A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
WILL BE HELD ON TUESDAY 23RD JULY 2013 AT 3:00pm BOARDROOM, MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence: Prof. Shitij Kapur
2 Declarations of Interest
3 Minutes of the Board Meeting held on 25th June 2013 Attached
4 MATTERS ARISING

STRATEGY

5 To receive Review of Equality performance & Development of New Equality Objectives Page 8 App A

QUALITY

6 To receive the Service Quality Indicator Report Page 17 App B
7 To receive the Infection Control Annual Report 2012/13 Page 25 App C
8 To receive the Nursing Annual Report 2012/2013 Page 36 App D

PERFORMANCE AND ACTIVITY

9 To discuss the Finance Report Month 3 Page 73 App E

GOVERNANCE

10 To receive a Report from the Acting Chief Executive Page 83 App F
11 To receive an Update from the Council of Governors Page 87 App G
12 To receive an update on Kings Health Partners Page 90 App H
13 To receive the Mental Health Act Management Annual Report 2012/13 Page 91 App I
14 To receive the Assurance Framework Report Page 106 App J
15 To receive the Audit Committee Minutes and Signed and Sealed Page 115 App K

INFORMATION

16 Director’s Reports Verbal
17 Forward Planners Page 127 App L
18 Any other business

To consider a motion that representatives of the press and other members of the public be excluded 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

Date of Next Meeting: Tuesday 10th September – 1:00pm, Maudsley Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ. Please send apologies to Alison Baker 0203 228 4763 alison.baker@slam.nhs.uk

Please note that minutes from this meeting are a public document and will be published on the Internet and may be requested under the Freedom of Information Act (2000). Any attendee that would like their name omitted from the minutes should discuss this with the minute taker. Note that it may not always be possible to oblige as this is dependent on the persons role and the business being discussed.
MINUTES OF THE SIXTY SIXTH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 25TH JUNE 2013

PRESENT

Madeliene Long Chair
Dr Martin Baggaley Medical Director
Dr Patricia Connell-Julien Non Executive Director
Robert Coomber Non Executive Director
Nick Dawe Director of Finance
Harriet Hall Non Executive Director
Gus Heafield Acting Chief Executive
Kumar Jacob Non Executive Director
Prof Shitij Kapur Non Executive Director
Zoë Reed Director of Strategy & Business Development
Dr Jane Sayer Acting Director of Nursing and Education

IN ATTENDANCE

Mark Allen Service Director, Addictions CAG
Sam Antwi-Marful Deputy Director, B&DP CAG
Alison Baker PA to Chair & Non Executive Directors
Matt Beavis Assistant Director of Nursing (from item 10)
Lucy Canning Service Director, Psychosis CAG
Dan Charlton Head of Communications
Prof Tom Craig Director of R&D
Dr Gill Dale Director of Research Quality
Eleanor Davies Service Director, B&DP CAG
Prof Sir Robert Lechler Executive Director, King's Health Partners
Paul Mitchell Trust Board Secretary
Rosie Peregrine-Jones Assistant Director of Quality and Assurance

APOLOGIES

Steve Davidson Service Director, Psych Medicine and MAP CAGs
Louise Norris Director of Human Resources
Noel Unwin Vice Chair, Members’ Council

DECLARATIONS OF INTEREST
Routine declarations were made:

- Madeliene Long declared an interest as a Lewisham Borough Councillor and an Honorary Fellow of King's College London.

- Zoe Reed declared an interest as Chair, of Society for Anglo Chinese Understanding.

- Dr Patricia Connell-Julien declared an interest as a former employee of Kings College London and as a Trustee of Southside Certitude Support.
- Prof Shitij Kapur declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. Prof Kapur advises and consults with pharmaceutical companies periodically.

**MINUTES**

The minutes of the meeting held on the 28th May 2013 were agreed as an accurate record of the meeting.

The draft minutes of the Service Quality Improvement Committee May meeting were noted.

**BOD 69/13 MATTERS ARISING**

There were no matters arising from the previous minutes.

**BOD 70/13 RATIFICATION**

The Board of Directors ratified the recent Consultant post:

Dr Stephen Miller – Consultant Psychotherapist, Personality Disorder Service.

The Board of Directors ratified the recent Consultant post.

**BOD 71/13 PRESENTATION – KINGS HEALTH PARTNERS – (Verbal)**

Prof Sir Robert Lechler updated the Board of Directors on KHP activity. He reported that the development of the Full Business Case was underway, the key was to capture the bold vision of the new integrated organisation. Work was underway with organisations responsible for primary care, social care and academic development.

Prof Sir Robert Lechler confirmed that groups of integrated services would become institutes. Part of the vision would be to optimise the use of the current estate, particularly with some imaginative thinking regarding the Denmark Hill site. As had been stated before, the merger was not driven by money, but if the partner organisations were not able to release significant funds for investment, the potential merger would be unlikely to be viewed a major success. The Finance Directors were working with McKinseys on the level of savings that could be generated.

There were also commercial opportunities available to the organisations through some ground breaking use of technology.

Further discussions on refining options would be taking place at the Partners Board meeting being held in July 2013.

The Board of Directors noted the presentation.

**BOD 72/13 PRESENTATION – R&D ANNUAL REPORT & OPERATIONAL CAPABILITY STATEMENT**

Prof Tom Craig presented the Board of Directors with an update on R&D activities and achievements, and sought the Board's approval for the R&D Organisational Capability Statements. He highlighted the work had taken place within Psychosis.
with CBT including a graded exercise therapy, along with Eating Disorders where cognitive remediation therapy had been developed.

The CRIS system which had come out of the NIHR Biomedical Research Centre was being implemented in Cambridge & Peterborough, Camden and Islington, West London and Oxford. There were also multiple dementia trials now being funded.

One new area of research was AVATAR therapy, whereby treatment was using a double room set up, to reduce the hearing of the voices. Prof Craig emphasised that clinical trials were very important to maintaining funding for the Trust.

Prof Craig highlighted that while the numbers of trials had increased fourfold, there had not been a corresponding increase in the number of people recruited on to trials.

The Board of Directors noted the presentation and approved the SLaM R&D Organisational Capability Statement.

BOD 72/13 SERVICE QUALITY INDICATOR & INFECTION CONTROL REPORT
Gus Heafield explained that following discussions at the Board meeting in May incidents and RIDDOR data were now reported on a rolling 12 months basis. This provided a more robust perspective of data over a longer period and suggested that for incidents, the year on year data was comparable. However when looking at CAGs it was noticeable that the B&DP and Psychosis CAGs seemed to be reporting more incidents than last year. Lucy Canning explained data had not been reported for three wards, this had now been rectified.

Gus Heafield confirmed that the Trust remained consistent at 92.17% for Child need risk screen however the Psychological Medicine CAG figures had dropped by 3% which was currently under review. Overall the Trust met the 7 day follow up target which was applicable to all adult services. CAMHS had been reviewed against this target as it was considered an area of good practice.

The CPA 12m review showed a marked improvement on last month and a great deal of work had been undertaken at Performance Management. The target would now be met thanks to work from the teams, the challenge was making sure this progress was sustained.

The surveillance report on Infection Control was noted.

The Board of Directors noted the reports.

BOD 73/13 SLaM CLINICAL AUDIT ANNUAL REPORT 2012/13
Rosie Peregrine-Jones explained that the report informed the Board of Directors of the clinical audit work undertaken in 2012/13 and priorities for 2013/14. There were 31 projects completed by the end of March 2013 and a further 7 underway and carried over into the 2013/14 programme. This was an increase in the number of completed projects compared with previous years. A significant number of projects were monitoring CQUIN/quality contract standards, the increase in CQUIN contracted audits had an impact on the capacity of the team to cover the usual
The Board of Directors noted the report.

BOD 74/13 FINANCE REPORT – MONTH 2
Nick Dawe reported that the Trust was reporting a £1.5m net deficit which was an £1.5m adverse variance from plan, with a £1.3m EBITDA which was a £1.9m adverse variance from plan. If this variance was to continue a financial risk rating of 2 would be achieved within Q1 under the current rating system. There was some indication that the rate of increase of overspend had slowed, much of the reduction was due to the issue of reserves, deployment of provisions and re-profiling of budgets.

Overall both the CAG and infrastructure positions had deteriorated within the month 2. The position continued to be driven by large overspends in the B&DP and Psychosis CAGs which together represented 68% of the current operational deficit. This position was being partially offset by a phased release of the contingency reserve and the year to date release of £0.66m of provisions but these were not sufficient to fully negate the current rate of overspend. A monthly break even trajectory for the two CAGs would be produced for future meetings to facilitate close monitoring. Actions listed were recommended for approval.

A detailed report on Estates expenditure would be brought to the next meeting.

Discussions with NHS England to agree a contract for MSU/LSU beds and a range of other specialist services with Specialist Commissioners were progressing but not yet agreed. It was recommended that these discussions be concluded by the end of June and representations be made to the NHS Commissioning Board if the suggested contract showed any more than a 4% reduction in value from 2012/13.

It was noted that further discussion would be taking place at the following Part 2 meeting.

The Board of Directors noted the report and agreed the recommendations listed.

BOD 75/13 ACTING CHIEF EXECUTIVE REPORT
Gus Heafield explained that the new learning centre had now opened, the project was funded by the Maudsley Charity and was delivered on time and on budget. It provided world class facilities for staff to use for meetings, events and conferences.

NHS England had confirmed the designation of 15 new Academic Health Science Networks. Southwark and Lambeth Integrated Care would be bidding to attain Pioneer Status as part of the government’s initiative to encourage, support and promote 10 sites across the UK in order to showcase genuinely innovative integrated care provision.

The Board of Directors noted the report.
BOD 76/13 COUNCIL OF GOVERNORS UPDATE

Paul Mitchell reported that steps were being taken to recruit up to two Non-Executive Directors with professional skills and experience particularly sought in business development/marketing and clinical or academic research. A fuller brief would be worked up.

Robert Coomber was due to come to the end of his present term as Non-Executive Director on 30th June 2013. The Nominations Committee had recommended the reappointment for a period of up to three years to the meeting of the Council of Governors, which had been agreed unanimously.

The next joint Governors meeting would be held on Thursday 18th July in the new Maudsley Learning Centre, a programme would be circulated nearer the time.

The Board of Directors noted the report.

BOD 77/13 CHANGES TO THE FT CONSTITUTION

Paul Mitchell explained that a two stage approach to amend the Constitution had been agreed, stage 1 was carrying out the changes required as a result of changes to the Monitor model Constitution, these changes had since been approved by Monitor. Stage 2 was to carry out a wider review of the FT Constitution making recommendations to meetings of the Board of Directors and Council of Governors.

The name Members’ Council had been applied since FT authorisation, as a result of the passing of the Health and Social Care Act 2012 all governing bodies were now to be referred to as Councils of Governors. As was reflected in the Monitor core Constitution these changes had already been made at stage 1.

It was agreed to tighten up the wording and clarify the definitions around recommendation 2.5 - Significant Transactions.

The revised Constitution would be presented to the general Members’ meeting for approval in September 2013.

The Board of Directors agreed the recommendations and confirmed the ongoing process.

BOD 78/13 SAFEGUARDING CHILDREN ARRANGEMENT DECLARATION OF COMPLIANCE

Dr Jane Sayer explained that this report gave a context to current arrangements. Matt Beavis explained that good levels of compliance were being reported. As staff became more involved there developed a culture of more safe practice.

The Trust Child Need and Risk Screen had received positive external feedback based on its required increased focus on the child. Increased text boxes allowed staff to account for their decisions made in the safeguarding of the child. Dr Martin Baggaley explained that a scoping exercise was currently being undertaken to look at taking this work forward within adult safeguarding.

The Board of Directors noted the report.
BOD 79/13 DIRECTOR’S REPORTS
There were no Director’s reports noted.

BOD 80/13 FORWARD PLANNERS
The Forward planner was noted.

BOD 81/13 ANY OTHER BUSINESS
No any other business was considered.

BOD 82/13 MOTION TO EXCLUDE THE PRESS AND PUBLIC
The Board of Directors agreed that representatives of the press and other members of the public be excluded 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.

The date of the next meeting will be: Tuesday, 23rd July 2013 – 3:00pm Boardroom, Maudsley Hospital, Denmark Hill, London, SE5 8AZ

Chair
### TRUST BOARD OF DIRECTORS – SUMMARY REPORT

**Date of Board meeting:** 23rd July 2013

**Name of Report:** Review of SLaM’s equality performance and development of new equality objectives

**Heading:** Strategy

**Author:** Macius Kurowski, Equality and Diversity Manager and Kay Harwood, Head of Planning and Equality

**Approved by:** (name of Exec Member) Zoe Reed, Executive Director

**Presented by:** Zoe Reed, Executive Director

**Purpose of the report:**

This report provides an update on work undertaken to review the Trust’s equality performance and develop new equality objectives.

**Action required:**

The Board are asked to note:

1) that the Equality Delivery System [EDS] tool has been used to grade our performance which has, in turn, enabled us to identify new equality objectives, and

2) the timetable for developing and reporting on this work

**Recommendations to the Board:**

The Board are asked to agree the proposed EDS grades along with the 2013-16 equality objectives and subsequent publishing and plans for delivery of these objectives.

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**

The Trust must comply with the equalities legislation and NHS requirements, including Monitor and CQC

**Summary of Financial and Legal Implications:**

The Equality Act 2010 places a legal requirement on the Trust to publish one or more specific and measurable equality objectives. The Trust’s previous equality objectives were set out in the single equality scheme which ends this year. An Equality Impact Assessment has been undertaken to have due regard to the general equality duty in the development of the equality objectives.

**Equality & Diversity and Public & Patient Involvement Implications:**

The equality objectives have been developed using the EDS. This involved collecting and analysing evidence on the Trust’s equality performance. The evidence was shared with service users, carers, staff and representatives of local groups/communities and partner organisations at a partnership time event (PTE) at which they graded the Trust’s equality performance. The final equality objectives aim to address the most significant equality priorities identified by this process.
South London and Maudsley NHS Foundation Trust

Review of SLaM’s equality performance and development of new equality objectives

PURPOSE OF THE REPORT
This paper provides the Board with an update on work undertaken to review the Trust’s equality performance and develop new equality objectives. It seeks ratification of Equality Delivery System [EDS] grades for the Trust’s equality performance and new equality objectives for the Trust.

BACKGROUND
The Equality Act 2010 places a legal requirement on the Trust to publish the following:

- Annual information to show how we complied with the public sector equality duty
- One or more specific and measurable equality objectives

The Equality Act 2010 outlines the protected characteristic groups for which the Trust must demonstrate due regard, these are:

- Age
- Sex (Gender)
- Sexual Orientation
- Race
- Marriage and Civil Partnerships
- Gender Re-assignment
- Pregnancy and Maternity
- Disability
- Religion or Belief

The Trust published reports on ‘Meeting the public sector equality duty’ in January 2012 and 2013. The Trust’s Single Equality Scheme set out our equality objectives but this ends this year. While there is no longer a legal requirement to publish an equality scheme the Trust is required to publish one or more equality objectives for 2013 to 2016.

In November 2012, the Board approved plans for the Trust to use the EDS to analyse evidence and engage with local interests to assess the Trust’s performance on equality; identify areas for improvement and develop equality objectives to address these. This work has incorporated feedback from BME specific events on mental health and policing.

REVIEW OF TRUST EQUALITY PERFORMANCE
We have used the EDS to assess our equality performance on 18 outcomes grouped into four goals relating to our service delivery, employment and leadership as set out in the table below.
<table>
<thead>
<tr>
<th>Function</th>
<th>EDS Goal</th>
<th>EDS outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service delivery</td>
<td>Better health outcomes for all</td>
<td>1.1: SLaM services meet the mental health needs of its service users, promote well-being and reduce health inequalities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2: SLaM assesses the individual mental health needs of service users and delivers appropriate and effective services</td>
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<td></td>
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<td>1.3: SLaM supports service users when they move through different mental health services and these changes are discussed with them</td>
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<tr>
<td></td>
<td></td>
<td>1.4: SLaM service users are free from abuse, harassment and bullying or get fair redress if they experience this</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.5: SLaM supports service users to maintain and improve their physical health</td>
</tr>
<tr>
<td>Improved patient access and experience</td>
<td></td>
<td>2.1: Service users, carers and local communities can easily access SLaM services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.2: SLaM service users are informed and involved in their diagnosis and care and exercise choice in their treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.3: SLaM patients and carers are listened to, respected and believe that their treatment and care outcomes are good</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.4: SLaM service user and carer complaints are handled respectfully and efficiently</td>
</tr>
<tr>
<td>Employment</td>
<td>Empowered, engaged and well supported staff</td>
<td>3.1: Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3: Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.4: Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.5: Flexible working options are made available to all staff, consistent with the needs of the service, and the way people lead their lives</td>
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<tr>
<td></td>
<td></td>
<td>3.6: The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population</td>
</tr>
<tr>
<td>Leadership</td>
<td>Inclusive leadership at all levels</td>
<td>4.1: Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.2: Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination</td>
</tr>
</tbody>
</table>
4.3: The organisation uses the Competency Framework for Equality and Diversity Leadership to recruit, develop and support strategic leaders to advance equality outcomes.

The EDS grades performance in terms of four grades and colours. The table below explains what level of performance each colour represents.

<table>
<thead>
<tr>
<th>Colour</th>
<th>EDS Grade</th>
<th>What this grade means about our performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Under-developed</td>
<td>We are doing very badly</td>
</tr>
<tr>
<td>Amber</td>
<td>Developing</td>
<td>We are doing OK but we need to do better</td>
</tr>
<tr>
<td>Green</td>
<td>Achieving</td>
<td>We are doing well</td>
</tr>
<tr>
<td>Purple</td>
<td>Excelling</td>
<td>We are doing very well</td>
</tr>
</tbody>
</table>

A summary of the work undertaken to assess the Trust’s performance is provided below. Further detail is contained in an EDS engagement summary report that will be published alongside the EDS grades and equality objectives. This information will be fed back to the services users, carers, staff and other interested people who contributed to this process.

**Service delivery:**

The strategy and business development directorate gathered and analysed evidence on the Trust’s performance from a range of sources including the Trust’s ‘Meeting the public sector equality duty report’, 1,039 inpatient PEDIC survey responses, 2,370 outpatient PEDIC survey responses, clinical audits, complaints data, research and community feedback from events on Mental Health and Policing, Faith and Mental Health and service user involvement.

A summary of this evidence was presented to around 40 service users, carers, staff and representatives from local groups/communities and partner organisations at a partnership time event (PTE) in Croydon on 20th May. Delegates discussed SLaM performance on each of the nine service delivery outcomes and were asked to grade the Trust’s equality performance on each of these. A meeting was also held with service user consultants on 14th June to enable them to share their views and grade the Trust’s equality performance in relation to service delivery.

