Board of Directors Meeting

To be held 24th July 2018
2:30pm - 5:15pm ORTUS, Maudsley 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
114/18 Welcome, apologies for absence & declarations of interest 2:40pm Page 1
115/18 Minutes, Action log review 2:45pm Verbal
116/18 Nurse’s story: Farida Pirani

Quality
117/18 Risk Focus: BAF Risk 13 – Mandatory Training 3:05pm Page 14
118/18 Snowy White Peaks/WRES – preparing for Year 2 3:20pm Page 22
119/18 Improving Staff Survey Response Rate 3:35pm Page 28

Strategy
120/18 Centre for Children and Young People’s Mental Health- Update 3:45pm Page 31
121/18 Strategy Implementation Progress Report 3:55pm Page 42
122/18 Trust Data Framework Dashboard & Development Performance 4:05pm Page 48

123/18 Chief Executive’s Report 4:15pm Page 53
124/18 Finance & Q1 NHSI Report 4:20pm Page 56
125/18 Performance Report 4:30pm Page 70
126/18 Capital Planning, Estates and Facilities Dashboard 4:35pm Page 108
127/18 Revalidation – Annual Report Governance 4:45pm Page 114

128/18 Council of Governors Update 4:50pm Page 136
129/18 Briefing from the FPC June Meeting Page 138
130/18 Briefing from the Mental Health Law July Committee & new TOR Page 141
131/18 Feedback from NED/Governor visit to Ladywell Unit For Noting 5:00pm Verbal
132/18 Updated CEO and Senior Management Team Objectives Page 148
133/18 Report from previous month’s Part II Page 151
134/18 Wrap-up and Next Meeting Page 152
135/18 Meeting Evaluation 5:10pm 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 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 NINETEENTH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 19 JUNE 2018

PRESENT

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

IN ATTENDANCE

Ermias Alemu
Colan Ash
Maureen Baker
Ray Baker
Nuala Conlon
Stephen Docherty
Judith Edwards
Nicola Gower
Kathryn Grant
Barbara Grey
Charlotte Hudson
Brian Lumsden
Russell Mascarenhas
Susan Shamash
Gill Sharpe
Murat Soncul
Ammaarah Umar
Governor
Head of Risk and Assurance
Public
Public
PMOA Directorate - Involvement
Chief Information Officer
CQC
PMOA Clinical Services Manager
Governor
Director, Quality Improvement
Deputy Director of Corporate Affairs
Deputy Lead Governor
NExT Director
CQC
Governor
Head of Information Governance
CQC

APOLOGIES

Alan Downey
Mike Franklin
Non-Executive Director
Non-Executive Director

BOD 94/18 WELCOME, APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST

Kristin Dominy declared that from the 1 July, she will be a member of the Lambeth Living Well Network Alliance Board.

Roger Paffard announced that, on 14 June, the Council of Governors approved the appointment of Béatrice Butsana-Sita as a Non-Executive Director of the SLaM Board, subject to DBS clearance which is due imminently (all other elements of the Fit and Proper Person regulations have been met).
The minutes of the Board held on 22 May 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.

Mr Baker and his wife, Mrs Baker, were introduced by Nuala Conlon, Involvement Lead, and Nicola Gower, Clinical Service Lead, for the Psychological Medicine and Older Adults Directorate (formerly the MHOAD Clinical Academic Group). Mr Baker thanked the Board for this opportunity to tell his story, which he hoped would be useful.

Mr Baker had been under the care of Croydon Community Mental Health Treatment (CMHT) service. In February 2018, he felt mentally unwell and reached out for crisis care by way of calling the team, using details on a purple, SLaM card he had been given for distressed or “in crisis” situations. He was told that he had been discharged from services and that his file could not be retrieved; he would need to be re-referred by his GP as it is not possible to self-refer. He had not at any point been told that he had been discharged; it had not been put in writing and his GP had not been informed either.

His GP re-referred him immediately, but he was treated as a new patient and had to complete a lot of forms. It then took ten weeks to get an appointment. He had always relied on being able to seek crisis support via the CMHT – it was a crutch to him – but to find out that he had been discharged without being told and that the emergency contact card was therefore useless, undermined that sense of security he had once felt. There was also a significant impact on his wife, Mrs Baker. He feels assured that the Trust is looking into what went wrong, and is thankful that he could rely on and trust his GP.

Otherwise, he has had positive experiences with the Trust and joining the SUCAG is one of the best things he ever did.

Geraldine Strathdee asked Mr Baker whether he had a copy of his care plan, which would explain what would happen if he was in crisis? Mr Baker confirmed that he didn’t, he just had the purple card with contact details on it which, in the event, were no use as he had been unknowingly discharged. He felt badly let down.

Matthew Patrick asked Nicola Gower and Nuala Conlon whether they understand what happened in Mr B’s case, and what changes are in place to ensure that these errors do not happen again. Nicola Gower confirmed that there has been a thorough review and Mr B’s clinical record shows a timeline containing events which should not have happened. Operational policies have been refreshed, and staff reminded that self-referrals are accepted. One of the main issues was that there was more than one team involved and there was a lack of communication. They have therefore revisited how care planning should work in a multi-disciplinary team. This learning has been share with other community teams.

Kristin Dominy asked Mr Baker if he was confident that the problems raised by his story will not happen again. He said that he was pleased to hear that action has been taken to prevent it happening again to him or anyone else. However, he did feel that there should be more than just a card with contact numbers on it for people who
need crisis support. There should be an email address so that the patient can record what the problem is and not just rely on a duty officer. There should also be a call-back option.

Mrs Baker added that the purple card should have been a lifeline, but it wasn’t. She had had to unexpectedly take her husband to A&E, which is not a good idea when someone is mentally distressed.

Roger Paffard thanked Mr and Mrs Baker for coming to the meeting to share their story, and for being so open and candid.

Mr and Mrs Baker gave their consent for their names to be shown in the minutes of this meeting.

**BOD 97/18 QUALITY IMPROVEMENT UPDATE (15.07)**

Barbara Grey, Director of Quality Improvement, attended to present this item. The paper was taken as read, and attention drawn to identified risks to the Quality Improvement programme and the mitigations that have been put in place. The Board’s input was sought as to whether the outcome measures as articulated are correct.

Anna Walker queried whether there was some work to be done to line up the QI priorities with the Trust’s strategy and the Quality Priorities for 2018-19. A lot of work has gone into developing metrics to monitor progress against key aims, and she sought clarity to what extent the QI aims overlap, or are a subset of, the strategy overall. Her biggest concern is around “right care, right time and in an appropriate setting” Quality Priority and what work – in addition to that around length of stay and crisis readmissions – is being done to promote that. As Chair of the Quality Committee, which “owns” the BAF risk on the QI programme, she would like to be very clear that QI priorities align with other quality objectives.

Michael Holland explained that the ICare programme of work gets to the heart of “right care, right time...” and is particularly important as it targets goals set by patients and carers. It was agreed that Anna Walker and Barbara Grey would meet separately to discuss the priorities in QI and how they align more explicitly with the wider strategy and Quality Priorities.

Ian Everall expressed concern about relying on data to assess performance when it may be unreliable, for example given the known under-reporting of violent incidents on Datix.

Duncan Hames agreed with the definitions suggested in the paper for return on investment (ROI), but added that the key to ROI is to take projects that have been proven successful and bring them to scale and wondered whether it might be useful to focus on improvements realised and implemented across a wider platform. He felt unsighted on examples of projects being scaled up. It was agreed that there would be a lot of value in both seeing how learning is shared, but also the extent of change that has been, and still is, required. Gus Heafield requested more information about the number, scope and scale of projects being undertaken using QI methodology and what they are trying to address. It is useful to have that kind of information to be able to answer questions and talk confidently about the benefits.

The Board reflected on the QI presentation they had received ahead of the formal meeting, identifying coproduction as something which, if approached and engaged
with properly, will address a lot of issues raised by service users. Kristin Dominy stressed the importance of these presentations being given across peer groups, as they will inspire teams to do something similar if not the same. Beverley Murphy highlighted a recent deep dive into restrictive practice which showcased how different teams have sought to address issues, using small scale projects.

Matthew Patrick felt that the high level proxy indicators suggested in the accompanying paper are appropriate for helping SMT and the Board identify any improvements arising from QI projects. Those measures may evolve, but they are a good start and the Board should look at them regularly.

Altaf Kara asked whether the investment in the QI programme has, to date, been sufficient to achieve scale up. Michael Holland reported that, having taken external advice and spoken to other organisations, SLaM appears to have achieved more than most at this point i.e. 18 months into implementation of the initiative. In his views, the level of investment is right; putting more money in will not change results at this stage. June Mulroy asked whether there has been any difficulty in engaging staff to participate and whether the Board can assist; Barbara Grey felt that some senior clinicians find it harder to engage than others, but that a plan is in place to address that.

In terms of next steps, the Board agreed that progress would be tracked against the measures set out in the supporting paper before a review at the Board in six months’ time.

**BOD 98/18 RISK FOCUS: BAF RISK 9 – ESTATES (15.32)**

Altaf Kara presented this item, a deep dive into BAF Risk 9: “The Trust estates strategy will be delivered over the next five years and is dependent on 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”.

At a recent Board development session on the BAF risks, there was discussion about moving the overall risk scoring for the Estates risk to 12 from 16. However, following discussion at the Business Development and Investment Committee (BDIC), the recommendation is that it remains at 16 (likelihood 4 and consequence 4), with the risk target moved to 9 (likelihood 3, consequence 3) from 8 (likelihood 2, consequence 4). It is also proposed that the following wording is added to the articulation of the risk: “Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget”.

Matthew Patrick added that the Senior Management Team had also focused on this risk and its scoring, but had decided that it did not fall within the top three BAF risks.

The Board approved the re-rating of the risk and target risk, as well as the additional wording.

Geraldine Strathdee sought clarification on the strategy for “integrated community hubs” as referred to in the supporting paper; this is something that SLaM will look to in the future depending on opportunity and where potential partners are, and where there is scope for doing things differently.

Geraldine Strathdee sought assurance that the estates strategy includes a focus on having therapeutic-designed environments; the benefits for service users as seen in
ES1, for example, are marvellous. Altaf Kara confirmed that this will be a feature of the refreshed strategy.

**BOD 99/18 CHIEF EXECUTIVE’S REPORT**

Matthew Patrick highlighted some key issues from his written paper.

The South London Mental Health and Community Partnership (SLMHCP or SLP) has now been operational for a year. In that time, £4.6m has been invested in new service developments; a fantastic achievement. The SLP is also working on a big programme in relation to complex care, negotiating with CCGs to take on the development and drive quality in those pathways. The SLP demonstrates that quality, when coupled with clinical leadership, works.

Matthew Patrick attended a Kings College Hospital liaison team visit the day before; the winter pressures do not yet seem to have ended for Emergency Departments in London. There has been a 25% increase in mental health presentations in A&E in the last month and teams are doing fantastic work under enormous pressure. The Board should be sighted on two initiatives designed to help address the unrelenting demand and subsequent pressure in the system.

The first, started by Beverley Murphy, involves a multi-agency meeting planned for 4 July, at which key bodies and organisations including acute trusts, the Metropolitan Police, the London Ambulance Service, NHSI, local authorities and CCGs have been invited to work collaboratively to find solutions to the increase in demand for mental health services across the system.

The other has been initiated by CCG colleagues and again will bring together multiple agencies across the system, including Oxleas, to look at how to create flow and reduce bottle necks.

Matthew Patrick also recently attended the King’s Health Partners Annual Conference and, with Bruce Clark, addressed delegates about the proposed Centre for Children and Young People (CYP). He and Roger Paffard also attended a seminar with the fundraisers for the CYP.

Geraldine Strathdee added that events like the KHP conference highlight the incredibly valuable investments in neuroscience, genetics, population health, genomics and data. The Board agreed that it should have a discussion about the Centre for Translational Informatics, as well as population health and what it means to SLaM, in the near future. Ian Everall reported that IoPPN is in the final stages of appointing an academic in population health. Michael Holland undertook to develop a discussion on population health at either a Board development session or at a Board meeting.

**BOD 100/18 CYBER SECURITY & GDPR (15.51)**

Stephen Docherty, Chief Information Officer, and Murat Soncul, Head of Information Governance, attended to present this item, updating the Board on how the Trust prepared for, implemented and will monitor compliance in respect of the General Data Protection Regulation (GDPR), as well as how Digital Services has worked with NHS Digital as early adopters of cyber security programmes.

Murat Soncul welcomed the arrival of GDPR, as the Data Protection Act 1998 needed an upgrade. The new Act brings with it a new definition of personal data and
new rights to data subjects. The Trust has done a lot of work over the last 18 months to prepare, including undertaking a full audit on what data the Trust holds and why. The new legislation is quite prescriptive about designing privacy features, and the Trust has adapted policies and procedures to comply with that. He has taken on the new role of Data Protection Officer, and it will be his responsibility to monitor compliance with the new Act.

Stephen Docherty provided an update on cyber security measures, including confirmation that SLaM email has now been certified as secure and the introduction of a data protection security toolkit and a cyber security dashboard.

Duncan Hames sought assurance regarding meaningful engagement between the clinical areas of the Trust and these developments. It was noted that Nicola Byrne, Deputy Medical Director and Caldicott Guardian, is the Chief Clinical Information Officer and she works very closely with the Digital Services team. A Digital Nurse Lead has also recently been appointed.

Russell Mascarenhas asked what the process is for staff to report a data breach on a ward to both the Board and to the Information Commissioner’s Office, given the 72-hour window to do so. He also queried how any trends in breaches would be picked up and reported. Murat Soncul confirmed that SLaM has adopted NHS Digital’s reporting portal, and is updating its processes in order to raise awareness amongst staff. Datix is the primary reporting tool in place, and reports from there are presented regularly. The Data Protection Officer must have access to the Board to be able to provide updates as they happen.

The Board discussed data sharing with partners, and Ian Everall queried the process in respect of some of the more complex areas, such as the Biomedical Research Centre. It was confirmed that there is an oversight committee made up of patients, people from the Trust and the IoPPN which reviews every single application to use data.

June Mulroy added that as partnerships and alliances develop across the boroughs, part of the benefit is supposed to be having a seamless service between organisations and shared access to care records; Murat Soncul confirmed that work is ongoing to give all care teams access to integrated care records, and “One London” has recently been awarded £7.5m in funding from NHS England to become a local health and care record exemplar and to develop a platform for sharing data.

**BOD 101/18 PERFORMANCE AND FINANCE REPORT (16.07)**

Kristin Dominy presented the performance section of this report.

Two NHS Improvement indicators have not been met according to the latest data; the IAPT recovery rate has fallen to 49.87% (against a target of 50%), and the 7-day follow up target was missed by 0.5%.

The Board was alerted to the challenges currently faced in respect of private overspill. There are currently 31 patients in private care and there were 36 last week. Escalation processes are in place, and patients are being treated as close to home as possible. The Trust is working with system partners e.g. local authorities and acute trusts to work on barriers to discharge, and to try to create flow on a larger scale.
Kristin Dominy has set target rates for dementia diagnosis across the boroughs which goes above that set nationally (67%) as all are already achieving the national standard. Lambeth, Southwark and Lewisham have a target of 85%, whereas Croydon has a target of 75%. The difference is due to the differential in funding.

Ann Moss Unit (a specialist care unit for older adults with complex mental health needs and dementia) is due to close by 31 August 2018. Alternative care settings are being identified for patients and appropriate consultation is taking place.

The position of Director of Performance, Contracts and Operational Assurance has been recruited to for a period of 12 months and that role will have an additional transformation function alongside the Programme Management Office. Resourcing issues have led to a delay in rolling out the Community QuESTT tool.

Work is underway to review statutory and mandatory training across the Trust, to ensure that it is set at the appropriate level.

Geraldine Strathdee asked what proportion of presentations which have led to the demand on beds are already known to the Trust. Kristin Dominy thought it was around 80%; there has been an increase in crisis presentations in A&E and it has not yet been possible to get to the bottom of the reasons for it. Matthew Patrick stressed that this is not just a trend for SLaM, or one which has happened over night. The increase has been seen nationally for months.

Roger Paffard noted that compliance with PSTS (Promoting Safe and Therapeutic Services) training remains stubbornly and unacceptably low. In view of the strategic importance and potential public perception, this is a priority to address quickly. Sally Storey explained that this is partly the result of a training environment being out of commission and the difficulty in finding a suitable replacement. The course is also being reviewed as it is five days long but could be shortened without reducing quality. Additionally, some staff may require de-escalation training as opposed to PSTS training which is largely physical. The Trust is applying the rule that no-one may work on a ward if they have not been PSTS trained, and training capacity has been increased to meet demand.

There will be a deep dive into the mandatory training risk on the BAF at July’s Board meeting.

Gus Heafield presented the Finance section of the report and highlighted financial pressures. Further to the earlier discussion around bed pressures, he stressed that the Trust has strategic arrangements in place with the STP for the funding of certain placements, so SLaM is not bearing the cost of all of the private beds in use.

The Trust was unexpectedly notified of a £0.52m reduction in its Research and Capability Funding (RCF) in May and must find mitigations for that position.

The Trust also received planning guidance feedback from NHS Improvement, saying that there were key elements of the Trust’s 2018-19 operational plan which require further review and follow up action. The letter did not raise any unexpected points e.g. Trust management are already aware that the workforce plan required further attention, and a detailed response has been prepared.
Roger Paffard added that, for the first time in this cycle, NHSI has decided to write to Trust Chairs. Authority has been delegated to the Finance and Performance Committee to respond.

Duncan Hames queried what mitigation could be put in place to mitigate the reduction in R&D funding, given that the written report presented to the Board says that there is little scope to develop a corresponding cost reduction. He asked what risk this presents. Gus Heafield explained that the National Institute for Health Research (NIHR) has not changed the funding model itself, but the weighting within that, and therefore there are some mitigations we are working on with the R&D team and IoPPN which will reduce the amount of additional pressure we have to manage in-year. However, this is a real challenge, but the focus is to maintain strategic R&D objectives and not to get knocked off course with short-term actions which impact on R&D capacity or capability. The balance of the reduction may need to come from contingency or further one-off measures and Gus Heafield will update the Board on progress through the finance reports. The issue and risks it presents has been flagged to NHS Improvement.

BOD 102/18 2018-19 OBJECTIVES: NEDS AND EXECUTIVE DIRECTORS (16.31)

The Board considered the proposed objectives and competency framework for the Non-Executive Directors, and the objectives for the Senior Management Team and Chief Executive, for 2018-19.

Anna Walker felt that whilst the objectives for the Board show “common threads”, the links between the Trust’s strategy, Quality Priorities, Board Assurance Framework, NED objectives and SMT objectives could be made clearer. She expressed concerns that gaps may appear, for example around measuring “right care, at the right time, in the right setting”. Whilst the paper supporting this item shows a driver diagram for the objectives, Anna Walker felt that it could be more robustly articulated.

Action: An updated set of objectives, reflecting more explicit reference to the Trust’s strategic priorities, including Quality Priorities, for the Senior Management Team and the Chief Executive to be brought back to the Board in July.

Kristin Dominy remarked, in Mike Franklin’s absence, that he is the designated NED for EPRR (Emergency Preparedness, Resilience and Response).

Anna Walker supported the inclusion of an SMT objective to “enable staff to make the best use of information with reliable IT infrastructure and applications”, but suggested taking this further and, as a Board, leading by example. The recent review of the Board’s effectiveness did point to use of data as an area for improvement.

The Board discussed the SMT objective to “improve translation of research into clinical practice” and whether this could be more specific and measurable. Matthew Patrick reminded the Board that this is the role of the CAG; Geraldine Strathdee added that it is also important to capture where clinical practice can inform research. There was an appetite for more examples where research has informed practice; Ian Everall pointed to a booklet on impacts which he will disseminate when ready.

BOD 103/18 BOARD ASSURANCE FRAMEWORK (16.40)

Beverley Murphy introduced this item and Colan Ash, Head of Risk and Assurance, attended. The full Board Assurance Framework (BAF) was last received in March
2018, and a detailed walk-through was given. Each risk was re-reviewed individually at a Board Development Session in May 2018, and the Corporate Risk Register has been refreshed.

The paper supporting this item made a number of recommendations arising from the Board Development Session, including the addition of a BAF risk around mandatory training compliance (for which there will be a deep dive at the July Board). Risk 4 (failure to align objectives with IoPPN) and risk 10 (damage to Trust reputation) are recommended for closure, the latter because it is subsumed into other risks.

Risk 6 (lack of capacity / commitment to work with external partners) was recommended for de-escalation to the Corporate Risk Register, albeit that it was also recommended that the Corporate Risk Register is re-named the Executive Risk Register in order to avoid confusion.

The supporting paper also outlined any changes to the risk ratings and risk appetite for each principal risk, as discussed. The Board, which has had scrutiny and oversight, was asked to approve the changes.

The Board approved the changes, acknowledging how far the engagement with, and presentation of, BAF risks has come, but recognising that all committees need to ensure that the BAF is adopted as business as usual to keep it “live”.

**BOD 104/18 TERMS OF REFERENCE – COMMITTEES’ YEARLY UPDATE**

The Board received updated Terms of Reference (ToRs) from the Audit Committee, the Finance and Performance Committee, and the Business Development and Investment Committee for approval. The Quality Committee presented theirs for approval in March 2018, whilst the Equalities and Workforce Committee ToRs are not yet due for a review as the Committee is less than a year old. The Mental Health Law Committee is due to present their updated ToRs for approval in July.

The Board approved the updated Committee Terms of Reference. It was recognised that those for the Business Development and Investment Committee are likely to evolve over the next year.

**BOD 105/18 QUALITY COMMITTEE MAY UPDATE**

Anna Walker, Chair of the Quality Committee, highlighted a number of quality issues taken forward at the last, very busy, committee meeting including (but not limited to) supervision practices, use of seclusion facilities, reducing restrictive practice, electronic tools to support the development of care plans and risk assessments, and a review of self-harm. Developments in the Trust performance dashboard are very welcome. Once the dashboard is in place, the Quality Committee will explore what more it needs by way of quality-related data.

**BOD 106/18 EQUALITIES AND WORKFORCE COMMITTEE MAY UPDATE**

Sally Storey presented this item. The Committee has reviewed how realistic the Trust’s workforce targets are, following the concerns raised within the committee.

The Senior Management Team shares concerns that the Trust’s target relating to the proportion of senior staff with a BME background is a stretching aspiration. BME staff make up 43% of total staffing, but only 24% of staff at band 7 and above, and achieving the target would require a shift in appointments that the organisation will
struggle to achieve in spite of its best efforts. However, the committee does not want to give the wrong signals about the Trust’s commitment to change by suggesting that it is reduced.

There is a commitment, as the year progresses, to doing more work to analyse data, review relevant benchmarks and assess action plans so that SLaM can get as close as is possible to the target it has set, and to make sure that the target in future is more grounded.

There has been a similar discussion in terms of the proportion of BME staff involved in disciplinary processes. Trust figures have moved in the wrong direction since work started in this area in the second half of last year, with more staff in total and more BME staff as a proportion being disciplined this year. However, the figures from year-to-year vary considerably. The intention is to leave the target as it is and revisit the “Review and Reflect Checklist” to ensure it is doing what it is intended to do.

SMT also considered targets of reducing turnover by ten percentage points from 18.6% within three years and improving the percentage of staff who recommend the Trust as a place to work by 15 percentage points from 60% to 75% in three years. Again, these are considered stretching, but it is believed that reducing them would appear to be limiting aspirations, which is not the intention. Sally Storey wished to make the Board aware of the lack of progress against these targets.

Matthew Patrick asked whether targets should only be set if they are benchmarked against best practice. Process should also be tracked using SPV charges so that variation can be properly monitored.

Anna Walker reflected that the engagement with the BME network seems very positive, and that the concerns about performance did not come from within that network, but within the committee.

**BOD 107/18 AUDIT COMMITTEE MAY & JUNE UPDATE (16.59)**

The report was taken as read. Duncan Hames highlighted that an all-staff communication had been issued to put into context confusing high-level messages about NHS funding, as the Trust’s end-of-year position (a net surplus of £10.5m) could be misconstrued as meaning that more could have been spent on front-line services or that the savings staff were asked to deliver were unnecessary.

Duncan Hames welcomed the recognition earlier in the meeting that the BAF needs to be kept live and felt that the opportunity probably rests in committees to test gaps in control and assurance. Now that there is far greater awareness at Board level, members can take a closer look at progress being made to mitigate these risks and ask very intuitive questions. Risk management within the Trust is in a much better place.

**BOD 108/18 COUNCIL OF GOVERNORS UPDATE (17.00)**

Brian Lumsden spoke on behalf of the Council of Governors.

He reflected on a really good Council of Governors’ meeting the previous week. Thanks to the Corporate Affairs team, engagement amongst Governors has increased a lot in the last year. The meeting had a good session on the Lambeth Alliance and there was an opportunity to learn more about plans to reduce bed occupancy. Governors are concerned that strategies to reduce beds and bed
occupancy will lead to patients being discharged to early and therefore increased readmissions and focus on community care. A bespoke session for Governors is being arranged on this, in addition to the session at the Council of Governors’ meeting.

Matthew Patrick clarified that there is no plan to reduce beds until such point as bed occupancy is consistently below 63%; Brian Lumsden agreed that this had been explained to the Governors at their Council meeting.

A small group of Governors recently had meetings with Harriet Harman MP and Helen Hayes MP to discuss mental health funding. Meetings with the CCGs have been arranged.

**BOD 109/18 NHSI SELF-CERTIFICATION REQUIREMENTS (17.03)**

The Board was asked to approve or make changes to the proposed content for self-certification forms that need to be submitted to NHSI in respect of (a) Corporate Governance; (b) Governor training; and (c) Availability of Resources. All three were approved by the Council of Governors at their meeting on 14 June and there was nothing that they wanted to input to the versions presented to the Board.

The Board approved the NHSI self-certification forms.

**BOD 110/18 GUARDIAN OF SAFE WORKING (17.04)**

The report was presented for noting. Michael Holland highlighted the reduction in agency locum use to cover on-call shifts since October. 32.5 hours of fines have been applied this quarter owing to breaches and a new rota is being instituted to avoid those breaches.

**BOD 111/18 REPORT FROM PREVIOUS MONTH’S PART II MEETING (17.04)**

The report was noted.

**BOD 112/18 WRAP UP AND NEXT MEETING DATE (17.05)**

The Board noted the poster displayed by a member of the public gallery, gave an undertaking to read it and to capture their acknowledgement in the minutes of the meeting.

**BOD 113/18 MEETING EVALUATION (17.05)**

June Mulroy was invited to lead the meeting evaluation. She identified key outcomes around QI metrics; changes to the BAF on estates issues; good progress on digital issues. She found the patient story very moving and helpfully honest; she could not help but reflect that if the processes articulated in the QI presentation before the main meeting about care planning had been put in place for Mr Baker, he and his wife would not have faced the difficulties that they had. She had been pleased to see an important focus on service users at this meeting.

She reflected that a lot of support is being given to build systems and processes, and that it is important to see how governance processes operate on the front-line. It is tricky to balance issues e.g. between information and learning, when there is a lot of innovative work going on. She was pleased to see a review of statutory and mandatory training.
June Mulroy felt that time had been used effectively and welcomed improved use of data. She believed that the Trust commitments had been met.

The date of the next meeting will be:
24 July 2018, 14.30 – 17.00, ORTUS CENTRE

Representatives of the press and members of the public were asked to withdraw from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 (2) Public Bodies Admission to Meetings Act 1960)
**Public Board meeting 24 July 2018 – Action points**

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<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></td>
<td><strong>March 2018</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<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</td>
<td>On July agenda</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>June 2018</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>102/18</td>
<td>2018-19 Objectives: NEDs and Executive Directors</td>
<td>An updated set of objectives, reflecting more explicit reference to the Trust’s strategic priorities, including Quality Priorities, for the Senior Management Team and the Chief Executive to be brought back to the Board in July.</td>
<td>RE</td>
<td>July</td>
<td>On July agenda</td>
<td></td>
</tr>
</tbody>
</table>

**Key:**
- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule
REPORT TO THE TRUST BOARD:  PUBLIC
24 July 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Risk Focus: Principal Risk 13: Mandatory Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Sally Storey, Director of HR, OD and Education &amp; Development</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Sally Storey, Director of HR, OD and Education &amp; Development</td>
</tr>
</tbody>
</table>

Purpose of the paper

The Board has committed to looking in-depth at one of the risks on the Board Assurance Framework at each Board meeting. This paper presents Principle Risk 13 for detailed Board consideration and discussion:

Mandatory training - 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.

This was a new risk, added to the BAF in June 2018. The existing risk rating is at Annex A.

The Board is asked to:
- discuss the report
- consider the controls and assurances in place
- consider the appropriateness of the action plans
- agree that the risk rating remains at 12 until the next quarter’s compliance results are known

Executive summary

Following strenuous efforts over a sustained period, the Trust has seen in a steady improvement over the past year in mandatory training compliance, and overall compliance has now reached our target of 85%. The Trust is still not where it needs to be in terms of compliance in all subjects, however, and some key subjects remain a challenge. These include life support, PSTS, and infection control, and specific action plans are in place which are already addressing each of these.

A wide range of controls are in place, and these have brought the initial assessment of the risk rating down. A gap in control and in assurance relating to the confidence in compliance data has been the subject of much effort across a number of teams and is close to being resolved.

In the light of the actions taken, and the resultant improvements in compliance levels, the risk rating has come down from 20 to 12. It is recommended that it remains at 12 until the next quarter’s compliance figures are known.

Risks / issues for escalation

This report covers BAF Risk 13 – Mandatory training - If the Trust fails to meets 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>
</tr>
</thead>
<tbody>
<tr>
<td>31 October 2017</td>
<td>Equalities &amp; Workforce Committee (in training report)</td>
</tr>
<tr>
<td>21 November 2017</td>
<td>Quality Committee (in training report)</td>
</tr>
<tr>
<td>20 February 2018</td>
<td>Equalities &amp; Workforce Committee (in training report)</td>
</tr>
<tr>
<td>13 March 2018</td>
<td>Quality Committee (in training report)</td>
</tr>
<tr>
<td>10 April 2018</td>
<td>Equalities &amp; Workforce Committee (as first draft of new BAF 13 proposal)</td>
</tr>
<tr>
<td>21 May 2018</td>
<td>Senior Management Team (to review approach to mandatory requirements)</td>
</tr>
<tr>
<td>21 May 2018</td>
<td>Board at awayday (detailed review of proposed new BAF prior to Board meeting approval)</td>
</tr>
<tr>
<td>19 June 2018</td>
<td>Board of Directors Meeting (BAF 13 formally approved as part of Full BAF report)</td>
</tr>
<tr>
<td>17 July 2018</td>
<td>Quality Committee (in training report)</td>
</tr>
</tbody>
</table>

1. Introduction

Following strenuous efforts over a sustained period the Trust has seen in a steady improvement over the past year in mandatory training compliance, and overall compliance has now reached our target of 85%. The Trust is still not where it needs to be in terms of compliance in all subjects, however, and some key subjects remain a challenge.

2. Current compliance rates

Current compliance by directorate and by subject matter are shown in the tables below. The trend over the past six months is shown by subject. The trend by directorate is not available because of the shift to boroughs from CAGs.

