<tr>
<td>Author</td>
<td>Charlotte Hudson, Deputy Director of Corporate Affairs</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
</tr>
</tbody>
</table>

Purpose of the paper

To produce a summary report for consideration in the part of the Board meeting held in public which lists the items which were discussed in the Part II (private) meeting the previous month.

Executive summary

The detail below refers to the Part II meeting held in May 2018.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item discussed</th>
<th>Summary of discussion</th>
<th>Lead Director</th>
<th>Reason for taking in PII</th>
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<td>Lambeth Alliance Business Case</td>
<td>The Board discussed the business case for the Alliance</td>
<td>Kristin Dominy</td>
<td>Commercial in confidence</td>
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AGENDA: Part 1

Quality Improvement Focus
Presentation by teams about their QI Projects (located at the back of the room)  2:30pm

Opening Matters
Welcome, apologies for absence & declarations of interest
Minutes, Action log review  Charlotte  2:40pm Page
Board Level Review of Serious Incident  Beverley  2:45pm Page

Quality
Risk Focus: BAF Risk – to be confirmed
Centre for Young Persons and Douglas Bennett House: SOCs  Altaf
Dashboard – Trust Data Framework  Nichola/Michael
Staff Survey – suggestions for improvement and target aspirations – Action
March  Sally
Freedom to Speak Up Guardian – Quarterly Board Reporting  Zoe
Snowy White Peaks/WRES – preparing for Year 2  Zoe

Performance
Chief Executive’s Report  Rachel
Finance & Q1 NHSI Report  Gus
Performance Report  Kris
Capital Planning, Estates and Facilities  Altaf
Revalidation – Annual Report  Michael

Governance
Briefing from the BDIC June Meeting  Adam
Briefing from the FPC June Meeting  Stephen
Briefing from the Mental Health Law July Committee  Kay
Council of Governors Update  Charlotte

For Noting
Wrap-up and Next Meeting
Meeting Evaluation  Ian  Verbal

The next Board of Directors Meeting will be held on 18th September 2018
2:30pm, at the ORTUS, Learning Centre, 82-96 Grove Lane, SE5 8SN.
Maudsley Hospital

Please note that minutes from this meeting are a public document and may 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.

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