**Employment:**

In order to demonstrate the Trust’s performance an assessment of our people practices and policies and the impact of those has been undertaken against the NHS Grades Manual for the EDS. A summary of this assessment are in the following section. An initial assessment was undertaken against the grade criteria by the Human Resources Department. This assessment for each criteria was then discussed, checked and validated through the Joint chairs of the Lesbian, Gay, Bi-sexual and Transgender (LGBT) Group, the lead for the Disability Forum, and the Chair of the Joint Staff Side Committee. It is also the intention to obtain feedback and assessment from the Black and Minority Ethnic (BME) network chairs or a representation of those, although that was not possible to do at this juncture.

**Leadership:**

The strategy and business development directorate held a session at the Trust’s Senior Leadership Group on 2nd July at which senior leader’s graded the Trust’s performance on leadership and equality.

**PROPOSED EDS GRADES**

The table below provides a summary of the EDS assessment of the Trust’s equality performance. As mentioned above further detail will be provided in a report that summarises the feedback and grading provided to us through the PTE and EDS engagement process.
<table>
<thead>
<tr>
<th>EDS Goal</th>
<th>EDS Outcome</th>
<th>Final EDS Grade</th>
<th>Evidence for this Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better health outcomes for all</td>
<td>1.1</td>
<td>Developing</td>
<td>Analysis of evidence suggests that most service users get a good service from SLaM services, although some service users with some protected characteristics are less likely to report this than others. They face particular barriers and problems that need to be addressed to improve their outcomes and experiences.</td>
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<td></td>
<td>1.2</td>
<td>Developing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>Developing</td>
<td></td>
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<tr>
<td></td>
<td>1.4</td>
<td>Developing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.5</td>
<td>Developing</td>
<td></td>
</tr>
<tr>
<td>Improved patient access and experience</td>
<td>2.1</td>
<td>Developing</td>
<td>Scoring and evidence from service users, carers, staff and local interests suggests that SLaM services are doing OK on equality but we need to do better.</td>
</tr>
<tr>
<td></td>
<td>2.2</td>
<td>Developing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3</td>
<td>Developing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.4</td>
<td>Developing</td>
<td></td>
</tr>
<tr>
<td>Empowered, engaged and well supported staff</td>
<td>3.1</td>
<td>Achieving</td>
<td>In some aspects of each of the criteria it was deemed that the Trust had good practices and approaches for all protected characteristic groups, but in other areas this was less so. One of the key issues is not having robust data for all the protected characteristics for all staff as this was never historically collected or recorded. Feedback suggests that where this information is anonymous it is more likely to be provided.</td>
</tr>
<tr>
<td></td>
<td>3.2</td>
<td>Achieving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3</td>
<td>Developing</td>
<td></td>
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<tr>
<td></td>
<td>3.4</td>
<td>Developing</td>
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<tr>
<td></td>
<td>3.5</td>
<td>Developing</td>
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</tr>
<tr>
<td></td>
<td>3.6</td>
<td>Achieving</td>
<td></td>
</tr>
<tr>
<td>Inclusive leadership at all levels</td>
<td>4.1</td>
<td>Developing</td>
<td>SLG identified aspects of performance that the Trust performed well on and others in which the Trust can improve.</td>
</tr>
<tr>
<td></td>
<td>4.2</td>
<td>Developing</td>
<td></td>
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<tr>
<td></td>
<td>4.3</td>
<td>Not applicable: The Trust does not use the Competency Framework for Equality and Diversity Leadership</td>
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</tbody>
</table>

PROPOSED 2013-16 EQUALITY OBJECTIVES

The evidence, feedback and scoring collected during the EDS engagement process has been used to identify five priority areas of improvement for the Trust’s equality performance. Each of these five areas for improvement will be address by an equality objective. These are set out below:

Service delivery:

Equality Objective 1: All SLaM service users have a say in the care they get

What does this objective aim to achieve?

To ensure SLaM service users are informed and involved in their diagnosis and care and exercise choice in their treatment.

Why did we choose this equality objective?

The Trust has made a commitment to view everything from the service users’ point of view and to work with service users as a joint endeavour in pursuit of their recovery and well being. Our evidence suggests that service users with some protected characteristics are currently less likely to be as actively involved as others.

This objective relates to EDS outcome 2.2. Analysis of the scoring and evidence provided by local interests during our EDS engagement identified this as a priority area in which the Trust should seek to improve its equality performance.

Analysis of PEDIC data and other evidence suggests that inpatients who are Black or Black...
British, aged over 65 years old, Lesbian or Gay or disabled and outpatients who are Black or Black British, aged over 65 years old or disabled should be a priority for this objective as they are currently less likely to report positive experiences in relation to the EDS outcome when compared to service users as a whole.

How will we measure delivery of this equality objective?

Our target for this objective will be for service users with protected characteristics to report equally positive experiences when compared to service users as a whole.

We will measure progress in achieving this objective by using service user experience reported for the following PEDIC survey questions:

- Do you feel actively involved in making decisions about your care?
- Do you understand the different treatments available to you?
- Has the purpose of your medication been explained to you?
- Have the possible side effects of your medication been explained to you?
- Have you received a copy of your care/recovery plan?
- Did you jointly develop your care/recovery plan with a member of staff?

We will also explore how other methods of measuring delivery (such as clinical audits, evidence from local interests in future EDS engagement, etc) can help monitor progress; identify barriers and further action that can be taken to achieve this objective.

Equality Objective 2: SLaM staff treat all service users and carers well and help service users to achieve the goals they set for their recovery

What does this objective aim to achieve?

To ensure SLaM service users and carers are listened to, respected and believe that their treatment and care outcomes are good.

Why did we choose this equality objective?

If the Trust is to achieve its aim of promoting recovery, social inclusion and mental wellbeing, then SLaM staff must treat service users and carers with dignity and respect in the care they provide and help them achieve the goals they set for their recovery.

This objective relates to EDS outcome 2.3. Analysis of the scoring and evidence provided by local interests during our EDS engagement identified this as a priority area in which the Trust should seek to improve its equality performance.

Analysis of PEDIC data and other evidence suggests that inpatients who are Black or Black British, Asian or Asian British, Lesbian or Gay or aged over 65 years olds and outpatients who are Black or Black British, Lesbian or Gay or aged over 65 years old should be a priority for this objective as they are currently less likely to report positive experiences in relation to the EDS outcome when compared to service users as a whole.

Evidence from service users, staff and local communities highlights the importance of religion and spirituality in the recovery of service users. Evidence from clinical audits on the recognition of religion within care planning highlights that the Trust needs to improve its performance on this. Therefore religion and belief will also be a priority protected characteristic for this objective.

How will we measure our delivery of this equality objective?

Our target for this objective will be for service users with protected characteristics to report equally positive experiences when compared to service users as a whole.

We will measure progress in achieving this objective by using service user experience reported for the following PEDIC survey questions:
• Do you feel you are being treated with dignity, empathy and respect?
• Do you feel you individual needs (cultural, spiritual, faith) are taken into consideration?
• Do you trust staff/this service with your care?
• Do you have hope that the care you are having from this team will help you?
• Do you feel restraint and injected medications are only used as a last resort with minimum use of force?

We will also explore how other methods of measuring delivery (such as clinical audits, evidence from local interests in future EDS engagement, etc) can help monitor progress; identify barriers and further action that can be taken to achieve this objective.

Equality Objective 3: All service users feel safe in SLaM services

<table>
<thead>
<tr>
<th>What does this objective aim to achieve?</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure SLaM service users are free from abuse, harassment and bullying or get fair redress if they experience this.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Why did we choose this equality objective?</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is vital that service users in the Trust’s inpatients services feel safe and feel they can get help from staff if they do not. This objective aims to support the work the Trust has prioritised in its Quality Account on patient safety.</td>
</tr>
</tbody>
</table>

This objective relates to EDS outcome 1.4. Analysis of the scoring and evidence provided by local interests during our EDS engagement identified this as a priority area in which the Trust should seek to improve its equality performance.

Analysis of PEDIC data and other evidence suggests that inpatients who are Black or Black British, Asian or Asian British, Lesbian or Gay or disabled should be a priority for this objective as they are currently less likely to report positive experiences in relation to the EDS outcome when compared to service users as a whole.

<table>
<thead>
<tr>
<th>How will we measure our delivery of this equality objective?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our target for this objective will be for service users with protected characteristics to report equally positive experiences when compared to service users as a whole.</td>
</tr>
</tbody>
</table>

We will measure progress in achieving this objective by using service user experience reported for the following PEDIC survey questions:
• Do you feel safe on the ward?
• Can you approach staff to help you feel safe on the ward?

We will also explore how other methods of measuring delivery (such as clinical audits, evidence from local interests in future EDS engagement, etc) can help monitor progress; identify barriers and further action that can be taken to achieve this objective.

Employment:

Equality Objective 4: Roll-out and embed the Trust’s Five Commitments for all staff

<table>
<thead>
<tr>
<th>What does this objective aim to achieve?</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that all staff are aware of the Trust’s Five Commitments and that staff are expected to demonstrate these behaviours at all times.</td>
</tr>
</tbody>
</table>
The Five Commitments are the standards of attitudes and behaviour that all staff and managers are expected to adhere to, in support of delivery of high quality, compassionate care, strong leadership and collaborative working with colleagues.

The overarching standard is for all employees to develop mutual, respectful relationships, and these are exemplified in the 5 Commitments.

**Why did we choose this equality objective?**

This forms the foundations for setting standards of behaviour for all staff towards service users, carers, the public and other staff. The Trust Five Commitments are:

- Be caring, kind and polite
- Be prompt and value your time
- Take time to listen to you
- Be honest and direct with you
- Do what I say I am going to do

**How will we measure our delivery of this equality objective?**

The assessment of whether staff are meeting the Trust’s Five Commitments will be measured and monitored through the annual Appraisal process.

**Leadership:**

**Equality Objective 5: Show leadership on equality though our communication and behaviour**

**What does this objective aim to achieve?**

To create an environment where we are able to have open, honest and respectful conversations about equality at all levels of the Trust. The Board, Executive and senior leadership modelling behaviour that is expected of all members of staff.

**Why did we choose this equality objective?**

The importance of improving understanding, communication and openness on equality at all levels of the Trust was identified as a key issue by the Trust’s Senior Leadership Group.

**How will we measure our delivery of this equality objective?**

Measures of success for this objective include the following:

- **Board & Executive-level:** Recognition and response to equality implications of decisions in Board papers and minutes
- **CAG/Directorate-level:** Discussion of equality in CAG executive and infrastructure directorate meetings and in communications within CAG and directorates
- **Team-level:** Discussion of equality in team meetings and sharing good practice and problems on equality with other teams.
- **Individual-level:** Discussion of equality with colleagues and with line managers during appraisals
- **SLaM-wide:** Improving the provision of good quality information on equality and the Trust's performance on equality internally and externally

**How will we report progress on the equality objectives?**

We will report our progress in delivering this equality objective by:

- Providing information in the Trust’s annual workforce report to the Board.
- Publishing information in the Trust’s annual report on ‘Meeting the public sector equality duty’ in January 2014 and in subsequent years.
- Providing feedback through EDS engagement in June 2014 and in subsequent years.
We will also explore how we can reflect progress in delivering this equality objective by publishing information in the Trust’s Quality Account and Annual Report.

**Who is responsible for delivering the equality objectives?**
Responsibility for delivery of the objectives on service delivery rests with each of the CAGs that deliver the Trust’s services. Responsibility for the delivery of the objective on employment rests with the Human Resources Directorate. The Trust’s Equality and Human Rights Group [EHRG] will be responsible for monitoring delivery of all equality objectives; providing feedback on delivery as required and for reporting progress to the Board and local interests.

**NEXT STEPS**
It is proposed that following Board approval, the final EDS grades and equality objectives will be published on the Trust website along with a short report to summarise the details of the Trust’s EDS engagement in developing these. The timeline for next steps is as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
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</thead>
<tbody>
<tr>
<td>22 July 2013</td>
<td>Ratification of EDS grades and equality objectives by Board</td>
</tr>
<tr>
<td>26 July 2013</td>
<td>Feedback to Trust-wide EHRG</td>
</tr>
<tr>
<td>27 Sep 2013</td>
<td>Outline plans for delivery from CAGs submitted to the EHRG</td>
</tr>
<tr>
<td>29 Nov 2013</td>
<td>Final plans agreed at the Trust-wide EHRG</td>
</tr>
<tr>
<td>Jan 2014</td>
<td>Board to receive Public Sector Equality Duty report for 2013 prior to publication</td>
</tr>
<tr>
<td>May 2014</td>
<td>EHRG to review delivery of equality objectives</td>
</tr>
<tr>
<td>5 Jun 2014</td>
<td>Partnership Time Event focusing on equality</td>
</tr>
</tbody>
</table>

The Human Resources and Strategy and Business Development Directorates will work together with CAGs, through the EHRG to develop delivery and reporting plans for the equality objectives. Service delivery objectives will be brought together with work on business planning, Quality Accounts and CQUIN requirements to ensure these respond to equality issues, minimise reporting requirements and ensure the best use of resources.

Progress of delivery will be monitored twice a year through the EHRG who will provide updates for the Board and feedback to CAGs. An interim update on progress will be provided in the Trust’s annual report on ‘Meeting the public sector equality duty’ published on 31st January 2014.

A partnership time event will be held on 5th June 2014 to provide feedback on the work undertaken to improve the Trust’s equality performance and deliver the Trust’s equality objectives. This will provide an opportunity for local interests to re-grade the Trust’s equality performance; identify what the Trust is doing well and what can be done better.

**RECOMMENDATION**
The Board are asked to ratify the proposed EDS grades; 2013-16 equality objectives and subsequent publishing and plans for delivery of these objectives.

Macius Kurowski, Equality and Diversity Manager
Kay Harwood, Head of Planning and Equality
July 2013
TRUST BOARD OF DIRECTORS

SUMMARY REPORT

Date of Board meeting: 23rd July 2013

Name of Report: Service Quality Indicator Report

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

Author: Roy Jaggon
       Head of Performance Management

Approved by: Gus Heafield
(name of Exec Member)

Presented by: Gus Heafield

Purpose of the report:
To present to the Board the monthly service quality indicator report.

Action required:
To review, the service quality indicator report, and note the planned way forward in development over the coming months.

Recommendations to the Board:
The Board are asked to accept the service quality indicator report and the planned work streams in progressing this further.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The report provides quality indicator data for each CAG, and therefore provides a source of assurance of service quality.

Summary of Financial and Legal Implications:
Quality targets written into the core contract quality schedules this year include; seven day follow-up post discharge, and copies of care plans given to patients.

Equality & Diversity and Public & Patient Involvement Implications:
There are no immediate or direct implications to equality & diversity or public and patient involvement.
SERVICE QUALITY INDICATOR REPORT

This is a monthly report consisting of Monitor targets and internal indicators which are by CAG and by borough and provides a year to date view of performance.

Month 3 Commentary

Patient Experience
This segment of the quality strategy illustrates a consistent picture for patient surveys and copies of care plans.

The patient experience question: ‘Do You Feel Safe?’ is a Quality Account indicator for this year and reported quarterly. This quality account indicator states that 90% of patients will respond positively. All wards are expected to share how they are performing against this with service users and jointly develop action plans. Service User Consultants within Psych Med and MAP SUAGs have also been reviewing PEDIC reports and sending additional comments and suggestions to ward managers.

Violence reduction programmes are being run across the organisation and the Psychosis CAG is going to be running a pilot to improve patient experience on women's wards to try to find practices that could be spread across the CAG. Borough based focus groups with Link Workers/ Peer Support Workers have been undertaken as part of the Patient Experience CQUIN targets. Five domains were discussed which included safety. The focus groups provided invaluable feedback and has helped us to identify practical steps which can be undertaken to help service user feel safer on the wards.

The Tree of Life project, led by Adrian Webster, will also help to address some of the issues linked to service users feeling safe on the wards. The project will be rolled out shortly within all Psychosis inpatient wards and aims to break down barriers between staff and services users using a narrative therapy approach.

Some variation in responses is expected due to the different patient groups being treated on our wards. Within CAMHS, there are many reasons why young people do not feel safe on the wards. Just the concept of being away from home/family and in hospital is particularly scary for young people and this is without including all of the other day to day business of a mental health busy ward. The wards are now regularly undertaking PEDIC surveys which allows them to explore the young person’s feeling and action plan appropriately.

B&D wards often report higher rate of incidents, which will impact on how safe patients may feel. Action plans have been undertaken by the nursing and quality team.

Service Users tend to report that they feel less safe on the Triage wards within Psych Med. A specific work programme is underway to address this.

CPA 12m review shows that CAGs have delivered on previous trajectories and projections and across all areas the Trust has met this target. The numbers of complaints are the total for the year so far, compared to the same period last year. The numbers of complaints continue to be less than last year.
Access
The Trust remains compliant with delayed discharges, and early intervention targets.

HTT gate keeping: the commentary for last month is as follows:
‘Following the Quality Account Audit May 2013 the recommendation for this indicator is ‘Ensure that the exemptions being applied to the indicator are either agreed with Monitor/DH or ceased’. The Trust will comply with this recommendation by adhering strictly to the Monitor definition of exemptions for this indicator. This will include operational / data recording issues as well as changes to ePJS and therefore this is a period of transition’. We are currently working on implementing these changes and reporting using the Monitor definition for the Q1 Monitor submission’

The implementation of the audit recommendations have now taken place however as stated last month Q1 is a period of transition and as a result the performance is 89.94%. The Trust has not therefore met this target for Q1. Moving forward we would expect to meet this target in coming months and this is illustrated in the improvement in performance over the three months of the quarter:

<table>
<thead>
<tr>
<th>Month</th>
<th>%</th>
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<tbody>
<tr>
<td>April '13</td>
<td>87.9%</td>
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<tr>
<td>May '13</td>
<td>87.5%</td>
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<tr>
<td>June '13</td>
<td>93.9%</td>
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</tbody>
</table>

Patient safety
Overall the Trust has met the 7 day f/u target which is applicable to all adult services (AMH, MHOA and specialist services). We review performance of CAMHS against this target as it is considered an area of good practise. CAMHS have relatively small numbers and there were three patients not followed up for the quarter. We remain consistent at 92.87% for Child need risk screen.

Incidents data and RIDDOR data continue to be reported based on a rolling 12 months compared to last year. As was the case last month BDP and Psychosis CAGs have consistently more incidents than last year. Overall across the Trust there are marginally more incidents for the same time period last year.

RIDDORs in the Psychosis CAG continues to be higher than last year.

A verbal update will be available at the meeting.

Patient Outcomes
The Trust continues to deliver on paired outcome scores across all CAGs.

Inpatient and Community Contextual Information
This information is similar to previous months and shows no significant variations in activity.