### Directorate

<table>
<thead>
<tr>
<th>Directorate</th>
<th>2 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Adolescent Services</td>
<td>82.15%</td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>83.93%</td>
</tr>
<tr>
<td>Lambeth Directorate</td>
<td>87.22%</td>
</tr>
<tr>
<td>Croydon Directorate</td>
<td>88.90%</td>
</tr>
<tr>
<td>Southwark Directorate</td>
<td>85.54%</td>
</tr>
<tr>
<td>PMOA</td>
<td>87.88%</td>
</tr>
<tr>
<td>Lewisham Directorate</td>
<td>87.91%</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>73.79%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>85.83%</td>
</tr>
</tbody>
</table>

### Core Subjects

<table>
<thead>
<tr>
<th>Subject</th>
<th>Dec 2017</th>
<th>March 2018</th>
<th>2 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Support - Group 1</td>
<td>91.82%</td>
<td>90.07%</td>
<td>92.93%</td>
</tr>
<tr>
<td>Basic Life Support – Group 2</td>
<td>70.32%</td>
<td>66.57%</td>
<td>76.59%</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>87.11%</td>
<td>85.91%</td>
<td>91.33%</td>
</tr>
<tr>
<td>Fire Safety Awareness</td>
<td>79.79%</td>
<td>80.07%</td>
<td>84.90%</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>84.44%</td>
<td>84.53%</td>
<td>90.04%</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>62.10%</td>
<td>70.55%</td>
<td>77.45%</td>
</tr>
<tr>
<td>Infection Control Level 1</td>
<td>90.31%</td>
<td>89.01%</td>
<td>92.63%</td>
</tr>
<tr>
<td>Infection Control Level 2</td>
<td>57.08%</td>
<td>67.34%</td>
<td>76.04%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>79.69%</td>
<td>77.74%</td>
<td>81.33%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 1</td>
<td>86.71%</td>
<td>92.75%</td>
<td>88.97%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 2</td>
<td>88.46%</td>
<td>84.62%</td>
<td>96.30%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 3</td>
<td>86.69%</td>
<td>86.26%</td>
<td>91.09%</td>
</tr>
</tbody>
</table>
### Moving and Handling - Patients

<table>
<thead>
<tr>
<th>Group</th>
<th>Dec 2017</th>
<th>March 2018</th>
<th>2 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients - Group 1</td>
<td>89.31%</td>
<td>82.58%</td>
<td>79.53%</td>
</tr>
<tr>
<td>Patients - Group 2</td>
<td>82.50%</td>
<td>84.44%</td>
<td>88.87%</td>
</tr>
<tr>
<td>Patients - Group 3</td>
<td>81.40%</td>
<td>78.57%</td>
<td>92.11%</td>
</tr>
</tbody>
</table>

### Prevent Awareness

<table>
<thead>
<tr>
<th>Group</th>
<th>Dec 2017</th>
<th>March 2018</th>
<th>2 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent</td>
<td>86.51%</td>
<td>88.64%</td>
<td>92.75%</td>
</tr>
<tr>
<td>Workshop</td>
<td>76.01%</td>
<td>84.39%</td>
<td>89.06%</td>
</tr>
<tr>
<td>PSTS Awareness</td>
<td>78.88%</td>
<td>78.04%</td>
<td>84.28%</td>
</tr>
<tr>
<td>Conflict</td>
<td>84.28%</td>
<td>81.32%</td>
<td>78.50%</td>
</tr>
<tr>
<td>Resolution</td>
<td>85.91%</td>
<td>84.77%</td>
<td>90.12%</td>
</tr>
<tr>
<td>Disengagement</td>
<td>85.27%</td>
<td>84.25%</td>
<td>88.42%</td>
</tr>
<tr>
<td>PSTS Team Work</td>
<td>80.07%</td>
<td>83.12%</td>
<td>86.47%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>85.91%</td>
<td>84.77%</td>
<td>92.82%</td>
</tr>
<tr>
<td>Adults Alerters</td>
<td>85.27%</td>
<td>84.25%</td>
<td>88.42%</td>
</tr>
<tr>
<td>Adults Alerters Plus</td>
<td>88.23%</td>
<td>87.25%</td>
<td>91.28%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>93.89%</td>
<td>93.67%</td>
<td>97.01%</td>
</tr>
<tr>
<td>Children Level 1</td>
<td>88.23%</td>
<td>87.25%</td>
<td>91.28%</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>77.27%</td>
<td>77.89%</td>
<td>87.15%</td>
</tr>
<tr>
<td>Children Level 2</td>
<td>85.91%</td>
<td>84.77%</td>
<td>92.82%</td>
</tr>
<tr>
<td>Children Level 3</td>
<td>85.27%</td>
<td>84.25%</td>
<td>88.42%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>79.68%</td>
<td>81.16%</td>
<td>85.83%</td>
</tr>
</tbody>
</table>

### Non-core – Mental Health Specific Subjects

<table>
<thead>
<tr>
<th>Dec 2017</th>
<th>March 2018</th>
<th>2 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>85.66%</td>
<td>89.00%</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>82.60%</td>
<td>84.94%</td>
</tr>
<tr>
<td>Mental Health Act Training</td>
<td>81.64%</td>
<td>84.02%</td>
</tr>
</tbody>
</table>

### 3. Reasons for low compliance and impact

The key causes of low compliance include an increasing list of training topics deemed as mandatory, leading to difficulty in releasing staff from duty to train, training capacity issues both in terms of trainer and venue availability, challenges with a new learning management system, LEAP, that has led to a loss of faith in the data it holds, manual work-arounds to compensate while the system is being sorted being missed, training requirements over-specified for some groups of staff, a slower development of e-learning alternatives than would be ideal, and in some cases a lack of effective management by line managers.

The LEAP system was offline for a short period in April for an upgrade, and for a two-week period there was a problem with Skills for Health e-learning programmes failing to record completion.

The effects of failing to meet mandatory training targets could include patient care being compromised by a lack of up to date training, and staff safety and well-being compromised leading to poor staff experience. In extreme cases the Trust could be liable for failing to meet its own and external standards.

On a more positive note, the conversion of the majority of courses from taught face to face sessions to e-learning packages with a quick assessment questionnaire which, if passed, avoids the need to complete the learning package, has transformed the experience for staff and reduced the burden of training. Data cleansing work on ESR and work to improve the communication between our systems has begun to feed through into more accurate data in LEAP, though this work is ongoing.

### 4. Controls

A key control is the trust’s Mandatory Training Policy and matrix of training requirements by staff group. A range of further controls have been put in place to reduce the likelihood and minimise the consequences of the risk.

Actions have included:

- a substantial programme to cleanse data held on our HR and payroll system, ESR, that feeds LEAP, our learning management system, to ensure data held on LEAP is accurate
- improvements to the process of information flows from ESR into LEAP
- work with our software developers to iron out problems in LEAP
• shifting an increasing range of training to e-learning, introducing e-assessment which, if passed, means people do not have to repeat the training
• exploring new venues as former venues have been lost, working closely with the developers of LEAP to iron out teething problems with the new system
• automated email alerts to staff and to line managers when compliance is due to expire
• the Trust’s appraisal policy does not allow staff to be rated as satisfactory or above if they are not fully compliant
• mandatory training focus at directorate performance reviews chaired by the COO
• executive directors leading by example, and holding conversations starting with their direct reports and cascading through all levels as a matter of urgency to stress the importance of mandatory training, the consequences of non-compliance for the safety of service users and staff, and the consequences for the Trust
• personal intervention by the Director of Nursing and Medical Director
• live issues log, tracking issues relating to compliance and actions to address the issues
• direct email contact by the Education and Development Department with staff who are non-compliant, in addition to the reminder emails automatically generated by LEAP
• additional resource to prioritise data cleansing on ESR
• a review the Trust’s statutory and mandatory training, comparing our requirements with those of our SLP partners, seeking alignment where possible to reduce the burden of training on staff and on services
• further action led by the Director of Nursing to reduce/focus content of training in a number of subjects

5. Specific actions in relation to current areas of concern

Life Support

Additional BLS (Basic Life Support) courses have been put on to improve compliance. Multiple dates are available for ILS (Immediate Life Support) from late July and the Education department will be piloting a half-day refresher course following a retender for our external provider as well as training more SLaM staff to co-deliver the training. Not all courses are running at full capacity, however, and DNA rates are increasing, which represents poor use of resources. This is being picked up in performance meetings. Staff are being sent additional emails, copied to their manager, to encourage bookings.

PSTS

The numbers of staff requiring PSTS training has increased following a change in practice to enforce the requirement that all clinical staff working in in-patient services require full PSTS training. From July 2018 we will be moving PSTS disengagement training to the ORTUS Training Centre, to use their larger training rooms to enable a greater number of delegate spaces to be offered. PSTS disengagement training is also currently being run on a Saturday to offer more options for staff. Plans are in progress to streamline PSTS training and deliver it differently and over a shorter period.

Infection Control

The content of the Infection Control e-learning package is currently under review by the Nursing Directorate. Staff completions are tracked, as with all mandatory training, through appraisal and local performance meetings.

6. Gaps in controls

The work on cleansing data held in ESR and improving the flows of information from this system into the LEAP system is a significant piece of work, made more complicated by the reorganisation into boroughs. One particular challenge is with leavers, and staff who move from one department to another, and the speed with which the changes are reflected within the LEAP system. This currently involves many time-consuming manual steps, and work to speed this up through automation is taking place involving the Education and Training, HR and IT teams.
We are developing processes to include honorary contract holders and staff who are employed by other bodies, such as social services, for the first time in the LEAP system. Without such processes that give these workers access to LEAP, we are not able to use LEAP to provide assurance that they are adequately trained.

7. Risk rating rationale

The initial likelihood of this risk occurring without any controls was determined to be 5, but taking into account controls in place at the time, the current risk rating was assessed as 4. There has since been further improvement in compliance over recent weeks, and improvements in the accuracy of data held on LEAP, and the likelihood is now considered to be approaching 3. The definitions are below. It is recommended however that the likelihood remains at 4 and is reduced if compliance with the 85% target is achieved in all subjects in the next quarter’s results.

<table>
<thead>
<tr>
<th>Likelihood score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rare</td>
</tr>
<tr>
<td>2. Unlikely</td>
</tr>
<tr>
<td>3. Possible</td>
</tr>
<tr>
<td>4. Likely</td>
</tr>
<tr>
<td>5. Almost certain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often might it/have it happen</td>
</tr>
<tr>
<td>This will probably never happen/recur</td>
</tr>
<tr>
<td>Do not expect it to happen/recur but it is possible it may do so</td>
</tr>
<tr>
<td>Might happen or recur occasionally</td>
</tr>
<tr>
<td>Will probably happen/recur but it is not a persisting issue</td>
</tr>
<tr>
<td>Will undoubtedly happen/recur, possibly frequently</td>
</tr>
</tbody>
</table>

The initial consequence for the Trust associated with the risk was determined as 4, and assessed as 3 taking into account the controls in place at the time. Taking into account the improvements and compliance data for the current quarter the consequence severity has reduced and now considered to be approaching 2. The definitions are below. It is recommended however that the consequence remains at 3, and is reduced if compliance with the 85% target is achieved in all subjects in the next quarter’s results.

<table>
<thead>
<tr>
<th>Consequence score (severity levels) and examples of descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Negligible</td>
</tr>
<tr>
<td>2 Minor</td>
</tr>
<tr>
<td>3. Moderate</td>
</tr>
<tr>
<td>4 Major</td>
</tr>
<tr>
<td>5 Catastrophic</td>
</tr>
</tbody>
</table>

| Breaches of mandatory/key training attendance rare |
| Localised pockets of poor attendance for mandatory/key training |
| Poor staff attendance for mandatory/key training |
| No staff attending mandatory/key training |
| No staff attending mandatory key training/key training on an ongoing basis |

The overall risk rating should therefore remain at 12 and be reviewed again in September when the next quarter’s training attendance data is available.

The proximity of the risk has been judged as immediate.

8. Risk Appetite

The Board’s risk appetite for workforce risks is currently cautious, within a range of 1 to 8. This is considered appropriate.

9. Risk target

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

10. Sources of assurance

Assurance is provided through a monthly training dashboard and by weekly compliance statistics, by subject and by directorate, that are published on our intranet. These feed into the routine Performance and Contract Management reports to the Board and the Quality Committee, and are considered by the Workforce and Equalities Committee on a regular basis.

11. Gaps in assurance
The accuracy of data in LEAP remains a gap until the data cleanse in ESR is completed and the flow or information between ESR and LEAP is speeded up.

12. Conclusion

Following strenuous efforts over a sustained period the Trust has seen in a steady improvement over the past year in mandatory training compliance, and overall compliance has now reached our target of 85%.

The Trust is still not where it needs to be in terms of compliance in all subjects, however, and some key subjects remain a challenge. These include life support, PSTS, infection control, moving and handling and safeguarding, and specific action plans are in place which are already addressing each of these.

A wide range of controls are in place, and these have brought the initial assessment of the risk rating down. A gap in control and in assurance relating to the confidence in compliance data has been the subject of much effort across a number of teams and is close to being resolved.
**Annex A: BAF Risk 13 - current**

**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 and patient safety and of breaching regulation of the local training gaps with a risk to the safety of staff and patients

<table>
<thead>
<tr>
<th>Owner:</th>
<th>HRD</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>Regulation &amp; Compliance</td>
</tr>
<tr>
<td>Risk Appetite</td>
<td>Minimal-Cautious (nominal range 1-8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Consequence</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Level</td>
<td>20</td>
<td>12</td>
<td>4</td>
</tr>
</tbody>
</table>

**Last reviewed:** new risk Jun-18 **Next review:** Sep-18

**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.

**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.

**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.

**Sources of Assurance**

Education & Training Committee. Monthly training dashboard. E&D

**Gaps in Assurance**

LEAP data accuracy concerns.
Training compliance reports. Mandatory training compliance part of routine Performance and Contract Management reports to Board, Audit Committee and Quality Committee.

<table>
<thead>
<tr>
<th>Assurance on the effectiveness of Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>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%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Request for Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open as new risk</td>
</tr>
</tbody>
</table>

Page 21 of 152
REPORT TO THE TRUST BOARD: PUBLIC
24 July 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>WRES Implementation Plan - Update Year 1; Planning Year 2.</th>
</tr>
</thead>
</table>
| Author | Zoë Reed, Director and FTSU Guardian on behalf of the Snowy White Peaks Group  
Mike Franklin, NED  
Arleen Elson, Chair BME Staff Network,  
Patience McLean, Workforce Equality Programme Manager,  
Michael Kelly, Deputy Director HR |
| Accountable Director | Matthew Patrick, Chief Executive |

Purpose of the paper

This paper provides an update on Year 1 of the Workforce Race Equality Standard (WRES) Implementation Plan. This was approved by the Board in September 2017, following the Board meeting in May 2017 which set out the Trust Board’s three aspirations for workforce equality.

The paper also sets out some proposals for Year 2 which starts in mid September 2018. Further analysis and work is required on a number of these and final decisions on the composition of Year 2 will be contained in recommendations to the Equalities and Workforce Committee in September.

Executive summary

The WRES Year 1 Implementation Plan was approved in September 2017, comprising 15 components contained within 4 strands

- Culture and Leadership
- Over-representation in Disciplinary Procedures
- Recruitment
- Career Development.

The Snowy White Peaks Group has been pleased to see the take up of the Plan recognizing that there has been varying degrees of progress in implementing all the components with some proceeding at a slower pace than planned, some faster and some proving not as relevant as first envisaged. Data from the first half-year of the WRES Year1 Implementation Plan [October – March 2018] reported in last financial year’s Workforce report was not encouraging given that there was an increase in the number of disciplinaries [over the previous year] and an increase in the proportion of BME staff within that number.

Whilst it is recognized that the first 6 months of such an all-encompassing programme is likely to have its ups and downs, nevertheless this has spurred that SWP Group to review all elements of the Year 1 Plan and make recommendations for Year 2.

Recommendations

- That the Board note the progress on Year 1 of the WRES Implementation Plan and the activities to be undertaken to finalise the components for Year 2.
- That the Board delegate to the Equalities and Workforce Committee in September the finalisation of the Year 2 WRES Implementation Plan once all analysis is complete.
- That the Inclusive Leadership Programme undertaken in Year 1 be extended to increase the coverage of managers and leaders with staff responsibility in the Trust. This will require the
commissioning of a further Phase of sessions at a cost of c.£20k. Detailed recommendations will be brought to the Equalities and Workforce Committee.

- To note that, as acknowledged in the September 2017 Board report that established the WRES Implementation Plan, funding has been provided to establish a band 4/5 post 3.5 days per week to support the administration and project reporting of the WRES Implementation Plan.

**Risks / issues for escalation**

This report relates to 3 Risks in the the Board Assurance Framework:

BAF Risk 1 - Workforce - 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

BAF Risk 7 – Quality & statutory compliance - 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.

BAF Risk 13 – Mandatory training - If the Trust fails to meets 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.

1. **Background and Purpose**

The WRES Year 1 Implementation Plan was approved in September 2017, comprising 15 components contained within 4 strands

- Culture and Leadership
- Over-representation in Disciplinary Procedures
- Recruitment
- Career Development.

The Snowy White Peaks Group has been pleased to see the take up of the Plan recognizing that there has been varying degrees of progress in implementing all the elements with some proceeding at a slower pace than planned, some faster and some proving not as relevant as first envisaged. Data from the first half-year of the WRES Year1 Implementation Plan [October – March 2018] reported in last financial year’s Workforce report was not encouraging given that there was an increase in the number of disciplinaries [over the previous year] and an increase in the proportion of BME staff within that number. Whilst it is recognized that the first 6 months of such an all-encompassing programme is likely to have its ups and downs, nevertheless this has spurred that SWP Group to review all elements of the Year 1 Plan and make recommendations for Year 2 and how the second year of the programme will be finalised.

2. **Culture and Leadership**

This strand comprised 5 components

- Communication Plan
- Inclusive Leadership Organisational Intervention
- Thinking Space Programme
- Mainstreaming monitoring
- Equalities Mandatory Training Improvement

The **Communication Plan** is led by the CE and the Board. Following approval by the Board there were a number of good pieces of communication and the intention now is to review the Communication Plan with the Communications Department to ensure all aspects of the WRES Implementation Plan are fully incorporated in mainstream communications. One new component in the Communication Plan for Year 2 is that Arleen Elson, Patience McLean and Rachel Evans Director of Corporate Affairs will visit every inpatient
unit to talk about the WRES ambitions and to highlight the Chair and Chief Executive’s commitment. A poster will be produced to put up in staff areas, coupled with written materials to leave in nursing stations.

The **Inclusive Leadership** Programme has been well received. Two Phases of 9 days [18 sessions] each were held in 3 different locations across the Trust. Close on 600 managers have been through the Programme and the feedback has been positive. A session was also offered to Board Members, Governors and Partners to attend and this was well received. A good relationship has been developed with the provider, Enact Solutions, and they are developing, at no extra cost, ‘reminder’ videos for participants to return to for a refresher. They are also collaborating with us in running surveys [of managers-participants and those they manage] to anonymously check effectiveness of learning. The results of these surveys will inform the provision of targeted development programmes to support managers to continue their development and practice as Inclusive Leaders. Details of this will be reported to the Equalities and Workforce Committee. There remains a substantial number of managers/leaders yet to experience the Programme and it is recommended that the Trust commission Phase 3 in autumn 2018. This is likely to require c.£20k and detailed proposals will be brought to the Equalities and Workforce Committee in September.

**Thinking Space** was something the Head Psychology & Psychotherapy [P&P] had already commissioned prior to the Board approving the WRES Year1 Implementation Plan and it made sense to incorporate it within the WRES Implementation Plan. The Provider ran some sessions within the P&P department and the remaining 3 were made available to the WRES Year1 Plan. The sessions overall were poorly attended however the Provider drew out some interesting perspectives. The option to re-commission the Provider to undertake a further Thinking Space exercise has been explored. However the SWPs is not sure what questions it would want explored to inform the development of the WRES Implementation Plan, through a second stage, so it is not being pursued.

There is another piece of work underway to develop some QI projects in conjunction with the Lambeth IAG/SLaM joint working group. Should it become apparent that this QI programme would benefit from the Thinking Space approach then it is proposed any further commissioning be undertaken as part of that QI Programme.

There was a component agreed in the Year 1 Implementation Plan to **mainstreaming monitoring** however this has not been implemented. The purpose, stated in the September 2017 Board Report, of using existing mechanisms to monitor progress towards achieving the WRES 3 Aspirations was to ‘demonstrate culturally that this area of activity is as significant as all other areas monitored through the Performance Structures’. It is felt that this remains, for culture and leadership reasons, a valid element in the WRES Plan and the Performance Team will be asked to work with HR and the Workforce Equalities Programmes Manager to incorporate WRES KPIs into the routine performance monitoring framework and structures. As part of the next phase of development of the PowerBI Dashboard a related Requirement for Year 2 is to ensure that we have more contemporaneous data so that we can be aware, in real time, of any peaks in relation to disciplinaries etc. and that the relevant managers and professional leads can consider plans to mitigate. Monthly oversight of disciplinaries will be undertaken by the Director of HR, OD and Education and Development to identify peaks and trends.

The final component in the Culture and Leadership strand is the **Mandatory Training Improvement**. This work is underway to secure wholesale overhaul and improvements. It was originally planned for the new offer to be available from October 2018 however this is now scheduled for end of this financial year. There is a parallel piece of work underway to review and define what is Mandatory in the training offer and this work will feed into that review. Development of the overall suite is being overseen by the Equality, Diversity and Inclusion Group.

### 3. Over-representation in Disciplinary Procedures

This second of the four strands in the WRES Year 1 Implementation Plan comprised 2 elements

- Implementation of Reflect and Review Checklist
- Explore RCN Cultural Ambassadors Programme and Trade Union Involvement

The first 6 months since the start of the use of the **Reflect and Review Checklist** (R&R) has demonstrated that it has not been properly implemented because only c.14 of the cases in Q3 and Q4 2017/2018 used the Checklist. It should be noted that because the Checklist was introduced part way through the year...
earlier cases would not have been through that process. A number of steps are being taken to rectify the problems including the robust enforcement of the requirement that every disciplinary must have an R&R Checklist. There is to be engagement with the Chief Operating Officer and Service Directors about how to improve the processes and increase buy-in. HR will also be clear that their role is to engage actively with managers in advance of the use of the Checklist to provide constructive challenge and explore alternative routes to solve the problems rather than a disciplinary.

There will be further work by the SWPs Group to examine existing data as well as feedback from the review with the CoO and Service Directors with recommendations reported to the Equalities and Workforce Committee in September. Following this the R&R Checklist will be refreshed as necessary and it will be emphasized that a crucial part of the process is that conversations must happen between the manager and the person concerned. The intention of this work is to ensure that all disciplinary recommendations do use the R&R Checklist which is signed off at SMT level. [nb some Disciplinary Investigations will proceed immediately and not be subject to the outcome of the R&R process – eg if they involve safeguarding or fraud – nevertheless the Checklist is still to be completed]. Regular monitoring will identify progress with this component - with Quarterly reporting on the ratio of BME/Other staff referred into the disciplinary process. This is because Board Aspiration 2 is that Disciplinary Proceedings should have proportionate referral and therefore it is important that a close watch is kept on this component.

There was a recommendation that the idea of adopting the RCN’s Cultural Ambassadors Programme be explored. What this exploration has highlighted is the need to ensure that all Trade Union reps are alerted to and fully equipped to respond to issues to do with racial discrimination as it impacts BME staff at work. For Year 2 the plan is to offer training and support to all TU reps and ensure they are aware of the WRES Implementation Plan and the important role they can play in supporting delivery.

4. Recruitment

The third strand comprised 3 components

- Review advertising strategy
- Routine monitoring and reporting of recruitment data
- Ensuring recruitment panel chairs are trained

The review of advertising was focused on Band 7 vacancies upwards. This Media sources review was completed on target - December 2017. No substantial changes were identified as necessary.

The aim of the routine monitoring and reporting of recruitment data component was to examine the process for all posts Band 7 upwards and look at the ethnic breakdown of applicants at Application, Shortlist and Appointment stages. The analysis was then to be made to the Board at CAG/Directorate level. The intention was that where disproportionate recruiting was shown over a 12 month period, the CAG/Directorate would be asked to develop a specific action plan. The first baseline report was due [as per the September Board Report] in October/November 2017 and quarterly thereafter.

Following the restructure of the Trust, reporting will now be on an Operational Directorate/Corporate Directorate basis. An analysis of Q3 and Q4 2017/18 will be undertaken on this basis and included in the September Equalities and Workforce Committee report to set the baseline. Directorate will then be invited to develop action plans for the October Board. Quarterly reports will then be made to closely keep track on Board Aspiration 1: proportionate representation in posts from Band 7 upwards. In parallel with this there will be a re-examination of our commitments on recruitment numbers, ensuring that we remain wholly committed to equal representation, while understanding what would constitute stretching but achievable progress. Work is progressing on this and it will be reported to the Equality and Workforce Committee in September for final decision.

The final component in this strand was ensuring recruitment panel chairs are trained. In accordance with Trust Policy ‘At least one member, and in any event the chair, of the interview panel should have attended the Trust’s Recruitment and Selection training course’. The September 2017 Board report said that this would be rigorously applied. Achievement of this component cannot be demonstrated as no mechanism exists to check the qualification of Panel Chairs. For Year 2 it is intended that a mechanism will
be established to check qualification of Panel Chairs as part of the process for establishing recruitment panels. The mechanism that will be used is that records for those attending the R&S training will be uploaded onto TRAC. In addition the Recruitment and Selection Training course will be reviewed to ensure it is up to date with current thinking about what is most effective in this area.

5. Career Development

The final strand comprised 5 elements
- Diversity in Recruitment Champions
- Talent Management Plan
- Temporary Promotions Policy
- BME staff access to leadership and other development courses
- Mentoring Programme

The Diversity in Recruitment Champions has been highly successful and has overachieved the target number. The WRES Implementation Plan Year1 envisaged training 30 people in Bands 4-7, currently 70 have been trained and there is a waiting list of people keen to undertake the development training and participate in recruitment panels. It is planned to calculate what the maximum number of DiR Champions is that can still guarantee to have opportunities to practice their skills on at least 2 recruitment panels per year and then produce a timetable of courses for Year2 that maintains the number of DiRs at the maximum. Twice-yearly reporting [starting October 2018] will be undertaken on BME staff that are DiR Champions as part of demonstrating achievement towards one of the three KPIs for the Board Aspiration 3: Career Opportunities – perceived proportionate access [KPI 1/4 – Aspiration 3].

The WRES Implementation Plan Year1 included the piloting of the Trust’s Talent Management Plan which was being developed with a view to systematic roll out across the Trust once approved by SMT. The aim was that the Pilot would have a positive action perspective. Target date for Pilot completion in one CAG was end March 2018. It is recommended that the SMT review the findings of the Pilot and decide next steps for report to the Equalities and Workforce Committee in September as part of the Year 2 Plan.

The Temporary Promotions Policy remains an area of concern to the BME Staff Network and assurance has not been able to be provided to the SWPs that the lack of opportunity in the past has now been overcome. Discussions have been held at the BME Staff Network and the SWPs about setting up a system whereby the availability of Temporary Promotions opportunities is not something that is secret. Staff would understand if they are not eligible to apply [eg because they were not part of the particular pool/team where the opportunity has arisen] but nevertheless would like to know what is available and changes that are occurring to colleagues. HR together with the Communications Department are going to explore the possibility of developing a page on the intranet that lists upcoming Temporary Promotions.

It is recognised that Temporary Opportunities are one of the best ways for staff to develop their skills and talents and prepare them for future promotion. It would make sense to see Temporary Promotions as one of the few real-time development opportunities the Trust has at its disposal and it could therefore target its use, rather than simply view it as a temporary vacancy that a line manager has to fill. HR are going to review our approach to interim stepping up opportunities, so that the process is seen as fair and transparent. They will also ensure that every interim opportunity is supported by a targeted development package. Consideration will be given to developing a scheme that takes a positive action approach to staff from under-represented groups at senior level posts. If this is feasible, then, for example, it is envisaged it could link BME Talent Management to Temporary Promotions opportunities – by identifying a cohort of talented BME staff who could benefit from the development opportunity of undertaking a temporary post in another area and then apply them to the next appropriate opportunity. The results of these pieces of work will be reported to the Equalities and Workforce Committee in September as part of the recommended package of actions for Year 2 of the WRES Implementation Plan.

The Year 1 Plan included a proposal to promote BME staff access to Leadership and Development courses. Data on who attends courses specifically targeted on BME Leadership development is not available from the national providers so whilst we are aware anecdotally of BME staff who have attended these and other generic Leadership Development courses, we do not have systematically gathered data that can be reported. For Year 2 the proposal is to continue to identify and promote development opportunities to BME staff. Mechanisms for data capture will be explored to see if it is possible to have twice-yearly reporting [starting October 2018] to enable the Board to keep track of the numbers of BME
staff that have benefitted from these programmes as the second KPI demonstrating Board Aspiration 3: Career Opportunities – perceived proportionate access [KPI 2/4 – Aspiration 3]

As reported in the September 2017 Board paper, preparing the Mentoring Programme has required a great deal of organisation and effort. It is now fully developed and ready for launching very shortly. This will be promoted as a major Initiative in WRES Year2. There will also be twice-yearly reporting [starting October 2018] on BME staff that have benefitted from the Mentoring Programme as part of demonstrating Board Aspiration 3: Career Opportunities – perceived proportionate access [KPI 3/4 – Aspiration 3].

The annual staff survey results comparing BME staff and White staff perceptions of support for career development is the fourth KPI being monitored as part of demonstrating Board Aspiration 3: Career Opportunities – perceived proportionate access [KPI 4/4 – Aspiration 3]

6. Resources

The Workforce Equality Programmes Manager has been appointed to run the WRES Implementation Programme with support from the SWPs working group.

The appointment of the Administrative/Project Technical support [identified as required in the September 2017 Board report] now needs to proceed with all urgency as the workload of the Workforce Equality Programmes Manager is developing rapidly and the launch of the Mentoring Programme will greatly add to this. It is worth pointing out the role of the Manager extends across all 9 protected characteristics and, in line with the Trust’s identified priorities, in addition to BME staff, those with Lived Experience of mental health issues, LGBTQ+ staff and staff with disabilities are all keen to get networks developed and supported. An additional post for 3.5 days per week at Band 4/5 is required and resources to fund it have been identified.

7. Summary

The first 9 months of Year 1 of the WRES Implementation Plan has provided useful learning with a range of degrees of progress. The Snowy White Peaks Group’s reflection is that the components of the plan largely remain valid however there is a need in Year 2 to become much more focused in ensuring full implementation in all parts of the Trust and in obtaining detailed monitoring and more contemporaneous data that will enable Operational Directorates and Corporate Directorates to spot issues as they arise and adjust their plans and behaviours accordingly.

To remind ourselves, the Board’s 3 Aspirations approved at its May 2017 meeting are that by 2021 there will be proportionate numbers of BME staff

- Across all senior grades
- Within disciplinary processes
- Accessing career development opportunities

Zoë Reed
For Snowy White Peaks Group
FINAL 16July2018
Title | Improving Staff Survey Response Rate
---|---
Author | Michael Kelly, Deputy Director of HR
Accountable Director | Sally Storey, Director of HR, OD and Education & Development

Purpose of the paper

To provide options to further increase the response rate to the Staff Survey for 2018 following feedback from other NHS organisations with higher response rates that the Trusts. This follows discussion at the Equalities and Workforce Committee where opportunities to increase the response rate had been requested.

The Board are asked to support and endorse the recommendations.

Executive summary

The Staff Survey is a critical means of obtaining feedback from staff about what it is like to work for the Trust and how they experience their working lives.

Whilst completion of the Staff Survey has increased it is recognised that further opportunities could be embraced as a means of increasing the Staff Survey response rate.

This paper outlines activities and approaches other NHS Trusts have taken to increase their staff survey results including feedback from Surrey and Borders NHS FT which had the highest response rates for Mental Health Trusts in England.

Within the paper are recommendations to continue with some elements we have undertaken in the past for the staff survey plus some additional recommendations to increase the response rate for the 2018 Survey.

Risks / issues for escalation

BAF Risk 1 - Workforce - 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.

The 2017 Staff Survey results were presented to the Equalities and Workforce Committee. Following this, the committee asked for ways that would help improve the overall response rate for the 2018 Staff Survey. The Staff Survey response rate was 44% in 2017, 40% in 2016 and 38% in 2015.

It was suggested that contact is made with the Mental Health Trusts with the highest response rates for the 2017 Staff Survey. The national Survey Centre advised that the two Mental Health Trusts with the highest response rates were Surrey and Borders NHS Foundation Trust with 68% response rate and Devon Partnership Trust with 67% response rate. Both were contacted although to date we have only received feedback from Surrey and Borders NHS Foundation Trust. We are following up feedback with Devon Partnership Trust. The national average for mental Health Trusts in England for 2017 was 52% response rate.
Feedback from Surrey and Borders was that the Chief Executive, over the past 2 years, had set a very ambitious stretch target response rate of 80%. This was from a response rate of 54% in 2014 and 59% in 2015. Increasing the response rate to achieve the target of 80% was led and driven by the Trust Board and Executive Team was made an objective of each Divisional Director.

Completing the staff survey was kept topical and has been described as something that everyone wanted to achieve. Surrey and Borders published weekly results which became quasi league tables for each service and this created a degree of healthy competition and positive engagement within the Trust. Constant communication and engagement by the Executive was described as essential and staff were given time to complete the survey during working hours.

Surrey and Borders have offered incentives by the way of 2 Amazon Kindles last year for the best responses rate and had offered iPad Minis in the previous year. Progress to improve the response rate had taken over 2 years so it was described as taking time to build.

Our Trust Approach

Our approach has been to provide a covering letter in the pack from the CEO which outlines feedback from the previous year and what has been done in response to that. Our staff survey is fully on-line as distributing paper copies across the organisation was logistically difficult to do in the timeframe for completing the survey and the response rate was always much lower.

The Staff Survey is advertised on the intranet and in e-news and with increased and more frequent promotion through the communications team this may increase the response rate. We already offer protected time to complete the survey but this could be emphasized more and staff having an expectation to be allowed to complete the survey during work time.

We have previously published staff survey results weekly. How they are used to monitor progress against achieving an increased target could be made an integral part of the performance management process through PACMAN.

We currently and in the past have offered vouchers through a prize draw conducted by our survey contractor. Last year we gave 25 x £20 vouchers to staff who had completed the survey picked at random by Picker. Promotion of the prize draw is included in the CEO covering letter but the selection for vouchers happens after the survey has closed and therefore, incentivising during the survey window may have a more positive affect on completion.