Roy Jaggon
Head of Performance Management
Strategy and Business Development Directorate
### PATIENT EXPERIENCE & ACCESS INDICATORS

#### Year to Date 2013/14

<table>
<thead>
<tr>
<th>Patient Experience Indicators</th>
<th>95.00%</th>
<th>95.00%</th>
<th>95.00%</th>
<th>95.00%</th>
<th>2013/14</th>
<th>2012/13</th>
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<tbody>
<tr>
<td>PEDIC Survey In Progress</td>
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<td>Year To Date - 2013/14</td>
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<tr>
<td>Q) Do you feel safe? As at end of Q1 2013/14</td>
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<td>CarePlan Copy Given</td>
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<td>Year To Date - 2013/14</td>
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<tr>
<td>CPA - 12 Month Review</td>
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<td>As at 15th July 2013</td>
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<tr>
<td>June M03 - 2013/14</td>
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<td>Quarterly Target</td>
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<td>Complaints M3 - June 2013 YTD</td>
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#### CAGs

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<th>CAGs</th>
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<tr>
<td>Addictions</td>
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<td>Behavioural and Developmental Psychiatry</td>
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<td>Child and Adolescent Mental Health Services</td>
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<td>MHIQA and Dementia</td>
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<td>Mood Anxiety and Personality</td>
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<td>Psychological Medicine</td>
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<td>Psychosis</td>
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<tr>
<td>Totals</td>
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</tbody>
</table>

*Please Note: the results for "Do you feel safe?" are reported quarterly for 2013/14. This information comes from the PEDIC/Freedom data source - which is where the CAGs upload their survey submissions. Addictions are currently submitting their surveys on a bi-annual basis. The "Do you feel safe?" target is taken directly from the Quality Account 2012/13 document with a definition of "At least 90% of patients will respond positively".*

#### Access Indicators

<table>
<thead>
<tr>
<th>Access Indicators</th>
<th>7.50%</th>
<th>95.00%</th>
<th>100.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed Discharges</td>
<td></td>
<td></td>
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<tr>
<td>Year To Date - 2013/14</td>
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<tr>
<td>HTT Gatekeeping</td>
<td></td>
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<tr>
<td>Year To Date - 2013/14</td>
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<tr>
<td>Early Intervention: New Referrals</td>
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<tr>
<td>As at 8th July 2013</td>
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</table>

*Please Note: the Home Treatment Team Fears reflects new current practice in the Monitor definition implemented for 2013/14.*
### Year To Date - 2013/14

#### Patient Safety Indicators

<table>
<thead>
<tr>
<th>CPA 7 Day Follow-Up %</th>
<th>CPA 7 Day Follow-Up Numbers</th>
<th>Brief/Full Risk Screen</th>
<th>Child Risk Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>%</strong></td>
<td><strong>Total</strong></td>
<td><strong>Achieved</strong></td>
<td><strong>Not Achieved</strong></td>
</tr>
<tr>
<td><strong>%</strong></td>
<td><strong>Exemptions</strong></td>
<td><strong>%</strong></td>
<td><strong>%</strong></td>
</tr>
</tbody>
</table>

**Boroughs**

- **Croydon**
  - 94.44% + 0.56%
  - 102/112
  - 137/129
  - 6/29
  - 94.05% + 14.05%
  - 95.90% - 0.10%

- **Lambeth**
  - 95.73% - 0.73%
  - 112/112
  - 145/129
  - 5/28
  - 96.74% + 16.74%
  - 95.57% - 0.43%

- **Lewisham**
  - 99.00% - 0.00%
  - 99/99
  - 138/129
  - 1/18
  - 99.18% + 16.18%
  - 95.90% - 0.95%

- **Southwark**
  - 97.89% + 2.89%
  - 93/93
  - 122/129
  - 2/27
  - 96.48% + 14.48%
  - 93.43% - 2.57%

**Totals**

- 96.85% + 1.85%
- 431/593
- 593/129
- 14/148
- 92.84% + 12.84%
- 92.75% - 3.25%

---

The following applies to both CAG and Borough breakdowns for CPA 7 Day Follow-Up.

For the CPA 7 Day Follow-Up % - the percentage is calculated by the achieved figure divided by the total discharges minus any exemptions.

---

The above table shows the figures for Violence & Aggression. There is a RAG rating used, based upon the comparison between two periods of 12 month rolling average - June 2013 to July 2012 vs. June 2012 to July 2011 (Last year). For Patient Falls the comparison is based on June 13 vs. June 12 (Last year). The figures are representative of cases / incidents recorded on DisiX at 4th July 2013.

**Green highlights** where there is a reduction in the figure recorded when compared to last year.

**Amber highlights** where the figure recorded is the same as or is not greater than 5 when compared to last year.

**Red highlights** where the figure recorded is greater than 5 when compared to last year.
## June 2013 - Month 3

### Patient Outcomes

<table>
<thead>
<tr>
<th>CAGs</th>
<th>Paired Outcome Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions - 3 Month Rolling as at 30th June 2013</td>
<td></td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td></td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services - YTD</td>
<td></td>
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<tr>
<td>MHOA and Dementia - YTD</td>
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<tr>
<td>Mood Anxiety and Personality - YTD</td>
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<tr>
<td>Psychological Medicine - YTD</td>
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<tr>
<td>Psychosis - YTD</td>
<td></td>
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</tbody>
</table>

### TOPS Compliance Report

<table>
<thead>
<tr>
<th></th>
<th>Start</th>
<th>Exit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>98.54%</td>
<td>96.36%</td>
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</tbody>
</table>

### CGAS Reporting

<p>| | |</p>
<table>
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<tbody>
<tr>
<td></td>
<td>97.00%</td>
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</table>

### HONOS Reporting

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<td>100.00%</td>
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<td></td>
<td>100.00%</td>
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</tbody>
</table>
### June 2013 - Month 3 (YTD)

**INPATIENT CONTEXTUAL INFORMATION**

<table>
<thead>
<tr>
<th>Category</th>
<th>No of Beds - as per Bed State Report</th>
<th>LOS (Days) - 12 month rolling average figure</th>
<th>Admissions (YTD)</th>
<th>Transfers in (YTD)</th>
<th>Transfers Out (YTD)</th>
<th>Discharges (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td></td>
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<tr>
<td>Behavioural and Developmental Psychiatry</td>
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<td>8</td>
<td>106</td>
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<td>101</td>
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<tr>
<td>Forensic</td>
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<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>105</td>
<td>264</td>
<td>17</td>
<td>125</td>
<td>112</td>
<td>24</td>
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<tr>
<td>MHOA and Dementia</td>
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<tr>
<td>Mood Anxiety and Personality</td>
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<tr>
<td>Psychological Medicine</td>
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<tr>
<td>Triage</td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tr>
<tr>
<td>Acute</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>868</td>
<td>1,048</td>
<td>1,263</td>
<td>693</td>
<td>719</td>
<td>1,251</td>
</tr>
</tbody>
</table>

*Please Note: The No of Beds has been populated via Bed State Live - with the figures taken on 9th July 2013 - refresh time was 18:37 pm.*

*Please Note: Due to ward closures within Behavioural & Developmental Psychiatry and opening of the new EFFRA ward within River House the higher numbers of Transfers In & Out will represent these changes.*
### Community Contextual Information

**June 2013 - Month 3**

#### CAGs

<table>
<thead>
<tr>
<th>CAG</th>
<th>Caseload M03 - June 2013</th>
<th>Discharges (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>3,543</td>
<td>647</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>2,897</td>
<td>617</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>6,177</td>
<td>1,288</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>4,622</td>
<td>1,124</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>5,778</td>
<td>1,226</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>4,795</td>
<td>2,406</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7,870</td>
<td>429</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>37,275</strong></td>
<td><strong>7,759</strong></td>
</tr>
</tbody>
</table>

#### Boroughs

<table>
<thead>
<tr>
<th>Borough</th>
<th>Caseload M03 - June 2013</th>
<th>Discharges (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>7,692</td>
<td>1,588</td>
</tr>
<tr>
<td>Lambeth</td>
<td>7,916</td>
<td>1,559</td>
</tr>
<tr>
<td>Lewisham</td>
<td>5,655</td>
<td>1,349</td>
</tr>
<tr>
<td>Southwark</td>
<td>6,665</td>
<td>1,497</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>36,787</strong></td>
<td><strong>7,676</strong></td>
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</table>

#### Community

<table>
<thead>
<tr>
<th>12 month rolling</th>
<th>Patient Seen</th>
<th>Appointment attended</th>
<th>Group Contacts</th>
<th>Phone Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Seen</strong></td>
<td>4,704</td>
<td>51,511</td>
<td>4,295</td>
<td>19,223</td>
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<tr>
<td><strong>Appointment attended</strong></td>
<td>2,105</td>
<td>11,190</td>
<td>1,428</td>
<td>9,960</td>
</tr>
<tr>
<td><strong>Group Contacts</strong></td>
<td>7,119</td>
<td>54,736</td>
<td>4,868</td>
<td>90,108</td>
</tr>
<tr>
<td><strong>Phone Calls</strong></td>
<td>6,496</td>
<td>36,733</td>
<td>2,800</td>
<td>32,466</td>
</tr>
<tr>
<td></td>
<td>8,792</td>
<td>54,062</td>
<td>8,735</td>
<td>36,722</td>
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<tr>
<td></td>
<td>11,964</td>
<td>68,758</td>
<td>2,998</td>
<td>17,196</td>
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<tr>
<td></td>
<td>8,425</td>
<td>119,712</td>
<td>6,589</td>
<td>62,293</td>
</tr>
<tr>
<td></td>
<td>50,932</td>
<td>400,338</td>
<td>31,727</td>
<td>228,633</td>
</tr>
</tbody>
</table>

**Boroughs**

<table>
<thead>
<tr>
<th>Borough</th>
<th>Patient Seen</th>
<th>Appointment attended</th>
<th>Group Contacts</th>
<th>Phone Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>10,890</td>
<td>92,907</td>
<td>5,739</td>
<td>54,118</td>
</tr>
<tr>
<td>Lambeth</td>
<td>11,609</td>
<td>103,557</td>
<td>11,933</td>
<td>56,487</td>
</tr>
<tr>
<td>Lewisham</td>
<td>7,918</td>
<td>67,320</td>
<td>3,452</td>
<td>42,516</td>
</tr>
<tr>
<td>Southwark</td>
<td>10,986</td>
<td>92,244</td>
<td>7,266</td>
<td>54,613</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>47,663</strong></td>
<td><strong>400,338</strong></td>
<td><strong>31,727</strong></td>
<td><strong>228,633</strong></td>
</tr>
</tbody>
</table>
TRUST BOARD - SUMMARY REPORT

Date of Board meeting: 23 July 2013

Name of Report: Annual Infection Control report to the Trust Board

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

Author(s): Karen Taylor [Assistant Director of Nursing – Infection Control]

Approved by (name of Executive member): Dr Martin Baggaley, Medical Director

Presented by: Dr Martin Baggaley, Medical Director

Purpose of the report:
To present the Infection Control programme for 2013 – 2014
To outline activity of the Trust Infection Control service 2012 - 2013

Action required:
The Trust Board to ratify the Infection Control programme for 2013 – 2014

Recommendations to the Board:
To note the report

Relationship with the Assurance Framework (Risks, Controls, and Assurance):
Compliance with Outcome 8 and the Health & Social Care Act 2009

Summary of Financial and Legal Implications:
None

Equality & Diversity and Public & Patient Involvement Implications:
The Infection Control programme is developed to positively support diversity issues
INFECTION CONTROL REPORT TO THE TRUST BOARD OF DIRECTORS
July 2013

This report covers the period from 1 July 2012 to 30 June 2013

The Trust’s Infection Control Team [ICT] members are: Dr Martin Baggaley, Director of Infection Prevention and Control [DIPC]; Karen Taylor, Assistant Director of Nursing, Infection Control and Tom Culligan, Infection Control Nurse. External IC advice is obtained when required from the IC Doctor at Kings College Hospital.

Access to a 24 hour infection control advice service is available, operated by members of the ICT, Assistant/Deputy Directors of Nursing, Modern Matrons [MMs] and Clinical Service Leads [CSLs].

The ICT has used the programme for 2012/2013 agreed by the Trust Board in July 2012. The Team has developed the programme for 2013/2014. [Appendix 1]

Other activity is governed by the imperatives contained in the Health & Social Care Act [HSCA], 2009.

Progress so far on the Infection Control programme 2012/2013:

1. POLICIES & PROCEDURES

1.1 The ICT attends meetings to determine common ground to develop IC pathways and systems, and share policies in the Kings Health Partners.

1.2 The Safe handling and disposal of sharps guideline has been amended to strengthen the section on protective clothing and venepuncture, and in particular, glove use.

1.3 The IC web site is updated on a regular basis to provide policies, product information and educational material.

2. EDUCATION & TRAINING

2.1 The ICT attends the monthly induction Market place for all new staff. Training is provided on: Action to take in the event of a needle stick injury; “5 Moments for hand hygiene” and; Management of diarrhoea. Service users have been involved with a number of induction sessions, including those for Student nurses. In addition to the Induction programme, the DVD on Standard IC precautions is included in Fire Safety awareness for all Trust staff.

2.2 Statistics on numbers of staff by Clinical Academic Group [CAG], who have completed the National IC ‘e’ learning programme are included in the reports to the CEO Performance Review meetings [CEOPMR] and IC Team and Committee meetings. The uptake continues to increase.

2.3 IC Road shows were held on all major sites in October 2012. Educational materials were handed out on hand hygiene, personal protective equipment; and “Bare below the Elbows” were handed out. They were well attended by staff, patients and visitors.

2.4 The training sessions for Aramark Supervisors by the ICT continue. Current topics are raised in addition to highlighting the importance of high cleaning standards.

2.5 The editions of the IC newsletter featured information on:
   • Waste management
   • Food Hygiene at Christmas
• Sharps Safety and the appropriate use of Insulin pens.

These were circulated to all Ward Managers [WMs] and Heads of Nursing for them to place on notice boards, and were uploaded to the IC website.

2.6 Retractable needle forums have been held to assist staff with the use of phlebotomy safety devices advised to be made available alongside standard equipment in Clinic rooms. This will ensure that the Trust is compliant with the EU Council Directive - Prevention from sharp injuries in the hospital and healthcare sector.

2.7 To raise awareness during the Norovirus Winter season, the Top Ten Tips on Norovirus fact sheet was circulated to all Ward Managers.

2.8 Ad hoc teaching sessions have been carried out and training records are maintained.

3. AUDIT

4.1 Audit strategy 2012/2013 & Infection Control dashboard

The ICT continues with the audit strategy to ensure that policies have been implemented. WMs, MMs and CSLs continue to complete hand hygiene, commode and decontamination of patient equipment [including mattresses] audits on a quarterly basis. The results of the audits for each ward are included in an Infection Control dashboard which is presented at CEOPMR.

4.2 Spotlight checks in Inpatient areas

A “Spotlight” checklist has been developed to assist the ICT with the regular visits to wards. This is to ensure compliance with key drivers, including those set by the CQC, and that IC is part of everyday clinical practice. The checklist includes standards relating to:

- Cleanliness & tidiness
- Hand hygiene including ‘Bare Below Elbows’
- Waste management including Sharps bins
- Awareness of the name of the Trust DIPC
- Documentation of the cleaning of patient equipment, including mattresses
- Food Hygiene

All Waste Management critical issues are escalated to the Estates & Facilities Department

All findings are fed back to WMs, MMs and CSLs.

From 1 January – 30 June 2013, 65 Spotlight checks have been carried out by the ICT.

4.3 Infection Control environmental audits in the Community.

Audits on Community units are nearing completion. Educational materials and the Decontamination guidelines have been handed out during the visits.

4.4 PLACE Inspections

Members of the ICT have been involved with the PLACE assessments process within the Trust.

5. SURVEILLANCE

Surveillance of alert organisms and blood borne viruses from July 2012 – June 2013 is being maintained - See Appendix 2.
As part of an assurance framework, monthly rates of *C. difficile* infections and MRSA colonisation/infection are forwarded to the Trust Board of Directors and to the monthly CEO PMR. In the event of a confirmed infection, e.g. MRSA, *E. coli* bacteraemia or *C. difficile*, a root cause analysis will be completed by the IC Team. Procedures will be reviewed and an action plan developed.

6. **URINARY CATHETERS**

In order to comply with the NICE IC guidelines for primary and community care, the ICT monitor the numbers of indwelling catheters in the Trust. Copies of the Trust guidelines and a staff leaflet are forwarded to the relevant wards.

7. **INOCULATION INJURIES**

There have been no infections identified after reported injuries.

The ICT is notified of staff and patient needle stick incidents that have been reported electronically on the Datix web system. A report detailing all inoculation incidents and action taken by the IC Team is presented at the IC Committee.

There have been a small number of incidents involving the use of Insulin pens which are intended for self administration only. Consequently a Blue Light Bulletin on the safe use of Insulin has been issued for action by the MMs and CSLs to ensure that this equipment is not used to avoid the risk of needle stick injury.

A poster outlining action to take following an Inoculation injury has been widely circulated.

8. **CAPITAL PLANNING & SERVICE DEVELOPMENT**

The ICT and a Senior project manager from Capital Planning have had regular meetings for an exchange of information on building schemes. This is to ensure compliance with the recently published: "Health Building Note 00-09: Infection Control in the Built Environment" in which it states: "the infection prevention and control team should be consulted throughout every stage of a capital project and their views taken into account.". The ICT has attended minuted Steering Groups.

The ICT also attends Design and Planning meetings as and when required.

An audit sheet outlining the projects is discussed at the IC Committee.

The ICT has carried out testing of the drinking water in newly commissioned Trust wards/Units:
- Croydon Triage.
- Mapother House, Maudsley hospital.
- Maudsley Dining room.
- 312 Brixton Road Community Mental Health Team.

9. **CLEANING & CATERING**

In order to resolve cleanliness issues and ensure compliance with Food Hygiene legislation, the ICT attends:
- The Patient Environment Operational Action Group
- Client Environment Board
- Cleaning & Catering Contract meetings.

The ICT also attends the monthly Trust Hotel services and Aramark review meetings.
INCIDENTS

10.1 Oak Processionary Moth incident, Bethlem site

Following identification of this potentially serious Public Health issue, the ICT liaised with the then Health Protection Agency. The Team took part in weekly teleconferences and contributed IC advice.

MEDICAL DEVICES AND EQUIPMENT MANAGEMENT

Members of the ICT continue to attend the Medical Devices & Competencies Groups and Physical Healthcare Committee.

12. INFLUENZA

1500 Influenza vaccines have been ordered for staff and patients for the Influenza season in late 2013.

The ICT has attended the Influenza Pandemic and Emergency Planning meetings to contribute to the review of the overall Trust plan.

13. TRUST LAUNDRY CONTRACT

The ICT have been involved with the tendering for the Laundry contract. The Team has visited Laundries to ensure compliance with the current relevant national guidelines.

14. SWIMMING POOL

The ICT is involved in overseeing the monitoring of the quality and treatment of the swimming pool water at BRH. Testing of the pool is carried out on a monthly basis.

15. PROFESSIONAL DEVELOPMENT

The ICNs have attended conferences and study days relating to Infection Control issues. Members of the ICT are undertaking an MSc in Public Health and have developed and presented a poster for the Community & Hospital IC Association conference in Canada.