Additional recommendations

In addition to continuing with some of the above elements it is suggested the following are also implemented:

1. Have a clear set response rate stretch target of 60% for 2018; 65% for 2019 and 70% for 2020. This could be considered a set objective for the Senior Management Team (SMT). The SMT could then translate that into stretch targets for all Directors across the Trust.

2. Roving laptops and/or laptops placed in staff rooms for all inpatient wards. These could be used to encourage ward-based staff to complete the survey without having to leave the ward area.

3. Weekly reminders to complete Staff Survey as part of a standard team brief cascade. With initial emphasis on completing it early and clearly stated protected time for staff to complete.

4. Weekly reminders to line managers to allow staff work time to complete the survey.

5. Promoting access to pcs in training centres/IT hot desk rooms on each main site for staff to use to complete the survey if staff would prefer to do so away from the ward.

6. League tables on response rates published weekly and monitored through performance management process emphasizing positive engagement.
7. Guidance to all staff how to access their Trust email account through office 365 so no need to be based at a Trust pc in order to complete the survey and which can be done at a time to suit them.

8. Offering a financial incentive of £100 for each 500\textsuperscript{th} staff survey completed – so 500, 1000, 1500, 2000, 2500 etc. Awarding prizes on this basis there will be a cost of £500 however this can be met against the current prize draw cost. We can ask our contract provider to set up a process to identify the winner for each threshold.

9. HR Business Partners actively visiting their respective sites to encourage completion.

10. Giving bars of chocolate and sweets to make the completing the survey more fun. Moorfields NHS FT took this approach and increased the response rate. It is estimated this will cost approximately £2000.
REPORT TO THE TRUST BOARD: PUBLIC

24 July 2018

Title | Request for continued support in development of a viable financial position in the Strategic Outline Case for the Maudsley Centre for Children and Young People’s Mental Health

Author | Matthew Longmate

Accountable Director | Altaf Kara, Director of Strategy and Commercial

Purpose of the paper

The Trust is in the early stages of scoping the potential for developing its CAMHS, in partnership with other providers and commissioners, to support better mental health and life outcomes for children and young people - locally, nationally and internationally. The purpose of this paper is to provide the Board with an overview of the current draft Strategic Outline Case for one supporting element of this project, a new Centre for Children and Young Peoples Mental Health on the Maudsley site. The paper also seeks to draw to the Board’s attention the need for further work prior to requesting approval to proceed to the next stage, which would include the development of the outline business case moving to full business case should the extensive engagement and consultation planned support that move.

The Board is asked to:

1. Familiarise itself with the overview of the current draft of the Strategic Outline Case document. Owing to commercial sensitivities at this stage, the Strategic Outline Case document itself cannot be placed in the public domain and as such is not included in these papers. The draft SOC will be considered in the private session of the Board following this meeting.

2. Note the agreement of the Programme Board decision to allow an additional 30 days to review and revise the financial model to increase certainty.

Executive summary

The Trust has for some time been giving thought to how to improve mental health and life outcomes for the children and young people we serve. This work has already involved a number of partnership discussions and will involve many more if we progress. We also see this as a strong vehicle for philanthropic fundraising. Much of the work is focused on outward facing contributions, for example working with young people in schools and with teachers. In addition, there is a strong partnership element with KCL and the IoPPN to ensure that appropriate research drives advances in knowledge, best practice, and better life experience. The following paper focuses on one supporting element to this project, namely the building of a new Centre for Children and Young Peoples Mental Health on the Maudsley site. The proposal is for a child and young person friendly build that will bring together opportunities for training and education, clinical service provision, exciting new R&D opportunities and a much closer working between all of these elements. The paper reprises the processes that have brought us to the development of a Strategic Outline Case, an overview of the content of each of the sections to the case and a number of additional areas which require discussion and thought.

The paper is intended as a common basis to describe to key parties the processes, structures and outputs that have emerged through this process and as such has formed the basis for discussion at the Programme Board, Maudsley Charity Board, BDIC and KCL ECAP.
The business case, has been developed under the auspices of the Centre for Children and Young Peoples Mental Health Programme Board comprising a range of SLaM stakeholders alongside the key strategic and funding partners Maudsley Charity and Kings College London.

The Financial case is a very complex area of the business case being a composite of the I&E and cash impact of items including:
- Trust underlying financial and activity position
- Projected growth and commissioning intentions
- Current and future planned clinical and operational changes
- Projected inflation rates
- The consequence of Douglas Bennett House
- The consequence of the Centre for Children and Young Peoples Mental Health
- The consequence of a Managed Service for complex equipment
- The consequence of disposals of a number of Trust sites

Each of these inputs themselves has a high degree of sensitivity within their own model and also can be indirectly affected by the influence of other items or their timing.

The business case has an iteration of the financial model, a snapshot of the model at the point it was when the case drafting was complete.

Further discussions on scheme cost, cashflow and Income and Expenditure (I&E) following that have identified a number of further revisions required to the financial model and assumptions including the need to have detailed thought on mitigation of adverse drivers for the I&E position and likewise mitigations for the management of cash.

Whilst the paper covers in full the development process and an overview of the Strategic Outline Case, this financial model is described, and it is suggested this should be the focus of the time with the Board.

**Risks / issues for escalation**

Give the level of organisation wide clinical, operational, estate and strategic change necessary to deliver the complex portfolio of developments, service change and disposals to deliver this scheme every element of the Trust BAF is relevant.

BAF Risk 1 - Workforce
BAF Risk 2 – Operational Delivery Structure
BAF Risk 3 – Informatics
BAF Risk 5 – Partnership working with service users
BAF Risk 7 – Quality & statutory compliance
BAF Risk 8 – Finance contracts
BAF Risk 9 – Estates
BAF Risk 11 – QI delivery
BAF Risk 12 - Finance – cost management
BAF Risk 13 – Mandatory training

**Committees where this item has been considered**

<table>
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<tr>
<th>Date</th>
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<tr>
<td>11/07/2018</td>
<td>CYP Programme Board</td>
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<tr>
<td>23/11/2018</td>
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**Request for Continued Support in Development of a Viable Financial Position in the Strategic Outline Case for the Maudsley Centre for Children and Young People’s Mental Health**

Section 1: Overview of the process and summary of the Strategic outline Case: Capital development process in the NHS
Capital development processes within the public healthcare sector, charitable sector and education sector have varying forms of regulatory and legal frameworks through which significant investment decisions are made.

On reviewing with the proposed funding partners processes the NHS was deemed to have the most stringent, and as such this model was adopted in order to ensure that every party’s requirements could be met through a single capital development process.

Within the NHS, this investment regimen is mandated by the Department of Health and Social Care and regulated by NHS Improvement through a policy of delegation stemming from the Treasury. The Treasury process named “The Green Book: Appraisal and Evaluation in Central Government” follows an iterative development process which, aligned to a gateway review process, allows for an iterative development from the initial inspiration through to the final detailed commercial appraisal and approval to proceed.

The stages of this process include:

1) Strategic Outline Programme (SOP) – Identification of a strategic intent and validity of a general approach to moving forwards with the business case development process.

2) Strategic Outline Case (SOC) – Initial stage of the formal business case development process with the intention of consolidating the strategic narrative developed within the SOP and moving into an economic evaluation of a potential options for its delivery. Also at this stage there is a high level block design (RIBA Stage 2 – concept design) undertaken in order to estimate the capital required alongside an initial assessment of the activity and revenue impact.

3) Outline Business Case (OBC) – This stage takes the SOC and develops the preferred option arising from a more detailed economic assessment and starts the first stage of detailed design (1:250 scale with elevations – RIBA Stage 3 developed design). This allows for the capital model to be determined in greater detail and further work on detailed analysis of the operating models and revenue impact expands the financial case to show a clear view of affordability.

4) Full Business Case (FBC) – This completed the business case development stages and at this point the focus is on the detailed commercial negotiations and contracting models, detailed design (1:50 scale including room layouts and mechanicals and electricals – RIBA stage 4 technical design). This position where an agreed contractual mechanism and formal agreement of a Guaranteed Maximum Price with the developer affords the completion of the financial case and the capacity for rigorous assurance, where appropriate, agreement to proceed and contract the deal.

This process is nuanced where an organisation is financially stable, a Foundation Trust and the development requires no public or private borrowing and is non-contentious. If these criteria are met, then the OBC and FBC phases can be aggregated into a single stage so as to reduce the cost and timeline to approval to proceed.

The business cases themselves follow the same 6-case model covering the following areas in ever increasing levels of detail.

1) Strategic Case – this defines the strategic context including an overview of the organisations, rationale for change, the proposed development, impact on existing services, risks, dependencies and constraints

2) Clinical Quality Case – This defines the organisational clinical strategy and the clinical case underpinning the development

3) Economic Case – This defines the current state of the services, critical success factors, benefits, options assessment, preferred option, capital estimate and net revenue impact

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4) Financial Case – This defines the affordability assessment, funding streams, impact on income and expenditure and states the assumptions underpinning the analysis

5) Commercial Case – This defines the procurement strategy, approach to managing commercial risk, key contractual arrangements and elements relating to managing associated disposals

6) Management Case – This defines the structure of the programme designed to undertake the delivery and implementation of the scheme including the project structure, approach to risk management, project review and assurance and performance management and post project review.

Identifying the strategic direction (the SOP)

In July 2017 a strategic outline programme was developed. The work identified that there were two clear threads of development. One was a core programme of novel and forward thinking clinical and research activities that would enable the centre to have meaningful change locally and more broadly in society and secondary to this a requirement for an estate that can meet the needs of modern clinical services and enable its transformation through research and education.

This analysis within the case identified a significant investment requirement both in terms of revenue for the programmes of work and capital for a facility and new diagnostics.

Formalising the partnership

A programme Board was established in January 2018 to allow meet three key criteria to allow the scheme to develop to a deeper level of maturity.

1) Agree a series of prioritised areas of focus for the Centre
2) Develop a fundraising bid for King’s Health Partners (KHP)
3) Develop the Strategic Outline Case

The Programme Board to this point has been established as below with workstreams leading the development of core elements of the strategy and investment case.

The core partnership is formed of a triumvirate of organisations each bringing their unique perspective and input to the scheme.

South London and Maudsley (SLaM) bring with them a longstanding history of being a pre-eminent clinical and research led Mental Health NHS Trust, having access to a significant and diverse population of service users and talented clinicians.
King’s College London (KCL) bring the breadth of research and academic activity of the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) which is delivered in collaboration with SLaM and has a history dating back to the inception of the IoPPN at the Maudsley Hospital in 1914.

Maudsley Charity bring with them an opportunity to access a broad range of charitable and philanthropic donors both through the charity directly and through their influence and support of the King’s Health Partners broader fundraising programme.

**Agreement of fundraising priority**

In early 2018-19, a proposition was put forwards to Kings Health Partners for a portfolio of clinical, research and academic programmes to compete with other significant schemes from other AHSC members to become a major fundraising priority.

The strategic merit was recognised and the scheme was prioritised with a fundraising goal of some £35m towards the research programme and the capital requirements of the scheme.

**Moving forward to a Strategic Outline Case for investment**

A competitive process was undertaken to find a partner to take forward the economic, commercial, architectural design and financial development of the Strategic Outline Case. Of those responding to the tender, a collaboration led by KPMG was selected comprising the following:

- KPMG: Overall accountable for the engagement and undertaking the commercial, financial and accounting elements of the case
- Currie and Brown: Project management of the collaboration, authoring of the Strategic Outline Case document and cost advice
- NBBJ Architects: Development of the schedule of accommodation and architectural design and site planning advice

The Programme Board sub-groups were used to provide detail and subject matter expertise to the KPMG led team.

**Section 2: The Strategic Outline Case**

There are a number of different perspectives on the development of such a novel centre which incorporates new and existing NHS and specialist clinical services, reprovision of facilities, significant portfolios of research activity and wide reaching academic and education services.

From the perspective of the public sector investment process, beyond a clear strategic drive to make a societal change, there is a key requirement to clearly identify the consequences of any service development to the public purse in terms of the capital and revenue consequence.

As a result of this, the business case structure noted in the preamble above can appear to emphasise the built environment and clinical services impact working towards an affordability position for the NHS. This is somewhat intentional in order to ensure that the capacity of the NHS Trust to deliver its core business is not impacted and thus there is no risk of degradation of care to those accessing SLaM’s services.

The following offers a précis of the key focal points of the six chapters to the Strategic Outline Case which can be reviewed in more detail within that document.

**The Strategic Case**

A core focus of the strategic narrative is around the definition of the purpose of the Centre as a driving force in the development of Children and Young People’s Mental Health with key intents to:

- Contribute and drive forwards a global movement for young people’s mental health
- Boost resilience and prevention through identifying and promoting wellbeing
- Discover risks and causes of mental illness health and develop cures and novel early interventions targeting prevention
- Accelerate translation and improvement across the local community, UK and world
- Deliver, demonstrate and expand access to outstanding clinical services
- Develop leaders across healthcare and communities through education and training

The development of a new facility to house the clinical and research activities, although secondary to the core purpose stated above, has been evaluated as having a number of key strategic benefits, including:

- Supporting collaboration by providing space, facilities and equipment to support scientists, clinicians and educators to work together and with others
- Creating a vibrant, positive and healing space for young people, families and the local community supporting a good patient experience and breaking down barriers and stigma
- Seamless and holistic care for young people from well-being advice to high intensity care and opportunities to take part in research and access novel treatments
- Support for the development of new models of care unconstrained by historic accommodation, ways of working and supported by new technology
- Provision of modern, world class facilities with the right spaces, equipment and technology e.g. for clinical studies with babies, children, adolescents, young adults and their families
- Creating a beacon for a new drive to transform the mental health of young people, drawing attention and helping tell a story about what is possible, educating and inspiring others to collaborate and pursue the agenda

The Clinical Quality Case

There are a number of key areas where development of the Centre can expand and improve the delivery of clinical care and the level of quality of that care in support of delivery of the Trust strategic objectives.

The clinical quality case describes the opportunity to develop services against the following key areas:
- Need for improved strategic fit of services
- Need to meet national, regional and local policy imperatives
- Need for better access to services
- Need for improved clinical quality of services
- Need for development of existing services and/or provision of new services
- Need to meet training, teaching and research needs
- Need for improved environmental quality of services
- Need to make more effective use of resources

A positive impact on the clinical quality of services provide within the Centre will be a key determinant in the ability to make a strong case for investment to the regulators and commissioners of the affected services where any adverse revenue consequence is identified against the status quo.

The Economic Case

In drawing together the analysis of a long list of options an economic assessment was undertaken looking at various permutations of aggregation of clinical, research, academic and educational functions within a Centre and the relative benefits and costs associated.

These ranged from the various functions residing in their existing accommodation across SLaM, IoPPN and KCL (the do nothing case) through to a complete aggregation in a facility on the Maudsley Hospital campus.

These items were shortlisted in order to exclude those permutations with a lower economic benefit and to support the identification of an indicative preferred option for assessment of the associated cost to feed into the financial and affordability analysis. To undertake this shortlisting a series of critical success factors were used, these included:
- Quality of Clinical Care
- Quality of Clinical Environment
- Supply Side Capacity and Capability
- Quality of research
- Quality of research environment
- Strategic Fit
- Deliverability / Achievability
- Future Flexibility
- Value for Money (VfM)
- Potential Affordability

From this assessment the preferred option was identified as the one that expressed the opportunity to deliver the greatest level of economic benefit. The option proved to be the one that drew all key elements of the offering together in a new facility. This was taken through an indicative block design process to identify fit within the Maudsley Hospital estate as follows.

Building out from the schedule of accommodation a gross internal area of 8700m² was modelled with an estimate of capital required for the facility of £76.94m.

The benefits arising from this opportunity can be expressed into two groups – non-financial benefits and financial benefits – with the latter subcategorised into cash releasing, non-cash releasing and societal. The following have been identified as the key areas supporting the case for change:

<table>
<thead>
<tr>
<th>Group</th>
<th>Benefit Listing</th>
<th>Measurable Currencies</th>
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<tbody>
<tr>
<td>Clinical and Research</td>
<td></td>
<td>• Speed of time</td>
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<td></td>
<td></td>
<td>o Reduced time to identify causes</td>
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<td></td>
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<td>o % Early contact and signposting</td>
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<td>o Earlier recognition of those affected</td>
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<td>• Clinical care process</td>
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<td>o Improved management of condition</td>
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<td>o Effective self-management &amp; coping strategies</td>
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<td></td>
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<td>• Patient outcome</td>
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<td></td>
<td></td>
<td>o % Reduce impact of side effects from treatment</td>
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<td></td>
<td></td>
<td>o % Reduced incidence of acute physical conditions</td>
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<tr>
<td>Educational</td>
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<td>• % Reduced school absenteeism</td>
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<td>• Improved level of attention</td>
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<td>Social</td>
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<td>• Social care process</td>
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<td></td>
<td></td>
<td>o % Improved peer and familial relationship</td>
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<td></td>
<td></td>
<td>o % Access to emotional, neuropsychological and psychological development</td>
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<td></td>
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<td>o % Reduced NHS demand in emergency, acute and primary care services</td>
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<td></td>
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<td>o % Eliminate public perception of mental health ‘stigma’</td>
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<tr>
<td>Table: Business Case Benefits</td>
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<td>-----------------------------</td>
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<tr>
<td><strong>Patient outcome</strong></td>
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<tr>
<td>-  % Reduced substance and alcohol use and dependence</td>
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<td>-  % Reduced incidence of intergenerational transfer of mental health issues</td>
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<tr>
<td><strong>Criminal justice</strong></td>
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<tr>
<td>-  % Reduced rate of offending and re-offending</td>
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<tr>
<td><strong>Mortality</strong></td>
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<td>-  % Reduced incidence of death caused through self-harm and/or suicide</td>
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<tr>
<td>-  % Reduced incidence of deaths caused by eating disorders and/or substance/alcohol abuse</td>
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<td><strong>Economic</strong></td>
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<td>-  % Reduced reliance and expenditure on complex psychological interventions</td>
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<td>-  % Increased productivity and economic output of individuals</td>
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<tr>
<td>-  % Reduced rate of youth and adolescent unemployment</td>
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<td><strong>Policy</strong></td>
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<tr>
<td>-  Improved national framework and policy and adoptions for this care group</td>
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<td></td>
</tr>
<tr>
<td>-  Improved international national framework and policy and adoptions for this care group</td>
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<tr>
<td><strong>Cash-releasing</strong></td>
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<tr>
<td>-  Increased on-going donation</td>
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<td>-  Increased income from Maudsley Learning</td>
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<tr>
<td>-  Savings/income from internal space</td>
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<td>-  Reduced agency staff cost</td>
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<td>-  Increased income through identifying volunteers for NIHR portfolio studies</td>
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<tr>
<td>-  Reduced expenditure on maintenance of old building</td>
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<tr>
<td><strong>Non-Cash releasing</strong></td>
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<tr>
<td>-  Improved patient outcomes of SLAM service users</td>
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<td>-  Reduction time spent in recruitment due to staff retention</td>
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<tr>
<td><strong>Societal</strong></td>
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<tr>
<td>-  Wider economic impact through early identification and better management of MH conditions</td>
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<tr>
<td>-  Improved quality of life for wider society including reduced rate of suicide</td>
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</table>

**The Commercial Case**

There are four main areas of focus within the commercial case which cover the procurement strategy, management of risk, key contractual arrangements and procurement timetable. At this early stage of the business case development this section covers the higher level principles to be applied to the development of the commercial and contractual relationships with suppliers over the coming full business phase and summary contracting of any deal.

With respect to procurement strategy there is a requirement for the NHS, as the predominant financial contributor and ultimate asset owner, to follow public sector procurement regulations which are based on the use of the OJEU procurement process or existing frameworks procured appropriately in line with this legislative requirement.

The *de facto* approach to the market for the built environment within the NHS is the DHSC framework Procure 22 which is a pre-procured solution for capital development and is closely aligned both to the capital development process of the NHS and also has a strong contractual mechanism developed over its 10 years of its various iterations.

This framework also has a clear approach to the management of risk alongside the adoption of risk by both the NHS and the principle supply chain partner (PSCP) in a model that ensures parties are liable for items of risk within their capacity to influence.

It is anticipated that between July and October 2018 the Trust will go through a competitive procurement process under the Procure 22 framework to identify a PSCP that will support all of the key stakeholders through the remainder of the pre-construction process (development of the FBC) and then take control of the construction process once a guaranteed maximum price has been established.
The Financial Case

The financial case looks to review the consequential impact on SLaM of the delivery of the Centre in order to validate that, along with the associated development Douglas Bennett House, there is a viable route to deliver the scheme and an affordable position moving forwards. The business case reviews the financial position both in terms of I&E and cash using a series of assumptions agreed between SLaM and KPMG.

Impact on Cash

A number of models have been appraised as to how to most accurately calculate the capital expenditure required for the CYP build. The standard DHSC method is based on data taken from the Health Premises Cost Guides (HPCG; standardised per m² values for various forms of NHS clinical and non-clinical developments) and inflated through the use of the following factors:

- Location adjustment indices;
- BIS Tender Price Index of Public Sector Building Non-Housing (PUBSEC) inflation indices;
- Contingency;
- Optimism Bias (a standard calculation of public sector optimism in pricing capital schemes).

Whilst effective at early strategic stages the Trust, unusually in these instances, has a well-developed comparator scheme against which their developer has approached the market for actual costs for construction and as such a greater level of certainty.

The scheme (DBH) is greater in scale at 9,942m² and predominantly clinical accommodation which has a higher per m² rate than office accommodation and other such which makes the predominance of the CYP scheme. The DBH scheme has a value of £68.3m and as such an average cost per m² of £6,869.

The CYP scheme at 8,710m², costed by the aforementioned method of inflated HPCG values generated a scheme cost of £76.9m or a cost per m² of £8,820; significantly in excess of the comparative scheme in DBH.

Given the level of certainty around the DBH scheme given its more detailed and further progressed development a view has been taken that it would be inappropriate to propose the cost of a smaller building with less clinical space as being in excess. Therefore for the purposes of this cashflow analysis the scheme has been assumed to have the same cost as DBH.

The impact on the cash position of the Trust is summarised in the following table:

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</thead>
<tbody>
<tr>
<td>Net cash outflow/inflow</td>
<td>15,080</td>
<td>(24,647)</td>
<td>(24,829)</td>
<td>(16,121)</td>
<td>16,509</td>
<td>(6,376)</td>
<td>(558)</td>
<td>(65)</td>
<td>(70)</td>
<td>(135)</td>
<td></td>
</tr>
<tr>
<td>Opening Cash Balance</td>
<td>55,094</td>
<td>45,527</td>
<td>20,698</td>
<td>4,578</td>
<td>21,087</td>
<td>14,711</td>
<td>14,154</td>
<td>13,848</td>
<td>13,784</td>
<td>13,713</td>
<td></td>
</tr>
<tr>
<td>Closing Cash Balance</td>
<td>70,174</td>
<td>(24,647)</td>
<td>(24,829)</td>
<td>(16,121)</td>
<td>16,509</td>
<td>(6,376)</td>
<td>(558)</td>
<td>(65)</td>
<td>(70)</td>
<td>(135)</td>
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</tbody>
</table>

The unmitigated impact of these two schemes, applied over the routine Trust factors influencing the cash balance, leads to a position whereby the 2019-20 opening cash balance of £70.2m profiles to a closing cash balance in 2023-24 of £14.7m at the end of construction. The lowest level of cash held is at the close of 2021-22 where the balance is £4.6m, a position of concern whilst unmitigated.

At present a number of mitigations have been identified and costed but not applied to the model in order to give the Trust the opportunity to better understand, along with the regulators, where appropriate levels of tolerance sit for these schemes to progress unencumbered by borrowing and the resultant extended and more costly alternative capital approvals regimen.

The mitigations and their impact are the combination of elements of value engineering (cost reduction) and additional cash release (disposals) and have a combined impact of £25.56m and as such would increase the closing balance post construction to £40.35m:
Value Engineering
- Removal of training and conference area in favour of, say, ORTUS; net reduction in cost £3.4m
- Removal of a nominal 15% of office seats (303 seats to 260 seats); net reduction in cost £1m
- Procurement efficiencies through common supply chain; net reduction in cost £2.5m

Disposals Opportunity
- Disposal of Munro Centre; net benefit £5.25m (as per estate strategy estimate)
- Disposal of Kent and Medway estate; net benefit £13.5m (as per estate strategy estimate)

Dependent on the profiling of these it is likely that the concerning closing balance in 2021-22 can be brought to a more favourable position. At present the assumption is that the Kent and Medway estate will be disposed of by 2021 meaning the outturn cash position for that financial year would increase from £4.6m to £18.1m.

Further opportunities could be identifiable, such as disposals opportunities at Bethlem and on the Maudsley site, although it would be preferred to avoid the need to take this form of action as there are other clinical and strategic priorities that will require future investment.

Impact on Income and Expenditure

The analysis of the I&E impact for SLaM is based on the comparator between the “do nothing” case (inclusive of delivery the DBH scheme) and the do something case of both DBH and CYP.

The I&E surplus position of the Trust bolstered significantly in 2022/23 due to gain on the disposal of Mapother and Michael Rutter Centre. There is an assumed on-going deficit in the I&E position from 2024/25 of 0.3% as a net result of the following:

- Increased expenses:
  - Managed service cost for the diagnostic equipment;
  - FM cost increase;
  - Higher depreciation charge to reflect the additional assets;
  - Additional PDC charge.
- Savings, Income
  - Receipt of rental income from KCL;
  - Cash releasing benefits realised through the CYP;

As part of this revenue case there is an implied level of CIP required to mitigate the I&E impact to the organisation form both schemes of c4% per annum across the 10 years of analysis (inclusive of the planned removal of the current deficit position). The requirement is broken down effectively as:

- 2% directly related CIP programme
- 1% related to clearance of the underlying deficit position
- 1% related to service developments

Mitigations are included within the financial model for much of this but there is an unmitigated 0.8% CIP which needs resolution.

A related opportunity exists to look at the revenue benefit arising through the delivery of an energy efficient district heat and power solution, either alone or alongside King’s College Hospital, where plant and equipment is provided by an energy supplier against a guaranteed Trust saving on utilities expenditure over the term of the agreement.

The Management Case

As described previously the Programme Board has a structure that enables both a good level of oversight and governance but also offers a series of workstreams to offer subject matter expertise across the broad range of needs in establishing the strategic and estate requirements of the scheme.
A process to identify risk and emerging issues has been implemented which includes both static processes to identify risk such as risk workshops but also the organic appraisal of existing and emergent risks and issues as they develop.

Alongside stakeholder engagement throughout the development process a number of mandated external reviews are undertaken to ensure the viability of the scheme is in line with all appropriate clinical and built environment requirements. These include:

- Stakeholders Engagement
- Quality Improvement Plan & Service Reviews
- Travel Assessment & Plan
- Equality Impact Assessment
- Design Quality Indicator for Health
- BREEAM
- Design and Access audit

A benefits realisation process and post project review model will be implemented within the FBC and this will be tied into the organisational governance and audit framework to ensure that the scheme is delivering against the stated objectives. The key areas of assessment will be:

- Achievement of system-wide benefits;
- Achievement of benefit realisation plan;
- Achievement of project design benefits;
- Achievement of Trust-wide Key Performance Indicators; and
- Achievement of System-wide mental health transformation planning requirement

Section 3: Next Steps

As discussed at the front of this paper there is a complex financial model underpinning this work and this requires further time to ensure it is both accurate and viable prior to requesting permission to advance to Full Business Case.

1) 30 days further financial analysis and due diligence covering:
   a. Value engineering assumptions
   b. Agreement of cost model and its variance or relationship to the DBH cost model
   c. Valuation of disposals
   d. Work to increase Internal confidence in the viability of the financial model
   e. Discussion with NHSI as to the process assumptions and resultant cash and I&E impacts
2) Revision of the financial case of the Strategic Outline Case
3) Procurement (through Maudsley Charity) of a communications agency
4) Reporting back to the Programme Board, BDIC and Trust Board for approvals to proceed to the next stage of development; the Full Business Case
Purpose of the paper
This paper provides a very brief recap of our strategy, ‘Changing Lives,’ and an update on implementation progress.

It also serves to set the agenda for a Board Development session on implications and next steps on the strategy that is scheduled for 24 September 2018.

Executive summary
Since sign off of ‘Changing Lives’ at the Board in September 2017, all parts of the implementation plan have moved forward, significant momentum has developed behind the programme, and several important milestones have been achieved. These include:

Quality
- Continued success at using Quality Improvement (QI) as an organisational development tool such as in training the organisation in the principles of Quality Improvement and in making leadership walk arounds and pre-Board events part of ‘business as usual’.
- Development of an implementation plan for the large-scale QI initiative (iCare)
- Taking forward improvements in estates and IT customer services

Communities as well as individuals
- The Lambeth Alliance went live in July 2018; discussions started in Southwark and Lewisham
- Re-organisation into borough and specialist operating divisions; CAGs and a Quality Centre
- Progress and significant clinical benefits in the South London Partnership

Research into clinical practice
- R&D strategy developed
- Strategic outline case for the Children and Young People’s Centre produced
- Launch of Maudsley Learning

Enablement – money; information; governance
- Signed control target and ahead of plan
- Good progress on developing MH-UAE implementation plan
- Good progress on implementing IT strategy

However, two significant tensions have also emerged: (i) the stress on our workforce through the coming together of the reorganisation and preparation for the CQC’s recent visit, and (ii) the lack of an agreed standard methodology / approach to, and capability/capacity in, larger-scale transformation as the rate of change in the organisation grows. These tend to exacerbate our primary risk 1 – staff recruitment and retention - and we may not have allocated sufficient resources and investment to deal with this issue.

Looking ahead, we will need to respond to this risk and also deal with other potential barriers. These include:
- Achieving better ownership of strategic goals widely in the organisation
- Addressing capability and capacity gaps in the organisation whilst also achieving our financial
plan
- Adjusting current implementation projects to:
  - Get better at scaling up successful QI projects
  - Define outcome measures for the strategy faster than currently scheduled
  - Define our approach to population health and linkage to IMT agenda and to IoPPN
  - Shaping our model for Integrated Care
- Building a shared approach and developing expertise in change / transformation management to support the Trust’s vision, and,
- Potentially stop doing some things

We will also need to consider some of the key implications of the strategy to stay ahead of the change and therefore help steer it at the Board:

- Clarifying what SLaM will look like in the future considering, for example:
  - More decentralised as divisions become more autonomous
  - Nature and role of the centre to ensure consistency
  - Impact on the organisation
- Restructuring options to deliver the Trust strategy – core vs non-core; delivering estates and commercial strategy
- 5-year financial strategy

This forward look will drive the agenda for September’s Board Development session.

Risks / issues for escalation
This paper relates to all the risks below.
BAF Risk 1 - Workforce
BAF Risk 2 – Operational Delivery Structure
BAF Risk 3 – Informatics
BAF Risk 5 – Partnership working with service users
BAF Risk 7 – Quality & statutory compliance
BAF Risk 8 – Finance contracts
BAF Risk 9 – Estates
BAF Risk 11 – QI delivery
BAF Risk 12 Finance – cost management
BAF Risk 13 – Mandatory training

1.0 Introduction
This paper provides a very brief recap of our strategy and an update on implementation progress. The paper also serves to set the agenda for a Board Development session on implications of the strategy that is scheduled for 24 September.

2.0 Changing Lives
Changing Lives is the name of SLaM’s five-year strategy, covering the period 2017-22. It is an evolutionary strategy in that its three patient-facing aims in particular have been an integral part of the Trust’s strategy for the last 5 years. In bringing them together, and in some cases relaunching them with more focus or more investment under the banner of Changing Lives, we are hoping to move them further, and to do so faster.

2.1 What it is
There are three patient/public facing aims of the strategy and one enabling aim:

Patient/public facing aims
- Relentless focus on **quality** of care, experience (including estates), and on outcomes
- Supporting **communities as well as individuals**
- Improve the translation of **research into clinical practice**
Enabling aim

- Make the best use of money and information and work to leading standards of governance

2.2 How it is different

The evolution of our patient/public facing strategic aims is shown below

The diagram also illustrates our over-arching measure of the effectiveness of our strategy: mental health value delivered (as measured by outcomes valued) for resources used in their delivery.

3.0 How we are doing

Nearly one year in, we have launched all the implementation programmes that we determined are needed to make the strategy a reality. We monitor and further develop them as a Trust Executive with a combination of monthly deep dives and problem-solving meetings. Whilst the organisation is coping with the extent of change and managing business as usual, pressure is being felt throughout – exacerbated by our CQC visit preparation. Key points and issues of note:

- **Quality**: since September, the focus has been to embed the Quality Improvement (QI) programme and invest in IMT and estates. In the last six months, our quality focus has been more around the basics and compliance for CQC. ‘Good’ is the target for this inspection.
  
  - Quality priorities agreed for the organisation
  - Quality priorities evolving from what was primarily an Organisation Development initiative to one that will equally focus on supporting the “scale-up” of successful improvements (including defining return on investment measures)
  - Our iCare programme (QI large scale initiative) to clarify the shape of pathways and how they work across community teams and in-patient settings is close to completing a simplified implementation plan
  - Re-organisation into operating divisions, CAGs and a quality centre is an opportunity to instil greater ownership of quality initiatives at the divisional level
  - There has been significant work taking forward the Estates strategy (particularly programmes for Douglas Bennett House and Children and Young People’s Centre) and improving work processes, but there remains much to do – particularly in capital programme delivery to time and budget and consistently improving the performance of our cleaning and catering supplier, ISS, and refreshing and delivering our community estates strategy
  - The Digital Me programme is being rolled out which is the vehicle by which we continue to invest in IMT infrastructure and target problem areas so that staff are properly enabled to do their work. We have also identified improved informatics/use of data/benchmarking as needs to be addressed
Leadership walk arounds indicate that staff are more pressured than usual because of the coming together of the reorganisation and the visit from CQC and though we have a strategy for better engagement and communications, we may need to invest more if we are to follow through on the commitment of treating our staff as our most valued asset.

We are continuing to improve our engagement with service users, carers and their families in how we develop and deliver care through our SUCAG network and we continue to work with partners in the community to establish a blueprint for stronger community relations. This involves close working with Independent Advisory Groups by Borough and through our involvement with bodies such as Overview and Scrutiny Committees. Our engagement and communication strategy with community partners and other external stakeholders needs more work and may benefit from a dedicated Board Development session.

Communities as well as individuals: since September, our key focus has been to move forward our alliance contract in Lambeth (went live in July). We have also started discussions both with Southwark about a potential contractual joint venture which would include GP federations and with Lewisham. Our South London Partnership has delivered benefits in clinical areas and, though fewer and slower coming, in some non-clinical (e.g. the nursing programme):

Still need to iron out some contractual issues and how central infrastructure will support the Lambeth Alliance (e.g. the role of the quality centre and IMT in the alliance)

GP s are missing from the Lambeth Alliance arrangements. Whilst this is a recognised issue, tackling it is felt to be a medium term (2-3 year) objective

The Southwark conversation involves GP federations, GSTT and the CCG. We are hoping to achieve shadow form by the Autumn with go live April 2019

The reorganisation of operational management has been successfully executed and by September, working with CAG leaders, we plan to fully implement the quality centre and define the working processes across it, the CAGs and the delivery units

On South London – we are seeing significant clinical synergies and increasingly non-clinical ones (Nursing Programme across all 3 trusts, appointed common estates director across SWLSG and SLaM; moving forward to appoint a common HR director for SWLSG and SLaM).

Research into clinical practice: the focus to date has been on developing a research strategy for SLaM that advances priority setting and clarifies funding flows; on launching CYP and Maudsley Learning; and on continuing to support the development of KHP initiatives such as the Mind/Body programme, the CTI and the Institute programme:

Strategy was focussed on getting basics into place – the next steps are for SLaM to define an ‘ask’ of the BRC – particularly around information needs relating to executing population health

Completed a strategic outline case (SOC) for the Children and Young People’s centre
  ▪ Agreed as key fundraising priority for KHP
  ▪ Aiming to open in December 2022

Maudsley Learning launched, and Sean Cross appointed as Director as of 1 June 2018 for an initial term of two years

Mind/Body programme continuing to progress though influencing the system, developing a long-term sustainability model and harnessing the catalytic power of the institute programme need to be defined further

Regular updates and presence of the research agenda both at the Senior Management Team and the Board have been highlighted as gaps.

Money, information and governance: the summary is that we have managed money and governance well and focussed on customer service through the IMT function. There will be new governance challenges ahead and the next stage of our Digital strategy will need to address how to attain the full power from information – particularly to execute our vision of delivering population health:

Money: we have managed money well and will reduce our structural deficit to £8m for £12m if we execute our plan without recourse to more one-off (non-recurrent) measures than currently planned.
• Last year ended with the achievement of our control total and a cash injection from the centre. We agreed our control total for 2018-19 (£0.7m surplus) and are £0.3m ahead of plan at the end of M2.

• In terms of the commercial strategy, we are executing our growth strategy in UAE through out-patient clinics in Abu Dhabi and the Al-Amal contract; we have launched Maudsley Learning; and are identifying the commercial return required from excess estate in the next 5 years.

  o Governance: Over the last year there was considerable focus on improving the strength and transparency of our governance structures and there will be new challenges ahead
    • Developed robust approaches to due diligence and frameworks for risk evaluation and risk management (e.g. red lines)
    • New challenges ahead include governance of overseas and commercial activity and governance in the light of different, multi-partner borough contracts.

  o Information: We are executing our digital strategy though further clarification of benefits is needed
    • The most pressing concern is developing an ‘ask’ of the CTI for an information strategy to support our population health strategy

4.0 Impact on Risks

If we achieve our strategic aims, we will reduce the likelihood of all of our key BAF risks and the consequence of many of them (see table below).

However, this progress report suggests that two significant tensions have also emerged: (i) the stress on our workforce through the coming together of the reorganisation and preparation for the CQC’s recent visit, and (ii) the risk of people at all levels feeling ‘left behind’ through a lack of clarity around the Trust’s default processes, and skills, in respect of managing significant change. These tend to exacerbate our primary risk 1 – staff recruitment and retention - and we may not have allocated sufficient resources and investment to truly mitigate the risk.

The rate of change has accelerated in the last 10 months since last September (the time we agreed the strategy) and will continue to be higher than it was for some period of time – at least the time horizon of the strategy (next four years) and probably beyond. This does raise the question of whether we are sufficiently geared up, at senior levels, to manage change.

Finally, we have done our best to deal with risk 6 – impact of (new) contracts on financials and ability to provide high quality services in our negotiation of the Lambeth Alliance – but we have only just started working under a novel contract in Lambeth and will only be able to judge outcome properly in 12 to 18 months.

<table>
<thead>
<tr>
<th>BAF risk</th>
<th>BAF risk description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Workforce</td>
<td>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.</td>
</tr>
<tr>
<td>2. Operational delivery structure</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>
</tr>
<tr>
<td>3. Informatics</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>
</tr>
<tr>
<td>5. Partnership working with service users</td>
<td>If the Trust fails to listen to the experience of people that use services and / or fails 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.</td>
</tr>
<tr>
<td>7. Quality &amp; statutory compliance</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 its other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.</td>
</tr>
</tbody>
</table>
8. Finance - contracts

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.

9. Estates

The Trust estate strategy will be delivered over the next five years and is dependent on significant capital investment. During the five year’s 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.

11. QI delivery

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.

12. Finance – cost management

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.

13. Mandatory training

If the Trust fails to meets 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.

5.0 Looking ahead

Looking ahead, we will need to respond to the risks discussed above and also deal with other potential barriers. These include:

- Achieving better ownership of strategic goals widely in the organisation
- Addressing capability and capacity gaps in the organisation whilst also achieving our financial plan
- Adjusting current implementation projects to:
  - Get better at scaling up successful QI projects;
  - Define outcome measures for the strategy faster than currently scheduled;
  - Define our approach to population health and linkage to IMT agenda and to IoPPN;
  - Shaping our model for Integrated Care
- Building a shared approach and developing expertise in change / transformation management to support the Trust’s vision, and,
- Potentially stopping some projects.

We will also need to consider in depth some of the key implications of the strategy to stay ahead of the change and thereby help steer the organisation effectively at the Board such as:

- Clarifying what SLaM will look like in the future by considering questions such as:
  - Will SLaM be more decentralised as divisions become more autonomous?
  - What will be the nature and role of the centre to ensure consistency, performance and growth?
  - What is the resulting impact on organisation structures, management and governance processes?
- Restructuring options to deliver the Trust strategy – core vs non-core; delivering estates and commercial strategy; workforce implications
- 5-year financial strategy

This forward look will drive the agenda for September’s Board Development session.

6.0 Proposal for future updates

We propose that future updates on the strategy take place every six months and follow this format.
REPORT TO THE TRUST BOARD: PUBLIC

24 July 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Trust Data Framework and Dashboard Development</th>
</tr>
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</table>
| Author| Nicola Byrne, Deputy Medical Director & CCIO  
Martin Black, Quality Improvement Information Development |
| Accountable Director | Michael Holland, Medical Director |

Purpose of the paper

- To update the board on project progress and ensure direction continues to meet expectation, including future board requirements
- To provide background to live demonstration of the Dashboard at the meeting
- To invite board to explore the dashboard and provide feedback
- To request board use Dashboard prior to any service visit to inform their visit, support promotion of the Dashboard as part of cultural change in working and facilitate discussion with teams on their views and understanding of the Dashboard; how it is / not yet, informing their work

Executive summary

Progress

- The Trust Dashboard using automated reporting and viewed by Power BI software has been built. It comprises the 12 agreed indicators each with a respective definition. The Dashboard can move between Trust, Directorate and Team level for 11 of the indicators and will be accessible to all staff
- Development and implementation has been slowed due to the complexity involved in the service directory mapping and restructuring, cleansing of the ESR data and competing demands upon the Business Intelligence team’s time (there continues to be a remaining unfilled BI team post). Despite this we are on track to deliver the Trust Dashboard in July as planned
- Subject to successful testing with Directorates due to commence shortly, we plan for a live demonstration at this Board meeting on the 24th July prior to Trust wide roll out

Future

- We are already developing branch datasets for patients and carers, service delivery, finance and workforce data – this includes the prioritisation of the Quality Priorities
- We continue to develop our thinking regarding how we assess data requests, including how we question whether the data is essential, will be good enough in quality to be informative and how it will be used in practice
- We continue to refine the usability of the Dashboard and simplify how it is accessed (including developing an app for this purpose)
- We are exploring how we further staff engagement and improve general levels of data literacy across our staff group
- We are not prioritising procuring SPC functionality at present but this remains on our radar
- Our development roadmap remains under the scrutiny of the GDE & QI board
Risks / issues for escalation

Board Assurance Framework – mitigating risks

As a platform for data visualisation to inform action, this project impacts on:

- Recruiting and retaining highly skilled staff (risk 1)
- Trust informatics systems development (3)
- Listening to experience of service users (5)
- Establishing QI investment results in demonstrable improvement (11)
- Ensuring stable financial position (12)

Risk: The key risk to delivery of the project, highlighted at May Board, remains the unsuccessful ongoing efforts to recruit to the BI team, especially given the volume of demand on the team; this has on balance been managed to date. Future progression and pace of development remains subject to this risk.

Committees where this item has been considered

Updated iterations of this project presented at the following

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
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<tbody>
<tr>
<td>March 18</td>
<td>Trust Board</td>
</tr>
<tr>
<td>May 18</td>
<td>Quality Committee</td>
</tr>
<tr>
<td>May 18</td>
<td>Trust Board</td>
</tr>
<tr>
<td>May 18</td>
<td>GDE &amp; QI Board</td>
</tr>
</tbody>
</table>

Iterations of the project have also been presented to Clinical Directors and Service Directors in April and the Clinical Quality Reference Group with our local commissioners in June.

Project background

Group
- Michael Holland, Medical Director
- Harold Bennison, Director of Performance, Contracts & Operational Assurance
- Anthony Schnaar, Head of Business Intelligence
- Barbara Grey, Director SLaM Partners
- Martin Black, Quality Improvement Information Development
- Nicola Byrne, Deputy Medical Director & CCIO

Project aims
- A shared conceptual framework that aligns data use across the organisation
- Access to data for all staff via an automated Trust Dashboard displaying key data
- Routine use of the Dashboard at all levels to drive more data informed decisions
- A culture shift in how all staff use and understand data

Project principle

To follow and promote ‘MUSiC’ standards for data use in the Trust, namely all data to be Meaningful, Understandable, Simple + Consistent.

Project progress

The Trust Dashboard

The Trust Dashboard using automated reporting and viewed within Power BI software has been built. It comprises the 12 agreed indicators each with a respective definition. The Dashboard can move between Trust, Directorate and Team level results for 11 of the indicators and will be accessible to all SLaM staff.
Currently the data remains in **run chart format**, displaying data graphically against time to support the identification of signals of change in the data, rather than identifying ‘special cause’ variation as ultimately envisaged through SPC software (discussed further below).

Testing is now planned to start the **week beginning 9/7/18** with Clinical Directors, Service Directors, business managers and heads of professions. Feedback will be sought by survey asking respondents **what they liked about it; what they did not like about it; what did they use it for and how would they improve it?**

The testing is behind schedule. This is due to a combination of the following:

- The complexity of the service directory work (reflecting new divisional structures) and mapping across multiple systems
- On-going data cleansing of the ESR
- Competing demands upon the BI team’s time including CQC related requests

Subsequent to successful testing and any required modifications, at the time of writing we’re on track to deliver the Dashboard presented as a live demonstration to the Board on the 24/7/18 meeting and for the dashboard to become live and accessible to all staff following this. We anticipate still needing to do revisions following feedback and continued testing up to and including that week.

Following the launch of the new intranet in August, the Dashboard will be easily accessible to all staff through the homepage, but staff will all have access to it through staff-wide Power BI licences prior to this.

**Development of branch datasets**

Future work is planned for branch datasets off the Trust Dashboard, with **patients and carers, service delivery, finance and workforce** data branching out from the Dashboard. The next significant focus is the development of automated reporting (where applicable) for the Trust Quality Priorities.

The introduction of the Trust Data Framework gives us opportunity to align existing reports, datasets and dashboards within the ‘branch data sets’ concept. This will allow better navigation, consistent use of terms and definitions, so creating a greater experience and understanding for members of staff.

**Project governance**

We’re confident that we have now established a governance structure for the project that will, on an ongoing basis, support conversations about who needs what data for what purpose, and in what format and frequency. The weekly meetings reviewing project delivery and prioritisation continue, combined with regular steering group meetings every two months with reporting to the GDE & QI board. Our discussions thus far have benefited from the team’s different, cross-cutting perspectives across BI, QI, clinical and contractual lines with a healthy degree of mutual challenge about data quality and what matters.

As previously discussed, it is envisaged that through this process of constructing datasets we will systematically scrutinise both data currently collected and new requests. Three questions in particular will drive development in keeping with the **MUSiC** data principle of the project, as described above. Namely:

1. **Is this data essential?**

   Does each measure in a branch dataset serve a purpose distinct to that of other data already being looked at elsewhere? Is there a proxy measure already collected that would be sufficient for the stated purpose? We will align data requested by each committee with the ambition that the sum total will be that currently needed to run the Trust safely, effectively and within budget.

2. **Is the quality of this data good enough?**

   Given requests stem from an individual leader, expert or committee’s desire to address an important question, we see an essential task of our group as providing the requester(s) with the context and challenge to assess whether the data requested will in reality give them the information they require;
we recognise we need to improve this feedback loop for senior staff and board members. One key task to do so will be addressing the distinction – or gap - between the intended purpose of a data field on ePJS and how it is used in practice.

From the perspective of this project team, we’d argue that historically we have as an organisation ‘put the cart before the horse’ in terms of data quality, in that we have directed data fields be built and reported on prior to establishing whether our mechanisms for ensuring the data is routinely and consistently collected (and thus reasonably accurate), are assured. If we are to learn from our experience we need to stop reliance on simple direction to staff to tick additional boxes or open up new forms for completion, as we know from repeated attempts to do so this approach fails. Instead we need to ensure we improve the usability of ePJS, so data collection is integrated into the work stream for frontline staff, drawn wherever possible ‘as silent running’ in the background to data entry driving direct care, rather than data collection to be in and of itself an additional (and thus poorly completed) administrative task for clinical staff.

We will also be drawing on external recognised standards for data quality, namely the European Statistical Systems (ESS) quality dimensions and principles. Most relevant here are those concerning accuracy and reliability; timeliness and punctuality; coherence and comparability. Given the above, we want in future to be assured that data quality is good enough to be informative and not actively misleading prior to building it into the automated dashboard reporting. Otherwise numbers generated will only be measuring staff compliance in administration, or the adequacy of our data fields, rather than addressing the question of interest. If we improve our scrutiny of data we can be more confident that we are providing committees and the Board with accurate information.

3. How will the data be used?

We want to ensure data dashboard requests provide a streamlined dataset that provides essential assurance and improvement, with all data thus displayed being required for decision making at all levels of the organisation, and not only for committee assurance purposes or interest.

Dashboard refinement

Access and usability

We want to continue to improve Dashboard user experience in terms of its ease of access, visual clarity and system navigation. To this end we have taken feedback on the appearance of the screens – colour, font, structure – from the various committees and groups where the dashboard has already been shown in draft form and have changed it accordingly. Our BI team has also visited colleagues in KHP to learn from their approach, including their use of ‘tool tips’, bookmarking and navigation.

Regarding accessibility, the BI team is developing an app for the Dashboard; in time, we envisage a similar external app for commissioners. This will enable commissioners to freely access this information online and support them to interrogate the data prior to focused discussion in meetings.

Development of SPC functionality

In the light of earlier frustrations to procure Statistical Process Control software, given the limitations of the current market, we have moved this down our priority list, as discussed at the May Trust board. However we remain committed to achieving this functionality and since May we have continued to liaise with potential suppliers, held discussions with Trust procurement and written our specifications.

Staff engagement

We recognise that staff engagement will entail raising awareness of the Dashboard and its purpose, alongside raising basic data literacy.

We are currently looking to address this through:

- Raising awareness of the Dashboard through its prominent position on the new intranet, Maud
- Learning from KHP in terms of exploring the use of embedding data guides in the Dashboard itself
- Further dedicated QI data training workshops for staff
• Proposing to BRC Informaticians a joint grant application focused on improving clinician engagement with data

• The Dashboard has embedded analytic functionality to allow us to see who is using the Dashboard; we will use this information to inform how we direct further efforts to improve engagement

It is also of note that the Dashboard only currently contains simple run charts for the reasons described above regarding SPC functionality. We now see this delay as helpful in that it gives us the opportunity to start engagement with the data at a more basic level to improve data literacy across all staff groups.

Project challenges

As previously discussed, challenges regarding staff resource in terms of an unfilled vacancy in the BI team remain, alongside that of the team continuing ‘BAU’ and responding to competing organisational demands. In terms of plans for the post, currently we are looking to appoint a less experienced person to the team at a lower banding as a development opportunity for them, providing them with the support needed to develop their skillset.

Project review

On the 19th July as a team we are holding a project review day to have more dedicated discussion time to review progress thus far. We will seek to agree the right development balance resource-wise between the needs of assurance, governance, QI and clinical work (e.g. outcomes), and across our different data groupings (patient & carers, service delivery, workforce and finance). We will also have more in-depth discussion of the Dashboard functionality e.g. how we might further develop embedded contextual ‘3-dimensional’ information for data points on the graphs.

Conclusion

We remain on track to deliver the Dashboard in July, accessible to all staff via the new intranet in August. We continue as a project group to learn from experience elsewhere and refine our thinking alongside the refinement of the Dashboard itself. Our roadmap remains under the scrutiny of the GDE & Quality Improvement board; meanwhile we warmly welcome all feedback from end users of the Dashboard, from Board to frontline.
1. Care Quality Commission

The Care Quality Commission carried out their announced inspection of our services, alongside some unannounced visits, over two weeks in July (Monday 2 – Friday 13). The inspection was in line with the CQC’s new methodology and they inspected our forensic, eating disorders, acute and psychiatric intensive care unit (PICU) services. The inspectors also visited our community services for older people and mental health crisis services, which includes home treatment and our health based places of safety.

Our approach, as you would expect, was to be welcoming, responsive and open. CQC visits give the Trust an opportunity to showcase the range of services we provide, the dedicated people who work here and the service users we work with. They also provide us with an opportunity to benefit from fresh and independent eyes being cast over our services, picking up areas where we could improve further.

The inspectors visited us during a heat wave, over a period of significant pressure on our acute care pathway, and a very significant internal reorganisation. I was, therefore, really proud of how committed and professional everyone was during the two week period, and indeed before and now after. We were also able to talk to many of the positive changes we have made. For example, in the last financial year, our recruitment efforts have resulted in a very significant reduction in our vacancy rate for nurses. Our new models of care for forensics and Tier 4 CAMHS, developed as part of the South London Mental Health and Community Partnership, are resulting in fewer patients placed out of the area in beds outside our Trusts. Our proactive bed management is also helping to maintain an up-to-date position on bed occupancy and links with our community teams.

Challenges remain, however, and we are working continuously to improve the care that we provide and the experiences of our patients and staff. We are being helped by our internal quality improvement team who are supporting us to put QI methodology in to action. We welcome the CQC’s inspection and look forward to their follow-up ‘well-led’ inspection in August to continue learning lessons from what they tell us.

2. ‘Seni’s law’ - Mental Health Units (Use of Force) Bill

I was very pleased that Steve Reed MP’s private members bill, The Mental Health Units (Use of Force) Bill, aiming to ensure better monitoring of the use of force against patients in mental health units, was approved by MPs in the House of Commons on Friday 6 July, and will now go to the House of Lords.
As a Trust we are supportive of the Bill, also known as Seni’s Law. The Bill calls for more recording of how restraint is used, will ensure that police wear body cameras if they carry out restraint unless there are legitimate operational reasons for not doing so, and states that hospitals will have a senior manager responsible for ensuring training in restraint.

In September 2010, Olaseni Lewis died following a police restraint in one of our services at the Bethlem Royal Hospital. His death represented, and continues to represent a tragedy for his family, his friends and his community. We have passed on our condolences to the Lewis family and apologised to them for the loss of their son – we continue to stay in touch with them and offer our support.

The Trust has learnt a great deal and made changes to how we work as a result of Olaseni’s death. New processes have been put in place to improve how we train and support staff so that they can deliver safe care to people who become mentally unwell. Working alongside the police, we have improved how staff communicate and collaborate with them in high risk situations.

We hope that this Bill will support the NHS and police to continue to make the necessary changes to reduce the possibility of this ever happening again.

3. Multi-Agency Discharge Event (MADE) partnership events

The Trust is striving to address service pressures by working across the wider health and social care system. Working jointly with our commissioners, across all boroughs, we are implementing the first fully comprehensive series of mental health, Multi-Agency Discharge Event (MADE) partnership events.

The MADE events are being held in two parts. The first to review all internal delays and the second to resolve external delays with system partners. We are taking the acute trust model for MADE events and aiming to develop barrier-free pathways to discharge for all patients over 50 days length of stay, or with a planned discharge within 14 days of the MADE events. Events are planned throughout the summer and autumn to occur twice in every borough.

4. South London Mental Health and Community Partnership

A first full year’s positive impact on many areas for the three partner trusts and our patients is captured in the South London Mental Health and Community Partnership’s (SLP) Annual Review 2017-18. Colleagues from many teams across the trusts have come together in a genuine partnership to make strong progress in areas such as bringing care closer to home, and improving outcomes for some of our most vulnerable specialist patients.

Highlights from 2017-18 include:

- a transformation in the approach to supporting and rehabilitating south London Forensic patients with major reductions in out of area placements, and significant repatriations and step-downs
- one-third fewer overall CAMHS patients inpatient bed days outside of area – meaning children and young people are cared for closer to their families
- a new career pathway for nursing staff across the Trusts, new roles, and enhanced training and development opportunities
5. Celebrating the 70th anniversary of the NHS

The Trust celebrated the 70th anniversary of the NHS in style. There were tea parties at Bethlem, Ladywell, Lambeth and Maudsley with, staff, patients and service users enjoying tea, cakes and other refreshments. The trade union Unison and individual teams also held their own parties to celebrate NHS70. A member of staff and a volunteer attended a service of thanks, for NHS staff, patient groups and volunteers, at Westminster Abbey. Photos of the events were shared widely on all our social media platforms.

To mark the 70th birthday of the NHS an exhibition in the Maudsley Long Gallery ‘Alternative Seventy: Artists across seven decades of NHS’, celebrates the work of some unfamiliar artists whose work is held in the Bethlem Museum collection, as well as work by artists who have exhibited with the Bethlem Gallery from 1948 to the present day. The exhibition will run until September 2018.

I’m also proud that Professor Ulrike Schmidt, Consultant Psychiatrist at SLaM’s Eating Disorders Service and Professor of Eating Disorders at the IOPPN, has been announced as one of the NHS70 Women Leaders. This recognition award for women leaders in healthcare is in celebration of the NHS turning 70 years old, and 100 years of women’s suffrage. This award was presented by the Women’s Leadership Academy, part of the NHS London Leadership Academy.

Dr. Matthew Patrick
Chief Executive
July 2018
REPORT TO THE TRUST BOARD:  PUBLIC
24th JULY 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Finance Report As At 30th June 2018 (Q1)</th>
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<tbody>
<tr>
<td>Author</td>
<td>Andy Bell, Tim Greenwood &amp; Mark Nelson</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Gus Heafield</td>
</tr>
</tbody>
</table>

Purpose of the paper

The Finance Report provides an update on the financial position of the Trust as at 30th June 2018 (month 3). The summary financial statement and calculation of the Use of Resource rating from the NHSI Q1 submission is attached to the report in Table 2.

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

Executive summary

Headlines

- Q1 YTD £0.1m favourable to plan
- However, if costs proceed at the current rates significant forecast pressures (£5.8m+) will require action in order to achieve the Trust’s Control Total. Recovery plans to ensure delivery in development.
- CIP still expected to deliver £16.4m but slippage on Overspill will require replacement schemes.
- Cash position remains robust at £70.0m YTD.
- Capital spend is £1.9m YTD (£2.9m lower than plan). Strategic Estates programmes (NAU, Norbury ward, DBH, CAMHS Tier 4 & CYP) are due to commence later in the year.
- All figures stated in key drivers and risks below represent full year forecast impacts.

Key Drivers (included in the forecast)

- Key areas driving overspend operationally YTD are:
  - Overspill (58% in Lambeth) - £1.2m +
  - Ward Nursing Costs - Bank and Agency - £1.5 to £1.9m run rate pressure
  - CAMHS - Income, Kent, Fostering & Adoption - £1.0m

- Key areas driving overspend corporately are:
  - Medical - Junior Doctors Costs - £1.1m
  - Estates – ISS Contract dispute and utilities inflation - £0.5m
  - HR - training income and advertising spend - £0.5m
  - Reduction in R&D income - £0.35m.

Key Risks (not included in the forecast)

- Southwark Local Authority fail to fund Complex Placements (£1.0m to £1.8m)
- SLaM unable to mitigate longer term Overspill pressure (an additional £0.0m to £5.0m)
- SLaM unable to dispose of Southbrook Rd for Operational reasons (£0.4m)
- DH Do not fully fund additional 2% Pay Award (£2.5m per 1% unfunded)
- SLaM are unable to deliver backloaded CIP requirement (SLP & Boroughs) - £1.0m to £1.8m average run rate increase per month.
Risks / issues for escalation

BAF Risk 1 - Workforce - 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 8 – Finance contracts - 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 9 – Estates - 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.

BAF Risk 11 – QI delivery - 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 Finance – cost management - 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.
1) Current Position

At Month 3 ytd, the Trust had made a surplus of £2.9m, a favourable variance of £0.1m against its surplus control total.

The in month variance position has been effected by the earlier than planned sale of the Woodlands Unit where proceeds from the sale were taken last month, 1 month in advance of the Plan. The year to date position on this is now in line with the Plan.

Although the Trust is on plan ytd, it faces a number of cost pressures which unless tackled early on, could compound pressure on delivery of the plan that is back-loaded in terms of cost reductions.

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

The Trust is currently rated by NHSI as a 3 against use of resources (where 1 is best out of a 1-4 range – see Table 2). The rating was originally scored at 2 but due to an override has been downgraded to a 3. The override kicks in due to a score of 4 against the Trust’s capital service cover. This score is in line with the ytd Plan and will improve by year end provided the Plan is met. The Trust retains good ratings against liquidity (cash position), I&E margin and distance from financial plan. However it is currently scoring a 2 on its use of agency staff.

2) Financial Risks & Key Issues

- The Trust continues to remap its services in line with the new borough structures. This month has seen the disaggregation of overspill costs such that the financial impact is now falling more reasonably on those Boroughs that are overperforming against their CCG contracts. This has impacted on Lambeth in particular. Further work is required to allocate remaining management and medical budget/costs to Boroughs. These residual budget/costs currently reside under the Chief Operating Officer and Medical Director service lines.

- Acute overspill averaged 29 beds in the month – an increase of 10 compared to May. 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 £1.1m ytd after the impact of risk shares. Clearly this is a major risk to our financial plan if it continues at levels well above the 3 beds included in the plan. The main areas of concern are Lambeth (21% above contract) and Southwark (10% above contract).

- Ward nursing costs remain high and out of step with budgets set at safer staffing levels. This is particularly so in Lewisham and Croydon where many wards are exceeding their pay budgets by +10%.

- As at month 3, the Trust had generated CIP savings of £1.8m. The current adverse variance from the CIP plan of £0.9m is largely driven by our failure to meet acute overspill targets as indicated above. The Trust’s PMO will continue to focus their assurance work on ensuring that any slippage on schemes is arrested/minimised and that substitute schemes are developed where this is not possible. The Trust is largely meeting its CCG QIPP targets although it is not keeping to its baseline acute obs positions and there have been delays in restructuring the Social, Hope and Recovery Project in Lambeth. A gap remains on the Southwark QIPP plan where proposals to resolve have been put to the CCG. The Trust is awaiting a response.
• Complex placements are reporting a balanced position. However there remains a key risk in Southwark where the Local Authority (LA) are no longer in a Section 75 arrangement with the CCG. This means the Trust is more exposed on securing the funding required to meet those placement costs. The Trust has no contract with the LA and the LA are indicating they will not meet the full cost of those placements. Discussions are taking place to resolve this issue and SLaM are awaiting formal notification from Southwark LA/CCG.

• The Trust had planned for a reduction in agency costs, in line with the new NHSI ceiling. However agency usage over the first 3 months is £0.5m above this ceiling. Although the new ceiling is £2.3m lower than last year, the position is being compounded by our agency costs also increasing. They are £0.5m higher than at this point last year and on current run rates will exceed the new ceiling by £3.5m at year end. Medical agency costs are disproportionately high and agency usage is highest in the adult boroughs.

• Last year the Trust, overall, met its cost and volume income targets (higher risk income that relates directly to increases/decreases in activity). However the performance overall, masked areas where income was not on plan. Some of these areas have continued to underperform going into 2018/19, whilst others have moved from a surplus into a deficit and are now driving a bottom line income deficit of £1.1m at month 3. Corresponding pay underspends will mitigate 37% of this variance but a number of services are required to improve their performance over the remaining 9 months.

• Details regarding the funding of the pay award for agenda for change (AfC) staff grades are yet to be announced. The pay award is due to take place in July. The Trust had planned on a 2% uplift from NHSE to meet the declared commitment to fund the wage award in full (1% from the CCG tariff uplift plus 2% from NHSE). It is unclear how this payment will be calculated centrally – the Trust has been asked for no information – and whether it will cover costs linked to the national pay award such as bank staff working through NHS Professionals. Until this is clarified it remains a risk to our plan.