Karen Taylor
Assistant Director of Nursing – Infection Control
July 2013
INFECTION CONTROL PROGRAMME & AUDIT STRATEGY– 2012/2013

Our vision is that no person is harmed by a preventable infection

1. Introduction

The Infection Control Team (ICT) includes: Infection Control Doctor – Cover provided by Kings College Hospital, Karen Taylor - Assistant Director of Nursing. Infection Control Nurse – Tom Culligan. Dr Martin Baggaley is the Trust Director of Infection Prevention and Control (DIPC). The programme was developed and outlines specific targets to ensure compliance with: The Health & Social Care Act [2009]. It ensures that the ICT offers a rapid response and high quality service to reduce the risk of infection to patients, staff and visitors. The programme will be reviewed with the publication of new Government Statutory Regulations or any other infection control issue regarded as a priority by the ICT that may occur within the Trust in 2013/2014. This includes the key imperative from the NHS Commissioning Board - Everyone Counts Planning for Patients 2013/2014. Domain 5 deals with patient outcomes that relate to treating and caring for people in a safe environment and protecting them from avoidable harm.

The ICT aims to ensure that Infection Control (IC) is part of quality and safety within the Clinical Academic Groups to deliver clean and safe care throughout the Trust. Whilst highlighting that everyone has infection prevention and control responsibilities. As part of an assurance framework, surveillance of alert organisms will be maintained and included in IC reports and feedback to relevant staff, i.e. monthly data to the Trust Board of Directors and Performance Management Reviews. The Trust Board will also receive a quarterly report outlining progress on the audit strategy.

2. Programme

<table>
<thead>
<tr>
<th>2.1 Policies and Procedures</th>
<th>PERSONS RESPONSIBLE</th>
<th>TARGET DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The IC policy and accompanying clinical guidelines will be reviewed to reflect published professional guidance and relevant legislation.</td>
<td>ICT</td>
<td>Ongoing</td>
</tr>
<tr>
<td>The IC web site will be updated on a regular basis to provide: policies, product information, educational material and appropriate links.</td>
<td>ICT</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.2 Education and training</th>
<th>PERSONS RESPONSIBLE</th>
<th>TARGET DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The IC education programme has been developed and will be used in: Inductions – Marketplace, involving service users, for new Nursing, Support and Contract staff – for Medical staff ▪ Supporting managers in the development of Knowledge &amp; Skills Framework indicators for IC for all staff ▪ Supporting Inpatient &amp; Community staff to ensure good rates of uptake of the National IC ‘e’ learning programme.</td>
<td>ICT/Education &amp; Training Department</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
| 2.3 Audit | A proposed strategy has been developed [Appendix 1]. This will include audits on:
- Spotlight checks on all Inpatient areas
- Antibiotic prevalence study
  - Main and ward kitchens throughout the Trust
  - Waste management, in collaboration with E & F
- IC Standards on an ad hoc basis

The ICT will continue to support key staff undertaking the Hand hygiene, patient equipment, mattress and Commodes as part of an IC dashboard presented to the Trust Board and CEOPMR. Poor scores will be fed back to the CAGs and training needs will be identified. | ICT | Ongoing | 31/03/13 |
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4 Surveillance</td>
<td>Monitoring to ensure that results are received by the ICT in a timely manner. Feedback of results to all Clinical services. In the event of a confirmed infection, e.g. MRSA, <em>E. coli</em> bacteraemia or <em>C. difficile</em>, and as a zero tolerance approach, a root cause analysis will be completed by the IC Team. This is to identify why an infection occurred and how future cases can be avoided. An action plan will be developed.</td>
<td>ICT/DIPC</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>2.5 Hand hygiene</td>
<td>As part of the “Zero tolerance to non compliance with hand hygiene”, the Trust will comply with the WHO “5 Moments for hand hygiene” initiative and will include service user involvement. Road shows will be held in key areas of the Trust to ensure compliance with the hand hygiene clinical guidelines including the correct use of alcohol hand gels at the point of care in all Inpatient/Community units.</td>
<td>ICT</td>
<td>Ongoing</td>
<td>1/10/13</td>
</tr>
</tbody>
</table>
| 2.6 Capital Planning & service development | To ensure that SLaM premises are designed and built to facilitate the prevention and control on infection, IC advice will be given to Capital Planning and E &F with reference to the following:
  - When preparing service specifications for engineering and building services
  - When preparing tender processes for building and commissioning. | Capital Planning Department/ E & F Managers | | 31/03/13 |
| 2.7 Hotel Services & Contracting processes | The ICT will continue to be involved in all stages of the contracting process for Hotel services and other services that have implications for infection control: Portering & Laundry services and Clinical waste disposal. The ICT will monitor Cleaning programmes and systems e.g. ensuring that these are visible in patient care areas and attend contract meetings to ensure high standards of cleanliness. This is in line with the framework for best practice, Confidence in caring. The ICT will continue to support and work with Modern Matrons [MMs] and Clinical Service Leads [CSLs] in their roles of infection prevention and improvement within their CAGs. The ICT will attend: Client Environment Board; Patient Environmental Operational Group; Hotel service, Cleaning contract review meetings. | ICT/Hotel Services Managers/ Environment Manager | 31/03/13 |
| 2.8 Medical Devices and Equipment Management | The ICT will continue to attend the Medical Devices and competencies Group meetings. Advice will be given on infection control risks associated with the purchase, lease or loan of medical devices and other equipment used within the Trust. ICT to work with MMs, CSLs and Ward Managers to ensure cleaning, including robust documentation, of all patient equipment, e.g. mattresses. Advice will be given on the cleaning of specific clinical equipment. A report detailing all inoculation incidents and action taken by the IC Team will be presented at the IC Committee. | ICT | Ongoing |

| ICT | 1/5/13 & 1/9/13 | ICT | Ongoing | ICT | Ongoing | ICT | Ongoing | ICT | 1/5/13 & 1/9/13 |
AUDIT STRATEGY

1. Introduction

The audit strategy has been developed to check compliance with the Trust IC policy and clinical guidelines.

The IC Team will meet with Modern Matrons [MMs] & Clinical Service Leads [CSLs] within the Clinical Academic Groups [CAG] to discuss the findings of audits and how to address any poor scores. The IC Team will support the MMs in the change and improvement of practices in the prevention of infection. Training requirements will also be identified.

All audit tools will be reviewed and developed in line with existing Trust risk management tools. The Trust Board will receive a quarterly report outlining progress on the audit strategy.

2. Spotlight checks on Inpatient areas

A “Spotlight” checklist has been developed to assist the IC Team with the regular visits to wards. This is to ensure compliance with key drivers, including those set by the CQC, and that IC is part of everyday clinical practice.

The checklist includes standards relating to:
- Cleanliness & tidiness
- Hand hygiene including ‘Bare Below Elbows’
- Waste management including Sharps bins
- Awareness of the name of the Trust Director of Infection Prevention & Control
- Documentation of the cleaning of patient equipment, including mattresses
- Food Hygiene

All Waste Management critical issues are escalated to the Estates & Facilities Department

All findings are fed back to Ward Managers, MMs and CSLs

Time period: Ongoing

3. Trust Infection Control Dashboard

The ICT will continue to support key staff, including Ward managers and Modern Matrons undertaking the following audits as part of an IC dashboard:

- Hand hygiene

Mattresses
Examination of patient equipment
Commodities [where applicable]

The dashboard will be presented to the Trust Board on a regular basis. Poor scores will be fed back to the CAGs.

Time period: Ongoing

4. Infection Control environment audits in the Community

A programme of audits will be carried out in Community units throughout the Trust to ensure compliance with critical IC standards including hand hygiene and waste & sharps management.
5. **Antibiotic prevalence study**

The study will be carried out in collaboration with the Trust Pharmacy Department to check compliance with the Trust Antibiotic clinical guideline.

**Time period:** 2 – 4 weeks.


Meetings with a Senior Project manager in Capital Planning ensures that the ICT receives information and gives advice on refurbishments, new builds or change of use. A table of all projects is included with infection control reports presented at Team and Committee meetings.

**Time period:** Ongoing.

7. **Main and ward Kitchen audits**

These will be carried out annually, and following any serious concerns, in collaboration with the Head of Hotel Services, on the main sites [Maudsley, Lambeth, Bethlem Royal Hospitals Ladywell Unit and Woodland House]. This is to ensure compliance with food hygiene legislation.

**Time period:** Ongoing.

8. **Waste management audits**

The IC Team will carry out the audits in collaboration with E & F. This is to ensure compliance with the Trust Waste Policies and National imperatives.

**Time period:** Ongoing

**Other audits:**

**Isolation precautions audit** – To be carried out following risk assessment and when it has been necessary to place a patient in Isolation. This is to ensure best practice to reduce the risk of cross infection to patients’ whilst providing appropriate protection to staff.

- **Urinary catheter care** – In order to comply with the NICE IC guidelines for primary and community care, the ICT will monitor the numbers of indwelling catheters in the Trust. Following identification of a patient with an indwelling urinary catheter [IDC] copies of the Trust guidelines and a staff leaflet are forwarded to the relevant wards. Clinical staff will then complete the audit tool from the "Essential steps to safe, clean care" and also the weekly review chart to outline the reason why there is the continued need for IDC.

Additional Infection Control audits will be carried out in areas throughout the Trust as the need arises and in response to publication of new or reviewed guidelines.
MRSA: For the months of July 2012 – June 2013, there have been 5 newly identified colonized* patients (Inpatient MHOA – 1, Psychological Medicine – 1 and Psychosis – 3). There were no cases of infection.

Antibiotic resistant infections e.g. **ESBL, VRE, etc.** ESBL [July – September 2012 ]
There have been three cases in urine samples from patients on three different wards.
Information on the patients’ symptoms was obtained and advice was given on appropriate treatment.

CMRSA, PVL*** etc. Nil cases

Hep C: From July 2012 – June 2013, 18 out of 195 of those screened for Hepatitis C antibody were positive.

Hep B: From July 2012 – June 2013, 202 patients were tested for HepBsAg. Following further tests, one patient was found to be HepBeAg positive. No further action required by the Infection Control Team

HIV: For the months of July 2012 – June 2013, 148 patients were tested for HIV. 2 results were positive. No further action required by the ICT.

C. difficile Nil cases

Notifiable diseases: Campylobacter spp There have been three cases on two wards, at the Ladywell Unit and Bethlem Royal Hospital. In all cases the ICT liaised with the local Health Protection Unit. No further action required by the ICT

Pulmonary tuberculosis [TB] Two patients who attended two different Community Mental Health Units were found to have Pulmonary TB in May and June 2013. The ICT liaised with the Consultants in Communicable Disease Control in Southwark and Croydon for the follow up of patient and staff contacts.

Other infections: Diarrhoea & Vomiting During 2012/13 there were 23 outbreaks of confirmed/probable viral gastroenteritis on Inpatient units. These were investigated by the ICT. Reports and summaries were forwarded to the monthly CEOPMR and the IC Committee.

Chickenpox/Shingles There has been 1 case of Chickenpox and 7 cases of Shingles on 7 different units between October 2012 and June 2013. In each case, all staff and patient contacts were identified and advice was given to care staff on the likelihood of spread.

* Colonisation – the presence of microbes on or in the body, growing and multiplying without invading the surrounding tissues or causing damage
** Extended spectrum beta-lactamases. Vancomycin resistant enterococcus
*** Panton Valentine Leucocidin
N.B MRSA was identified in clients, the majority of whom were transferred into the Trust. There were no cases of infection and no secondary spread.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 23rd July 2013

Name of Report: Annual Nursing Report, April 2012-March 2013

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

Author: Sarah Burleigh, Acting Programme Director (Nursing Excellence and Magnet Recognition)

Approved by: Jane Sayer, Acting Director of Nursing and Education

Presented by: Jane Sayer, Acting Director of Nursing and Education

Purpose of the report:
To inform the Board of Directors of the progress made against the objectives of the Nursing Strategy in the 2012-2013 financial year.

Action required:
For the Board of Directors to receive the report.

Recommendations to the Board:
That the report is received and approved.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
Developing and encouraging an innovative culture and quality focus is an identified goal within the Assurance Framework. The Nursing Strategy, 2009-2014 has a key focus on improving quality of care, empowering staff, and rewarding innovation. The report highlights progress in these areas, and provides evidence for the Trust to illustrate its commitment to quality within the financial constraints of the current situation.

Summary of Financial and Legal Implications:
The Nursing Strategy implementation is partially funded by SLaM charitable trustees through a grant to the Magnet Programme. The programme is working to establish new ways of working, and also to embed these within the culture of nursing in the trust, in order to achieve sustained change.

Equality & Diversity and Public & Patient Involvement Implications:
The Nursing Strategy is inclusive, and pays particular attention to the empowerment of staff within decision-making processes, the development of specific programmes of care tailored to the needs of people using our services, and the nursing contribution to the wider community.
The Annual Nursing Report to the Trust
Board of Directors

April 2012 – March 2013

Dr Jane Sayer
Acting Director of Nursing and Education
Sarah Burleigh
Acting Programme Director (Nursing Excellence and Magnet Recognition)
July 2013
1. INTRODUCTION
This report seeks to inform the Board of Directors on the progress and achievements related to the Nursing Strategy (2009 - 2014). The report covers the period April 2012-March 2013.

1.1 Context
Within the NHS, nurses are the largest professional group with 663,656 Registered Nurses, of whom 61,541 are Registered Nurses (Mental Health). The number of Registered Nurses (RNs) employed in South London and Maudsley NHS Foundation Trust has fluctuated over time, with the trend in 2011-12 appearing to be a reduction in RNs and an increase in HCAs (see Charts 1 and 2), which is at variance with national data that show a increase in the proportion of RNs to Health Care Assistants (HCAs). The figures for the last year show a reduction in both RNs and HCAs across the Trust.

Chart 1: Numbers of nursing staff employed, 2006-2012

![Chart 1: Numbers of nursing staff employed, 2006-2012](image)

Chart 2: Proportion of RNs to HCAs, 2006-2012

![Chart 2: Proportion of RNs to HCAs, 2006-2012](image)

In addition there are approximately 400 student nurses in training in the Trust at any one time. Commissioned student nurse numbers were reduced across London last year, which reflects...
the changing workforce requirements. Registered Nurses and Health Care Assistants account for 45% of the Trust workforce.

Key to maintaining professional standards and excellent nursing practice is effective nursing leadership. This is embedded within the organisation with each clinical service having a Head of Nursing functioning as the Clinical Academic Group strategic nursing leader, and Modern Matrons and Clinical Service Leaders responsible for overseeing quality of care and environmental issues at the clinical service level. Many of the Team Leaders are nurses and provide professional leadership at the point of care delivery. Strategic nursing roles exist focusing on developing and implementing policy relating to specific areas requiring statutory compliance and assurance eg: safeguarding children, infection control, physical and public health and identifying and monitoring standards of practice. There are three nurse consultants - dual diagnosis, persistent aggression and violence, and CAMHS. The Director of Nursing and Education, the Programme Director (Nursing Excellence and Magnet Recognition) and Assistant Directors of Nursing in addition to operational functions provide leadership in nursing performance and standards. We have also recently appointed the first two Advanced Nurse Practitioners to work within the South London and Maudsley in the CAMHS CAG.

1.2 Nursing Strategy
The Nursing Strategy was ratified by the Board of Directors in March 2009 and covers the period 2009 - 2014. It is based on the Magnet Recognition Programme (American Nurses Credentialing Center). It is an outcomes-focused strategy and incorporates the following sections:

- Transformational Leadership
- Structured Empowerment
- Exemplary Professional Practice
- New Knowledge, Innovations and Improvements

In July 2009 the Nursing Strategy was published and circulated to all Trust nursing staff. Although acknowledging previous achievements, this strategy is revolutionary in its ambition and focus, and has generally been well–received within the organisation. Evaluation of the Strategy is focused on key outcomes, and these are reported to relevant Nursing Councils on a regular basis.

1.3 Shared Governance
The process by which nursing manages its work to meet the outcomes defined in the Nursing Strategy has changed, with the introduction of a Shared Governance system (see Diagram 1). Local Nursing Councils have representatives at the Trusts’ Working Councils, and Nursing Executive. This ensures that nurses at all levels participate in decision-making to the highest level.
1.4 Magnet Recognition Programme
Magnet is a system of accreditation of nurses and nursing practice, which focuses on setting and maintaining consistently high standards of care delivery. The Magnet programme was successful in securing funding from SLaM charitable trustees, and the programme commenced in January 2010, with the appointment of a Programme Director. A number of Magnet-badged activities are embedded in practice and there is now a considerable spread of initiatives that underpin the development of the nursing workforce and nursing practice. An initial gap analysis resulting in RAG rating against the 145 Magnet standards showed that the Trust had a significant effort to make in a number of areas. Chart 3 demonstrates the progress that has been made against the 145 Magnet standards. The three remaining red items have detailed action plans.

Chart 3: Magnet gap analysis by rating
Cultural differences between the Magnet standards and the UK healthcare systems mean that a very small number of standards are unachievable in the short to medium-term, and possibly beyond. In particular, Magnet requires all nurse managers to have at least a baccalaureate degree in nursing upon submission of the application. This remains a challenge, with eighteen Ward Managers forecast to fall short of this standard by July 2013. Kings College London have completed a detailed review of international equivalency of nursing and academic qualifications, and this is currently with the American Nurses’ Credentialing Center for consideration.

2. TRANSFORMATIONAL LEADERSHIP

The role of the Nursing Directorate within the Trust is to provide strategic direction and leadership to nurses employed within the Trust, to raise clinical standards and to support clinical services to improve the patient’s experience. In addition it oversees the development and progression of mental health student nurses from the three partner universities. The Nursing Strategy outcomes associated with Transformational Leadership are:

<table>
<thead>
<tr>
<th>TL1</th>
<th>100% Ward Managers/Team Leaders with a degree in nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>TL2</td>
<td>100% Band 8 nurses in an advisory, expert or clinical leadership role achieved or studying at Masters level qualification</td>
</tr>
<tr>
<td>TL3</td>
<td>Trust scores above the national average for nursing staff on the staff survey</td>
</tr>
</tbody>
</table>

2.1 Ward Managers/Team Leaders with a Degree in Nursing

One of the criteria required for successful application for Magnet accreditation is that all Nurse Managers have at least a degree in nursing. SLaM has been in negotiation over the applicability of this criterion in mental health in the UK, and has continued to work on increasing the academic qualifications of Nurse Managers. The benefits of doing so are to support the ability of the Clinical Academic Groups to deliver on all three parts of the mission, including research and teaching by nurses, and to equip Nurse Managers with the skills and knowledge required. This has led to the commissioning of a top-up degree programme from London South Bank University, and continued support to nurses studying at other providers. At the point of first audit (January 2010), 21% of in-patient managers met the required standard. The figure has now increased 67% in April 2013. Work has been undertaken with Kings College London to map international equivalence of UK Degrees and Diplomas, and feedback is awaited from the American Nurses’ Credentialing Center. Chart 4 shows the number of in-patient managers who met the requirement in April 2013.

Chart 4: Number of Ward Managers with a degree, January 2010 – April 2013
2.2 Band 8 Nurses with a Masters Level Qualification

The Nursing Executive Senior Nurses have been studying at Masters Level in a variety of subjects since the beginning of the Magnet programme. Masters courses undertaken have included Public Administration, Infection Control, Mental Health Studies, Leadership and Mental Health Research. The two nurses currently without a Masters have started a Masters in Leadership and Service Improvement in Healthcare in September 2012.

Chart 5: Nursing executive Senior Nurses’ qualifications, January 2010 – April 2013

2.3 Nurse Engagement

Previous staff surveys have been reported at a Trust or Directorate/CAG level, but not by professional group. Magnet requires the Trust to report findings for nurse engagement at a unit level. Unit-level analysis is not currently available, but analysis of Trustwide nursing staff satisfaction reported through the staff survey has produced some interesting findings, and provided direction for areas of nursing infrastructure that need to be strengthened. Table 1 shows the comparative engagement scores for nursing staff in SLaM and other London mental health Trusts in 2012, and Chart 6 shows an improvement in nursing engagement from 2009 to 2012. The engagement measure is based on three key findings: nurses’ perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work or receive treatment, and the extent to which they feel motivated and engaged with their work.
Table 1: Mean engagement scores for Mental Health Nurses in London Mental Health Trusts, 2012

<table>
<thead>
<tr>
<th>Name of Trust</th>
<th>Mean Engagement Score</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet, Enfield and Haringey Mental Health NHS Trust</td>
<td>3.83</td>
<td>97</td>
</tr>
<tr>
<td>Camden and Islington NHS Foundation Trust</td>
<td>3.43</td>
<td>124</td>
</tr>
<tr>
<td>Central and North West London NHS Foundation Trust</td>
<td>3.72</td>
<td>80</td>
</tr>
<tr>
<td>East London NHS Foundation Trust</td>
<td>3.74</td>
<td>65</td>
</tr>
<tr>
<td>North East London NHS Foundation Trust</td>
<td>3.94</td>
<td>28</td>
</tr>
<tr>
<td>Oxleas NHS Foundation Trust</td>
<td>4.23</td>
<td>79</td>
</tr>
<tr>
<td>South London and Maudsley NHS Foundation Trust</td>
<td>3.91</td>
<td>99</td>
</tr>
<tr>
<td>South West London and St George's Mental Health NHS Trust</td>
<td>3.6</td>
<td>77</td>
</tr>
<tr>
<td>West London Mental Health NHS Trust</td>
<td>3.89</td>
<td>90</td>
</tr>
</tbody>
</table>

| London Mean Score                                                 | 3.78                  | 739                   |
| National Mean Score                                                | 3.62                  | 4,283                 |

Chart 6: Mental Health Nursing engagement scores in SLaM, London Mental Health Trusts and all Mental Health Trusts, 2009-2012

In order to obtain unit level data for Magnet purposes, and to provide more information to teams in order to improve engagement, the Nursing Directorate and Audit Department undertook a focused survey within in-patient wards and community teams, replicating the national survey questions that measure engagement. All nurses and Health Care Assistants identified on e-rostering in September 2012 (n=1590) were sent an electronic survey, containing the nine questions that contribute to the engagement score in the national survey. Staff were assured that responses would be anonymous, although they would be collated at the team level. The survey ran from the 4th October to 16th November 2012. The overall response rate was 40.3% (640 responses).

The findings from the 2012 survey showed that in-patient nurses were reporting very similar engagement rates in 2012 to 2011, with a fall of 0.02 in the overall score (non-significant). Community nurses, however, who were not surveyed previously, reported overall engagement
at 3.72 compared to 3.84 for the in-patient staff, a difference that appeared to be statistically significant (p=0.005). In particular, community nurses reported less engagement in their willingness to recommend the Trust as a place to work or receive treatment. There was no significant difference between RNs and HCAs in their overall scores. Broken down into constituent parts, the mean scores are presented in Table 2 and the mean engagement scores for each question in Chart 7.

Table 2: Mean scores for key components of the engagement score, October 2012

<table>
<thead>
<tr>
<th>Key Findings, Nurses and HCAs</th>
<th>2011, in-patients</th>
<th>2012, in-patients</th>
<th>2012, community</th>
<th>2012, all nursing staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff members’ perceived ability to contribute to improvements at work</td>
<td>3.89</td>
<td>3.83</td>
<td>3.83</td>
<td>3.82</td>
</tr>
<tr>
<td>Willingness to recommend the Trust as a place to work or receive treatment</td>
<td>3.80</td>
<td>3.81</td>
<td>3.50</td>
<td>3.74</td>
</tr>
<tr>
<td>Extent to which staff feel motivated and engaged in their work</td>
<td>3.92</td>
<td>3.87</td>
<td>3.83</td>
<td>3.86</td>
</tr>
<tr>
<td><strong>Overall engagement score</strong></td>
<td><strong>3.86</strong></td>
<td><strong>3.84</strong></td>
<td><strong>3.72</strong></td>
<td><strong>3.81</strong></td>
</tr>
</tbody>
</table>

Chart 7: Mean engagement scores by question, all respondents

Results of the national and local surveys have been reported through Nursing Councils, and nursing staff have been asked to discuss within local teams.

2.4 Other Transformational Leadership Activity

2.4.1 Leadership Activities
Nurses in SLaM continue to access opportunities to develop their leadership skills and knowledge. Forty staff (mainly nurses) have conducted service improvement projects over the past two years within the RCN leadership programme in the Trust. Thirty Band 6 nurses have been working part-time as Magnet Ambassadors since September 2010. These staff have received a leadership development programme over two years, and four members of the group have been promoted to Band 7. Six of the Ambassadors attended the Magnet
2.4.2 Student Nurses
The Trust has been involved in the development of a new pre-registration programme with King’s College London, which allows people with a relevant degree to enter a two year accelerated training leading to nursing registration and a Post Graduate Diploma, (PGDip) SLaM is fully committed to this programme, as previous audit has shown that this is a group of students who perform exceptionally well throughout their training, and are significantly more likely to be successful in job applications than students undertaking traditional three year training programmes, even at degree level. The second cohort of PGDip students is about to qualify and we are holding recruitment events throughout the summer.

The first cohort of PGDip students have been commissioned with London South Bank University, and we are evaluating a group supervision model of mentorship. This approach involves two Heads of Nursing co facilitating a supervision group for the cohort of students (11) for the duration of their course. The facilitators receive group supervision from Barbara Grey. We are writing up the evaluation findings to identify the benefits, if any, of using this approach with students.

3. STRUCTURAL EMPOWERMENT
Within an effective organisation, decision-making occurs at the point at which the decision has impact. To ensure that this happens, the Nursing Strategy required the development of a structure that supports empowerment of clinicians, with infrastructure enabling and monitoring the delivery of clinical care – the Shared Governance model demonstrated above. The Nursing Strategy outcomes associated with Structural Empowerment are:

<table>
<thead>
<tr>
<th>SE1</th>
<th>&lt;5% Band 5 vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>SE2</td>
<td>&lt;8% RN turnover</td>
</tr>
<tr>
<td>SE3</td>
<td>&lt;3% sickness</td>
</tr>
</tbody>
</table>
The Trust will not have any incidents of nursing misconduct or lack of competence resulting in disciplinary action being required for nursing staff.

The Trust will not have any incidents of nursing misconduct or lack of competence resulting in new referrals to the NMC.

3.1 Band 5 Vacancies and Selection
The centralised selection process is a screening exercise to provide a base line level of knowledge and skill. Those who pass the centralised test are then invited to interview and the individual services will administer their interview and any other measures they wish to use, tailored to the needs of the service.

Candidates are invited to sit a written assessment at the selection days which includes:
- MCQ – Drug calculations
- MCQ – Technical questions (MHA etc.)
- Care planning exercise

A reduction in the number of Band 5 selection events took place in 2011. This was due to service changes and reconfiguration within the Trust, and services offering posts to redeployees. This meant that there have been fewer numbers of Band 5 posts available. Results from selection events held from June 2012 to April 2013 are presented in Table 3. An increase in the number of Band 5 selection events has resulted in an increase in the number of Band 5 nurses appointed last year, 61 Band 5 nurses have been appointed compared to 38 the previous year. It has not always been possible to obtain figures regarding actual appointments once the process has been handed over to local services.

Table 3: Selection event results, June 2012 –April 2013

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied</td>
<td>122</td>
<td>82</td>
<td>88</td>
<td>123</td>
<td>86</td>
</tr>
<tr>
<td>Attended</td>
<td>108</td>
<td>11</td>
<td>61</td>
<td>85</td>
<td>41</td>
</tr>
<tr>
<td>Passed</td>
<td>53</td>
<td>5</td>
<td>21</td>
<td>27</td>
<td>14</td>
</tr>
<tr>
<td>Appointed</td>
<td>24</td>
<td>5</td>
<td>13</td>
<td>15</td>
<td>4</td>
</tr>
</tbody>
</table>

3.2 Preceptorship Project
In October 2011 NHS London funded an 18 month project within SLaM to develop a framework for Preceptorship for nurses. This consisted of a Practice Development Nurse for Preceptorship researching and developing resources, raising awareness of the importance of peer support within the clinical areas for newly qualified staff, recruiting receptive teams, recruiting Preceptors to pilot the ‘buddy’ system, and facilitating Preceptee forums, Preceptorship surgeries and reflective study days for the Preceptees. The aims of the project were:
- To ensure support for our newly qualified nurses in what are challenging roles, increasing confidence and competence in their role and knowledge base and reducing the theory practice gap.
- Improve job satisfaction and morale, build a positive culture and improve emotional resilience which in turn will lead to improved consistent and integrated patient care and experience.
- Improve retention rates leading to a reduction in the use of temporary bank staff, recruitment and training, which in turn will reduce financial costs and improve teams and consistency of patient care.
- Improve attendance and pass rates of the KCL course by Preceptees

Outcomes/ Achievements of the Project:-
• Raised Awareness across the Trust about Preceptorship
• Increased number of Preceptors across in patient services.
• Specific support given to new Band 5 nurses.
• A preceptorship ‘toolkit’ was developed for all nurses to access on Nursing intranet page

3.3 Registered Nurse and Health Care Assistant Turnover
A reduction can be seen in the RN turnover of approximately 1% in the last year, and this is consistent with the aims of Magnet. A more significant decrease of nearly 5% can be seen in the turnover of unqualified nurses from approx 15.8 % to approx 11%.

Chart 8: SLaM nursing turnover rates, 2009-2012

3.4 Nursing Professional Issues and NMC Referrals

3.4.1 Competencies
As part of the accreditation process for Magnet the competencies for nursing staff have been reviewed to include six core competencies:

• Professional standards and conduct
• Medication Administration
• Medical Devices
• Physical Observation
• Observation and Engagement
• Mental Health Act Administration

All nursing staff will need to complete competencies every three years. Registered nursing staff will need to complete all the above competencies (MHA administration for community services to be revised to include community specific domains of the Mental Health Act). Unqualified nursing staff must complete:

• Medical devices – Level 1 and 2 dependent upon Band
• Physical observation – Level 1 and 2 dependent upon Band

The introduction of the Professional Standards and Conduct competency has been introduced to support the supervision and line management of all staff for Team Leaders and Ward Managers. This competency identifies specific behaviours and attitudes that are expected of
all nursing staff and will support supervisors and line managers in addressing any areas of concern or deficit.

The core competencies have been supplemented by additional CAG-specific competencies and these have been provided to the Nursing Directorate for record. Currently there is a specific CAG competency for B&D CAG, Mental Health of Older adults and Dementia, and a template for use in the Psychological Medicine CAG. On completion of the core competencies the individual nurse will be expected to retain a verification of competence record which they can use as a ‘passport’ to demonstrate the outcome and date of competencies. Evidence of completed competencies has been seen during the practice assurance visits.

It is expected that all competency assessments will be completed with rigour by assessors. Where there are performance issues or concerns around conduct and/or capability it is hoped that the competency assessments will support and assist the line manager. Where concerns are identified in relation to the rigour of assessment testing it is anticipated that senior managers and Heads of Nursing would respond accordingly following further identification of issues. The Nursing Directorate is currently in discussion with Human Resources regarding the action to be taken with individuals who are unable to meet the core standards following reasonable support, re-training and re-testing.

The Assistant Director of Nursing (Professional Development) has been working with colleagues from G&ST, and KCH in the development of a KHP competency document for Band 5 Nurses. This document encompasses all of the competencies required of a Band 5 nurse, and will be used in a developmental way with their clinical supervisors. The portfolio will be given to newly qualified Band 5 nurses in September 2013.

3.4.2 NMC referrals
Any Registered Nurse who is dismissed from the Trust is referred to the Nursing and Midwifery Council’s Fitness to Practise Directorate, where the case is considered. The referral will either be dismissed or referred for further investigation by the NMC. Based on the findings of the investigation, the NMC decides whether to conduct a hearing, which results in the following outcomes: no further action, caution (placed on record for a specified period of time), conditions of practice (often time-limited), or a striking off order, meaning the individual can no longer work as a Registered Nurse. From Jan 2012 to March 2013, there were five new referrals to the NMC of SLaM staff.

From January 2006 to end March 2013, SLaM referred 65 nurses to the NMC, a mean of 8 per year. Other Trusts do not publish their rates of referral, so it is difficult to compare, but from the NMC’s website it appears that on average the NMC receives allegations regarding 0.2% of the total number of nurses registered. Chart 9 shows the number of referrals that SLaM has made to the NMC from 2006.
The prime reason for SLaM to refer a nurse to the NMC has been due to Gross Misconduct. This term encompasses a number of types of misdemeanor, including mistreatment of patients, fraud, sexual misconduct, working without the correct immigration status, and issues relating to breach of confidentiality. From Jan 2012 until March 2013 one person referred has been struck off the register, five have an interim suspension order, three have a conditions of practice, three are waiting an interim orders hearing, eight are waiting to be investigated, and six are waiting a decision by the NMC (see chart 10).

3.6 Awards and Recognition

Recognising the nursing contribution to care is a core feature of the Magnet programme. SLaM is the first Trust in the UK to introduce the DAISY awards. DAISY is an acronym for Diseases Attacking the Immune System. The DAISY Foundation was formed in 1999 by the family of an American patient, J Patrick Barnes, who died at the age of 33. The family
considered what they could achieve in his memory and agreed that the one really positive aspect of his illness was the skilful and compassionate nursing care that he received. In addition to the DAISY awards that are made the Foundation also seeks to enhance nursing practice through grants for research and evidence-based practice projects.

The DAISY Award programme is overseen by a Committee comprising representatives from a wide background who have links to the Trust, including service users and carers. The committee is chaired by Madeliene Long, Trust Chair. Nominations can be made at any time and by anyone, and nomination forms have been widely circulated. SLaM has recognised 15 nurses and Health Care Assistants in 2012-13. The first DAISY awards were made at a special ceremony in June 2011 to six nurses and one Health Care Assistant.

The photographs above show the award winners Urvina Shah and John Robinson receiving their awards from Gus Heafield Acting Chief Executive, at the team leaders event in January 2013. The following have been given DAISY Awards in the past year: Kenneth Ejezie, Kanwal Bains, Eunice Adeshokan, Rose Fonge, Laura Baker, Pat Alma Smith, Lora Murray, John Robinson, Asha tait, Urvina Shah, Mary Monaghan-Coombs, Reuben Cole, Ruth Gatabaki, Bibi Jaffaur, Sean Baker

Jane Padmore, Nurse Consultant CAMHS Clinical Academic Group, and Vanessa Smith, Head of Nursing, Mental Health of Older Adults and Dementia Clinical Academic Group were both successful in securing Florence Nightingale Foundation travel scholarships to explore specific issues within their areas of expertise and interest. Dr Jane Sayer has also secured a Florence Nightingale Foundation leadership scholarship and is planning a study tour to Seattle.

4. EXEMPLARY PROFESSIONAL PRACTICE

Exemplary professional practice is the goal of the Nursing Strategy. Working within an agreed model, nurses should provide consistent, efficient and accountable care, which is centered on the needs of the patient, family and carers. Nurses work in collaboration with others, and are also able to make autonomous judgments within the scope of their experience and competence. They are expected to develop professionally, and contribute to working within a safe and clear environment. The Nursing Strategy outcomes associated with Exemplary Professional Practice are:

| EP1 | 80% nurses’ time spent delivering care in in-patient settings, 40% nurses’ time in community setting spent in face-to-face care delivery |
4.1 Professional Practice Model

Over the past 12 months the Assistant Director of Nursing (Practice Excellence) has been collaborating and liaising with senior nurses, patients and direct care staff in order to further develop our nursing Professional Practice Model (PPM). The Professional Practice Model has been developed by nurses to support them to explore their individual practice through reflection. It provides a framework to enable nurses to articulate what they do, drawing on evidence to support their interventions as well as have a clear understanding of the impact this has on patient outcomes. Over the past 6 months the model has been developed further to incorporate the 6 C’s of nursing outlined by the Chief Nursing Officer for England, Jane Cummings as her future vision and strategy to deliver compassion in nursing practice. The model has been incorporated into the violence reduction strategy implementation plan and has been explored by staff on two pilot sites in the B&D CAG to support reflective practice and development. A working party supported by the Communications department has been developing a Professional Practice Model Portfolio for all nurses in the organisation which will provide information and guidance on how the model can be used as a reflective tool in practice to support continuous professional development and the implementation of the 6 C’s of nursing - compassion in practice (NHS England, 2013). This will be formally launched in September 2013 and the impact of the model will be measured over time. The implementation and evaluation of the PPM will be shared with NHS England as part of the Compassion in Practice national strategy.

Diagram 2: SLaM's Professional Practice Model

4.2 Direct Care Time

Through participating in Productive Mental Health Ward and Productive Community Services teams are encouraged to carry out Direct Care Time (DCT) assessments. The monitoring of...
progress of modules and the sustainability of the programme in the inpatient services has now been handed over to CAG’s by the quality improvement team. To calculate DCT historically an activity follow was completed on a Band 5 Nurse over a 12 hour period capturing all activities including percentage of time spent in direct care activities. This was then repeated quarterly to determine any change in percentage over time. In order to reduce the resource needed to carry out the activity follow a self assessment tool has been developed. Thirty four wards completed these self assessments in October 2012 on Band 5 nurses. The chart below shows the % DCT per ward. The average DCT across these participating wards is 31%. The sustainability of all wards routinely completing these assessments is crucial in order to continuously collect data in the future. However consideration is to be given to the possibility of using technology more effectively in order to capture these data in a more efficient and effective way.

Chart 11: Percentage of Band 5 time spent in direct care activities, in-patient areas

There are currently eleven Community Mental Health Teams participating in Productive Community Services. There have been a number of challenges with collecting and collating patient facing time data which the quality improvement team and the practice council has been working to resolve with IT. There are plans for future data to be extracted from epjs however there are a number of restrictions with this: the contact entries are made following the patient contact and tend to include travel time, waiting time, admin time etc. This means that the % of PFT is not accurate and would appear much higher than the actual reality in practice. Also this does not provide the depth of information to enable staff to look at what other activities they are engaged with in order to improve efficiency to increase patient facing time.