3) Forecast

At Q1, the Trust is still forecasting to meet its NHSI control total. The Trust has identified financial risks totalling £5.8m by year end. These can be mitigated against provided –

• The SLP delivers net savings in line with the Trust plan
• NHSE fund the AfC pay award in line with the Trust plan
• The sale of assets take place in line with the Trust plan
• Outstanding QIPP issues are resolved with Southwark CCG

The remaining risk (c£2m) will need to be addressed by bringing down the current run rates in key areas previously outlined –

• Acute overspill
• Ward costs
• High agency costs
• Variable (activity driven) income shortfalls
• Infrastructure overspends particularly in Estates and HR
• Junior doctor costs
• On-going delivery of CIPs (current and those planned for later in the year)
### 1) Financial Summary

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Current Month Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
<th>Year To Date Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
<th>Variance Last Month (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Lambeth</td>
<td>18,206,800</td>
<td>2,103,500</td>
<td>575,700</td>
<td>5,127,400</td>
<td>542,700</td>
<td>(32,900)</td>
</tr>
<tr>
<td>02. Southwark</td>
<td>31,230,200</td>
<td>2,686,700</td>
<td>84,900</td>
<td>7,639,500</td>
<td>(171,300)</td>
<td>(256,200)</td>
</tr>
<tr>
<td>03. Lewisham</td>
<td>23,135,900</td>
<td>2,100,700</td>
<td>166,700</td>
<td>6,205,300</td>
<td>395,700</td>
<td>229,000</td>
</tr>
<tr>
<td>04. Croydon</td>
<td>14,403,100</td>
<td>1,090,200</td>
<td>(126,900)</td>
<td>3,991,500</td>
<td>386,000</td>
<td>512,900</td>
</tr>
<tr>
<td>05. PMOA</td>
<td>(1,766,400)</td>
<td>(113,100)</td>
<td>(41,100)</td>
<td>(547,300)</td>
<td>(200,100)</td>
<td>(159,000)</td>
</tr>
<tr>
<td>06. Child &amp; Adolescent Service</td>
<td>(304,500)</td>
<td>391,300</td>
<td>386,500</td>
<td>558,300</td>
<td>603,900</td>
<td>217,400</td>
</tr>
<tr>
<td>07. Clinical Support Services</td>
<td>8,424,300</td>
<td>646,900</td>
<td>(105,100)</td>
<td>2,067,400</td>
<td>(38,700)</td>
<td>66,400</td>
</tr>
<tr>
<td>08. Infrastructure Directorates</td>
<td>65,310,800</td>
<td>5,811,100</td>
<td>(236,500)</td>
<td>17,922,600</td>
<td>449,700</td>
<td>470,600</td>
</tr>
<tr>
<td>09. Corporate Income</td>
<td>(111,356,800)</td>
<td>(9,260,800)</td>
<td>128,700</td>
<td>(27,643,100)</td>
<td>265,700</td>
<td>(136,900)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,068,800</strong></td>
<td><strong>1,560,200</strong></td>
<td><strong>12,569</strong></td>
<td><strong>1,092,800</strong></td>
<td><strong>1,460,200</strong></td>
<td><strong>4,375,200</strong></td>
</tr>
</tbody>
</table>

#### Operational Deficit

- 01. Lambeth: £47,283,400
- 02. Southwark: £5,456,500
- 03. Lewisham: £575,500
- 04. Croydon: £15,321,600
- 05. PMOA: £1,702,200
- 06. Child & Adolescent Service: £1,127,800
- **Total**: £47,283,400

### 2) Key Cost Drivers

#### Area

<table>
<thead>
<tr>
<th>Area</th>
<th>2017/18 Mth 11 Variance £000</th>
<th>2017/18 Mth 12 Variance £000</th>
<th>2017/18 Total Variance £000</th>
<th>2018/19 Mth 1 Variance £000</th>
<th>2018/19 Mth 2 Variance £000</th>
<th>2018/19 Mth 3 Variance £000</th>
<th>2018/19 Total Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAGs</strong></td>
<td>194</td>
<td>212</td>
<td>4,340</td>
<td>336</td>
<td>391</td>
<td>831</td>
<td>1,558</td>
</tr>
<tr>
<td><strong>Infrastructure Directorates</strong></td>
<td>398</td>
<td>1,279</td>
<td>6,607</td>
<td>455</td>
<td>82</td>
<td>(127)</td>
<td>410</td>
</tr>
<tr>
<td><strong>Corp Income</strong></td>
<td>8</td>
<td>4</td>
<td>(599)</td>
<td>(48)</td>
<td>(89)</td>
<td>(129)</td>
<td>(266)</td>
</tr>
<tr>
<td><strong>Other including provisions released &amp; central CIPs</strong></td>
<td>(614)</td>
<td>(1,956)</td>
<td>(1,554)</td>
<td>336</td>
<td>760</td>
<td>422</td>
<td>1,518</td>
</tr>
<tr>
<td><strong>Use of Reserves</strong></td>
<td>301</td>
<td>974</td>
<td>(1,772)</td>
<td>(1,210)</td>
<td>(1,309)</td>
<td>(815)</td>
<td>(3,334)</td>
</tr>
<tr>
<td><strong>Total EBITDA</strong></td>
<td><strong>287</strong></td>
<td><strong>640</strong></td>
<td><strong>7,022</strong></td>
<td><strong>131</strong></td>
<td><strong>165</strong></td>
<td><strong>182</strong></td>
<td><strong>114</strong></td>
</tr>
</tbody>
</table>

#### EBITDA

- 01. Lambeth: £12,088,100
- 02. Southwark: £366,100
- 03. Lewisham: £182,500
- 04. Croydon: £1,718,900
- 05. PMOA: £1,127,800
- 06. Child & Adolescent Service: £84,100
- **Total**: £12,088,100

#### Trust Financial Position

- 01. Lambeth: £47,283,400
- 02. Southwark: £5,456,500
- 03. Lewisham: £575,500
- 04. Croydon: £15,321,600
- 05. PMOA: £1,702,200
- 06. Child & Adolescent Service: £1,127,800
- **Total**: £47,283,400

#### Items Not Included in NHSI Target

- 01. Lambeth: £480,900
- 02. Southwark: £43,000
- 03. Lewisham: £0
- 04. Croydon: £129,000
- 05. PMOA: £4,000
- 06. Child & Adolescent Service: £0
- **Total**: £480,900

#### NHSI Control Total

- 01. Lambeth: £2,459,000
- 02. Southwark: £883,500
- 03. Lewisham: £5,361,500
- 04. Croydon: £3,078,900
- 05. PMOA: £80,100
- 06. Child & Adolescent Service: £5,445,200
- **Total**: £2,459,000

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

- **Acute/PICU Overspill**

Overall 29 overspill beds were used by the Trust in June, an increase of 10 compared to the previous month and 26 beds above our original plan. The main drivers of this contract overperformance and hence resort to using beds outside the Trust are Lambeth (21% above contract) and Southwark (10% above contract). The use of overspill and other non local CCG beds has resulted in a cost pressure, after application of risk shares, of £1.1m after 3 months. The Trust response to this is picked up in the Performance Report.

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

![Total Acute/PICU Beds Used By LSLC CCGs Since 1/4/16](chart1)

![Total LSLC CCG Acute/PICU Beds Used Since 1/4/16](chart2)

Overall local CCG bed usage increased again in June. The main outlier continues to be Lambeth where bed numbers are 20% above their contracted level of activity resulting in a potential risk share payment to the Trust of £0.25m. The second graph above indicates how far we are away from achieving our goal of 85% occupancy where the blue line indicates actual CCG bed usage versus the red and purple lines indicating 100% and 85% bed usage respectively.
• **Use of Agency Staff**

NHSI have set a ceiling to spend no more than £15.1m on all agency staff. By way of comparison, the Trust spent £17.2m on agency in 2017/18. The Trust is currently £0.5m above that ceiling at Q1 and at present rates of expenditure will be £3.5m above the ceiling at year end and in excess of its 2017/18 position. Agency cost reductions form part of the annual plan and rely upon meeting the NHSI ceiling. As at month 3 ytd the Trust had incurred an additional expense of c£0.8m above the cost of employing permanent SLaM staff, assuming a 20% agency premium.

Medical agency represents 29% of total agency costs (a disproportionately high level of spend compared to other groups of staff). A breakdown of all agency use compared to permanent/bank usage ytd is given below –

<table>
<thead>
<tr>
<th>Directorate</th>
<th>All Staff</th>
<th>Agency Usage</th>
<th>Agency Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>6,363</td>
<td>571</td>
<td>9%</td>
</tr>
<tr>
<td>Southwark</td>
<td>9,235</td>
<td>635</td>
<td>7%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>6,559</td>
<td>596</td>
<td>9%</td>
</tr>
<tr>
<td>Croydon</td>
<td>13,597</td>
<td>1,461</td>
<td>11%</td>
</tr>
<tr>
<td>PMOA</td>
<td>8,744</td>
<td>272</td>
<td>3%</td>
</tr>
<tr>
<td>CAMHS</td>
<td>8,850</td>
<td>453</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>18,721</td>
<td>661</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72,070</strong></td>
<td><strong>4,648</strong></td>
<td><strong>6%</strong></td>
</tr>
</tbody>
</table>

• **Ward/Unit Nursing Costs**

At month 3 ward nursing costs overspent by £145k (£482k ytd). This is similar to the 2017/18 average but still 4% above budgets that have been set at safer staffing levels. The main areas of concern are
the Lewisham and Croydon adult wards which represent 74% of the total ward/unit nurse overspend. In addition Eden PICU (Lambeth) is 29% above its funded nurse establishment.

- **Cost per Case/Cost and Volume Income (variable income aligned to activity)**

The position has deteriorated from 2017/18, with 3 Directorates standing out –

- Croydon – income below target on Forensic Ward In The Community (additional beds not occupied), Psychosis Unit (activity below plan) and Pick Up service (revised target not being met). In addition the ADHD clinics are now only breaking even whereas last year they were overperforming against reduced income targets
- PMOA – part of this year’s CIP programme was to retain the 17/18 income targets but make progress towards meeting them. This is yet to occur uniformly with some of those services that underperformed last year - in particular, neuro psychiatry and eating disorders outpatients – continuing to underperform. In addition Chronic Fatigue, Affective Disorders and the Centre For Anxiety Disorders and Trauma are not currently meeting activity targets.
- CAMHS – the underperformance largely relates to outpatient services, in particular the Conduct Adoption and Fostering service and the Childrens Forensic Team where insufficient activity is taking place to fully meet costs. There is likely to be some catch up in terms of activity being recorded on the systems and some improvement is expected in line with previous years. However there are also income shortfalls on inpatient services where activity remains below target in Kent whilst delays in converting beds at Acorn Lodge into high dependency beds means income target are also not being met. The PICU Unit should be fully open from July ensuring that its income targets will be met.

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 3 £'000</th>
<th>Actual Invoiced At Month 3 £'000</th>
<th>Surplus/Deficit(-) At Month 3 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>645</td>
<td>667</td>
<td>(22)</td>
</tr>
<tr>
<td>Southwark</td>
<td>395</td>
<td>412</td>
<td>(17)</td>
</tr>
<tr>
<td>Lewisham</td>
<td>151</td>
<td>152</td>
<td>(1)</td>
</tr>
<tr>
<td>Croydon</td>
<td>7,178</td>
<td>7,031</td>
<td>147</td>
</tr>
<tr>
<td>PMOA</td>
<td>4,841</td>
<td>4,450</td>
<td>390</td>
</tr>
<tr>
<td>CAMHs</td>
<td>5,888</td>
<td>5,300</td>
<td>588</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>19,098</strong></td>
<td><strong>18,012</strong></td>
<td><strong>1,086</strong></td>
</tr>
</tbody>
</table>

Some of these shortfalls (37%) are being offset by corresponding pay underspends but it will be important to take swift action if these positions are not to drift over the coming year.
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 3 the LA element of placements has cost £0.97m with zero recovery as yet from Southwark Council. The Council have indicated they are only willing to purchase activity up to a value of £2.1m leaving a potential forecast gap of £1.8m.

3) Cost Improvement Programme (CIP) – see Table 3

In order to deliver on its control total for 18/19, the Trust has set a savings target of £16.4m (17/18 - £27m). Of the schemes that make up this figure, £3.8m are currently rated as red in terms of their delivery. This would have been lower but for the majority of overspill savings now being rated as red given the challenging start to the year.

As at month 3, the Trust had generated savings of £1.8m which represents a £0.9m (32%) shortfall from Plan. This largely relates to lower than anticipated savings from the reduction in overspill as the Trust continues to experience overspill levels significantly above what had been assumed in the Plan. Considerable senior management focus is being applied to this issue and a reduction trajectory is being targeted based on improvements in rate of discharge. It is projected that this trajectory will result in overspends which equate to a shortfall against this savings scheme of £1.2m.

The overall forecast is to achieve the full CIP target of £16.4m. This is reliant on partial turnaround of the overspill CIP and further mitigating CIPs and lock-ins to be developed. Looking ahead there are also key savings to be delivered in the second half of the year from estates, the South London Mental Health Partnership and the borough reconfiguration. Further assurance work is on-going to de-risk identified schemes and to identify additional savings. The PMO will continue to focus their assurance work on ensuring that any slippage is highlighted with a view of getting significant traction on the recovery plans at an early stage to increase assurance over delivery of the target.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMH</td>
<td>Adult Mental Health – used in this report to cover a programme of investment in community schemes that aim to reduce the usage of acute/triage beds in the Trust</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bring together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CIPs</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CPC/C&amp;V</td>
<td>Cost per Case and Cost and Volume income varies depending upon the amount of clinical activity being undertaken</td>
</tr>
<tr>
<td>EBITDA</td>
<td>Earnings before interest, tax, depreciation and amortisation is an accounting measure used as a proxy for an organisation's current operating profitability</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>MHOA</td>
<td>Mental Health of Older Adults</td>
</tr>
<tr>
<td>NCA</td>
<td>Non Contracted Activity - a patient treated by SLaM where no contract exists between the Trust and the Commissioner (e.g. a Lewisham resident who has a Bromley GP will not be charged against the Lewisham contract but will be invoiced as an NCA to Bromley CCG)</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement – the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>O/P</td>
<td>Outpatient</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit - provide mental health care and treatment for people whose acute distress, absconding risk and suicidal or challenging behaviour needs a secure environment beyond that which can normally be provided on an open psychiatric ward</td>
</tr>
<tr>
<td>PoS</td>
<td>Place of Safety – under section 136 of the Mental Health Act, the police have the power to take an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a “place of safety” where they may be assessed by a doctor</td>
</tr>
<tr>
<td>QIPP</td>
<td>The Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help reduce the cost of services to the CCG</td>
</tr>
<tr>
<td>STF</td>
<td>Sustainability &amp; Transformation Fund that is intended to support providers to move to a sustainable financial footing</td>
</tr>
<tr>
<td>Triage</td>
<td>Triage ward – used to admit patients for a short period of time where their needs are assessed before being either discharged to the care of community teams or transferred to an acute ward</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent – is a concept used to convert the hours worked by several part-time employees into the hours worked by full-time employees e.g. 1 wte = 1 full time employee</td>
</tr>
<tr>
<td>YTD</td>
<td>Year To Date</td>
</tr>
</tbody>
</table>
1. The Trust continues to remap its services in line with the new borough structures. This month has seen the disaggregation of overall costs such that the financial impact is now being more reasonably on those Boroughs that are overperforming against their CCG contracts. This has impacted on Lambeth in particular.

2) Acute overspill averaged 29 beds in the month – an increase of 10 compared to May. The net financial impact of overspill and loss of NCA income is £1.4m ytd excluding the impact of risk shares. Clearly this is a major risk to our financial plan if it continues at levels well above the 3 beds included in the plan. The main areas of concern are Lambeth (21% above contract) and Southwark (10% above contract).

3) The Trust had planned for a reduction in agency costs, in line with the new NHSI ceiling. However agency usage over the first 3 months is £0.5m above this ceiling. Although the new ceiling is £2.3m lower than last year, the position is being compounded by our agency costs also increasing. They are £0.5m higher than at this point last year and on current run rates will exceed the new ceiling by £3.5m at year end. Medical agency costs are disproportionately high and agency usage is highest in the adult boroughs.

4) Ward nursing costs remain high and out of step with budgets set at safer staffing levels. This is particularly so in Lewisham and Croydon where many wards are exceeding their pay budgets by +10%. Ward nursing costs are disproportionally high and agency usage is highest in the adult boroughs.

5) At Month 3 ytd the Trust made a surplus of £2.9m, a favourable variance of £0.1m against the NHSI 18% control total. However, the performance overall, masked areas where income was not on plan. Some of these areas have continued to underperform going into 2018/19, whilst others have moved from a surplus into a deficit and are now driving a bottom line deficit of £1.2m at month 4.

6) Details regarding the funding of the pay award for agenda for change (AFC) staff grades are yet to be announced (this is clarified a risk to our plan).

7) The Trust is currently rated by NHSI as a 3 against use of resources (where 1 is best out of a 1-4 range). The rating was originally scored at 2 but due to an over-reaction against the Trust’s capital service cover has been downgraded to a 3. The Trust retains good ratings against liquidity (cash position), I&E margin and distance from financial plan. However it is currently scoring a 2 on its use of agency staff.

8) Last year the Trust, overall, met its cost and volume income targets (higher risk income that relates directly to increases/decreases in activity). However the performance overall, masked areas where income was not on plan. Some of these areas have continued to underperform going into 2018/19, whilst others have moved from a surplus into a deficit and are now driving a bottom line deficit of £1.2m at month 4.

9) Details regarding the funding of the pay award for agenda for change (AFC) staff grades are yet to be announced (this is clarified a risk to our plan).

10) The Trust had planned for a reduction in agency costs, in line with the new NHSI ceiling. However agency usage over the first 3 months is £0.5m above this ceiling. Although the new ceiling is £2.3m lower than last year, the position is being compounded by our agency costs also increasing. They are £0.5m higher than at this point last year and on current run rates will exceed the new ceiling by £3.5m at year end. Medical agency costs are disproportionately high and agency usage is highest in the adult boroughs.

Key Financial Drivers
- Performance v CIP - £0.3m below the NHSI Plan - 32% < target
- Ward Nursing - £0.5m overspent
- Acute Overspill - £1.4m overspent excluding impact of risk share
- Complex/Non Secure Placements - £0.3m underspent excluding impact of risk shares
- Cost per Case/Cost & Volume - £1.1m ytd < target excluding offsetting pay costs.

Other Metrics
- Forecast FSR less than 20% in next 12 months
- Better payment practice (cash from NHS by value)
- Cash at bank and in hand
## Monthly Figures Year to Date Figures

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Current Month Actual (£)</th>
<th>Year To Date Variances From Live Budgets (£)</th>
<th>Variance from Last Month (£)</th>
<th>Notes Re Mth 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Lambeth</td>
<td>18,208,800</td>
<td>2,103,500</td>
<td>517,700</td>
<td>5,127,400</td>
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<tr>
<td>02. Southwark</td>
<td>31,230,200</td>
<td>2,068,700</td>
<td>84,000</td>
<td>7,639,500</td>
<td>(171,300)</td>
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<tr>
<td>03. Lewisham</td>
<td>23,135,900</td>
<td>2,100,700</td>
<td>165,700</td>
<td>6,205,300</td>
<td>395,700</td>
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<tr>
<td>04. Croydon</td>
<td>14,403,100</td>
<td>1,090,000</td>
<td>126,000</td>
<td>3,911,500</td>
<td>385,000</td>
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<td>05. PMDA</td>
<td>(1,765,400</td>
<td>(1,13,100)</td>
<td>(41,100)</td>
<td>(547,300)</td>
<td>(202,100)</td>
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<td>06. Child &amp; Adolescent Service</td>
<td>(304,500)</td>
<td>391,300</td>
<td>386,100</td>
<td>558,300</td>
<td>630,000</td>
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<td>07. Clinical Support Services</td>
<td>8,424,300</td>
<td>646,900</td>
<td>(105,100)</td>
<td>2,067,400</td>
<td>388,400</td>
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<tr>
<td>08. Infrastructure Directorates</td>
<td>65,310,800</td>
<td>5,811,100</td>
<td>(236,500)</td>
<td>(7,922,600)</td>
<td>449,700</td>
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<tr>
<td>09. Corporate Income</td>
<td>(111,305,800)</td>
<td>(926,400)</td>
<td>(126,700)</td>
<td>(27,643,100)</td>
<td>(27,643,100)</td>
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<tr>
<td>10. Corporate Other</td>
<td>(75,434,800)</td>
<td>(5,822,600)</td>
<td>(422,000)</td>
<td>(17,043,500)</td>
<td>1,518,500</td>
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<td>11. Contingency - planned</td>
<td>1,600,000</td>
<td>150,000</td>
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<td>(490,000)</td>
<td>(300,000)</td>
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<td>12. Other reserves/reservations</td>
<td>(14,203,800)</td>
<td>(863,000)</td>
<td>0</td>
<td>(2,964,900)</td>
<td>(2,153,000)</td>
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<td>13. Post EBITDA Amt</td>
<td>12,068,100</td>
<td>(365,100)</td>
<td>182,000</td>
<td>(1,716,900)</td>
<td>(114,100)</td>
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<td>Trust Financial Position</td>
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<td>Items Not Included In NHSI Target</td>
<td>(499,001)</td>
<td>(493,000)</td>
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<td>(129,000)</td>
<td>4,000</td>
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<td>NHSI Target Control</td>
<td>(2,459,000)</td>
<td>883,100</td>
<td>381,100</td>
<td>(3,078,900)</td>
<td>(80,100)</td>
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<td>Corporate Analysis</td>
<td>Full Year Live Budgets (£)</td>
<td>Current Month Actual (£)</td>
<td>Year To Date Variances From Live Budgets (£)</td>
<td>Variance from Last Month (£)</td>
<td>Notes Re Mth 3</td>
</tr>
<tr>
<td>A) Estates &amp; Facilities</td>
<td>29,500,700</td>
<td>2,590,000</td>
<td>5,400</td>
<td>7,637,700</td>
<td>143,300</td>
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<td>B) Nursing &amp; Quality</td>
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<td>463,100</td>
<td>(28,600)</td>
<td>1,317,900</td>
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<td>C) Digital Services</td>
<td>8,155,700</td>
<td>653,000</td>
<td>70,100</td>
<td>1,971,600</td>
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<tr>
<td>D) Finance</td>
<td>3,668,500</td>
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<td>13,300</td>
<td>986,000</td>
<td>(35,100)</td>
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<td>E) Human Resources</td>
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<td>1,258,500</td>
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<td>F) Strategy &amp; Business Development</td>
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<td>13,200</td>
<td>(10,200)</td>
<td>202,400</td>
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<td>G) Chief Executive</td>
<td>4,646,200</td>
<td>403,000</td>
<td>16,000</td>
<td>1,156,600</td>
<td>(10,300)</td>
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<td>H) Medical &amp; Clinical Governance</td>
<td>13,480,200</td>
<td>1,123,100</td>
<td>(3,800)</td>
<td>3,097,700</td>
<td>227,100</td>
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<tr>
<td>I) Chief Operating Officer</td>
<td>(0,000)</td>
<td>113,900</td>
<td>216,500</td>
<td>801,100</td>
<td>(169,700)</td>
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<td>J) South London MH Partnership</td>
<td>290,900</td>
<td>59,300</td>
<td>20,500</td>
<td>74,300</td>
<td>10,100</td>
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<td>K) R&amp;D</td>
<td>(4,035,100)</td>
<td>(437,400)</td>
<td>(26,500)</td>
<td>(1,145,700)</td>
<td>89,100</td>
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<tr>
<td>L) Infrastructure Directorates</td>
<td>65,310,800</td>
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<td>(7,922,600)</td>
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<td>M) Corporate Other</td>
<td>(75,434,800)</td>
<td>(5,822,600)</td>
<td>(422,000)</td>
<td>(17,043,500)</td>
<td>1,518,500</td>
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<tr>
<td>N) Total Reserves</td>
<td>16,063,400</td>
<td>1,050,000</td>
<td>0</td>
<td>(3,034,800)</td>
<td>(2,514,700)</td>
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<tr>
<td>Corporate Other</td>
<td>(59,371,200)</td>
<td>(5,822,600)</td>
<td>(333,000)</td>
<td>(17,040,500)</td>
<td>(1,518,500)</td>
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# NHSI Summary For South London & Maudsley NHS Foundation Trust

## Key data

<table>
<thead>
<tr>
<th>Plan</th>
<th>YTD</th>
<th>ACT</th>
<th>YTD</th>
<th>Variance</th>
<th>Plan</th>
<th>YTD</th>
<th>ACT</th>
<th>YTD</th>
<th>Variance</th>
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<tbody>
<tr>
<td>£’000</td>
<td>£’000</td>
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</table>

**Performance against control total**

- Surplus/(deficit) before impairments and transfers: 2,867, 2,951, 84
- Adjusted financial performance surplus/(deficit) including PSF: 2,999, 3,079, 80
- Control total: 3,987, 4,050, 63

**Performance against control total excluding PSF**

- Adjusted financial performance surplus/(deficit) excluding PSF: 2,999, 3,079, 80
- Less provider sustainability fund (PSF): (477), (477), 0
- Control total excluding PSF: 2,522, 2,602, 80

**Adjusted financial performance as a % of Turnover (I&E Margin)**

- Including PSF: 3.13%, 3.18%, 0.05%
- Excluding PSF: 2.65%, 2.70%, 0.06%

**EBITDA**

- EBITDA value: 1,607, 1,738, 131
- as a percentage of related income: 1.68%, 1.80%, 0.12%

**Capital**

- Gross capital expenditure: 4,819, 1,948, 2,871
- Disposals / other deductions: (10,100), (10,100), 0

**Charge after additions/deductions**

- (5,281), (6,152), 2,871
- Less donatioms and grants received: 0, 0, 0
- Less PFI capital (IFRIC12): 0, 0, 0
- Plus PFI residual interest: 0, 0, 0
- Other including additions to financial assets / prior period adjustments: 0, 0, 0

**Total CDEL**

- (5,281), (6,152), 2,871

**Cash**

- Cash and cash equivalents at period end: 72,289, 73,047, 758
- DHSC capital financing: 0, 0, 0
- DHSC interim revenue financing: 0, 0, 0

**Agency and contract**

- Total agency costs excluding outsourced bank: 4,139, 4,648, (509)
- Updated agency ceiling: 4,139, 4,139, 0
- Agency costs as a percentage of gross payroll costs: 5.89%, 6.45%, 0.65%

**Turnover**

- Total operating income: 95,802, 96,786, 984
- Less capital donations/grants income impact: 0, 0, 0
- Remove impact of prior year PSF post accounts reallocation: 95,802, 96,786, 984

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## Use of resources risk rating summary

<table>
<thead>
<tr>
<th>Plan</th>
<th>YTD</th>
<th>ACT</th>
<th>YTD</th>
<th>Variance</th>
<th>Plan</th>
<th>YTD</th>
<th>ACT</th>
<th>YTD</th>
<th>Variance</th>
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**Capital service cover rating**

- 4
- 4

**Liquidity rating**

- 1
- 1

**I&E margin rating**

- 1
- 1

**I&E margin: distance from financial plan**

- 1
- 1

**Updated agency rating**

- 1
- 2

**Risk rating after overrides**

- 3
- 2
Table 3  Summary CIP Performance

TRUST CIP POSITION

<table>
<thead>
<tr>
<th>Financial Position M3</th>
<th>RAG Ratings &amp; Risks</th>
<th>OVERALL RAG RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total No. of CIPs</strong></td>
<td>70</td>
<td><strong>AMBER</strong></td>
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<tr>
<td><strong>No of Schemes</strong></td>
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<tr>
<td><strong>FYP £'000s</strong></td>
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<tr>
<td><strong>Forecast £'000s</strong></td>
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<td></td>
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<tr>
<td><strong>% Plan</strong></td>
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<td></td>
</tr>
<tr>
<td>Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forecast Outturn</td>
<td>16,401</td>
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<tr>
<td>YTD Plan</td>
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<tr>
<td>YTD Variance</td>
<td>(£896)</td>
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<td>YTD Achieved %</td>
<td>67%</td>
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<td>Non Pay</td>
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<td>Forecast Outturn</td>
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<tr>
<td>YTD Variance</td>
<td>(1,269)</td>
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<tr>
<td>YTD Achieved %</td>
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<thead>
<tr>
<th>Summary of Progress</th>
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<tbody>
<tr>
<td>The position at Month 3 is £213k behind the in month target of £950k and £896k lower than the YTD target of £2.7m.</td>
</tr>
<tr>
<td>The primary drivers behind the YTD position includes acute overspill which accounts for £700k of £896k YTD underachievement. Over £187k however this is mainly due to a timing difference.</td>
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<tr>
<td>The full year forecast is expected to deliver to the plan of £16.4m which includes values of £2.5m in relation to lock ins. There are some potential risk areas within the forecast which require consideration:</td>
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<tr>
<td>a) within the forecast there is £2.8m of schemes which are Red Rated - this includes savings relating to the borough restructure, Estates and SLP collaboration</td>
</tr>
<tr>
<td>b) the CIP phasing requires significant delivery in the 2nd half of the year with 64% of the target expected to be delivered from M7-12, therefore much resilience and scrutiny is required around the planning and management of the projects to ensure that delivery does not deviate in the later part of the year.</td>
</tr>
<tr>
<td>The key movements contributing to the forecast variance are:</td>
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</table>

**Significant movements in M3**

- Overspill on beds -1.21 £m
- CAMHS - Shortfall due to potential challenges with the Southwark estates costs associated with the redesign of the service -0.06 £m
- Trustwide - The lock in position is expected to be more favourable than planned 1.15 £m
- Corporate Services: 0.08 £m
- Medical - ahead of target on training review 0.04 £m
- Nursing & Clinical Governance - slightly ahead of target on staffing reviews in Health and Safety and Chaplaincy 0.00 £m

**Summary**

| CAGS                  | 1.27 £m |
| Trustwide             | 1.15 £m |
| Corporate             | 0.12 £m |
| Total                 | 0.00 £m |
Title | Performance 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 (CIP, QIPP and CQUIN).

To report on emergency preparedness status and current actions.

Executive Summary:
The NHS Improvement Single Oversight Framework indicators were achieved in May 2018 with the exception of 7-day follow-up.

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

The Programme Management Office is now supporting the 18/19 oversight process for CIP, QIPP and CQUIN. £4.8 million of the CIP programme is currently rated as high risk.

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 regarding section 75 and to align CAMHS services to the outcome of the recent review; 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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 July 18</td>
<td>Quality Committee</td>
</tr>
<tr>
<td>23 July 18</td>
<td>Finance &amp; Performance Committee</td>
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Appendix 1 - Glossary

Appendix A – May Performance Dashboard
1. **Report Summary**
The following areas of the report contain noteworthy risks:

- NHSI indicators – 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 confirms an agreed approach with commissioners to evaluate their investment plans and the Five Year Forward View transformation trajectories, 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 June is being validated at the time of writing.

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**

![HTT Gatekeeping](image)

Fig. 1 **NHSI Indicators: HTT Gatekeeping.**

The Trust has consistently achieved in excess of the 95% target. 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 target for the Early Intervention waiting time has been increased to 53% for 2018/19. The Trust has consistently achieved in excess of the target, although the service is monitoring the impact of increased growth and 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. 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 red line in the chart, the most recent data being March 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.

![IAPT Waiting 6 week standard](image)

**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 March.
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 had not been met in Lewisham since July 2017. The team has specifically restructured to increase step 2 intervention and continued improvements can be seen in adherence to the 6 week target, with the team meeting 75% in May 2018. Additional investment has been agreed as part of the 2018/19 refresh given the increasing access requirements.

2.1.4 IAPT Recovery
The IAPT recovery rate exceeded the 50% target in March 2018 and again in May 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 March 2018). Lewisham, Lambeth and Croydon services are generally delivering a recovery rate around 50% with Southwark performance improving following the interventions in 2017.

To ensure that there is no effect from the 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 payment mechanism for IAPT services, moving away from a 100% block. Commissioners agreed to the SLaM proposal for a simple process with minimal changes to be piloted in 2018/19 and to use the learning throughout the year to inform any longer term changes. A national tool that automatically calculates outputs from local data is in development, and SLaM and their commissioners have provided feedback to NHS Digital on this initial work. Once the tool has reached a testing phase, it will be piloted in one SLaM borough. This joint work is enabling a review of the outcome indicators and should result in a simplified process.
2.1.6 7 Day Follow Up

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 and only achieving 89% in May. 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. Provisional data for June shows improved performance with the target once again being met.

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.

2.1.8 Community QuESTTT

The pilot Community QuESTTT was introduced in the December 2017 Board Report. The intention is to provide insight into the pressures and risks in community teams using automatically reported data, similar to the inpatient QuESTTT (which is reported using a manual return). The inpatient parameters are being reviewed and adapted to the community services context to ensure relevance.

The development continues to use QI principles and will continue to test the usefulness of the tool for the MHOAD memory and community teams before rolling out to a broader audience. This also aligns to the on-going work around reconciliation of workforce data which underpins several of the proposed measures in the community QuESTTT. The trust reorganisation has relocated the older adult liaison teams to their relevant boroughs and the implications of this are being worked through to ensure like-for-like comparisons can be made when the data is rolled up at directorate level.

The dashboards have been reviewed by senior management in the Directorate and revisions have been requested. Due to the Trust reorganisation and the transition to a new reporting system, these
changes have not yet been implemented but once completed, the next phase will be to test the dashboards locally and to structure future changes around what information the teams will find most meaningful. Examples of the current drafts dashboards are displayed below, although these will change as the development takes place. The usefulness of the selected parameters will be explored to ensure that as the tool develops, it provides a realistic picture of the position for each team.

The pilot is also highlighting a need to consider how Power BI charts can be presented legibly to committees in standard PDF documentation format as opposed to live on computer screens.
2.1.9 Community Wait Times

Community wait times were presented to the Quality Committee in April, reporting on the amount of time that service users had to wait for their first face-to-face contact with services following referral, and the number of service users still waiting after 12 months. The highest level of waits over 12 months were found in Lewisham CAMHS (259 patients), Croydon Personality Disorders and Psychological Therapies (152 patients), and Southwark Psychological Therapies (184 patients). The latest waiting list report shows the first two teams still hold the same level of patients waiting over 12 months, although the number in the Southwark Psychological Therapies Team has dropped to 132.

![Patient waiting report chart]

It has been agreed that a deep dive will be undertaken in these areas and preliminary work has started.

Lewisham CAMHS have undertaken an initial assessment locally of the patients waiting over 52 week which indicated up to 80% may be data recording issues. The remaining 20% are being more carefully reviewed and decisions being made in July to either correct the data recording or arrange appropriate actions. This exercise will set the standard for managing any waits over 12 months across CAMHS and then the threshold will reduce in stages below 52 weeks.
Croydon Personality Disorders and Psychological Therapies have waits of between 51 weeks and 140 weeks for the different interventions they offer, and they will review whether 152 patients is an accurate reflection of those waiting more than 12 months.