4.3 Medication Errors
Medication errors are routinely discussed in the Practice Council by senior nurses as well as direct care staff. This provides an opportunity to develop a clear strategy to reduce administration errors across the organisation as well as consider ways of improving consistency with reporting incidents. The chart below shows that there has been a gradual increase in errors reported as an ‘E’. Plans to address and monitor this have been agreed at the Practice Council.
4.4 Supporting Safe and Therapeutic Services
SLaM reports assaults on staff to the National Patient Safety Agency and NHS Protect, and receives nationally benchmarked data based on the annual number of assaults per 1000 staff. The results from 2004/5-2011/12 are shown below.
The data show an increase in assaults against staff in SLaM over the last few years but still significantly lower than the peak in 2006. SLaM lies second in the London Trusts for the preceding year. The increase in assaults in 2011-12 may be due to a number of factors, but one significant issue is that many mental health Trusts are re-structuring services and undergoing organisational change in order to meet budgetary requirements.

The Practice Council provides an opportunity for staff, including those working in clinical care, to discuss and implement strategies for the reduction of violence, in line with the Trust Quality Strategy, and work being led by the Nurse Consultant Promotion of Safe & Therapeutic Services. The current data is showing a slight increase in assaults against staff from the previous year. It is recognized however that the number of reported injuries through RIDDOR have reduced so the severity of incidences has reduced and is a positive. Most Clinical Academic Groups hold regular violence reduction groups, and these are focusing on implementation plans to achieve the strategic aim of reduced incidence of violence. There remains an increase in reporting activity where CAGs have been focusing on violence reduction; for example the B&D CAG's increase relates to improved reporting and more anticipatory reporting of low to moderate incidents.
A variety of interventions have been discussed at the Practice Council and currently a tested clinical toolkit is being rolled out across some in-patient services. The future aim is for this toolkit to be part of a planned training program that combines quality. Also a number of positive research initiatives from local Magnet projects looking at improving care delivered are subsequently is seeing reduced incidences of violence.

### 4.5 Public and Physical Healthcare

**Improving the Physical Health of Service Users - Early Recognition of the Deteriorating Patient**

Throughout the Trust the early warning score (EWS) charts are implemented across all inpatient areas. Since the introduction of the EWS there has been a decline in inpatient deaths

Chart 16: Number of inpatient deaths classified as failure to rescue, 2009-2013

![Chart showing number of inpatient deaths classified as failure to rescue, 2009-2013.](image)

The failure to rescue parameter has been developed as an indicator to assess if any deaths occurred could have been potentially prevented, therefore differentiating between these and sudden and unexpected deaths.

Three projects that have evolved following the themes of incidents, these are:

- The pilot between the Maudsley Hospital and Kings’ Medical Assessment Unit, which aims to improve access to medical support, assessment and treatment for physical health problems that our service users experience.
- Nursing at night work-stream that seeks to improve the implementation of the engagement and observation policy throughout the night, as well as improving the environment and equipment to support staff in caring for patients at night time.
- Improvements in the monitoring of patients post-rapid tranquilization.

To improve learning, knowledge and experience in the management of the deteriorating patient, the Directorate was successful in winning a bid from NHS London to pilot a simulation programme using high fidelity simulators. The experience will give the opportunity to have multidisciplinary learning, with particular acknowledgment to the human factors and communication barriers that affect patient safety.
4.5.1 National Patient Safety Thermometer
In 2012 the NHS moved to the full implementation of the National Safety Thermometer. The Safety thermometer is a point prevalence survey that is completed across the NHS on one day each month. The survey measure the prevalence of four patient safety harms.

- Falls
- Pressure ulcers
- Venous thrombosis embolism
- Cather associated Urinary Tract Infections

South London and Maudsley performs well below the national average for falls, VTEs and catheter associated infections, however not for all new pressure areas. This is a quality improvement target (13/14) for older adults to reduce this by 1% for all grade 2 ulcers and above. The Older Adults CAG meet weekly to review all pressure ulcers. Nursing staff have attended a five day wound care program at Kings and state that they now feel empowered to care for people who have a high risk of pressure sores.

4.6 Patient Satisfaction
Reflections over the past 12 months for patient experience has demonstrated a number of service improvements and lessons learned that have resulted in an improved patient experience.

4.6.1 Annual National Community Patient Experience Survey (NCS) 2011/12
Following the 2008 NCS results, the Trust was rated in the bottom 20% of worst performing mental health Trusts in England and the worst performing mental health Trust in London. Through a series of collaborations including nursing staff and service users, a number of underperforming areas were identified. Those underperforming areas included patient involvement in their care plans; patient safety; and ineffective support and goals setting around ‘day to day living’.

Through ongoing internal PEDIC survey monitoring and co-produced service improvement initiatives, the 2010 and 2011 national surveys highlighted clear improvement in all of those underperforming areas. The Trust is now rated in the top 20% of best performing mental health Trusts in England and the best performing Trust in London.

4.6.2 The development of PEDIC and the Trust Patient Experience CQUIN targets/initiatives:
The development of the PEDIC system throughout the Trust has been challenging and yet it has also helped to change behaviour and the culture by embedding patient experience surveys as an ongoing function within the delivery of health care. Following the introduction of PEDIC in 2009, the PPI team accepted all ongoing patient satisfaction surveys and developed a series of new patient experience surveys including the Productive Ward and Community surveys. However, this array of multi-varied surveys made the process of data comparisons across the Trust and between teams extremely difficult, time-consuming, but most importantly the PPI team struggled to respond to our Trust-wide CQUIN targets.

The new PEDIC approach for 2012, which has been successfully piloted through February and March 2012, will implement a number of changes. These now include:

- Standardised PEDIC surveys for 90% of teams and wards within the Trust, which will enable us to compare, contrast, and learn more effectively and efficiently across the Trust, and to identify underperforming teams. The survey questions (partly set by Commissioners, service users and the Trust underperforming areas) are essentially derived from the NICE Service User Guidelines and the Quality Account. Other areas
to monitor include the complaints process, medicine management, and violence and aggression.

- All teams and wards will have to register to the PEDIC website enabling them to access their survey. They will be expected to print their required number of surveys (which we will monitor), when the survey is completed the surveys are then sent by Freepost to Fr3dom Health. All surveys results will be scanned into the PEDIC system.
- This new process means that all top-line results will be automatically pushed to all team leaders and/or to any appropriate party.

The pilot for this new system covered a five-week period in February and March and provided a return rate of over 600 survey responses. We anticipate over 20,000 by the end of the next financial year.

The “Think outside the box” campaign. Last year teams were given small amounts of money to work collaboratively with service users to think of innovative ideas to support making improvements to the patient experience. £30,000 was allocated to a number of successful projects, one being the patient information trolley at Lambeth in which volunteers visited service users and supported them with providing them with appropriate information in relation to their treatment and care.

4.7 Trustwide Exemplary Professional Practice Work

4.7.1 Infection Control

The Infection Control Team (ICT) provides a high quality rapid response service to reduce the risks of Healthcare Associated Infection (HCAI) for patients, staff and visitors. The ICT aims to ensure that Infection Control [IC] is part of quality and safety within the Clinical Academic Groups to ‘deliver clean and safe care’ throughout the Trust, whilst highlighting that everyone has infection prevention and control responsibilities. There are currently IC arrangements at Board level and clear lines of accountability in the Trust.

The ICT has been working to an annual work programme ratified by the Trust Board in July 2012. The programme was developed outlining specific targets to ensure compliance with the Health & Social Care Act (HSCA), 2009. The Infection Prevention Society’s statement: “Our vision is that no person is harmed by a preventable infection” is included in this document. The ICT has also developed the annual audit strategy that includes the Trust IC dashboard, and the IC training programme.

As part of the IC training programme, the ICT attends the monthly induction Market place for all new staff. Service users have been involved with a number of induction sessions, including those for student nurses. The uptake by staff of the National IC ‘e’ learning programme continues to increase.

The IC policy and guidelines are reviewed as required and following publication of national imperatives. The Team is currently working in collaboration with other ICTs within Kings Health Partners to not only share policies but develop IC pathways and systems.

To prepare for an unannounced visit from the Care Quality Commission and to ensure compliance with the HSCA, a “Spotlight” check list has been developed. This enables the ICT to be able to carry out frequent visits to inpatient areas to check that IC is embedded in clinical practice.

In order to comply with the NICE IC guidelines for primary and community care, the ICT monitors the numbers of indwelling catheters in the Trust.

The ICT attends Steering Groups and regularly meets with Senior project managers to ensure compliance with the recently published: ” Health Building Note 00-09: Infection Control in the
Built Environment” in which it states: “the infection prevention and control team should be consulted throughout every stage of a capital project and their views taken into account.”.

Surveillance of alert organisms and blood borne viruses has been maintained. In the event of a confirmed infection, e.g. MRSA, *E. coli* bacteraemia or *C. difficile*, a root cause analysis will be completed by the IC Team. Procedures will be reviewed and an action plan developed.

4.7.2 Safeguarding Children

We are continually challenging all elements of our safeguarding children arrangements, striving to ensure that they are ever more embedded in day-to-day practice. The past year’s reviews (with full staff involvement and consultation; and based on Trustwide research, feedback and lessons learned from Serious Case Reviews) and revisions of the Child Need and Risk Screen, Training Strategy and Model and Domestic Violence Policy and Care Pathways are all reflective of the strengthening of these Trust safeguarding arrangements.

The Assistant Director of Nursing (Trust Named Nurse, Safeguarding Children) completed Trustwide qualitative phenomenological research as part of a Masters in Public Administration (MPA) and, as well as presenting the findings at nursing, paediatric and research conferences nationally and internationally, has used the research to review and strengthen the Trust safeguarding arrangements through a focus of increased shared governance and staff engagement.

The new Safeguarding Children Training Model has been designed very much with engagement and embedding safe and consistent principles in team-base practice in mind; and will see all clinical teams receiving annual team-based updates of national, local and Trust learning introducing more timely and effective dissemination of learning based around the preferences and suggested approaches expressed by our staff.

We are also working with Local Safeguarding Children Boards and partner agencies to create more opportunities for front-line direct care staff to meet, better understand the strengths and limitations offered by each organisation; and enable improved inter-agency communication, collaboration and information sharing. With a focus on early help for children and families we hope that a strengthening of connection of staff across the partnerships will better address the common pressures of; services more stretched by financial constrains with fewer resources, increasing caseloads and rising thresholds determining the levels of interventions offered. This will be centred, with the rest of our engagement with partner organisations, on continued, practical implementation of the “Think Family” agenda and ensuring that we help our staff to see the children and adults in our care as part of a family unit. Our focus is, where possible, on early intervention to meet need; as well as the times when we need to protect.

We are finding that our staff, through being more aware and informed of both their duties to safeguard and of the Trust arrangements to support them, are contacting our Trust Advice Line and requesting advice and consultation via this and their local Trust Safeguarding Leads. As a result we see a rising awareness of, for example, Domestic Violence and the impact on victims and their children. We have strengthened our policy and care pathways giving staff a single route to borough-based domestic violence specialist services.

The internal and external audits and inspections, as well as Trustwide research, suggest that there is a good level of awareness and assertive response by Trust staff in meeting the safeguarding needs of children and young people; but the Trust will continue to challenge its arrangements, staff understanding of these arrangements and their impact on outcomes for children and young people through robust internal and external scrutiny; continuing to clarify expectations and further embed safe principles in practice. With this in mind we are now asking our Trust safeguarding leads to regularly appraise us of the key strengths and concerns within their boroughs and what is being done to address concerns or gaps in
assurance in order to ensure that we respond quickly and assertively in the best interest of children and young people.

4.8 CAG Practice Headlines
Each CAG has been undertaking projects to improve practice locally, and examples of this work are detailed in Appendix 1.

5 NEW KNOWLEDGE, INNOVATIONS AND IMPROVEMENTS

Within the context of Kings Health Partners, nursing is working to improve its evidence base, develop new and innovative ways of working, and develop the reputation of the organisation. The Nursing Strategy outcomes associated with New Knowledge, Innovations and Improvements are:

| NK1 | The Trust meets the research strategy workforce outcomes: research awareness and ability to describe application of evidence to practice, 100% of RNs; actively involved in clinical research activity, 500 RNs; achieved/studying at Masters level, 100 RNs; achieved or studying at PhD level, 17 RNs; studying at post-doctoral level, 10 RNs |
| NK2 | £50,000 research income generated by nurses annually, from grants, scholarships and awards |
| NK3 | Thirty nursing publications annually in peer reviewed journals |
| NK4 | An additional twenty discussion articles published annually |
| NK5 | Twenty five nursing conference presentations annually, with a minimum of ten external presentations |

5.1 Research Strategy
The Nursing and Occupational Research Strategy has been ratified and actioned by the Research Council that meets quarterly, and now includes Social Worker attendance. The Council has been focused on increasing research literacy and activity in the underrepresented professions, and has built up a number of resources to support this activity, including centralised information about upcoming calls for abstracts, sources of funding for research and suggested lists for publication. Research presentations have been made at the Council, with the aim of providing critical support to first time presenters. The Council is also monitoring progress against targets, and agreeing annual targets for publication and presentation.

5.1.1 Research Mentor Project
Following a successful pilot project, the model adapted from an approach developed at the University of Virginia Health System, has been successfully repeated for a second year. As a low cost method of introducing clinical staff to research methodology, with the support of nurse and OT mentors with a Masters, this model has been further refined, and has achieved £265,550 funding over five years from the BRC for ten further projects to commence in April 2012. The twelve projects which commenced in April 2012 are summarised in Table 4, and are due for completion in July this year (2013) Eight further projects have been funded this year, and are summarized in Table 5.
Table 4: Research Mentor Projects Commencing in April 2012

<table>
<thead>
<tr>
<th>Evaluation of the SAGE intervention in Addictions</th>
<th>Evaluation of use of clinical interventions in PICUs</th>
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<tbody>
<tr>
<td>Evaluation of sleep hygiene group for people with ASD</td>
<td>Evaluation of impact of use of drug dogs Maudsley acute wards</td>
</tr>
<tr>
<td>Evaluation of the use of a standardised occupation assessment in OT</td>
<td>Examination of prevalence of police involvement in planned MHA assessments, and service user experience</td>
</tr>
<tr>
<td>Evaluation of OT interventions alongside CBT for anxiety disorders</td>
<td>Exploration of interventions to reduce violence with people with DSPD</td>
</tr>
<tr>
<td>Exploration of impact of reminiscence therapy for people with moderate dementia</td>
<td>Evaluation of impact of life history work for people with advanced dementia</td>
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<td>Evaluation of peer support training programme for staff-client interactions</td>
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</tbody>
</table>

Table 5 Research Mentor Projects Commencing in April 2013

<table>
<thead>
<tr>
<th>Evaluation of the outcomes of the Anxiety Disorders Residential Unit. ADRU, aimed at increasing the evidence base in severe treatment refractory OCD</th>
<th>Completing a data set of all patients using NOIIS scale (Nursing Observation of Illness Intensity Scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate the impact of the Family Partnership model</td>
<td>Improving patient involvement in care planning using a staff training/peer support tool</td>
</tr>
<tr>
<td>Delivering the re-motivation process, a progressive OT intervention for individuals with severe volitional challenges</td>
<td>Recovery focused music/multi media project</td>
</tr>
<tr>
<td>Service evaluation for the introduction of ward diaries to patients</td>
<td>A service evaluation of the recovery enabler project, in Lewisham older adults</td>
</tr>
</tbody>
</table>

5.2 Publications and Presentations

Counting the number of publications and presentations by SLaM nurses has been a useful if not yet a very sophisticated measure, and a driver for improving opportunities for nurses to engage in research activity. The results for 2009-2012 are presented below in Table 7, and by CAG in Charts 17 and 18. Although great progress has been made in increasing the number of presentations, more work is required on helping nurses to write for publication.

Table 6: Nursing Publications and Presentations, 2009-2011

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
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<th>2012</th>
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<tbody>
<tr>
<td>Total Number of Publications</td>
<td>30</td>
<td>21</td>
<td>30</td>
<td>18</td>
</tr>
<tr>
<td>Total Number of Presentations</td>
<td>27</td>
<td>25</td>
<td>64</td>
<td>62</td>
</tr>
</tbody>
</table>
5.3 King’s Health Partners. KHP Nursing and Midwifery Conference and Mentorship Awards

The first Kings Health Partners, Nursing and Midwifery Conference was held on May 10th at Stamford Lecture Theatre. Professor Robert Lechler (KHP) and Madeliene Long, Kings Health Partners and Trust Chair members of the KHP Partnership Board opened the conference. The conference was a great success with key presentations from every trust, and also an external speaker. Nurses from every hospital were represented, both through the presentations and workshops, but also posters and participation in the day.

Kings College London, also presented the annual Mentorship Awards to the winners from each branch of nursing. Nominations came from student nurses from Guy’s & St Thomas’, King’s College Hospital and the South London & Maudsley NHS Foundation Trusts. Without exception, the mentors were all described as being helpful, objective, compassionate,
excellent role models, experts in their fields, with many more worthy attributes. There were winners in a number of categories which included, Adult nursing, Mental Health nursing and Childrens’ nursing. Christine Hinchliff won the award for Mental Health nursing, and also won the overall winner of the 2013 KHP Mentorship Award Christine works at the St. Thomas’ A&E Psychiatric Liaison-Psychological Medicines CAG, and here are some of the words her students used in their nominations:

The photograph above shows Christine Hinchcliff with two awards, Mentor of the Year for Mental Health Nursing, and the overall winner of Mentor of the Year for KHP 2013. Also in the picture are; Professor Helen McCutcheon, Head of School, Florence Nightingale School of Nursing, Dr Jane Sayer, Acting Director of Nursing, South London and Maudsley NHS Foundation Trust and Angela Parry, Director of Clinical Education, Florence Nightingale School, Kings College London.

5.4 External Consultation
The Nursing and Education Directorate continues to maintain and develop external consultation services, including the following:

5.4.1 Early Warning Scores
The Trust has been given an HQUIP grant to roll out the early warning scores and quality improvement tools to other Mental Health Trusts across the country. Twenty other
participating organizations are now actively involved. This initiative will be governed by the national mental health and learning disability nurse directors forum and will run from 2013-15

5.4.2 Readiness for Work
The London Readiness for Work research programme completed in April 2013, having commenced in 2008, co-chaired by Jane Sayer, Acting Director of Nursing and Education at SLaM, and Linda Burke, Dean of the School of Health and Social Care at the University of Greenwich. The group comprised senior nurses and education provider representatives who had an interest in improving the employment rates of newly-qualified nursing staff. The group secured £160,000 from NHS London in 2009 to complete four research projects, two of which were co-hosted by SLaM. These completed in 2011, and the group secured a further £90,000 for three more projects, two of which were co-hosted by SLaM. Findings from the seven research projects included:

- Significant differences in employment rates of newly qualifying nurses, dependent on ethnicity, university of study and branch of nursing.
- Similar education and employer expectations of competence, but poorly described expectations of qualities, values and attitudes of newly qualified nurses, and subjective and inconsistent assessment of ‘soft’ qualities.
- The extent to which clinical placements impact on student nurses' experience of training and contribute to building resilience.
- The importance of the mentor role in students' learning.

The Readiness for Work group has presented its finding to a range of audiences, including to Lord Willis and LETB chairs and Directors of Quality in February 2013. The three London LETBs have committed to taking the findings forward in their commissioning and quality monitoring of pre-registration nurse training across London. The research findings have also contributed significantly to work commissioned by the London mental health Directors of Nursing in April 2012. This programme has consisted of a series of co-produced plans to improve the selection of people into pre-registration nurse training, into posts at the point of qualification, and to improve the practice experience of students whilst in mental health settings. Universities and Trusts have worked on standardizing expectations and processes, and are now considering further work to continue to attract good students into mental health nursing careers across London.

6. RECOMMENDATIONS
The Trust Board of Directors is asked to receive the report.
Appendix 1: CAG Nursing Practice

**Addictions**
- The Addictions Council has now had 6 meetings and has achieved a high rate of attendance by Addictions Council members and students attending the Nurse Exec, Prof Standards, Workforce, Practice and Research Council meetings.
- Addictions Council members are currently carrying out an audit of all Nurses and Drug Workers’ academic and professional qualification.
- One B6 nurse from Signpost has been accepted for the RCN leadership course.
- One of our B7 Ward Managers is part of the Clinical Leadership Network REAL Eminent Leaders initiative
- Three B6 Community nurses are completing or expecting to start ‘top up’ degrees.
- One nurse won a DAISY award.
- Current research/audit/clinical innovation activity:
  - Blackfriars Road CDAT: Spirometry Project.
  - Signpost: SAGE Project (Research Mentor Project looking at using group work to assist recovery).
  - Cross CAG-Contraception Provision Project.
  - Paul du Buf has been accepted to present a paper about the ‘On-Line Recovery Project’ at the Helsinki Mental Health Nursing Conference in May 2012.
  - Rosie Mundt-Leach has presented her survey of Nurse Prescribers in Addictions at the National Forum for Non-Medical Prescribers in Substance Misuse in London in February and the research report has been accepted for publication in Mental Health Practice Journal.
  - Addictions Nurses and Drugs Workers from different teams in the CAG are also currently involved in assisting with the CONMAN (Contingency Management) trial and the ACTAD Assertive Community Treatment for Alcohol Dependence (Outreach Programme) research trial for alcohol dependent patients.

**Behavioural and Developmental**
- The Team Leader and CBT Nurse Therapist in the Behavioural Disorders Unit are running a programme training all nurses and nursing assistants in Basic CBT Skills to enhance the continuity of CBT interventions for all patients. There is evidence that nursing staff are using CBT approaches daily, with nursing notes on the electronic Patient Journey System indicating that nurses are using specific CBT techniques in their interactions with patients.
- Following an audit of patient and staff responses to the Trust Smoking Policy in 2011, work is progressing to support patients to cut down and stop smoking. Nurses have worked with the patients on one female forensic ward to reduce smoking breaks from almost hourly to just two a day from early 2012, with the aim of working towards a totally smoke-free ward. The same ward also piloted the in-house exercise circuit as part of an integrated approach to physical health improvement.
- Audits have been carried out of mealtime incidents and, arising from this, of patients who miss breakfast. Nurses are working to reduce mealtime incidents and thus improve patients’ experience and food intake; and to support patients to eat breakfast and snacks in order to optimise nutrition and further reduce incidents.
- All inpatient wards are now actively participating in Releasing Time to Care, with three community teams undertaking Productive Communities.
- Two nurses have received Daisy Awards and a further twelve received Daisy Pins.
- All Band 6 and Band 7 nurses have completed a CAG Developmental Programme.
- The B&DP CAG Nursing Council continues to meet on a bi-monthly basis. The group has a total membership of 21 nurses. Key areas for the nursing council have concerned violence reduction and consideration of the involvement of nursing staff in research. To this end the Nursing Council has set up a Journal Club. Recent work is focusing on a
Senior Buddy Scheme and a Post-Trauma Support Group for staff is also being examined. The Trustwide Nursing Council is open to all CAG members to attend and the CAG has two staff who occupy senior roles within the Trustwide forums.

- The B&DP CAG Dual Diagnosis Group has been set up by Dave Weir, Strategic Nurse Advisor, Governance and Assurance, to shape the CAG response to the Trustwide Strategy and Policy for the care and treatment of service users with Dual Diagnosis. Membership has initially been taken from parties across the CAG who have either experience or an interest in this area. The Group is co-chaired by the Nurse Consultant for Dual Diagnosis, Cheryl Kipping. The group is focusing on how best we can implement the above policy and what options may work best across the CAG. Possible considerations are Dual Diagnosis Champions in each clinical area feeding into the wider forum or the creation of a temporary dual diagnosis worker to work with teams across the CAG to raise the profile of dual diagnosis work and the Trust Policy. A review of the current skill level of staff in this area is also being considered and key nursing staff have attended the five day dual diagnosis training.

- The B&DP CAG has setup its own Physical Health Forum, which meets monthly and has been running for over twelve months. Nurses who are physical health leads from each clinical area across the CAG attend. The group has completed four Medical Devices Competency Assessment days for assessors which have all been well attended, and feedback has indicated that these have been valued by attendees.

- A key part of the work has been around an audit of the physical health provision currently being delivered to service users within the CAG. The audit is the vehicle that has helped us to identify the areas to target within physical care. Staff have been offered and attended places on IMPaCT training programmes. Physical Health Champions have been identified for each service area and are being trained in physical health in severe mental illness awareness, medical devices competency, and smoking cessation.

- Nurses submitted applications for the Research Mentor Programme Awards and two were successful: Behavioural Developmental Unit – this project aims to evaluate the effectiveness of a nurse-led sleep group, Waddon Ward – this project aims to evaluate the impact of nursing practice on violent incidents, in a medium secure unit for men with personality disorders.

- National Harm Free Care initiative – Waddon Ward, River House are one of the teams in the Trust involved in this project.

- The security team, as part of the Nursing, Quality and Assurance team, has drafted the Security Strategy for the CAG which aims to challenge traditional views of security by incorporating Trust and CAG values around recovery. The security team have led on the following quality initiatives:
  - The use of drug dogs – August 2011 saw the publication of an article describing our non-custodial approach to the use of drug dogs.
  - GPS tracking – the Buddi scheme has been in place for two years. The security team has spoken at numerous conferences and events and a number of articles have been submitted for publication, with others in development. Leave incidents have greatly diminished and unescorted leave has greatly increased leading to a safer service with better outcomes for patients.
  - Quality Network for Forensic Mental Health – the team has led on the Network’s Physical Security events in 2011.
  - Pre-admission assessment – the security team working with ward based nursing staff have incorporated the DoH See, Think, Act relational security handbook into a pre-admission assessment for the forensic services which has been piloted since summer 2011. A review of the pilot is currently being undertaken.
  - Escape Vulnerability Assessment – the team has developed an assessment tool to add to the annual MSU Healthcheck in providing assurance against a Never Event. The tool has been successfully piloted and further collaboration with other external services will occur this year.
• Security Awareness Training – the team won a bid for monies to develop a London Wide Security Awareness Training e-learning package and is currently working with colleagues from the London-wide Security Leads.

• The B&DP CAG provides one of the co-chairs for the SLaM Nursing, Occupational Therapy and Social Work Research Council, which has links with relevant Institute of Psychiatry Departments and the KCL School of Nursing. The Council and its partners oversee allocation of BRC funding for small research projects by these groups and costs for advertised academic training opportunities.

• Nurses within the B&DP CAG have published five journal articles with three different nurse authors – three of these publications are with a nurse as first author; published two books as editor and nine chapters, again between three authors; presented at ten conference (two international and two national).

• Eight nurses have been sponsored to complete top up degrees and three nurses for MScs.

CAMHS

• The Snowfields and Bethlem Adolescent Units continue to provide high quality services to their clients and have continued to innovate and develop further services, including a new ‘Step Down’ service attached to SAU which provides intensive outreach and transition support for young people who may otherwise require longer hospitalisation.

• OAK and Ash wards in Kent are growing in confidence and have been developing and implementing robust practices including focussing on goal setting and reviewing, and patient involvement in EoC. The difficult experience of managing both wards all together (the Woodlands House Unit is very open plan) has led to the implementation of greater clarity around the separation of each wards’ processes and clinical work, and there are plans to further physically divide the building to progress this direction of practice. The teams and service users have reported benefits from these changes. Emma Addison has been appointed as the Senior Nurse Manager for Woodlands House.

• Acorn Lodge has been full and busy in recent months, and the team has had to meet significant clinical challenges which have ultimately led to some hard-won learning in the management of children with significant co-morbidity.

• The future of BYAU remains uncertain; meanwhile The BYAU staff are bringing their skills to other areas of the CAG in mutually supportive redeployments. Most have remained in CAMHS, and there has been welcome support in this transition from the B&D CAG.

• Debbie Hunt has been newly in post since early 2012 as the Senior Nurse Manager for the Bethlem CAMHS services.

• Community CAMHS services have all undergone significant service reconfiguration driven largely by non-NHS disinvestment in joint funded services. This has led in some Boroughs to a loss of some nursing staff, but there is a continued nursing presence and lead nurse in each area. The reconfigurations have also led to new lead nurse being appointed in Croydon (Linda Galvin) and Lewisham (Alistair Rice)

• While Nurses are in a minority in CAMHS National & Specialist outpatient services their numbers are growing, with a dynamic and central presence in the Eating Disorders service, and working in the Parenting services, and the newly arrived CIPP team – a specialist team providing pharmacological treatment and monitoring service to children with severe and multiple co-morbidities

• Several Nurses have successfully applied to study on long courses over the coming years, including CBT and Family Therapy courses (both major NICE recommended treatments in CAMHS)

• The CAMHS Nurses’ Council continues to be well attended at its quarterly meetings, where issues including nursing models, ANP role, training, service changes (see above) and practice assurance have been discussed.

• Future developments include:
• Strengthening links with KHP colleagues - including a CAMHS presence at the next KHP Child Health Training day
• Increasing focus on reducing medication errors and raising the importance of nursing standards ‘around the clock’, at weekends and at night.
• Maintaining and expanding nursing contribution to community and outpatient service

Mental Health of Older Adults and Dementia
• The CAG Nursing Council has been active since November 2011 and has representation from nurses at all levels working in a variety of settings. Direct care nurse representatives attend the Trust Nurse Executive and the four Councils that support it.
• We are developing local unit based Councils which are underway in 4 out of our 7 inpatient services and in Croydon community services covering the CMHT; Memory and Liaison Service, all are led by direct care staff. Our CNSs are leading on this in our community services and HTT. We believe that nurses can only truly impact on their practice if they are involved in decisions that affect them at a local level and aim to have a Council in all of our services. The nurses develop their own framework for running the meeting and to enable shared decision making a reality for all.
• Across our inpatient, specialist care and community services 10 B7 Managers have a nursing degree; 7 a non nursing degree; 1 is being supported this year and 1 without is due to retire. This includes our CNS roles.
• Three of our Senior Nurses attended the Magnet Conference in Los Angeles in October 2012 and were supported in this by the nursing directorate and the CAG.
• Our Assistant Director for Nursing and Quality won a prestigious Florence Nightingale Foundation Travel Scholarship – The CNO England Travel Scholarship to undertake a study in the USA on Reclaiming Clinical Leadership in Mental Health Nursing: An exploration of the principles of the Magnet Hospitals Models.
• Following a management restructure in the CAG we have developed 2 new Heads of Nursing roles to focus on quality and research in our inpatient and community service lines.
• We have developed a CAG Band 5 development programme that includes monthly taught sessions led by our inpatient and specialist care CNS and a peer supervision group facilitated by our Assistant Director for Nursing and our Associate Director for Education and Training.
• Our Executive have agreed to build on this programme by supporting the establishment of a B5 rotation programme for newly qualified nurses who have completed a post graduate diploma in nursing. This programme will offer 2 inpatient and 2 community placements each for 6 months and formal educational opportunities including Level 6 modules in dementia care at the IoP and mentorship for professional practice at KCL. In the second year they will undertake a funded level 7 dissertation module to provide a top up to a masters in nursing
• The CAG is committed to developing its remaining continuing care services from providing long term care for people with dementia to a specialist care model that provides time limited intervention to people with severe non-cognitive symptoms of dementia. We will develop our nursing workforce to deliver specialist interventions that reduce the severity of non-cognitive symptoms to enable service users to be transferred to other providers.
• The CAG reflected on how we support and assess nurses and healthcare assistants in the delivery of high quality inpatient care. Currently the NHS Knowledge and Skills Framework (KSF) provides generalist competencies for these staff groups but are overly complicated and do not articulate the core competencies our nursing staff require to deliver high quality care. We have developed a Capabilities Framework for Registered Nurses and Healthcare Assistants. This competency framework is specific to healthcare assistants and band 5 and 6 registered nurses. The competencies comprise of overall objectives and associated metrics to enable evaluation. To support managers in being able to implement and evaluate individuals against these competencies, a one day
A workshop was held that incorporated: an introduction to the competency framework, performance management, clinical supervision and undertaking coaching conversations. The day will be followed up with a forum to support implementation, trouble shooting and sustainability.

- The CAG implemented the Patient Safety Thermometer in each of our inpatient and specialist care services. This is a local improvement tool that monitors nurse sensitive indicators to measure the proportion of patients ‘harm free’. This tool had an immediate impact on patient safety as it identified a cluster of pressure ulcers on one of our specialist care units. In response we have developed local guidelines around reporting and monitoring of tissue viability. With the support of the Assistant Director of Nursing for Public and Physical Health we have developed a robust response to supporting direct care staff to deliver evidence based prevention and management of pressure sore care. This includes a weekly meeting where CAG Senior Nurses meet with the ADoN and representatives of the patient safety team to review and update every careplan.

- In response to the deficit in nursing staff's knowledge and skills in this area we have identified champions who are undertaking the tissue viability wound care module at KCL which has been adapted to meet the specific needs of nurses working in our CAG. In addition we commissioned an expert nurse as a guest speaker to deliver a CAG wound care study day. We are undertaking an audit of wound care, which will support the identification of training needs to ensure that awareness of pressure care issues is embedded within teams and that they know how to respond, escalate at an early stage and deliver evidence based care.

- We have revised our CAG Quality Network to provide a forum for Nurse and OT clinical specialists to share best practice and disseminate information on all aspects related to improving quality and will bring together the work streams previously discussed in the CAG Physical Healthcare Forum and the Essence of Care Meeting. The meetings will cover the following key improvement areas: Physical Healthcare; Tissue Viability; Falls; Privacy and Dignity; Wellbeing and Recovery; Nutrition; End of Life Care standards; Care planning and person centred care; CQC Preparedness. These meetings will also provide an hour of reflective practice using Action Learning (AL). AL is a management development strategy based on experiential learning principles. Revans (1980) defined AL as ‘learning to learn by doing with and from others who are also learning to learn by doing’. It is a forum for real managers tackling real problems with other managers who are able to freely challenge, advise and support their peers.

Mood, Anxiety and Personality

- The CAG has an international reputation for delivering outstanding clinical care with compassion
- A nurse – led standardised assessment tool is being put in place in community teams.
- World class education enabling staff and students to reach their full potential
- We have three Community Team Leaders undertaking top up degrees at London South Bank University
- Whole team training on Dialectical Behavioural Therapy is being rolled out in our community teams.
- A track record in delivering innovative clinical academic careers
- This is an area for further development by the CAG, which has many highly specialised nurses working at an advanced practitioner level
- A reputation for patient outcomes and protocols based on the best evidence
- Minimum data sets are in use on all units and community services to measure KPIs and compliance.
- Mock CQC visits carried out regularly to monitor standards.
- A strong tradition of vibrant nursing and midwifery leadership.
- Established Nursing Council across two CAGs
• Head of Nursing member of CAG Executive
• Head of Nursing is Lead for Safeguarding Children and Dual Diagnosis
• Head of Nursing is personal mentor for PG Dip. students
• A commitment to leading edge practice across complex patient pathways
• GP practice nurses working in partnership with IAPTss (many of the practitioners have nursing as a core profession)
• Community Teams working with Primary Care and improving interface
• A strong focus on internationally excellent nursing and midwifery research
• The CAG has successfully gained funding from the BRC to increase research capacity in nursing and OT.
• Head of Nursing sitting on working party to create a post for an expert assessment practitioner to roll out training and supervision in assessment for the teams.

Psychological Medicine
• Royal College of Psychiatrist accreditation was achieved for the Mother and Baby Unit.
• The Mother and Baby unit nurses were officially the happiest in the Trust following the Trust nursing engagement survey.
• The Eating Disorders day care and outpatients project “the invisible man” is improving the experience for men with eating disorders.
• The Modern Matron with another nursing colleague has represented the Trust in teaching mental health nursing skills to Saudi Nurses –they have been invited back to repeat this again in May. This was the first time that nurses from our country have been to Saudi to do this so this is a great honour and achievement.
• Eight nurses were supported to study for top-up degrees.
• Thirty seven staff, mainly from the crisis services care pathway have been trained in brief solution focused therapy and are implementing this in practice.
• Development by nurses in the CAG of an in-patient nursing assessment tool with colleagues from the nursing directorate which will be piloted on the triage wards very soon.
• The Lewisham mental health liaison team, with the support of the RTTC project have developed their own patient feedback tool suitable for people in crisis.
• Nurses in the CAG are further developing links with nursing colleagues in KHP: this includes neurology, renal, liver, palliative care and rehab. The focus on this so far has been the sharing of good practice and providing training sessions.
• Income generation from senior nurses in the CAG has enabled us to purchase some training equipment for staff such as books, gluteal muscle for practicing injection techniques, Barnados DVDs for young carers awareness.
• Seven teams are implementing Releasing Time to Care – 22 staff have completed the training.
• Medication safety project implementation in Lambeth Home Treatment team (self administration).
• Care planning workshops have been held in the Nursing Council.
• The Eating Disorders inpatient nursing team have introduced a fortnightly nursing forum facilitated by the charge nurses this is a space for nurses to reflect on their practice and develop and plan and implement innovations and good practice.
• Eating Disorders inpatient team has completed the recovery star training and staff have implemented the recovery model in their practice. They have introduced a weekly group for patients specifically working on the recovery star. Examples of this work are:
  • CPA proforma that patients complete with their named nurse before CPA meetings to ensure their views are discussed.
  • Introduction of patient folders containing general info and space for care plans and a record of all sessions they have.
• National Harm Free Care initiative –Triage ward Lewisham are one of the teams in the Trust involved in this project; they have implemented the use of “the safety thermometer”
(patient reported safety measure) Working towards improving staff and patient safety in the area of violence and aggression.

- The Team Leader in CASCAID has had a paper published on reviewing the standards for psychological support for adults living with HIV.
- All inpatient teams have fully implemented MEWS and are supported in monthly audits and ongoing additional training with the Modern matron. There has been a great improvement in this over the last year with scores in general consistently over 85%.
- One DAISY award nomination.