Although the Southwark Psychological Therapies service has seen a reduction in their numbers from 184 to 132 patients, the high figure has been recognised by the new Borough Director and is being addressed as one of her priorities for the new directorate.

### 2.2 Business Intelligence and Trust Information Developments

Significant progress is being made with the development of the Trust Data Framework and Trust Dashboard. The Trust Dashboard will be launched on the 24th July 2018 and contains a set of indicators drawn from different information domains, including: activity, workforce, patient experience and finance. The aim is that this single holistic view of meaningful and useful information will help develop a culture of using data, understanding what is happening, why it is happening, and promoting continuous quality improvement within clinical services. This positive initiative is a direct result of integrated working with the Quality Improvement team and the leadership of the Chief Clinical Information Officer.

The Business Intelligence (BI) team has actively sought exemplars of good practice using Microsoft Power BI. The feedback so far indicates that the Trust is leading the way in this area within the NHS and other Trusts are seeking assistance from us to understand our experience. Looking outside the NHS has highlighted that one of our partners, Kings College London University (KCL), are ahead in terms of design practices, particularly in navigation and accessibility. Lessons learnt from KCL have already been reflected in the design of the Trust Dashboard and work is underway to improve other existing dashboards, such as Community QuESTT.

Implementing and further development of the Trust Data Framework is a core objective of the BI team. Existing reports and dashboards are in the process of being reviewed on how they can be aligned within the ‘branch data sets’ methodology of the framework. This will provide better navigation, consistent use of terms and definitions, so creating a greater experience for members of staff.

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

The Mental Health Services Data Set (MHSDS) v3.0 has been mandated from 1st April 2018. A gap analysis has highlighted a number of changes required to the Trust clinical information system (PJS). The majority of the requirements will be met by the next system upgrade later this year and the remainder needs to be developed. Initial discussion with the Clinical System provider (AHC) and the Trusts Clinical Systems team has been completed. The development areas been agreed and planning has commenced and the timeframe for the remaining data items is being discussed.

The MHSDS v3 submissions covering April Refresh and May have been successfully made using an interim solution. The interim solution is needed until the clinical system is upgraded later this year and involves manual processes with assurance checks. Data quality checks are carried out to against historical measures to ensure good levels of compliance.

It is worth noting that NHS Digital are actively validating the accuracy of the national MHSDS submissions by conducting data triangulation exercises, specifically for Early Intervention, Children and Young People and general Data Quality indicators. Confidence in this national data set will allow NHS England to achieve its aim of discontinuing additional data returns as the required detail can be directly extracted from MHSDS. This of means that there is increasing scrutiny of the quality of submitted MHSDS data and the BI Team has already started to work more closely with the
commissioners (both NHSE and the CCGs) 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 May 2018 with the contract trajectory included through to March 2019, aiming at reaching 85% occupancy. 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.

To support comparison, the y-axis scale for the four individual CCG charts have the same range (50 – 110 equivalent beds per month). The pressure in all systems is evident, particularly Lambeth.
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.

Data has been collated on current patients with barriers to discharge with a LoS of more than 50 days, or those within 2 weeks of discharge, and an internal review of this cohort is being undertaken in July looking at their discharge requirements and producing action plans for each patient. This will be followed by a two day Multi Agency Discharge Event (MADE). The MADE event is an NHSI sponsored, system led, activity designed to bring together all the relevant agencies to remove barriers to discharge and to ensure a system solution. The July event will focus on Southwark adult beds and
is jointly led by SLaM and Southwark CCG. Other agencies will be in attendance. This will be followed by Croydon, Lambeth and Lewisham and the cycle will repeat each quarter.

The following chart shows the overall position from April 2017- June 2018 and the increased, ongoing pressure is evident. The colours represent the split between Acute (green) and PICU (grey) beds.

![Chart showing overspill](image)

**Fig. 10 – External Overspill, July 2017 through to end of June 2018**

A number of initiatives under the Improving Care and Outcomes (I-care) scheme are being piloted across the Trust, including:

- **Red2Green days** - Sometimes patients spend days in hospital that do not directly contribute towards their discharge. Through collecting and reporting ward-level data, this tool supports wards to reduce the number of ‘red days’ in favour of value-adding ‘green days. Four wards have been identified to trial this methodology.
- **Discharge coordination form** – This is being redesigned and tested within ward and community teams.
- **Violence & Aggression** – data shows a reduction in incidents over the last few weeks for a number of acute wards. Feedback and learning will be shared in due course.
- **Community diagnostic work** – Feedback and data is being shared with Service and Clinical Directors to agree common themes and will be used to develop change ideas more locally in each of the boroughs.
- **Care process model** – this is in its 7th iteration and has resulted in three workstreams; physical & therapeutic environment, ward rounds and measure for team effectiveness. The model will be tested on one ward in September and then rolled out within that borough.
3.1.1 Length of Stay: Acute Care Pathway

Figure 11 clusters the inpatient cohort within the acute care pathway (wk2, July) 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 whilst both Lambeth and Croydon have 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 – May 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. 12 – 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 May, the Trust recorded 537 bed days being lost to delayed transfers of care. At 2.5%, 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 MADE event will highlight whether any of the extended lengths of stays should be classified as DToCs. 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.

![Fig. 13 – Delayed Transfer of Care lost bed days by month](image)

![Fig. 14 – Delayed Transfers of Care, Lost Bed Days by Local Authority](image)
Figure 14 describes the number of days lost by local authority. The attribution of responsibility for delays process follows NHS England guidance and attribution agreed in consultation with local authorities.

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 70.4% in May, albeit with significant variation (58% - 91%). The four rates for SLaM boroughs are:

- Lambeth 75.4%
- Southwark 75.1%
- Lewisham 72.7%
- Croydon 67.2%

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.

Data harmonisation is under way for Lambeth, Southwark and Lewisham as well as work to improve diagnosis in care homes in these three boroughs. A meeting has been arranged with SLaM Memory Services to ensure congruence with new NICE guidance and to reduce waiting times in line with the forthcoming London six week referral to treatment target. In addition, a BME access project is in place in the boroughs of Southwark and Lambeth.

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. 15  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 June 2018 is shown in Figs. 16 and 17.

![Fig. 16 Adult Home Treatment Team caseload, referrals and discharges Apr 16 – June 18](image1)

![Fig. 17 Early Intervention caseload, referrals and discharges Apr 16 – June 18](image2)
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 Performance Management Framework is being updated to reflect the change to a borough delivery model. The first draft of performance information reflecting the new structure was piloted in the June PACMAN meetings and significant redesign is required to make it user-friendly. This redesign will consider the Trust high level dashboard and the Community QuESTT to create strong alignment between these reports.

An interim borough-based report has been rapidly developed to support PACMAN meetings in July and through Q2. During this period, the development of the new performance report (in Power BI) will continue to be tested with the intention to complete the redesign and transfer reporting over at the end of Q2.

In addition to the general redesign, a specific area of focus for improving reporting and therefore knowledge will be community waiting times.

The existing CAG-based performance dashboard is included as an appendix to this report as a reference and will continue to be produced until a suitable alternative is ready and tested.

In the June meetings (reviewing May performance), the key issues and associated actions remain consistent:
- Adult inpatient pathway pressures; external overspill and Delayed Transfers of Care (DTOC)
- Placements (Southwark and Lewisham)
- IAPT performance (noting the improved performance, as reported to the Quality Committee)
- 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

4.1 Training

4.1.1 Mandatory Training Compliance
Following strenuous efforts over a sustained period the Trust has seen a steady improvement over the past year in mandatory training compliance, and overall compliance has now reached our target of 85%. The Trust is still not where it needs to be in terms of compliance in all subjects, however, and some key subjects remain a challenge. These include life support, PSTS, and infection control, and specific action plans are in place which are already addressing each of these.

Causes of low compliance, impacts and actions plans were presented at the July Quality Committee.
### 4.1.2 Current Compliance Rates

Current compliance by directorate and by subject matter are shown in the tables below. The trend over the past six months is shown by subject. The trend by directorate is not available because of the shift to boroughs from CAGs.

#### Directorate Compliance

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<td>Child &amp; Adolescent Services</td>
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<td>Corporate Directorate</td>
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<td>Lambeth Directorate</td>
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<td>Croydon Directorate</td>
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<td>Southwark Directorate</td>
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<td>PMOA</td>
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<td>Lewisham Directorate</td>
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<td>Clinical Support Services</td>
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<td><strong>Grand Total</strong></td>
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#### Core Subjects

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<td>Health, Safety and Welfare</td>
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<td>Prevent Workshop</td>
<td>76.01%</td>
<td>84.39%</td>
<td>89.06%</td>
</tr>
<tr>
<td>PSTS Awareness/Conflict Resolution</td>
<td>78.88%</td>
<td>78.04%</td>
<td>84.28%</td>
</tr>
<tr>
<td>PSTS Disengagement</td>
<td>64.33%</td>
<td>67.04%</td>
<td>73.17%</td>
</tr>
<tr>
<td>PSTS Team Work</td>
<td>80.07%</td>
<td>83.12%</td>
<td>86.47%</td>
</tr>
<tr>
<td>Safeguarding Adults Alerters</td>
<td>85.91%</td>
<td>84.77%</td>
<td>89.82%</td>
</tr>
<tr>
<td>Safeguarding Adults Alerters Plus</td>
<td>85.27%</td>
<td>84.25%</td>
<td>88.42%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>88.23%</td>
<td>87.25%</td>
<td>91.28%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 and 2</td>
<td>93.89%</td>
<td>93.67%</td>
<td>97.01%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>77.27%</td>
<td>77.89%</td>
<td>87.15%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>79.68%</strong></td>
<td><strong>81.16%</strong></td>
<td><strong>85.83%</strong></td>
</tr>
</tbody>
</table>
4.1.3  Life Support
Additional BLS (Basic Life Support) courses have been put on to improve compliance. Multiple dates are available for ILS (Immediate Life Support) from late July and the Education department will be piloting a half-day refresher course following a re-tender for our external provider as well as training more SLaM staff to co-deliver the training. Not all courses are running at full capacity, however, and DNA rates are increasing, which represents poor use of resources. This is being picked up in performance meetings. Staff are being sent additional emails, copied to their manager, to encourage bookings.

4.1.4  PSTS
The numbers of staff requiring PSTS training has increased following a change in practice to enforce the requirement that all clinical staff working in in-patient services require full PSTS training. From July 2018 we will be moving PSTS disengagement training to the Ortus Training Centre, to use their larger training rooms to enable a greater number of delegate spaces to be offered. PSTS disengagement training is also currently being run on a Saturday to offer more options for staff. Plans are in progress to streamline PSTS training and deliver it differently and over a shorter period.

4.1.5  Infection Control
The content of the Infection Control e-learning package is currently under review by the Nursing Directorate. Staff completions are tracked, as with all mandatory training, through appraisal and local performance meetings.
5. Commissioning

All QIPP and investment schemes are now being managed using the Programme Management Office (PMO) principles. Service Development and Improvement Plans (SDIPs) have been drawn up and shared with each commissioner setting out the borough status for Five Year Forward View transformation initiatives and cross-referencing current performance, investment, challenges and change plans. Engagement from commissioners has been variable although over time the SDIP process should become embedded as it is the only way to ensure disinvestment and investment decisions aren’t made in isolation.

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 current plans indicate the potential for a ward closure early in 2019/20 which is based on SLaM activity trajectories and ICare plan. The current operational performance indicates that significant improvements must be achieved rapidly if the March 2019 targets are to be met.

There is on-going discussion with both Southwark Local Authority and CCG to evaluate the impact of changes regarding section 75 and to align CAMHS services to the outcome of the recent review. Whilst not formally signed off, there has been agreement from the review to communicate to CAMHS staff that whilst service developments are anticipated, there will not be a reduction to the CAMHS budget. Planning for the developments is now commencing.

However, Southwark local authority have reduced their adult 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 now needs to review this late decision to withdraw funding with Southwark local authority.

5.1 Lambeth and Croydon Alliances
The start date for the Lambeth Alliance continues to be July 2018.

The PMOA Operational Directorate are currently undergoing recruitment to the CPN posts confirmed as part of the Croydon Alliance.

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, as well as the appropriate staff consultations, the unit is on schedule to close by 31st August 2018. Alternative care settings have been identified for patients.

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>2,076</td>
</tr>
<tr>
<td>Amber</td>
<td>Requires some work</td>
<td>1,114</td>
</tr>
<tr>
<td>Green</td>
<td>Requires little work</td>
<td>5,314</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8,504</td>
</tr>
</tbody>
</table>

The QIPP risk dashboard is below:

<table>
<thead>
<tr>
<th>QIPP Ref</th>
<th>CCG</th>
<th>QIPP plan</th>
<th>Progress</th>
<th>Value (£)</th>
<th>RAG</th>
<th>YTD Variance (£)</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></td>
<td>209</td>
</tr>
<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>
<td>532</td>
<td></td>
<td>133</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>107</td>
</tr>
<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></td>
<td>26</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>21</td>
</tr>
<tr>
<td>LAM-1819-004-Q</td>
<td>Lambeth</td>
<td>SHARP</td>
<td>M1 variance of £33k</td>
<td>400</td>
<td></td>
<td>49</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>LEW-1819-005-Q</td>
<td>Lewisham</td>
<td>QIPP Triage savings</td>
<td>Implementation in June 18</td>
<td>200</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Code</td>
<td>Authority</td>
<td>Description</td>
<td>QIPP being achieved</td>
<td>Value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>--------</td>
<td></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></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></td>
<td></td>
</tr>
<tr>
<td>PMOA-1819-010-Q</td>
<td>Southwark</td>
<td>Ann Moss Way</td>
<td>Service improvement</td>
<td>893</td>
<td></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></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></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></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. 20 QIPP dashboard**

All QIPPs that have not been delivered in 17/18 (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 the 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.

- **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 is still awaiting a response.

**Amber Risks**

- **SHARP. Value £400k.** £400k QIPP & £133k CIP removed from annual budget. However, M3 budget confirms variance of £49k. This will be managed via PACMAN and recovery action plan is being drafted by the new Service Director for Southwark.

- **Lewisham Community Teams - A&L Team. Value £42k** This is a QIPP based on service improvement. There is a lack of clarity of a plan to deliver savings. Lewisham team are in the process of drafting a plan to recover the QIPP savings in year.

- **Southwark Placements. Value £472k.** This is being managed via Southwark PACMAN where performance is tracked and remedial initiatives are being identified. This QIPP is amber due to overspent budget and high spend placements trend from 17/18, and it is still unclear where Southwark Council sees its role in paying for its share of the agreement. Action plan is being drafted by the new Service Director for Southwark.

- **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 remains amber due to an overspend of £21k at M3.

- **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 national CQUINs for 18/19 are consistent with 17/18, being the second year of implementation in the two year contract cycle signed for 17/19. There are new local CQUINs still being finalised for 18/19. The discussions are collaborative and reflect that agreement is being reached in year.
The Physical Health (CQUIN 3A & 3B 2018-19) scheme’s risk position remains an ongoing challenge, in relation to lack of engagement with Primary Care in the completion and alignment of SMI CPA and QOF register. There is also a big challenge around resourcing due to the departure of two medical leads. Commissioners have been made aware of these issues and the Trust proposed moving the Q1 Milestones submission to Q2, and commissioners have agreed to do this without penalty. We are on track to submit Q1 requirements for the other CQUIN schemes.

The frequent attenders cohort size has increased for the Reducing A&E Attendances scheme but the Trust is still on track to achieve the delivery requirement for Q1.

For NHSE CQUINs, the Trust met with NHSE commissioners to agree achievable milestones for 2018/19 delivery and an agreement is in place with SLP colleagues on how we jointly report on the CAMHS element of the CQUIN.

The PMO team 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. Plans are being discussed to ensure a more robust monitoring of all CQUIN schemes going forward.

6. Programme Management Office (PMO)

6.1 Cost Improvement Programme (CIP)
### Plan/Forecast by RAG per month

![Plan/Forecast by RAG per month chart]

#### £000s
<table>
<thead>
<tr>
<th>Borough</th>
<th>Plan</th>
<th>Actual</th>
<th>YTD</th>
<th>YTD variance from Plan</th>
<th>Value of Additions Schemes YTD</th>
<th>Full year Plan</th>
<th>Full year Forecast</th>
<th>Full year variance from Plan</th>
<th>%</th>
<th>Overview comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural &amp; Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS</td>
<td>294</td>
<td>143</td>
<td>(151)</td>
<td></td>
<td></td>
<td>1,310</td>
<td>948</td>
<td>(562)</td>
<td>72.4%</td>
<td></td>
</tr>
<tr>
<td>Croydon</td>
<td>603</td>
<td>616</td>
<td>33</td>
<td></td>
<td></td>
<td>2,482</td>
<td>2,462</td>
<td>(19)</td>
<td>99.2%</td>
<td></td>
</tr>
<tr>
<td>Lambeth</td>
<td>360</td>
<td>300</td>
<td>(60)</td>
<td></td>
<td></td>
<td>1,786</td>
<td>1,642</td>
<td>(144)</td>
<td>91.9%</td>
<td></td>
</tr>
<tr>
<td>Lewisham</td>
<td>319</td>
<td>158</td>
<td>(161)</td>
<td></td>
<td></td>
<td>968</td>
<td>546</td>
<td>(422)</td>
<td>56.4%</td>
<td></td>
</tr>
<tr>
<td>MHOA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMOA</td>
<td>405</td>
<td>248</td>
<td>(257)</td>
<td></td>
<td></td>
<td>2,627</td>
<td>1,844</td>
<td>(783)</td>
<td>70.2%</td>
<td></td>
</tr>
<tr>
<td>Southwark</td>
<td>993</td>
<td>294</td>
<td>(699)</td>
<td></td>
<td></td>
<td>4,036</td>
<td>2,825</td>
<td>(1,211)</td>
<td>70.0%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Operational Boroughs</strong></td>
<td><strong>2,074</strong></td>
<td><strong>1,779</strong></td>
<td><strong>(1,195)</strong></td>
<td><strong>(1,083)</strong></td>
<td><strong>(1,036)</strong></td>
<td><strong>13,207</strong></td>
<td><strong>10,266</strong></td>
<td><strong>(2,941)</strong></td>
<td><strong>77.7%</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Overview comment**
- PMOA CIPs are on target, should meet (or possibly exceed) 1819 targets. Neurosurgery (Trust scheme 39) is the main challenge where current trends suggest that the CIP is unlikely to be met, & no achievement is forecast at the current time. Trust scheme 41 is less challenging, & may now be optimistic.
- The overspill scheme represents the whole amount of non-delivery. M1-3 overspill has been high and the forecast may remain to be somewhat optimistic.
The above information shows the summary of the Trust CIP schemes broken down by Operational Delivery Unit (ODU) and by risk as at M3. The table shows that of the 66 schemes at £16.4m in the Trust plan, £4.8m are at high risk. This is driven primarily by bed costs (overspill). £6.9m is rated medium for risk, driven primarily by overspends in inpatient nursing. The remaining £4.5m is rated as low risk of which £0.27m has been delivered.
7. Emergency Planning

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 and the inaugural meeting of this group will take place in August 2018, chaired by the Chief Operating Officer.

Working groups and a project board have been set up to address the areas of non-compliance as highlighted in the NHSE (London) annual EPRR assurance process from November 2017. These complement existing performance review meetings across the Trust. Key areas are as follows:

- The Trust has created a new EPRR Specialist Manager post, to be recruited to imminently. The post will lead on delivering specialised EPRR objectives for the organisation.

- The Trust is in the process of formalising its lockdown plan (to be included in the Secure Environments policy).

- The Trust is updating Business Continuity plans to reflect the recent move to Borough based operational directorates. A training needs analysis will be undertaken for both on-call directors and the wider organisation in relation to EPRR, focusing on specific aspects of risk.

- The Trust has its latest Disaster Recovery (DR) plan in draft, awaiting ratification and submission to NHSE(London). It is anticipated that this plan will be ratified imminently.

- The Trust is continuing with Business Continuity exercises and 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. A pilot training session took place in May, which was attended by both departmental representatives from SLaM, and representation from NHSE(London).

- A core EPRR team is currently preparing an updated version of the Emergency and Major Incident Plan (EMIP), to be presented to the September meeting of the Board.

The Trust has moved the risk associated with EPRR from the Executive Risk Register to the COO Delivery Risk Register.
8. Conclusion
The Trust continues to meet the NHS Improvement Single Oversight Framework indicators covered by this report with the exception of 7-day follow up. Provisional data for June does however show the target once again being met.

Pressure across the adult acute pathway (inpatient and community) has increased and is resulting in continued usage of external overspill inpatient beds. The first multi-agency discharge event (MADE) is planned in July.

The Programme Management Office is now supporting the 18/19 oversight process for CIP, QIPP and CQUIN. £4.8 million of the CIP programme is currently rated as high risk.

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 regarding section 75 and to align CAMHS services to the outcome of the recent review; 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>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bringing together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>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>
</tr>
<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 (CCGs)</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>
</tr>
<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>Abbreviation</td>
<td>Definition / Description</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – 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>PACMAN</td>
<td>Performance and Contract Management (meeting)</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 SWLStG 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>
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<td>SWL</td>
<td>South West London</td>
</tr>
<tr>
<td>SWLStG</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>
All Staff - Annual Leave Planning

Finance & CIPs

Acute CAG overspill (April - May)

Appraisal Completions

PMOA L2
Southwark
Lambeth
Croydon
Lewisham
Clinical Support Services L2
Child & Adolescent Services L2

Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18
M9 M10 M11 M12 M1 M2

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

Agency Cost (Phased NHSI Ceiling)

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

Activity

Delayed Discharges - Days Lost

Sickness (in arrears)

All Staff - Annual Leave Planning

Monthly Sickness (wte)
Sickness Rolling Year %

Days Lost

Agency NHSP Bank (WTE)
Admin Agency (WTE)
Admin & Clinical Vacancy (WTE)

Vacancy WTE

Nursing NHSP Bank (WTE)
Nursing Agency (WTE)
Nursing Vacancy (WTE)

Sickness (in arrears)
Appendix A Performance Management Framework Trust Summary

### 7 Day Follow Up (Target 95%)
- **Achieved:** 97%
- **Missed:** 3%
- 3 out of the 12 TDFU were missed by 1 day. All TDFU misses have been highlighted to the services and will be raised at the monthly PACMAN meetings.

### CPA 12 Month review
- **Patients with valid review:** 4668
- **Patients with overdue review:** 242

### HTT Gatekeeping (Target 95%)
- **Total Achieved:** 12
- **Total Missed:** 2

### Delayed Discharges
- **Target Below 7.5%**
- **Days Not Lost:** 203
- **Trust Days Lost:** 0

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

### IAPT Waiting Time (6 Weeks)
- **Croydon %**
- **Lambeth %**
- **Lewisham %**
- **Southwark %**
- **% Other CCGs**
- **% Trust Total**

### IAPT Waiting Time (18 Weeks)
- **Croydon %**
- **Lambeth %**
- **Lewisham %**
- **Southwark %**
- **% Other CCGs**
- **% Trust Total**

### Patient Surveys (PEDIC)
- **Do you feel involved in your care? (%)**
- **Friends and Family**
- **No. of FFT Responses**
- **FFT Score (%)**

### Training Completions (Apr and May not yet available)
- **Mandatory Training**
- **Mandatory Training Tier 1A**
- **Mandatory Training Tier 1B**
- **Clinical Risk**
- **Target**

### Learning and Growth
REPORT TO THE TRUST BOARD:  PUBLIC

24 July 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Capital, Estates and Facilities dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Matthew Neal - Director of CEF</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Altaf Kara – Director of Strategy &amp; Commercial</td>
</tr>
</tbody>
</table>

Purpose of the paper

1. This paper is brought to the board for information and discussion. The board is asked to feedback any changes it would like to see in future submissions.

2. The board is asked to note the contents.

Executive summary

The dashboard and summary paper show estates performance in key areas in the year to date up to M02 FY18/19:

The key points from the dashboard are:

- The cumulative estates & capital project spend to date at M02 FY18/19 (excluding IT, DBH & CYP) is 93.51% of plan with a year-end projected variance of £410k or 2.04% of plan.

- Key drivers of this variance in M02 relate to legacy slippage from FY17/18, prolonged feasibility studies and resourcing concerns which are being managed by the team with additional delivery and management resource now in place.

- The operating budget for the Directorate has been rebased and the dashboard information now includes Hotel Services. At M02 it shows a variance of £138k, 2.8% over budget with a year-end forecast of £29,406k – a variance of £70k at 0.2% over budget. Expected adjustments in M03 will bring the forecasted year end spend variance to £0k.

- Reactive maintenance performance KPI’s have been temporarily impacted by a incorrectly coded calls, the volume of CQC related activity and legacy hardware failures preventing site teams from closing out calls within agreed timescales. A review into the Service Level Agreements, Priority Coding policies and a PDA replacement programme for site operatives is currently underway to arrest this temporary performance and data integrity issue.

- Overall compliance performance continues to be strong, with mitigations in place for all areas where there are minor derogations.

The paper sets out an update to the key risks for FY 18/19, which continue to include the risk of variance in delivery of the capital plan, achieving substantial visibility of the estate where we are tenants and improving the estates/operations interface. Mitigations are in place and additional resourcing has been brought in whilst longer term recruitment is undertaken.

The paper also reports on the Douglas Bennett House and Children and Young Persons projects, updating the commercial and programme position as of M02 FY18/19 following substantial work being undertaken since the April 2018 Trust Board.

A supplementary Part 2 paper provides further updates on the FY18/19 & 19/20 Disposal programme.
Risks / issues for escalation

This report relates to the following Board Assurance Framework (BAF) risks, further risk and escalation items are noted below:

**BAF Risk 1 - Workforce** - 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 9 – Estates** - 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.

**BAF Risk 11 – QI delivery** - 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 Finance – cost management** - 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.

**ISS Contract:** In summary, the Trust feels that the expectations raised in the tender of this provider have been met with the services on the ground. There have been some instances where performance has fallen short, in the main these relate to catering and cleaning. The Trust has been quick to pick ISS up on these areas either through contract monitoring visits, close engagement with operational colleagues and through quarterly deep dive discussions led by the Director of Strategy and Commercial. There have also been some lessons learnt on our side, for example where there is close engagement with wards and where a housekeeping approach is taken. We will look to use these lessons learnt across the Trust and provide further detail of the monitoring regime in the next quarters report.

### Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 July 2018</td>
<td>Finance and Performance Committee</td>
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### Introduction & Context

This paper provides expanded commentary to the July 2018 CEF Dashboard Performance report to provide detail and further narrative.

The Board is advised that next CEF Dashboard will be tabled at the November 2018 Trust Board to ensure the data presented is in-sync with the FY quarters.

**Chart 1: Strategic Capital Schemes Update: Programme & Spend at M02 FY18/19**

**Children & Young Persons (CYP):**

- The CYP programme has only been developed through to the completion of the SOC due to the complex questions it raises around assurance of funding from various partners, affordability alongside DBH and viability to deliver a building of scale on the Maudsley site
- The SOC for CYP completed in July (to be presented for Trust Board Assurance)
- A favourable outcome at Trust Board will allow the scheme to progress to procure a Principle Supply Chain Partner (PSCP) with whom we can develop a detailed development and construction programme and associated cashflow and budgets
- It is anticipated that this will be reviewed at the next sitting of the Trust Board
- There has been no capital spend to date, a grant from the Maudsley charity has covered the development fees to date.
Douglas Bennett House (DBH):

- A viability assessment undertaken by KPMG as part of the CYP scheme has highlighted that there it is feasible to deliver the DBH and CYP schemes without short or long-term borrowing; this has a material impact on the development and assurance regulatory processes.
- Following completion of the CYP SOC discussions are planned to take place with NHSI to review the processes and procedures the Trust must follow with a view that the scheme can follow the regulators ‘transaction process’ as opposed to the ‘capital regimen’.
- The implication of this is that the current in development OBC can be converted into an FBC and the extensive external approvals process including NHSI and the Department is reduced to an overview and assurance; in combination this can mitigate some 12-18 months off the programme.
- The spend to date in FY18/19 at M02 on this scheme is £38k.

Chart 1: Strategic Capital Schemes Update: Cost & Cashflow at M02 FY18/19

Following the changes noted under Chart 1 there remain several variables to manage and actions to complete before a rebased cash flow projection can be provided:

1) Negotiation of programme approach with NHSI
2) Procurement of a principle supply chain partner for CYP
3) Rescheduling the DBH OBC into an FBC
4) Development of the FBC schedule for CYP

The delivery team anticipates being able to provide a more comprehensive update on cost and cash flow projects for the November 2018 Trust Board paper.

Chart 2: Strategic Capital Schemes Update: Cost & Cashflow at M02 FY18/19

Following the changes noted under Chart 1 there remain several variables to manage and actions to complete before a rebased cash flow projection can be provided:

1) Negotiation of programme approach with NHSI
2) Procurement of a principle supply chain partner for CYP
3) Rescheduling the DBH OBC into an FBC
4) Development of the FBC schedule for CYP

The delivery team anticipates being able to provide a more comprehensive update on cost and cash flow projects for the November 2018 Trust Board paper.

Chart 3: Capital Planning: M02 Cumulative Capital Planning & Estates (Excluding DBH, CYP and IT) Spend Against Plan FY18/19:

Performance Overview:

- M02 cumulative position is £163k, a variance of £2,349k or 93.51% of the plan.
- Forecast spend to end year is £20,476k, a variance of £410k or 2.04% of the plan.

Variance YTD driven by:

- FY17/18 Slippage has been added to the FY18/19 plan and the team are still working through a backlog of schemes driven by departmental turnaround activities and resourcing challenges throughout FY17/18.
- The forecast to year end variance above the plan is driven by capital slippage from FY17/18 being captured in early FY18/19, this will be reviewed and re-baselined for the November 2018 Board.
- An accrual error on the Bethlem LV project due to incorrect reporting of completion in the last quarter of FY17/18 has reduced the reported actual spend at M02 by approximately £400k.
- In year new project start delays associated with resourcing challenges including project management and in-house design have continued to impact on spend rates but are stabilising with the additional resource.
- Historic departmental performance and process issues following internal audits and significant changes in personnel following the reconfiguration of the department.
- Re-engineering of service specifications on several projects to fully define the scope of several projects.
- The team shall continue to monitor and review the forecast to year end and bring a revised forecast for the November 2018 Trust Board that aligns with the operational and clinical priorities of the Trust.

Departmental Improvement & Resourcing:

- New schemes are continuing to be developed through the revised Capital Review Group and will be delivered throughout FY18/19 against an NHSI plan that reflects the Trust’s priorities and the departments delivery capacity.
- Following the April 2018 Board, the Capital team has been further bolstered by additional project management and leadership resource.
Lessons learnt workshops are being arranged with all stakeholders for those schemes were significant scope creep and cost overruns were identified in FY 17/18. The outputs of which will inform the ongoing process improvement activities.

Chart 4: Significant Commercial Variation on Projects in FY18/19:

The following schemes have had significant commercial uplifts to their contract values in FY18/19:

- **Bridge House (£142k increase):** Driven by further identified opportunities to make the space more fit for purposes following the increase in the bed numbers. Team are due to hold a lesson learned session in July 2018 focusing on scope agreement.
- **NAU Refresh (£80k increase):** Driven by higher than expected tender returns from the market.
- **CAMHS PICU (£169k):** Driven by escalated working arrangements to arrest programme delays and the re-tendering of the Tyson House portion of the works to ensure a more robust scope was agreed from the outset.

Chart 5: CEF Departmental: Operating Budget Spend Against Plan M02 FY18/19:

Since the M11 FY17/18 Trust Board report the CEF Departmental Budget has been re-baselined for FY18/19 and the reported figures now include Hotel Services.

- **M02 YTD actual spend is £5,048k,** a variance of **£138k** or **2.8%** above plan.
- **M02 in-month actual spend is £2,528k,** a variance of **£76k** or **3.1%** above plan.
- **M02 variance caused by energy price increases, property rental increase pressures and Essentia costs impacting on revenue.**
- **M02 variance to be addressed in M03 by additional funding for energy, cross charging Addictions for rental increases and reapportioning Essentia costs to ensure maximal capitalisation.**
- **Forecast spend to year end is £29,406k,** a variance of **£70k** or **0.2%** above plan.
- **Further budgetary adjustments in M03 are expected to reduce the forecast year end spend variance to £0k.**

Chart 6: Estates: M02 In Month Reactive Call Response Rate % YTD FY18/19:

- **M02 Priority 1 (1-2 Hour Response & Close Out):** 1 of 3 jobs closed within KPI (33% target 100%)
- **M02 Priority 2 (2-4 Hour Response & Close Out):** 37 of 70 jobs closed within KPI (53% target 90%)
- **M02 Priority 3 (2 Day Response & Close Out):** 2353 of 2847 jobs closed within KPI (83% target 70%)
- In quarter Priority 1 performance was driven by the erroneous raising of calls to the Priority 1 code. One of these was attended and closed within the KPI timescale however the remaining two were linked to an external contractor and Ascom so therefore could not be closed out within the 2-hour window.
- In quarter Priority 2 performance was also driven by incorrect coding of reactive jobs and for those that were coded correctly they are not being closed out on the system in a timely fashion despite being attended within the SLA.
- The lack of working PDA units for the site team members has further caused delays closing out Reactive Calls, however the team is currently providing a full handset replacement and updating the supporting software.
- Overall performance has been impacted by the scale of work required in preparation for the CQC visit in M03.
- The Estates team are in the process of clarifying the Priority Codes, reporting policy and SLA’s which will be communicated with all site teams.

Chart 7: Estates: ISS Contract Year One Performance

See “risks and escalations” above.

Chart 8: Property Disposals: Disposal Performance against Plan at M11 FY17/18

The FY18/19 & 19/20 disposal plan reflects the ongoing work to the Estates Strategy as well as the moves and relocation programme.
As in previous quarters several of these potential disposals are high risk due to several factors:

- Third party stakeholders.
- Inter-dependency with wider operational activities such as lack of suitable decant space.
- Restrictive covenants.

The team is continuing to un-block these issues and work with the wider CEF directorate to address the efficient utilisation of the Trusts estate.

**Chart 9: Estates: Compliance Risk Assessment Completion M02 FY18/19:**

**Special Note:** Please be advised that the M02 Lightening Protection performance drop was caused by the late upload of several reports driven by a change of contractor.

**Anchor Points:**
- **Performance:** No Comment Required as 100% Compliant.
- **Assurance:** Inspections carried out by SAS annually. ROSPA registered. MiCAD schedules then updated.

**Asbestos:**
- **Performance:** No Comment Required as 100% Compliant.
- **Assurance:** Management Surveys carried out by TRAC Associates once (unless there is a material change to an existing building fabric, a previous survey was inaccurate, the Trust acquires a new asset, substantial removal works are undertaken, or regulations change) then uploaded to MiCAD Compliance Module by TRAC Associates and uploaded to MiCAD Asbestos Register by CEF staff. Trust plan updated every six months, bi-monthly working group meetings.

**Assurance Report:**
- **Performance:** No Comment Required as 100% Compliant.
- **Assurance:** Ashdale engineering carries out independent Statutory Engineering Inspections on boilers safety valves, lifts, lifting equipment and pressure vessels on an annual basis. MiCAD status reports are supplemented by regular contractor meetings.

**Electrical:**
- **Performance:** 99.71% - Deviation caused by two Emergency Lighting elements; Woodland House (where remedial works are underway) and Ladywell Unit (where remedial works are due).
- **Assurance:** Emergency Lighting testing undertaken in-house on an annual basis. Fixed Wire testing undertaken BS7671 on a 5-yearly basis (next due in FY 19/20). PAT testing carried out by Norwood Electrical on an annual basis. Regular contractor meetings inform the above.

**Fire:**
- **Performance:** 91.47% - Deviation caused by 17 x Fire Equipment tests that are being undertaken when data was captured, 16 x Fire Alarm tests that are complete, but paperwork is outstanding, 1 x Dry Riser test that is complete but awaiting paperwork, 3 x FRA/FSA’s complete but awaiting upload and 7 x FRA/FSA’s outstanding due to Fire Officer annual leave and will be updates as soon as practicable.
- **Assurance:** Fire alarms tested by Gretton Ward on a six-monthly basis. Dry Riser and Fire Fighting equipment inspections carried out by Standby Fire on an annual basis. Fire Risk assessments carried out in-house every five years, Fire Safety audits carried out in-house on an annual basis.

**Gas:**
- **Performance:** 88.89% - Deviation caused by 6 x Gas Safe Boilers and 4 x Gas Cookers where documentation was uploaded after the report was generated.
- **Assurance:** Trust wide inspection contract with GLC, boilers and gas cookers inspected on a six-monthly basis. Statutory inspections undertaken by Ashdale on a six-monthly basis.

**Lightening Protection:**
- **Performance:** 69.23% - Deviance caused by 11 x Lightning Conductor test certificates uploaded after the report was generated and 6 x Lighting Conductor Tests due to be run in June 2018 with a new supplier.
- **Assurance:** Annual testing by Omega (new supplier as of M02 FY18/19) on an annual basis to BSEN 62305.

**Legionella:**
- **Performance:** 98.47% - Deviation caused by 2 x Water Risk Assessments outstanding (one in a building in the process of being sold, MA27, and another in the Ladywell Unit, NZ01, that is being reviewed by UHL), and 3 x Water Coolers (SH01, US02 and XB01) where the supplier is still to confirm a visit.
- **Assurance:** Independent auditor (RM Associates, Dr Jane Tinkler). Water Risk assessments updated every two years, water coolers sanitised on a six-monthly basis.
CEF Directorate Performance Overview at M02 FY18/19

Douglas Bennett House (DBH) and Children & Young Persons (CYP):
- Programme and regulatory work in the last quarter has precludes an update programme at this time.
- See narrative portion of paper for further information.
- Full Programme and Cash Flow information to be presented to the FPC ahead of the next Quarterly Board meeting.

Chart 2 DBH: Cumulative Cash Flow YTD M02 FY18/19

Sold in FY18/19:
- None to date

Planned in FY18/19:
- Woodlands and Masters House (£15.2m net sale, £5.2m gain)
- Rye Lane (£1.5–1.75m net sale, £1.06m–£1.31m gain)
- Ann Moss Domus (ETBC net sale, ETBCm gain) – Subject to Council feedback.
- Southbrook Road (£0.8m–£1.0m net sale, £0.6m–£0.8m gain)

Slipped to FY 18/19:
- None to date

Chart 3 Capital Planning: Significant Commercial Variation on Projects in FY18/19

<table>
<thead>
<tr>
<th>Project</th>
<th>Original Budget</th>
<th>Revised Cost 1 (CRG/SMT Date)</th>
<th>Revised Cost 2 (CRG/SMT Date)</th>
<th>Revised Cost 3 (CRG/SMT Date)</th>
<th>Original Completion Date</th>
<th>Revised Completion Date</th>
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<tbody>
<tr>
<td>Bridge House</td>
<td>£250k</td>
<td>July 2017 CRG</td>
<td>March 2018 SMT</td>
<td>-</td>
<td>March 2018</td>
<td>July 2018</td>
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<tr>
<td>NAU Refresh</td>
<td>£250k</td>
<td>Feb 2018 SMT</td>
<td>Apr 2018 SMT</td>
<td>-</td>
<td>Aug 2018</td>
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</tbody>
</table>

Chart 4 Estates: M02 in Month Priority 1, 2 & 3 is Reactive Call Response and Priority 1 & 2 Open Call Refs YTD FY18/19

Chart 7 ISS Contract Update: Year 1 Performance & KPI’s (FY17/18)

- The team are currently reviewing and validating the contract KPI’s and overall performance.
- See narrative portion of paper for further information.
- Once the data has been validate detailed KPI’s will be presented to the FPC ahead of the next Quarterly Board meeting.

Chart 8 Property Disposals: Disposal Performance against Plan at M02 FY18/19

M02 forecast to year end is £17.5m - £17.95m net sale and £6.86m - £7.31m gain.

Sold in FY18/19:
- None to date

Planned in FY18/19:
- Woodlands and Masters House (£15.2m net sale, £5.2m gain)
- Rye Lane (£1.5–1.75m net sale, £1.06m–£1.31m gain)
- Ann Moss Domus (ETBC net sale, ETBCm gain) – Subject to Council feedback.
- Southbrook Road (£0.8m–£1.0m net sale, £0.6m–£0.8m gain)

Slipped to FY 18/19:
- None to date
Purpose of the paper

This paper is submitted to the Board for oversight as the Trust has a statutory duty to support the Responsible Officer (Dr Holland) in discharging his duties under the Responsible Officer Regulations and it is expected that provider Boards will oversee compliance.

The Board is asked to approve the report.

Executive summary

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider Boards (i.e. the Board of the South London and Maudsley NHS Foundation Trust) will oversee compliance.

The current report details the 2017-18 medical appraisal and revalidation cycle, including the total number of complete/incomplete appraisals for consultant and specialty level doctors. Details of changes to the appraisal system and processes over the 2017/18 cycle will also be made clear such as a change of software provider. The report will also show the feedback from consultants and specialty level doctors to various aspects of the appraisal process including appraiser quality.

An action plan is included to strengthen the current processes and fully comply with the regulations over the next appraisal year. One specific issue to consider will be how we develop the quality of the appraisal discussion. Annual whole scope of work appraisals are one way to support the continuing development of consultants and specialty level doctors. Medical appraisals provide this opportunity for reflection outside the line management structure. Good reflective discussion can support the retention of medical staff. This is important given some of the current difficulties with medical recruitment.

Risks / issues for escalation

BAF Risk 7 – Quality & statutory compliance - 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.
South London and Maudsley NHS Foundation Trust 2017/18 Revalidation Annual Board Report

1. Executive summary

By the end of the 2017/18 appraisal cycle there were 333 Consultant and Specialty & Associate Specialist Doctors (SAS Doctors) employed by the South London and Maudsley NHS Foundation Trust of whom 318 had completed appraisals. 15 appraisals were not complete due to maternity leave, long term sickness and being new starters to the Trust. Over the appraisal cycle the Trust made 13 positive recommendations with 7 deferrals and no non-engagement notice issued.

The Trust had a high level Responsible Officer quality visit by NHS England on 28 June 2017 (Appendix A).

An action plan has been made to strengthen the current processes and fully comply with the regulations over the next year.

The Trust has changed its appraisals and revalidation software from Allocate to SARD, which was developed by Oxleas and has since been adopted by other Trusts. The system helps us to customise our requirements for appraisal and is better value for the Trust.

A Trust Revalidation Advisory Group (Chair Dr Michael Holland) has been established with its first meeting held on 12 May 2017 (Terms of reference attached in Appendix B).

The Trust updated its Appraisal and Revalidation Policy, which in turn has been approved by the LNC (Local Negotiating Committee).

The Trust is in discussion with ‘The Cambian Group’ to facilitate their consultants having appraisals through the SLaM system. Although SLaM will help ‘The Cambian Group’ in both administrating and appraising their appraisals, ‘The Cambian Group’ will remain as the Designated Body for their doctors.

2. Purpose of the Paper

The purpose of this paper is to report to the Board the outcomes of the 2017-18 appraisal and revalidation cycle.

3. Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations\(^1\) and it is expected that provider Boards (ie the Board of the South London and Maudsley NHS Foundation Trust) will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;

\(^1\) The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013’ and ‘The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012’
• confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors;

• Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

However, according to the Pearson Report (2017) Taking Revalidation Forward more could be done to support doctors to meet the requirements for revalidation while maintaining the focus on personal development and improvement. The report includes recommendations for doctors, Responsible Officers and provider Boards and also the GMC. The report is a reminder that appraisals have several different functions (meeting the speciality specific requirements for revalidation, supporting the personal development and improvement for individual clinicians, and helping to identify any concerns about doctors at an earlier stage). One of the areas of interest is how to strength the voice of the patient through 360 processes.

4. Governance Arrangements

The Medical Director, Dr Michael Holland, is the Trust’s Responsible Officer. Dr Rosalind Ramsay is the Deputy Medical Director for QI and medical workforce and became the revalidation lead on 1 March 2017. Andrew Lumsden manages the appraisals and revalidation process as the revalidation project worker.

The Trust appraisal cycle for doctors runs from April to July annually. Throughout the appraisal period the project worker uses appraisal and revalidation management software to track individual appraisals. Doctors receive reminders to book their annual appraisal in January, with further reminders as needed in March. Once the appraisal meeting has taken place there is a 28 day window for completion of the appraisal outputs for a 1a sign off. If there is a delay in the completion beyond 28 days the appraisal is a 1b completed appraisal. If the appraisal happens after the 3 months preceding the appraisal due date, the appraisal is also marked as a 1b completed appraisal. In both these cases the project worker follows up the appraisee and appraiser to understand the reason for the delay.

New starters to the Trust have an appraisal organised within the first 3 months of arriving irrespective of their start date. The project worker receives notification of new starters directly by email from the GMC or through the monthly Trust starters and leavers reports. In this way the project worker can update the Prescribed Connections list. Every appraisal is reviewed by the DMD and if there are any issues of compliance the doctor/appraiser is notified for clarification and correction.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Detailed activity levels of appraisal outputs in individual departments:

• **Number of doctors** – 333 doctors with a Prescribed Connection to SLaM as on 31 March 2017

• **Number of completed appraisals** – 333 (134 completed 1a appraisals, 184 completed 1b appraisals). There were also 15 approved incomplete or missed appraisals (category 2) and 0 unapproved incomplete/missed appraisals (category 3)

• **Number of doctors in remediation and disciplinary processes** – 0
b. Appraisers

The Trust had 93 appraisers for the 2017/18 cycle which is a slight increase from the previous appraisal cycle (87); the number has been falling due to retirement, appraisers leaving the Trust and some appraisers stepping down due to other commitments and pressures. Recent recommendations suggest that appraisers should be doing between 5 and 20 appraisals a year. However in 2017/18 the majority of appraisers were doing 3-4 appraisals. To allow appraisers to do 5 appraisals a year would need more support through job planning. We have been encouraging all medical managers to train as appraisers.

Appraisals training
In 2017-18 we held 6 training sessions, including 3 for new appraisers and 3 for top up training. Over the year we trained 10 new appraisers and have 7 waiting for the next appraiser session in the summer of 2018.

Feedback indicated that the appraisers found the calibration exercises the most useful part of the training. We are also looking at including training on how to include QI into appraisals, and would like to develop training to support appraisers having more challenging but supportive conversations with colleagues.

We have encouraged all appraisers to attend the one day QI training My Role as a Leader in QI.

We have emailed all doctors information about SARD, the new appraisal and revalidation software, and how to use it. We have also held two drop-in sessions with our account manager from SARD for anyone who would like to look at their portfolio/appraisal.

Throughout the year appraisers are encouraged to contact the project worker or DMD directly for advice or support.

Currently the project worker matches appraisers and appraisees. We are interested in looking at the option of having more distance between appraiser and appraisee in terms of location or CAG which might support more robust appraisal conversations.

c. Quality Assurance

Outline of quality assurance processes:

For the appraisal portfolio:

- The appraisers complete their annual appraisal and confirm that the required supporting documentation is included and the requirement for revalidation is discussed so that the whole portfolio is complete prior to revalidation. Appraisers and appraisees can contact the revalidation team to clarify any doubts with documents or information which needs to be included.

- We are using the ASPAT tool to audit a random sample of appraisals from the 2017/18 cycle. Results are presented in Section 16. The audit demonstrated the lack of written information in some appraisal outputs although the appraisee may have given the appraiser positive feedback. There is a need for more clarity for appraisers about what information to include. With Allocate the previous software there was a difficulty with the lack of information about the whole portfolio. This year with the switch to SARD the new software in March 2018 there has been an issue with the lack of information about the appraisals before the previous appraisal.

- Use of the ASPAT tool indicates some PDPs could have smarter objectives. There has been a lack of evidence in relation to the 4 GMC domains, which we have
addressed by including reminders in the document about what to cover. Through the ASPAT audit we have identified the need for more work to help appraisers comment on revalidation readiness and presence of the necessary supporting information.

For the individual appraiser

An end of appraisal questionnaire was introduced in the previous year, which the appraisee needs to complete before the appraisal can be signed off. The project officer collates the information for each appraiser and feeds back to them individually, and alongside data for all Trust appraisers for comparison.

The feedback below is in relation to the questions asked and the percentage of responses.

The Appraiser

<table>
<thead>
<tr>
<th>Establishing rapport</th>
<th>Poor</th>
<th>Borderline</th>
<th>Satisfactory</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrating thorough preparation</td>
<td>0 / 0</td>
<td>0 / 0</td>
<td>6 / 2%</td>
<td>54 / 18%</td>
<td>239 / 20%</td>
</tr>
<tr>
<td>for your appraisal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening to you and giving you</td>
<td>0 / 0</td>
<td>3 / 1%</td>
<td>7 / 2%</td>
<td>34 / 11%</td>
<td>255 / 25%</td>
</tr>
<tr>
<td>time to talk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Giving constructive and helpful</td>
<td>0 / 0</td>
<td>3 / 1%</td>
<td>7 / 2%</td>
<td>41 / 14%</td>
<td>248 / 13%</td>
</tr>
<tr>
<td>feedback</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting you</td>
<td>1 / 0</td>
<td>0 / 0</td>
<td>5 / 2%</td>
<td>44 / 15%</td>
<td>249 / 23%</td>
</tr>
<tr>
<td>Challenging you</td>
<td>0 / 0</td>
<td>2 / 1%</td>
<td>14 / 5%</td>
<td>70 / 26%</td>
<td>105 / 6%</td>
</tr>
<tr>
<td>Helping you to review your practice</td>
<td>0 / 0</td>
<td>3 / 1%</td>
<td>8 / 3%</td>
<td>60 / 22%</td>
<td>228 / 76%</td>
</tr>
<tr>
<td>Helping you to identify gaps and</td>
<td>0 / 0</td>
<td>1 / 0</td>
<td>17 / 4%</td>
<td>67 / 22%</td>
<td>218 / 73%</td>
</tr>
<tr>
<td>improve your portfolio of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>your progress against your last</td>
<td>0 / 0</td>
<td>0 / 0</td>
<td>8 / 3%</td>
<td>63 / 21%</td>
<td>228 / 76%</td>
</tr>
<tr>
<td>Helping you to produce a new PDP</td>
<td>0 / 0</td>
<td>0 / 0</td>
<td>13 / 4%</td>
<td>54 / 18%</td>
<td>232 / 70%</td>
</tr>
<tr>
<td>that reflects your</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing the appraisal process and</td>
<td>0 / 0</td>
<td>5 / 2%</td>
<td>10 / 3%</td>
<td>55 / 18%</td>
<td>229 / 77%</td>
</tr>
<tr>
<td>paperwork</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>1 / 0</td>
<td>18 / 1%</td>
<td>102 / 3%</td>
<td>617 / 19%</td>
<td>2551 / 78%</td>
</tr>
</tbody>
</table>

Any responses which are below satisfactory are followed up with the appraisal lead discussing the mark with the appraiser.

For the organisation

- The appraisals team monitors the appraisals being carried out each week. This is to check that appraisals are being booked to take pace in the appraisals quarter within 3 months before the appraisal due date, and that the appraisal is signed off within 28 days.
- No complaint has been reported by appraisers or appraises in the last year.

d. Access, Security and Confidentiality

All appraisal portfolios are held within a secure server by ‘SARD’, the software supplier. For new starters in the Trust moving from another Trust there is a process for sharing the appraisals information with the Responsible Officer from the other Trust.

e. Clinical governance

Doctors are expected to bring outcome data, where available, for their patients. Each doctor is registered on the Trust incident reporting system ‘Datix’, which allows individual reflection on themes for their team and any serious incidents. Doctors are notified that they should contact the complaints department to collect complaints/compliments data. Doctors have
been specifically notified that any Board Level Inquiry or Coroner’s Inquest should be included in the appraisal portfolio and the reflection should be discussed in the appraisal.

If there are key items of information regarding a doctor the Responsible Officer reminds the doctor of the need to reflect on the specific issue and this information is also shared with the appraiser as a prompt before the appraisal. In 2017-18 the Responsible Officer has written to 4 doctors about specific issues to take to their appraisal.

6. Revalidation Recommendations April 2016-March 2017

- Recommendations total – 20
- Recommendations completed on time – 20
- Positive recommendations – 13
- Deferral requests – 7
- Non-engagement notifications – 0
- Reasons for all missed or late recommendations – N/A

7. Recruitment and engagement background checks

Each new consultant or SAS doctor must complete the same pre-employment checks whether this is for a substantive or locum/part time position. Doctors are unable to start within the Trust without a cleared DBS check, clearance from the Occupational Health Department, satisfactory references, confirmation of qualifications and GMC registration.

8. Monitoring Performance

Doctor’s performance is reviewed annually through the job planning cycle carried out by their line managers. If concerns are raised at any time during the course of the year this is investigated according to the Medical Disciplinary Policy.

9. Responding to Concerns and Remediation

Please refer to the Policy for the Rehabilitation and Remediation of Doctors’ Performance 2013. There are currently 4 consultants trained as case investigators in the Trust. We are reviewing options for top-up training for case investigators and looking at training more as needed.

10. Risks and Issues

The issues identified through the quality assurance exercise are:

1) Improve the appraisal and revalidation pathway to ensure information supporting revalidation readiness is available

2) Develop appraiser skills to deliver effective formative appraisals

3) Increase ability of appraisers to be confident in challenging and raising any concerns

4) Develop appraisers’ skills in writing comprehensive appraisal summaries
11. **Board / Executive Team Reflections**

The Trust is compliant with required processes but there is room to develop the different aspects of appraisals: how well the process supports the doctor and the appraisal lead to identify revalidation readiness; the support to appraisers to appropriately raise any concerns, and the further development of appraisals as a formative experience for consultants and SAS doctors to challenge and support them in their professional lives to grow and engage in the work of the Trust and in other roles.

12. **Corrective Actions, Improvement Plan and Next Steps**

<table>
<thead>
<tr>
<th>Gaps</th>
<th>Action</th>
<th>Responsible</th>
<th>Start Date</th>
<th>Finish Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilising the SARD system with other departments</td>
<td>Looking at engaging other departments such as Post Grad, to encourage doctors to upload information onto their appraisal which can be used in other aspects.</td>
<td>A Lumsden</td>
<td>01/04/2018</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Appraiser recruitment and engagement</td>
<td>Recruit and train new appraisers with support from CAG Clinical Directors to nominate possible appraisers. Review top up training/appraisers forum. Recruit more clinical academic appraisers through IoPPN.</td>
<td>R Ramsay</td>
<td>01/04/2018</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Support for Startwell consultants for appraisal</td>
<td>Including Revalidation and appraisal processes for the Startwell event.</td>
<td>R Ramsay/A Lumsden</td>
<td>01/05/2018</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Consultant retirement plan</td>
<td>Supporting consultants to make plans regarding GMC registration.</td>
<td>R Ramsay</td>
<td>01/04/2018</td>
<td>31/12/2018</td>
</tr>
<tr>
<td>Cambian’s link with SLaM for appraisal</td>
<td>Waiting on response from Cambian to carry out appraisal process</td>
<td>A Lumsden/G R Ramsay/G Willems</td>
<td>TBC</td>
<td>31/03/2019</td>
</tr>
<tr>
<td>Job planning and appraisal links</td>
<td>Looking to utilise the SARD system to make links between appraisal and job plan.</td>
<td>R Ramsay/A Lumsden/R Green</td>
<td>01/06/2018</td>
<td>30/9/2018</td>
</tr>
<tr>
<td>Review of HR processes within medical staffing</td>
<td>Processes have been established, however HR policies are still under review. Ensure link with clinical governance for doctors involved in complaints and investigations. Increase pool of trained case investigators.</td>
<td>R Ramsay/M Holland/G Willems</td>
<td>01/07/2018</td>
<td>15/12/2018</td>
</tr>
<tr>
<td>Potential link between clinical and</td>
<td>Meet IOPPN HR team to discuss a potential link of academic appraisals being linked to SARD.</td>
<td>R Ramsay/A Lumsden/G Willems</td>
<td>01/09/18</td>
<td>31/03/2019</td>
</tr>
</tbody>
</table>
13. **Recommendations**

We request the Board to approve and accept the report. The Board should note that this will be shared with the higher level Responsible Officer/NHSE.

The Board has to approve the 'statement of compliance' confirming that South London and Maudsley NHS Foundation Trust, as a designated body, is in compliance with the regulations.

14. **Reporting with small numbers**

*When completing appendices A-E, please note:*

It is recommended that the submission of this report to your organisation's Board takes into account whether the contents should be treated as confidential annexe with an appropriately controlled distribution. Any further publication or dissemination of the report should take into account whether this will identify individuals or make them potentially more identifiable. In such cases, it would be appropriate to provide a summary of the findings that removes or reduces these issues. Organisations with small numbers of relevant staff should take particular note of this issue.

15. **Annual Report Template Appendix A – Audit of all missed or incomplete appraisals**

<table>
<thead>
<tr>
<th>Doctor factors (total)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity leave during the majority of the ‘appraisal due window’</td>
<td>3</td>
</tr>
<tr>
<td>Sickness absence during the majority of the ‘appraisal due window’</td>
<td>4</td>
</tr>
<tr>
<td>Prolonged leave during the majority of the ‘appraisal due window’</td>
<td>1</td>
</tr>
<tr>
<td>Suspension during the majority of the ‘appraisal due window’</td>
<td>0</td>
</tr>
<tr>
<td>New starter within 3 month of appraisal due date</td>
<td>4</td>
</tr>
<tr>
<td>New starter more than 3 months from appraisal due date</td>
<td>0</td>
</tr>
<tr>
<td>Postponed due to incomplete portfolio/insufficient supporting information</td>
<td>0</td>
</tr>
<tr>
<td>Appraisal outputs not signed off by doctor within 28 days</td>
<td>0</td>
</tr>
<tr>
<td>Lack of time of doctor</td>
<td>0</td>
</tr>
<tr>
<td>Lack of engagement of doctor</td>
<td>0</td>
</tr>
<tr>
<td>Other doctor factors</td>
<td>0</td>
</tr>
<tr>
<td>(describe)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appraiser factors</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor</td>
<td>Number</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Unplanned absence of appraiser</td>
<td>1</td>
</tr>
<tr>
<td>Appraisal outputs not signed off by appraiser</td>
<td>0</td>
</tr>
<tr>
<td>Lack of time of appraiser</td>
<td>0</td>
</tr>
<tr>
<td>Other appraiser factors (describe)</td>
<td>0</td>
</tr>
<tr>
<td>(describe)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Organisational factors</strong></td>
<td></td>
</tr>
<tr>
<td>Administration or management factors</td>
<td>0</td>
</tr>
<tr>
<td>Failure of electronic information systems</td>
<td>0</td>
</tr>
<tr>
<td>Insufficient numbers of trained appraisers</td>
<td>2</td>
</tr>
<tr>
<td>Other organisational factors (describe)</td>
<td>0</td>
</tr>
</tbody>
</table>
16. **Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs**

<table>
<thead>
<tr>
<th>Total number of appraisals completed</th>
<th>Number of appraisal portfolios sampled (to demonstrate adequate sample size)</th>
<th>Number of the sampled appraisal portfolios deemed to be acceptable against standards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appraisal inputs**

<table>
<thead>
<tr>
<th>Scope of work: Has a full scope of practice been described?</th>
<th>30</th>
<th>30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Quality improvement activity: Is quality improvement activity compliant with GMC requirements?</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Patient feedback exercise: Has a patient feedback exercise been completed?</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Colleague feedback exercise: Has a colleague feedback exercise been completed?</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?</td>
<td>30</td>
<td>18</td>
</tr>
<tr>
<td>Is there sufficient supporting information from all the doctor’s roles and places of work?</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td>Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)?</td>
<td>30</td>
<td>25</td>
</tr>
</tbody>
</table>

**Explanatory note:**

For example

- Has a patient and colleague feedback exercise been completed by year 3?
- Is the portfolio complete after the appraisal, which precedes the revalidation recommendation (year 5)?
- Have all types of supporting information been included?

**Appraisal Outputs**

<table>
<thead>
<tr>
<th>Appraisal Outputs</th>
<th>Number of appraisal portfolios sampled (to demonstrate adequate sample size)</th>
<th>Number of the sampled appraisal portfolios deemed to be acceptable against standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal Summary</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td>Appraiser Statements</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>Personal Development Plan (PDP)</td>
<td>30</td>
<td>26</td>
</tr>
</tbody>
</table>
### Concerns about a doctor’s practice

<table>
<thead>
<tr>
<th>Concerns about a doctor’s practice</th>
<th>High level²</th>
<th>Medium level²</th>
<th>Low level²</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of doctors with concerns about their practice in the last 12 months</td>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capability concerns (as the primary category) in the last 12 months</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct concerns (as the primary category) in the last 12 months</td>
<td>7</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health concerns (as the primary category) in the last 12 months</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

### Remediation/Reskilling/Retraining/Rehabilitation

Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2016 who have undergone formal remediation between 1 April 2014 and 31 March 2016.

Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor’s practice.

A doctor should be included here if they were undergoing remediation at any point during the year.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)</td>
<td>0</td>
</tr>
<tr>
<td>Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)</td>
<td>0</td>
</tr>
<tr>
<td>General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)</td>
<td>0</td>
</tr>
<tr>
<td>Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)</td>
<td>0</td>
</tr>
<tr>
<td>Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)</td>
<td>0</td>
</tr>
<tr>
<td>Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies</td>
<td>0</td>
</tr>
</tbody>
</table>

Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc)  All Designated Bodies

| TOTALS                  | 0 |

### Other Actions/Interventions

#### Local Actions:

**Number of doctors who were suspended/excluded from practice between 1 April and 31 March:**

Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included

<table>
<thead>
<tr>
<th>Duration of suspension:</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Less than 1 week</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 week to 1 month</td>
<td>0</td>
</tr>
<tr>
<td>1 - 3 months</td>
<td>0</td>
</tr>
<tr>
<td>3 - 6 months</td>
<td>0</td>
</tr>
<tr>
<td>6 - 12 months</td>
<td>0</td>
</tr>
</tbody>
</table>

**Number of doctors who have had local restrictions placed on their practice in the last 12 months?**

| 0 |

#### GMC Actions:

**Number of doctors who:**

- Were referred by the designated body to the GMC between 1 April and 31 March

| 0 |

- Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March

| 0 |

- Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March

| 0 |

- Had their registration/licence suspended by the GMC between 1 April and 31 March

| 0 |

- Were erased from the GMC register between 1 April and 31 March

| 0 |

#### National Clinical Assessment Service actions:

**Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment**

| 0 |

**Number of NCAS assessments performed**

| 0 |
18. **Annual Report Template Appendix D – Audit of revalidation recommendations**

<table>
<thead>
<tr>
<th>Revalidation recommendations between 1 April 2014 to 31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations completed on time (within the GMC recommendation window)</td>
</tr>
<tr>
<td>Late recommendations (completed, but after the GMC recommendation window closed)</td>
</tr>
<tr>
<td>Missed recommendations (not completed)</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

**Primary reason for all late/missed recommendations**

For any late or missed recommendations only one primary reason must be identified

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Responsible Officer in post</td>
<td>0</td>
</tr>
<tr>
<td>New starter/new prescribed connection established within 2 weeks of revalidation due date</td>
<td>0</td>
</tr>
<tr>
<td>New starter/new prescribed connection established more than 2 weeks from revalidation due date</td>
<td>0</td>
</tr>
<tr>
<td>Unaware the doctor had a prescribed connection</td>
<td>0</td>
</tr>
<tr>
<td>Unaware of the doctor’s revalidation due date</td>
<td>0</td>
</tr>
<tr>
<td>Administrative error</td>
<td>0</td>
</tr>
<tr>
<td>Responsible Officer error</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate resources or support for the Responsible Officer role</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>Describe other</td>
<td></td>
</tr>
<tr>
<td>TOTAL [sum of (late) + (missed)]</td>
<td>0</td>
</tr>
</tbody>
</table>
### 19. Annual Report Template Appendix E – Audit of recruitment and engagement background checks

<table>
<thead>
<tr>
<th>Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent employed doctors</td>
<td>26</td>
</tr>
<tr>
<td>Temporary employed doctors</td>
<td>9</td>
</tr>
<tr>
<td>Locums brought in to the designated body through a locum agency</td>
<td>0</td>
</tr>
<tr>
<td>Locums brought in to the designated body through ‘Staff Bank’ arrangements</td>
<td>0</td>
</tr>
<tr>
<td>Doctors on Performers Lists</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
</tbody>
</table>

Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc

| TOTAL | 35 |

For how many of these doctors was the following information available within 1 month of the doctor’s starting date (numbers)

<table>
<thead>
<tr>
<th>Information Available</th>
<th>Permanent employed doctors</th>
<th>Temporary employed doctors</th>
<th>Locums brought in to the designated body through a locum agency</th>
<th>Locums brought in to the designated body through ‘Staff Bank’ arrangements</th>
<th>Doctors on Performers Lists</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>26</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Identity check</td>
<td>26</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Past GMC issues</td>
<td>26</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>GMC conditions or undertakings</td>
<td>26</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>On-going GMC/NCAS investigations</td>
<td>26</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Disclosure and Barring Service (DBS)</td>
<td>26</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2 recent references</td>
<td>26</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Name of last responsible officer</td>
<td>N/A</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Reference from last responsible officer</td>
<td>N/A</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Language competency</td>
<td>N/A</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Local conditions or undertakings</td>
<td>N/A</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Qualification check</td>
<td>N/A</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Revalidation due date</td>
<td>N/A</td>
<td>0*</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Appraisal due date</td>
<td>N/A</td>
<td>0*</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Appraisal outputs</td>
<td>N/A</td>
<td>0*</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Unresolved performance concerns</td>
<td>26</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
OFFICIAL

<table>
<thead>
<tr>
<th>designated body through 'Staff Bank' arrangements</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors on Performers Lists</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Other (independent contractors, practising privileges, members, registrants, etc)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>0*</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>N/A</td>
<td>35</td>
<td>35</td>
<td>35</td>
</tr>
</tbody>
</table>

* SLaM requests all new starters have an appraisal within the first 3 months of them starting, NHS England has confirmed this is acceptable.
# Agenda & Report

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:15</td>
<td></td>
<td>Introductions and meet with Medical Director, Responsible Officer, Appraisal Facilitator, HR Manager &amp; Medical HR Specialist</td>
</tr>
<tr>
<td>10:45</td>
<td></td>
<td>Meet with Medical Director, Responsible Officer &amp; Appraisal Facilitator, review of processes and IT systems</td>
</tr>
<tr>
<td>11:15</td>
<td></td>
<td>Meet with Medical HR Manager &amp; Medical HR Specialist</td>
</tr>
<tr>
<td>11:45</td>
<td></td>
<td>Break</td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td>Interview with appraisers</td>
</tr>
<tr>
<td>12:30</td>
<td></td>
<td>Meet with Medical Director, Responsible Officer, Appraisal Facilitator, HR Manager &amp; Medical HR Specialist, visit summary</td>
</tr>
</tbody>
</table>
Summary

The NHS England London Higher Level Responsible Officer (HLRO) Revalidation visiting team would like to thank Dr Michael Holland, Trust Medical Director and Responsible Officer (RO) for South London and Maudsley NHS FT (SLaM), Dr Rosalind Ramsay, Trust Deputy Medical Director and Revalidation Lead for South London and Maudsley NHS FT, Geoff Willems, Associate Business Partner for Medical HR and Andy Lumsden, Revalidation Project Worker, for their hospitality and openness throughout the visit, which took place on the 28th June 2017. The visit was on behalf of the Higher Level Responsible Officer (HLRO) Dr Vin Diwakar, to provide assurance that the RO and designated body has revalidation systems and processes in place in keeping with the RO regulations 2010/13. The visit was also to highlight good practice, to identify areas for development and to provide the RO with support and advice on any revalidation issues.

South London and Maudsley NHS FT provides care and treatment for children, adults and the elderly living in South London, specialist Child and Adolescent Mental Health services in Kent and specialist services for people from across England. Dr Michael Holland has been in post since September 2016, whilst Dr Rosalind Ramsay has been in post since March 2017. Although Michael and Rosalind have not been in post very long, NHS England noted that they both have a firm understanding of appraisal and revalidation and provide good leadership to their doctors.

As of 31st March 2017 SLaM had 349 prescribed connections. The 2016/17 AOA shows that out of 349 doctors connected only 17 did not undertake an appraisal. This shows that there are robust appraisal processes in place and Andy who is responsible for managing the systems engages well with the doctors, which has helped contribute to the Trust achieving a high appraisal rate. Furthermore, the revalidation team worked closely with their HR colleagues and there has been action taken to strengthen investigation and managing concerns processes.

In terms of employment checks, the pre/post-employment checks are carried out by the HR team and consist of confirming GMC registration status and type, checking for warnings/restrictions on practice, fitness to practice, checking identity, checking DBS information, language skills and qualifications. Furthermore, when an offer letter is sent to a doctor appraisal and revalidation information is included in the information pack.

There is a Revalidation Advisory Group, which meets every 6 weeks to discuss upcoming issues within revalidation. The group consist of the following NED and Chair – Dr Julie Hollyman, SLaM MAC chair – Dr Jane Marshall, HR Deputy Director – Medical HR Associate BP – Geoff Willems, Revalidation Project Officer – Andy Lumsden, Public Governor – Janet Davies, DMD for QI/medical workforce – Dr Ros Ramsay.
The Trust predominantly uses the locum agency Medacs when employing locums but they do use other locum agencies such as DRC Locums, PULSE and Athona. HR are currently reviewing locum use, especially long term locums, but have assured the visiting team that they have thorough checks before employing this group of doctors and have a brief exit form/interview for when they leave.

The visiting team discussed the policies they have in place at SLaM such as appraisal policy, employment policy and complaints policy and it was evident there were policies that are present and adhered to in this organisation.

The Trust is undergoing a procurement process for a new appraisal toolkit as they are facing a number of issues with their current supplier. NHS England visiting team suggested that before the Trust acquires a new system to ensure all appraisal documents are saved onto the shared drive so that nothing is lost during the transition. Also to ensure there is minimal disruption whilst training doctors onto the new appraisal system.

A summary of examples of good practice and suggested areas for development are outlined below:

**Examples of Good practice**

<table>
<thead>
<tr>
<th>Examples of Good practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>South London and Maudsley NHS FT is well led and the RO and his team have a good understanding of revalidation and governance with an eagerness to improve. The board are engaged and supportive of revalidation.</td>
</tr>
<tr>
<td>The administrative support for revalidation and appraisal is well organised and focused on improving the systems and processes. The high appraisal rate (95%) reflects this.</td>
</tr>
<tr>
<td>The Revalidation Team work closely with HR, who are working to NHS Employers standards.</td>
</tr>
<tr>
<td>There is lay representation on the Revalidation Advisory Group, which is good practice.</td>
</tr>
<tr>
<td>The RO and Revalidation Team are pro-active in taking the necessary action to improve processes such as taking action on the external report as well as taking action on procuring a new appraisal system.</td>
</tr>
<tr>
<td>The appraisers felt they were well supported by the RO and revalidation team.</td>
</tr>
</tbody>
</table>
Suggested areas for development

<table>
<thead>
<tr>
<th>Suggested areas for development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend the RO review information channels along which information about doctor's working in SLAM, but not connected to SLAM, might flow to include clinical work with other healthcare organisations and how the information is sought and/or shared.</td>
</tr>
<tr>
<td>Recommend the RO link with the RO’s of locum agencies and has information flows established to communicate either way, information regarding a doctors practice and any concerns.</td>
</tr>
<tr>
<td><em>(Information flows to support medical governance and responsible officer statutory function, NHS England 2016)</em></td>
</tr>
</tbody>
</table>
| A review of how patient feedback is distributed and the choice of colleagues for feedback. GMC suggests avoiding doctors handing out feedback forms directly to patients. Feedback forms could be handed out by administrators on the ward or in outpatients.  
Greater triangulation of complaints and low level concerns. |
| To ensure that they capture all their doctors scope of practice.  
To ensure all the appraisal documentation is saved onto the Trust’s shared drive when transferring onto the new appraisal system as well as minimal disruption whilst training doctors to use it.  
Appraisers – to provide them with performance feedback on their appraiser role as well as looking at ways to develop their role. |
References:
NHS England Medical Appraisal Policy:
https://www.england.nhs.uk/revalidation/appraisers/app-pol/
(Annex J for QA)
https://www.england.nhs.uk/revalidation/appraisers/qa-guidance-notes/
Medical appraisal guide (MAG) model appraisal form:
https://www.england.nhs.uk/revalidation/appraisers/mag-mod/
Doctor’s Medical Appraisal Checklist embedded within the MAG form but also found as a separate document here:
https://www.england.nhs.uk/revalidation/doctors/doctors-medical-appraisal-checklist/
Improving the inputs to medical appraisal (NHS England 2016):
https://www.england.nhs.uk/revalidation/appraisers/improving-the-inputs-to-medical-appraisal/
Information flows to support medical governance and responsible officer statutory function (2016):
https://www.england.nhs.uk/revalidation/ro/info-flows/Medical appraisal logistics handbook
https://www.england.nhs.uk/revalidation/ro/ma-handbook/
Medical appraisal logistics handbook:
https://www.england.nhs.uk/revalidation/ro/ma-handbook/
Appraisal skills training videos:
https://www.england.nhs.uk/revalidation/appraisers/video-workshops/
https://www.youtube.com/playlist?list=PL6IQwMACXkJ1zbMA27JZs9SgPXOuwgPWm
HEE appraiser workshop resources:
https://www.england.nhs.uk/revalidation/appraisers/meetings/hee-resources/
Trust Revalidation Advisory Group

**Purpose:** To provide oversight and scrutiny of the process by which consultants and SAS level doctors are appraised and revalidated thereby supporting the Responsible Officer (RO) in ensuring high standards of medical practice.

**Terms of Reference:**

1) To receive reports on doctors seeking revalidation and supported by the RO and to comment as appropriate.
2) To review reports on doctors not engaging with the process or subject to deferral and comment as appropriate. To receive reports on the outcome of actions in respect of these doctors.
3) To receive and scrutinise reports on doctors giving cause for concern to confirm that there is a clear plan of action, where an investigation is undertaken that this leads to an action plan with clear time frames, and to receive evidence that action plans are completed.
4) To sign off the Annual Report to the Trust Board on appraisal and revalidation.

**Membership:**

Governor from the Public constituency
Responsible Officer (Medical Director)
Deputy Medical Director
Chair Trustwide MAC
Revalidation Project Officer
Medical HR ABP

**Frequency of meetings:**

Every 2 months for first 6 months and then quarterly. Each meeting will last one hour.

The Terms of Reference will be reviewed after one year.
Council of Governors’ meeting - 14 June

The meeting had the largest turn-out of Governors in a very long time. As a result, it was lively and there was a good and valuable range of contributions from the floor regarding the matters at hand.

There was a presentation on the Lambeth Alliance, with an appetite for further discussion and opportunity for Q&A. The upcoming Planning and Strategy Working Group meeting has been extended to facilitate this. Governors also sought more time to talk about reducing length of stay and bed occupancy, as they are concerned that patients will be discharged too early. An extraordinary meeting of the Quality Working Group will be convened to discuss this.

The Council of Governors approved the appointment of Béatrice Butsana-Sita as a Non-Executive Director, subject to DBS clearance (which has now been received).

The Council also received the outcomes of the NEDs’ appraisals, including the Chair’s, and their objectives for the next year.

Members’ seminar - 12 July

On 12 July, SLaM membership and Governors hosted a seminar at the ORTUS entitled: “Mind and Body: don’t separate the inseparable”. Kate Lillywhite, Programme Director (Mind & Body) from King’s Health Partners gave the seminar, which was well-attended.

Planning & Strategy Working Group - 17 July

The next meeting on the group takes pace on 17 July, and it has been extended by half an hour to allow time for follow-up questions from the June Council of Governors’ meeting regarding the Lambeth Alliance and partnerships more generally. The group will also be hearing from Matthew Patrick about the Centre for Children and Young People, while Michael Holland and Barbara Grey will be providing an update on the Quality Improvement programme. Governors are particularly interested in how QI work aligns with the Trust’s strategy, and how return on investment is measured.
Visit to the Ladywell Unit – 19 July

The Governors welcome the opportunity to visit services and the new schedule starts with a visit to the Ladywell Unit on 19 July.

Governor / NED meeting – 24 July

The Governors will be meeting the NEDs ahead of the Board meeting on 24 July as an opportunity to put questions to them about areas of Governor concern. All Governors are canvassed for questions that they may want raised.

Quality Working Group - 26 July

The next meeting of the group is on 26 July. There are questions which the Governors plan to put to the NEDs present about use of restraint; bed pressures; development of a Quality dashboard; delays to mental health assessments; carer engagement and the transition from CAMHS to adult services. Otherwise, the agenda will be focusing on how lessons are learned in the Trust from complaints, feedback and Serious Incidents.

An extraordinary meeting of the group is being arranged to look at reducing length of stay and readmissions.

Care Quality Commission inspection: Governor focus group – 31 July

The CQC is holding a focus group for the Governors on 31 July, as part of the inspection process.

Membership & Involvement Group – 31 July

The group next meets on 31 July and Sally Storey, Director of HR, will be attending to talk about staff wellbeing.

Lobbying

A group of governors are having a follow-up meeting with Helen Hayes MP (Dulwich and West Norwood) on 17 July.

A meeting has been arranged between a group of Governors and members of Croydon CCG on 9 August.

A group of Governors will be meeting with the three Lewisham MPs in September.
Purpose of the paper

From FPC meeting of 12 June 2018
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.

Board Assurance Framework

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 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 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 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 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.
<table>
<thead>
<tr>
<th>KEY ISSUES SUMMARY</th>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(1). Reference Costs 2017/18</strong></td>
<td></td>
</tr>
<tr>
<td>The Head of Costing explained that reference costs aim to estimate the average unit cost to the NHS of providing defined services to NHS service users in England in a given financial year. Calculation by Trusts involves spreading total Trust costs over total numbers of service user occupied bed days ('OBDs') or contacts (irrespective of duration of contact). The costs for each defined service are then divided by the duration of the service to produce an average daily cost. After each year end Trusts submit the resulting averages to NHS Improvement for compilation.</td>
<td></td>
</tr>
<tr>
<td>The NHS intends to move to a ‘bottom up’ system in the future – Patient Level Information and Costing Systems (‘PLICS’)</td>
<td></td>
</tr>
<tr>
<td>The FPC Chair flagged a concern that, if the Trust does not implement a system such as PLICS which allows the true, full costs of services to be monitored more accurately, as services are transferred into alliances, the Trust may be left providing only services for which costs exceed income.</td>
<td></td>
</tr>
<tr>
<td>Flag for Board attention (as here).</td>
<td></td>
</tr>
<tr>
<td>The Head of Costing outlined the improved systems for analysing costs in which the Trust is investing, but reiterated that data capture systems such as electronic prescribing will have to be enhanced.</td>
<td></td>
</tr>
<tr>
<td><strong>(2). BAF risk 3</strong></td>
<td></td>
</tr>
<tr>
<td>The FPC Chair noted her concern that BAF risk 3 (informatic systems development) is currently allocated to the FPC for monitoring, but the FPC does not have the capacity/capability to review technical aspects of informatics systems. The meeting:</td>
<td></td>
</tr>
<tr>
<td>• noted that the FPC, the Quality Committee and the Quality Improvement group all covered aspects of BAF risk 3; and</td>
<td></td>
</tr>
<tr>
<td>• discussed whether/how the Trust’s other committees and groups were covering technical aspects of BAF risk 3, and whether/how reports to the Board kept it appropriately informed on this</td>
<td></td>
</tr>
<tr>
<td>Already flagged for attention at June 2018 Board meeting (Terms of Reference – Committees’ yearly update)</td>
<td></td>
</tr>
<tr>
<td>The Director of Nursing and Head of Risk will consider how best to allocate BAF risk 3 (informatic systems development) for review amongst Trust committees and groups and will report recommendations to the SMT and FPC (Oct.2018)</td>
<td></td>
</tr>
<tr>
<td><strong>(3). 2018/19 planning: letter from NHSI</strong></td>
<td></td>
</tr>
<tr>
<td>The CFO presented a letter from the Chief Executive of NHS Improvement titled ‘2018/19 operational plan feedback’ which the FPC discussed. The letter states that ‘NHS Improvement has reviewed [the Trust's 2018/19 operational plan] and has set out [in this letter] some key elements of [the plan] that require further review and follow up action’.</td>
<td></td>
</tr>
<tr>
<td>The Chief Executive noted that his experience was that we had received similar letters in the past and that his understanding was that Trusts that received this type of letter were those had submitted 2018/19 operational plans with which NHS Improvement was broadly content.</td>
<td></td>
</tr>
<tr>
<td>The meeting discussed workforce planning (section 2 of the letter). It was noted that at a couple of points the letter stated ‘we would like to understand ...’ and hence the letter was requesting responses on these points. It was also noted that there may be some inconsistencies between some workforce elements of the operational plan and some projections in the agenda papers of the Trust’s Equalities and Workforce Committee.</td>
<td></td>
</tr>
<tr>
<td>The CFO will coordinate a review of the robustness and consistency of workforce planning matters as dealt with in: (1) the 2018/19 operational plan and (2) other Trust management information and committee reporting papers. The CFO will report on this to the Board and will develop a response to send to NHS Improvement (July 2018).</td>
<td></td>
</tr>
<tr>
<td><strong>(4). Performance – bed pressures</strong></td>
<td></td>
</tr>
<tr>
<td>The COO advised that she is confident that 2018/19 Cost Improvement Programmes (‘CIPs’) and Quality Innovation Note only</td>
<td></td>
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</tbody>
</table>


<table>
<thead>
<tr>
<th>KEY ISSUES SUMMARY</th>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity and Prevention programmes (‘QIPPs’) are in a better position than for 2017/18, in part due to better management of the Trust’s Programme Management Office (‘PMO’). The COO noted that a team of four (previously, one) now managed bed pressures as such pressures had become more severe. The Chief Executive noted that clarity was needed as to ownership of the bed pressures issue. The COO noted that currently Lambeth is the main source of bed pressures across the Lambeth, Southwark, Lewisham and Croydon (‘LSLC’) system, and is thus causing issues for 3 other commissioners. However she is reluctant to ring-fence beds yet.</td>
<td>The Chief Executive suggested a meeting with other Chief Executives be held to review options and solutions</td>
</tr>
</tbody>
</table>

(5). Meeting evaluation

Comments from this evaluation were overall positive. One suggested improvement noted was that the meeting was a little ‘heavy’ on consideration of routine items. All present noted these points for action

---

### Key points of assurance

Points (3) and (4) above provide assurance

### Key risks to flag

The FPC concluded that no matters required escalation for the attention of the Board (minutes 46.1)

### Issues to be brought to the attention of other Committees

Nothing significant from this Committee meeting – the Audit Committee will receive a copy of this key issues report as a matter of course
Title | MENTAL HEALTH LAW COMMITTEE UPDATE
---|---
Non-Executive Director | Dr. Geraldine Strathdee, Chair, Mental Health Law Committee

Purpose of the paper

1. This is a regular report to the Board which sets out:
   - the key issues discussed at the Trustwide Mental Health Law Committee meeting on 5 July 2018 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.

2. 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 Mental Health Law Committee has conducted a review of its ToR and a final draft is offered for consideration and ratification by the Board. The draft terms of reference are attached at the end of this report.

Board Assurance Framework

**BAF risks**

**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.

Late and poor-quality reports for Mental Health Tribunals falls into this category as it will impact on patients and their legal representatives having sight of reports and time to prepare for the Tribunal hearing.

Failure to carry out Mental Health Act assessments and for persons requiring detention under the MHA and admission to hospital when they need the care leads to a risk that the Mental Health Act Code of Practice will be breached (Paragraph 14.78).

**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.

There is a need to rationalise and align the current multiple information data sources (13) analyse trends in the use of the Mental Health Act to provide a more accurate overview of our data, risks and performance.

---

**KEY ISSUES SUMMARY**

| Actions proposed to address key issues |
|---|---|
| Information for improvement and freeing | In order to improve information for decision making, a task |
**up time to care: Information, informatics and digital**

The finish group is being established to agree: how to rationalise and align the current multiple information requests and data sources (13); how data on trends and risks will be analysed, interpreted and reported to the Trust Board and other relevant committees; the format of live decision implementation support dashboards, needed for board to floor leaders in every team.

To make information more accessible, in line with Governor and carer requests, our policies, user and carer information, and toolkits will be put on the public facing SLaM website, with easy read versions, and feedback and suggestions for improvement sought.

This will also show SLaM's strengths and good practice in relation to the use of the legislation, and some of our unique CYP MH law Training courses and toolkits.

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**Meeting regulatory standards 'at-a-glance' report for all clinical and managerial leaders**

The July MH Law Committee welcomed a new, short summary format report of SLaM's compliance with regulatory standards by borough and inpatient areas. This showed that improvement is being made in the following areas:

- section 132 information to patients;
- capacity assessments and recording of capacity to consent,
- patients who are absent without leave (AWOL),
- completion of care plans and risk plans.

Additional information will, in future, be added on trends: community team’s compliance, medication issues, and care plan and risk assessment standards and training breaches.

The Medical Director and Head of Mental Health Legislation will lead work with relevant leaders to review the optimal Quality Improvement (QI) methodology.

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**Section 135 and section 136 regulatory breaches**

In December 2017, the legal requirements for patients brought to the Trust under a s136 to be assessed changed, reducing the time allowed for assessments from 72 to 24 hours.

In the period 30 April to 17 June 2018, there were 228 persons who presented at the Health Based Place of Safety (HBPoS), of which 43 (19%) remained in the Health based place of safety beyond 24 hours. 37 (86%) were due to there being no identified bed for admission.

Legal advice on action is being sought on behalf of the South London Partnership trusts and pan-London MH law committees with advice to executive lead (BM) and MH Law Committee chair within two weeks.

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**Delayed MHA Assessments**

Between March to May 2018, 105 community mental health assessments were cancelled, for the reasons set out in Table 1 below.

The executive team organised a multi-agency partnership event on 15 May 2018 to identify solutions and improvement plans. The notes of that meeting are annexed to this paper. Weekly conference call meetings across the multi-agency partners have begun and are proving helpful. Another action
<table>
<thead>
<tr>
<th>The highest reason for delayed assessment in 32 (40%) of cases was where no bed was available. The second highest was where the patient was not at home when the team attended for the assessment – 29 (27%) of cases.</th>
<th>planning event on 4th July across STP senior trust managers, clinical commissioning groups, police, ambulance service, and local authorities found that there has been no increase in demand for beds in mental health (in contrast to acute trusts), but there are 3 wards worth of delayed discharges and a timely complex needs strategy is essential.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Tribunal Reports</td>
<td>The issue of late Mental Health Tribunal reports received by the Trust Mental Health Act Department was discussed noting improvement required.</td>
</tr>
<tr>
<td>The timeliness and quality of medical, nursing and social work reports to the Mental Health Act Department and the Tribunal is under review and delays in report provision will be discussed in Operational Directorate Governance meetings. The professional heads will discuss how to support asset-based care planning.</td>
<td></td>
</tr>
<tr>
<td>Trends in use of the MH Act</td>
<td>The current information reports show trends we want to understand more fully, including the apparent significant reduction in use of detentions in Lambeth and rise in Southwark. This may be an artefact of the s.136 suite being sited in Southwark.</td>
</tr>
<tr>
<td>As in first point above regarding Information for improvement and freeing up time to care, a task and finish group is being established to agree: how to rationalise and align the current multiple information requests and data sources (13); how data on trends and risks will be analysed, interpreted and reported to the Trust Board and other relevant committees.</td>
<td></td>
</tr>
<tr>
<td>Ethnicity analyses</td>
<td>The MH Law Committee received an excellent report from Dr. Calum Moulton, analysing trust detentions by BAME, and finding some unexpected results. These will be fed back to the Equalities and Workforce Committee, and proposals for commissioning and resourcing further detailed analyses are being developed.</td>
</tr>
<tr>
<td>Half day workshop to be organised to look at the data in more detail. Proposals to commission and resource further detailed analyses were being developed.</td>
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</table>

**Key points of assurance**

**Strengthening Governance: MH Law Committee Terms of Reference**

The terms of reference (ToRs) have been revised to include the use of the MH legislation in a manner that promotes SLaM’s Human Rights and Equalities commitments, population health and recovery outcomes strategy, in addition to strengthening the core operational responsibility to deliver compliance with the MH legislation, CQC regulatory and Code of Practice Standards.

The purpose and duties of the Committee have been revised as follows:

**Purpose:**

The overall purpose of the Mental Health Law Committee is to monitor the Trust’s application of mental health legislation and provide assurance to the Board in terms of both activity and quality. The Committee will ensure that that recommendations made by the Care Quality Commission are adequately followed up and responded to.

**Duties:**

In carrying out its role, the Mental Health Law Committee will:

- Monitor and review of the use of the Mental Health Act and Mental Capacity Act.
- Ensure that the Trust’s systems for management of the Mental Health Act are robust.
- Analyse and understand any trends in application of mental health law and act accordingly.
- Prepare a forward workplan and keep track of actions arising.
- Monitor the performance of clinical services responses to Care Quality Commission Mental Health Act inspections.
- Report to the Board of Directors on the Trust’s application of Mental Health Law and the processes for the management of the Mental Health Act 1983 and Mental Capacity Act.
- 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.

**Strengthening Quality workplan**
The revised duties workplan is aimed at improving quality in both ToR strands. An implementation programme is progressing, including:
- revised membership of the MH Law Committee;
- clarity of the Board-to-floor implementation arrangements in the borough structures; development of our informatics strategy to monitor trends and compliance and reasons for non-compliance and improvement support needed;
- development and implementation of digital and clinical decision support tools;
- innovative training methods and user led content;
- planning a refreshed Quality Improvement strategy.

### Key risks to flag

**Delayed MHA Assessments** – failure to provide beds for patients who need admission under the MHA is a breach of the MHA. MHA Code of Practice 14.78 states “Clinical commissioning groups (CCGs) are responsible for commissioning mental health services to meet the needs of their areas ......” Delays with MHA assessment completion poses a risk to the patient and potentially other persons and has been identified by CQC as a national concern.

**Section 135 and section 136 regulatory** - overstays by persons in the Health Based Place of Safety (HBPoS) beyond the 24-hour assessment period for the section 135 or 136 places the Trust at risk of detaining a person without the legal authority to do so. This is an issue of concern to this Trust and our partners in the South London Partnership as well as Trusts in the wider London region. Legal advice is being sought and a decision to be made on the safest course of action to take.

### Issues to be brought to the attention of other Committees

The issues highlighted in the key issues summary report for the Board have been reported to the 17 July 2018 Quality Committee.
1. PURPOSE
The overall purpose of the Mental Health Law Committee is to monitor the Trust’s application of mental health legislation and provide oversight and assurance to the Board in terms of activity; legal application; statutory and regulatory compliance; code of practice; compliance with human rights legislation and equalities strategy; quality and patient outcomes.

2. DUTIES
In carrying out its role, the Mental Health Law Committee will:

- Monitor and review of the use of the Mental Health Act, Mental Capacity Act and any associated legislation, in particular Human Rights and Equalities duties;
- Draw on information to understand new and repeat uses of the legislation in each clinical service, including population demographic and clinical information, the quality of care, and trends in application of mental health law, and act accordingly;
- Adopt a strengthened human rights and equalities approach to the implementation of mental health legislation and related training;
- Receive assurance that the workforce is trained and supported to apply best practice standards and quality improvement, including the development of digital enablers to support care planning and clinical decision making;
- Ensure that the Trust’s systems for management of the Mental Health legislation are effective;
- Monitor the performance of clinical services in their responses to Care Quality Commission Mental Health legislation monitoring inspections, and receive assurance that support is in place for timely action to be taken to reduce all breaches in compliance with legal and regulatory standards;
- Prepare a forward workplan and keep track of actions arising within the agreed timescales;
- Report to the Board of Directors on the Trust’s application of Mental Health Law and the processes for the management of the Mental Health Act 1983 and Mental Capacity Act;
- 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
Non-Executive Director with Responsibility for the Mental Health Act (Chair)
Executive Director of Nursing (Deputy Chair)
Medical Director
Director of Social Care
Medical Leads for Operational Directorates
Chief Pharmacist
Head of Mental Health Legislation
Trustwide Clinical MCA Lead
Trustwide Clinical MHA Lead

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.

Trust staff key to the application of mental health legislation, and other significant stakeholders, shall be invited to attend each meeting:
Carer Representative
User Representative
Representatives from the four IMHA providers
Associate Hospital Manager representatives
MHA Policy Development Manager/MHA Advisor – as required

Other Trust staff will be required to attend to address specific issues as they arise.

3.2 Accountability
The Mental Health Law Committee is responsible to the Trust Board of Directors. As a minimum, the Mental Health Law 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 Mental Health Law Committee interacts primarily with the Quality Committee.

The Mental Health Law 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 Quality Committee. The Chairs of the Mental Health Law and Quality Committees should meet regularly in order to discuss the escalation reports and gaps in assurance or control. The Chair of the Mental Health Law Committee shall also be a member of Quality Committee.

The Mental Health Law Committee may remit matters to any other Board Committee as the Chair finds appropriate, and vice versa. Minutes of the Mental Health Law 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 Roles and Responsibilities
Chair: Non-Executive Director
Deputy Chair: Director of Nursing
Minutes and administration of meeting: Secretariat support will be provided by the SLaM executive.
Key contact in Trust: Head of Mental Health Legislation

3.5 Frequency of meetings
Meetings will be held at least four 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 and ensure that progress against identified actions is monitored.

Archives of minutes and papers relating to Mental Health Law Committee meetings are kept on the Trust shared drive and the Mental Health Act Department Intranet website.

3.7 Quorum
A quorum shall be eight members to include the following (or their deputy):
- Non-Executive Director with Responsibility for the Mental Health Act (Chair)
- Director of Nursing (Vice Chair)
- Medical Director
- Head of Mental Health Legislation
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>Name</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2007</td>
<td>Trust-wide Mental Health Act Committee Chair</td>
<td>TOR formally adopted by Board (of Directors).</td>
</tr>
<tr>
<td>June 2007</td>
<td>Trust-wide Mental Health Act Committee Secretary</td>
<td>TOR reviewed at inaugural meeting of new style Committee</td>
</tr>
<tr>
<td>March 2008</td>
<td>Trust-wide Mental Health Act Committee Secretary</td>
<td>TOR reviewed and update if required.</td>
</tr>
<tr>
<td>March 2014</td>
<td>Trust-wide Assistant Director of Mental Health Legislation</td>
<td>TOR reviewed and updated</td>
</tr>
<tr>
<td>August 2017</td>
<td>Director of Nursing</td>
<td>TOR reviewed and updated</td>
</tr>
<tr>
<td>June 2018</td>
<td>Director of Nursing/Non-Executive Director</td>
<td>TOR reviewed and updated</td>
</tr>
<tr>
<td>July 2018</td>
<td>Mental Health Law Committee</td>
<td>Draft ToR ratified</td>
</tr>
<tr>
<td>July 2018</td>
<td>Trust Board</td>
<td>Draft ToR approval sought</td>
</tr>
</tbody>
</table>
REPORT TO THE TRUST BOARD:  PUBLIC  
24 JULY 2018

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

Author | Rachel Evans, Director of Corporate Affairs

Purpose of the paper
For the Board to note the finalised key objectives for the Chief Executive and Senior Management Team, incorporating feedback from the June 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>23/05/18</td>
<td>Nominations Committee</td>
</tr>
<tr>
<td>11/06/18</td>
<td>Senior Management Team</td>
</tr>
<tr>
<td>19/06/18</td>
<td>Board of Directors</td>
</tr>
</tbody>
</table>

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 this year by reductions in the waiting time from referral to first assessment and reduction in crises readmissions by 10% by April 2019 (Quality Priority 2018/19). (Additional quality measures covering both inpatient and community care will be developed for future years).
   
   b. A reduction in violence by 50% over three years with the aim of reducing all types of restrictive practices (Quality Priority 2018 / 19).
   
   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 2018/19)*

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 2018/19)*

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. Agreeing a programme of work to enable staff to experience improved satisfaction and joy at work, as measured by reduced turnover of staff by 10%, increase to 75% of staff who recommend SLaM as a place to work and who would be happy with the standard of care for friends and family, over the next three years. *(Quality Priority 2018/19)*

c. 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, which will be brought back to the Board for discussion in the Autumn.

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 as a key part of delivering right care and quality.

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 the Board members champion the better use of data across the Trust both in its own meetings and committees and more generally, as measured by improved scores in the 2019 annual Board and Committee annual reviews.

   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.
REPORT TO THE TRUST BOARD: PUBLIC
24 July 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Report from previous month’s Part II meeting</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 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 June 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>
</tr>
</thead>
<tbody>
<tr>
<td>BODPTII 20/18</td>
<td>SLMHCP Board minutes</td>
<td>To review the minutes of the Board meeting of the South London Mental Health Community Partnership held in March 2018</td>
<td>Matthew Patrick</td>
<td>Includes financial information for each member of the partnership not yet in the public domain</td>
</tr>
</tbody>
</table>
Board of Directors Meeting
To be held 18th September 2018
2:30pm - 5:00pm ORTUS, Maudsley 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
/18 Welcome, apologies for absence & declarations of interest & Conflicts of Interest Register Charlotte 2:40pm Page
/18 Minutes, Action log review Gabrielle 2:45pm Page
/18 Patient Story Quality
/18 Risk Focus: BAF Risk – tbc 3:00pm Page Beverley/Amanda 3:15pm Page
/18 Q1 Lessons Learned Michael/Barbara 3:25pm Page
/18 Quality Improvement Update Zoe 3:35pm Page
/18 Freedom to Speak Up Guardian – Board Reporting Michael 3:45pm Page
/18 Learning from Deaths

Performance
/18 Chief Executive’s Report Rachel 3:50pm Page
/18 Finance Report Gus 3:55pm Page
/18 Performance Report Kris 4:05pm Page

Governance
/18 Board Assurance Framework Beverley 4:15pm Page
/18 Briefing from the FPC July Meeting Stephen 4:30pm Page
/18 Briefing from the BDIC July Meeting Altaf/Adam Page
/18 Briefing from the Quality July Committee Charlotte Page
/18 Council of Governors Update Charlotte Page

For Noting
/18 Report from previous month’s Part II Charlotte 4:50pm Page
/18 Wrap-up and Next Meeting Page
/18 Meeting Evaluation ? Verbal

The next Board of Directors Meeting will be held on 30th October 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