**Psychosis CAG**

**Transformational Leadership**

- Three nurses are participating in the joint Team Leader and Consultant CAG Leadership Programme
- Competencies of nurses.
- The Psychosis teams have continued to have their competencies assessed in medical devices and medication. The preparatory work has been undertaken to roll out the professional standards of conduct and behaviour competency and will include a 360 degree approach, including feedback from service users, carers, peer/colleague, self assessment and supervisory assessment. This is currently being piloted in the complex care pathway. Observation and Engagement competency have been implemented and compliance is monitored by regular visits to inpatient clinical area’s by the Heads of Nursing with further night visits being planned.

**Structured Empowerment**

- The two nursing councils configured by pathways held a joint one year conference with an emphasis on nursing research and developing the professional practice model in November 2012. The success of this event has resulted in the two councils merging into one council. Subsequent meetings have received presentations and participated discussions on HIV testing and improving the physical health of psychosis service users. CQUINS, CQC and the findings of the Francis report.
- In March 2013 the CAG developed and distributed its first Nursing Newsletter, this will be developed every quarter and content derived from CAG nursing events, and news will include CAG / Trust hot topics and areas for consultation.

**Exemplary Professional Practice**

- Teams across North Lambeth inpatients and community settings have commenced or plan to commence Kaizen improvement work ‘Reach for Success’. Based on the NHS competency framework using lean methodology and supported by External Facilitators, SLaM Partners and the trust’s Improvement facilitators. Nurses have been in integral in ensuring that small changes implemented so far are sustained and that communication across teams flows.
- During the Olympic Games the summer of 2012, Eden Ward (PICU) developed their own ‘Eden Olympics Sports Event’ in partnership with service users. The event was positively evaluated by service users in particular they enjoyed jointly working, to create flags, make celebratory cakes with staff and join in different events. The highlights for some were receiving medals for different sporting challenges or general attitudes on the day.
- Gresham 2 have improved on their meals work and extended improvements to include nurse led groups
- A number of community teams have developed co-productive recovery groups with service users many as a result of attending recovery focussed training.

**Productives Series**
Inpatient and community teams continued involvement in Productives has seen an average saving of £6,000 per ward after a formal evaluation was undertaken. In addition, more time has been allocated to direct patient care through efficiencies of systems and processes.

Community teams have taken advantage of the revised Productive community modules to improve working practices and involvement in wider and larger change programmes.

A Croydon ward team developed an electronic Patient at a Glance System which is used in team meetings every morning. It is not only a reporting out but includes action plans that are followed up as a priority during the day. Action plans and information in the PSAG are linked with patient care needs. Assessment and needs.

The Croydon Women service have collaboratively devised a self-help book, produced a calendar based on the recovery model and collaboratively produced a relaxation CD all with their service users.

Evolution – An interactive and dynamic patient at a glance information system was developed by a band 6 Acute Nurse. The system enables speedier gathering and sharing of patient information, ward requirements (for example audits) and between clinical ward staff.

**Daisy Awards**

- Eleven Psychosis CAG nurses have been achieved Daisy awards and three presented with nominee pins within the year.
- ES2, Wharton and LEO wards have achieved AIMS Accreditation; Wharton ward achieved theirs with Excellence. All teams are in their second four-year accreditation cycle. This demonstrates that the wards have sustained a high standard of care delivery, team work and leadership.

**Nursing Awards**

- The following wards and Community teams were recognised at the Nursing Celebration Event in January 2013: 
  - Most improved inpatient team of the year was awarded to Gresham 2
  - Most improved community team was awarded to Lewisham South Northover, Recovery and Support Team
  - AL3 was awarded Staff Engagement team of the year with a best combined score of 100% response.
- Six Psychosis CAG Nurses were selected as Magnet Ambassadors, they join a two-year development programme and will be expected to work with senior nursing staff within the CAG and across the trust, progress the Magnet.
- Four Psychosis Nurses received long service award in March 2013 amassing over 110 years of dedicated service to nursing and the NHS between them.

**New Knowledge Innovations and Improvements**

- The four psychosis projects funded over the past year have been completing data collection and undertaking analysis of the data. These projects should be near to completion in the next few months. A further four projects have been awarded funding for the coming year.
- Four acute wards are participating in the safer wards programme to reduce the incidence and impact of violence and aggression to improve the patient experience and reduce sickness absence through injury on our wards.
- A number of inpatient areas have implemented zoning as a useful tool to managing risk in both challenging acute and complex care setting.
- Heather Close has participated in working with SLaM partners to transform their service and develop their nursing practice of the team to meet the needs of the new
service for patients with challenging behaviours previously cared for in out of area placements.

- A Research Nurse Tutor in Psychosis commenced in post in November 2012. The post has one day allocated to assist with the implementation of the Safewards Research Programme. And four days assigned for work with nursing teams within the CAG. The work has included working directly with clinical services to provide teaching and supervision on identified issues related to research. Help a ward develop an audit tool for a new initiative. Develop a set of e-learning materials for nurses working within the CAG and providing input into an updated Enhanced Skills for Inpatient Care course.

Presentations

- A Band 5 nurse from Jim Birley Unit presented her work on Clozapine treatment and augmentation. She has also been successful in securing a clinical research scholarship from the BRC at Guys and St Thomas.
- Staff from Tony Hillis Unit presented their work on ‘How staff interactions impact on clinical outcomes’, including developing a training and peer support programmed based on their findings. Baseline data has been collected and the training programme has commenced.
- Staff on ES1 ward have presented work on how patient outcomes have improved in relation to occupied bed days, incidents, staff and patient experience since nursing staff have increased facilitating group.
- Ten nurses commenced their top up or Masters degrees in the Autumn 2012. Five further nurses commenced Bsc / PG Certificates in January 13. One band 5 nurse has been successful in achieving a place on the MSc Clinical Research course. This a year long seconded course which attracts replacement costs.

Jane Sayer, Acting Director of Nursing and Education
Sarah Burleigh, Acting Programme Director (Nursing Excellence and Magnet Recognition)
July 2013
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 23 July 2013
Name of Report: Finance Report June 2013
Heading: Performance
Author: Tim Greenwood, Deputy Director of Finance
Approved by: Nick Dawe
Presented by: Nick Dawe

Purpose of the report:
To present the financial performance of the Trust against budget for the first three months of the financial year ending 30th June 2013. To identify issues and risks where there is danger that the Trust will not deliver to plan or that may endanger a financial risk rating of 3 in future periods.

Action required:
The Board of Directors is asked to review the attached report and in particular to note that although there has been a reduction in the over spending trend in June, the underlying financial challenges facing the Trust are significant, particularly in respect of activity levels running far in excess of funded and contracted levels.

Recommendations to the Board:
Accept the attached Finance Report, subject to any changes agreed by the Board of Directors. Note the significant and growing risks to patient quality and financial stability arising from the fact that (in two boroughs) actual activity is significantly exceeding contracted and funded activity.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
This paper forms the basis of the on-going process that ensures risk identification; mitigation and management comply with the requirements of the Assurance Framework.

Summary of Financial and Legal Implications:
The Trust is expected to deliver to its financial plan and undertake levels of activity that are affordable and can be delivered at an appropriate standard.

Equality & Diversity and Public & Patient Involvement Implications:
The Finance Report enables the Board to assess and manage the organisation’s finances and ensure that the Trust’s strategic aims are achieved.
SLaM - Financial Overview as at 30th June 2013 (Month 3 / Q1)

Income and Expenditure

- **Cumulative Net YTD Surplus (deficit)**
  - £m
  - £-1m £0.7m -1.0%
  - £1m net deficit (£0.3m adverse variance from plan ytd)

- **Capital spend against plan**
  - £-1m £0.7m -1.0%
  - £1m net deficit (£0.3m adverse variance from plan ytd)

- **EBITDA YTD**
  - Forecast: £4.2m -£2.8
  - Actual: £3.3m EBITDA (£0.8m adverse variance from plan ytd)
  - Forecast: £4.2m -£2.8
  - Current Ratio (Liquidity): 2.01
  - Liquidity Ratio inc WCF (Days): 56 days
  - Better payment practice code
  - Pay forecast against plan including agency
  - Cash at bank and in hand: £71.7m
  - PDC funding: £0m
  - Working capital facility available (removed from 1/1/12): £15m

- **Net deficit of £1m was £0.3m below Plan at the end of June. This includes an operational deficit of £5.5m caused by overspends in the majority of CAGs, particularly Psychosis and B&D. The operational deficit is being partially offset by the Trust contingency reserve and other non recurring items but these are not sufficient to fully negate the current rate of overspend.**

Balance Sheet

- **Financial Risk Rating (from 5)**
  - Continuity of Service Risk Rating (from 4)
  - The overall position improved in the month. Whilst there were improved positions across a number of CAGs and infrastructure directorates, the main change occurred by –
    i) the release of a further £0.7m of provisions following a review of the position
    ii) taking account of £0.5m of income not previously built into the Plan for the AMH Transformation Programme and NHS England funded MSU/LSU placements

  The release of provisions at this level is limited and non recurring. The underlying position
  - Cost Improvement Programme
  - Cost per Case/Cost & Volume: £0.44m ytd < target
  - Performance v CIP: £0.94m -27% < target
  - Ward Nursing: £0.9m overspent
  - Acute Overspill: £0.6m overspent including impact of risk share
  - Forensic Placements: £0.9m overspent excluding impact of risk share
  - Drugs: £5k overspent

The financial risk rating has been calculated at 3 for Q1

The release of provisions at this level is limited and non recurring. The underlying position
## Table 1

### June 2013

#### The South London and Maudsley NHS Trust - Operating Budgets

<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. Psychosis</td>
<td>101,877,400</td>
<td>12,231,900</td>
<td>585,000</td>
<td>28,024,600</td>
<td>1,868,600</td>
<td>1,283,600</td>
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<td>02. Behavioural And Dev. Psych</td>
<td>213,400</td>
<td>1,050,800</td>
<td>841,900</td>
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<td>03. Mood, Anxiety, Personality</td>
<td>24,931,900</td>
<td>2,385,000</td>
<td>94,800</td>
<td>6,545,000</td>
<td>296,400</td>
<td>201,600</td>
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<td>04. Psychological Medicine</td>
<td>20,974,500</td>
<td>2,052,000</td>
<td>62,000</td>
<td>5,776,700</td>
<td>442,100</td>
<td>380,100</td>
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<td>05. Child &amp; Adolescent Service</td>
<td>17,659,900</td>
<td>1,716,100</td>
<td>(205,700)</td>
<td>4,153,800</td>
<td>(264,500)</td>
<td>(58,700)</td>
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<tr>
<td>06. MHOA And Dementia</td>
<td>29,693,300</td>
<td>3,530,700</td>
<td>95,200</td>
<td>8,124,400</td>
<td>358,800</td>
<td>263,600</td>
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<td>07. Addictions</td>
<td>(4,400)</td>
<td>8,500</td>
<td>10,600</td>
<td>41,300</td>
<td>118,000</td>
<td>107,400</td>
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<td>08. Clinical Support Services</td>
<td>1,748,000</td>
<td>169,300</td>
<td>(500,000)</td>
<td>491,000</td>
<td>54,000</td>
<td>19,000</td>
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<td>09. Infrastructure Directorates</td>
<td>47,115,600</td>
<td>3,919,300</td>
<td>(46,800)</td>
<td>12,119,200</td>
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<td>556,500</td>
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<td>10. Corporate Income</td>
<td>(192,215,400)</td>
<td>(16,333,100)</td>
<td>(188,700)</td>
<td>(48,618,800)</td>
<td>(137,400)</td>
<td>51,300</td>
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<td><strong>Operational Deficit</strong></td>
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<td>19,037,000</td>
<td>5,550,900</td>
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<td>11. Corporate Other inc provisions</td>
<td>(81,995,100)</td>
<td>(12,755,400)</td>
<td>(1,095,700)</td>
<td>(22,334,600)</td>
<td>(1,817,800)</td>
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<td>12. Contingency - planned</td>
<td>6,000,000</td>
<td>0</td>
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<td>(1,500,000)</td>
<td>(1,000,000)</td>
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<td>13. Contingency - committed</td>
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<td>14. Other reserves</td>
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<td><strong>Corporate Other</strong></td>
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<td>(2,413,600)</td>
<td>(22,334,600)</td>
<td>(4,734,300)</td>
<td>(2,320,700)</td>
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#### EBITDA

<table>
<thead>
<tr>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>Variance Last Month (£)</th>
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<tbody>
<tr>
<td>(16,013,000)</td>
<td>(2,024,900)</td>
<td>(1,130,200)</td>
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<table>
<thead>
<tr>
<th>Corporate 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>
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<tr>
<td>A1) Estates &amp; Facilities</td>
<td>16,634,100</td>
<td>1,661,100</td>
<td>237,800</td>
<td>4,797,500</td>
<td>618,800</td>
<td>381,000</td>
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<td>A2) Hotel Services</td>
<td>11,058,400</td>
<td>871,600</td>
<td>(52,100)</td>
<td>2,750,600</td>
<td>(20,200)</td>
<td>31,800</td>
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<td>B) Education &amp; Nursing</td>
<td>4,585,400</td>
<td>299,900</td>
<td>(72,400)</td>
<td>1,001,800</td>
<td>(122,600)</td>
<td>(50,200)</td>
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<td>C) Information &amp; I.T.</td>
<td>4,980,500</td>
<td>403,200</td>
<td>(31,400)</td>
<td>1,449,300</td>
<td>215,800</td>
<td>247,200</td>
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<td>D) Finance And Corp Governance</td>
<td>4,413,200</td>
<td>382,100</td>
<td>(50,800)</td>
<td>1,137,200</td>
<td>(300)</td>
<td>50,500</td>
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<td>E) Human Resources</td>
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<td>(61,900)</td>
<td>394,700</td>
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<td>(105,000)</td>
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<td>F) Strategy And Business Dev.</td>
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<td>17,800</td>
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<td>G) Chief Executive</td>
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<td>208,300</td>
<td>(28,000)</td>
<td>695,800</td>
<td>(27,300)</td>
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<td>H) Medical &amp; Clinical Govern.</td>
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<td>7,000</td>
<td>514,600</td>
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<td>I) Professional Heads</td>
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<td>104,100</td>
<td>(6,600)</td>
<td>347,600</td>
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<td>J) R&amp;D</td>
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<td>(577,700)</td>
<td>(6,200)</td>
<td>(1,689,100)</td>
<td>(17,800)</td>
<td>(11,600)</td>
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<td><strong>Infrastructure Directorates</strong></td>
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<td>3,919,300</td>
<td>(46,800)</td>
<td>12,119,200</td>
<td>509,800</td>
<td>556,500</td>
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<td>K) Corporate Service</td>
<td>(81,995,100)</td>
<td>(12,755,400)</td>
<td>(1,095,700)</td>
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<td>L) Trust Reserves</td>
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<td><strong>Corporate Other</strong></td>
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<td>(2,413,600)</td>
<td>(22,334,600)</td>
<td>(4,734,300)</td>
<td>(2,320,700)</td>
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### Table 2

**Monthly Variance By CAG (Colour Coded) Over A Rolling 12 Month Period**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Mth 4</td>
<td>Mth 5</td>
<td>Mth 6</td>
<td>Mth 7</td>
<td>Mth 8</td>
<td>Mth 9</td>
<td>Mth 10</td>
<td>Mth 11</td>
<td>Mth 12</td>
<td>Mth 1</td>
<td>Mth 2</td>
<td>Mth 3</td>
</tr>
<tr>
<td><strong>Psychosis</strong></td>
<td>0.81%</td>
<td>1.66%</td>
<td>3.81%</td>
<td>3.06%</td>
<td>3.24%</td>
<td>6.33%</td>
<td>8.94%</td>
<td>7.69%</td>
<td>12.67%</td>
<td>11.20%</td>
<td>7.08%</td>
<td>5.02%</td>
</tr>
<tr>
<td><strong>Mood, Anxiety, Personality</strong></td>
<td>7.11%</td>
<td>2.37%</td>
<td>-4.35%</td>
<td>0.59%</td>
<td>9.15%</td>
<td>0.97%</td>
<td>9.50%</td>
<td>3.06%</td>
<td>4.21%</td>
<td>4.67%</td>
<td>6.33%</td>
<td>4.14%</td>
</tr>
<tr>
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<td>0.11%</td>
<td>2.64%</td>
<td>6.27%</td>
<td>5.03%</td>
<td>-4.12%</td>
<td>5.72%</td>
<td>4.04%</td>
<td>4.35%</td>
<td>5.95%</td>
<td>10.20%</td>
<td>12.18%</td>
<td>3.12%</td>
</tr>
<tr>
<td><strong>Child &amp; Adolescent Service</strong></td>
<td>215.00%</td>
<td>-83.18%</td>
<td>-39.03%</td>
<td>-110.60%</td>
<td>-54.19%</td>
<td>-10.51%</td>
<td>-37.09%</td>
<td>-6.27%</td>
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</tr>
<tr>
<td><strong>Mhoa And Dementia</strong></td>
<td>2.67%</td>
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<td>-0.08%</td>
<td>-4.39%</td>
<td>-3.71%</td>
<td>-4.52%</td>
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</tr>
<tr>
<td><strong>Clinical Support Services</strong></td>
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<td>4.21%</td>
<td>6.75%</td>
<td>10.54%</td>
<td>-29.91%</td>
<td>-1.94%</td>
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<td>8.00%</td>
</tr>
<tr>
<td><strong>Infrastructure Directorates</strong></td>
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<td>-5.10%</td>
<td>5.54%</td>
<td>-5.72%</td>
<td>3.61%</td>
<td>6.64%</td>
<td>-4.90%</td>
<td>2.00%</td>
<td>5.06%</td>
<td>7.46%</td>
<td>-1.18%</td>
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<td><strong>Corporate Income</strong></td>
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<td>0.63%</td>
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<td>-15.86%</td>
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Trading Accounts

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<td>Mth 10</td>
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<td>Mth 2</td>
<td>Mth 3</td>
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<td>-1.06%</td>
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<td>3.18%</td>
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Addictions

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<td>Mth 12</td>
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<td>Mth 2</td>
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<td>1.32%</td>
<td>3.59%</td>
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<td>-14.70%</td>
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<td>5.77%</td>
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<td>5.14%</td>
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<td>7.47%</td>
<td>2.26%</td>
<td>-3.77%</td>
<td>0.82%</td>
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<td>-4.86%</td>
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Table 3 - 2013/14 Nursing Overspend - Monthly Data by Borough (£000's)

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<thead>
<tr>
<th>Month</th>
<th>CAMHS</th>
<th>MHOA &amp; DEMENTIA</th>
<th>ADDICTIONS</th>
<th>PSYCHOSIS</th>
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Table 3 - 2013/14 Nursing Overspend - Monthly Data by Borough (£000's)

### BEHAVIOURAL & DEVELOPMENTAL PSYCHIATRY

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### MOOD ANXIETY PERSONALITY

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### PSYCHOLOGICAL MEDICINE

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</tr>
<tr>
<td>12</td>
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<tr>
<td>Total</td>
<td>135</td>
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### SLaM

<table>
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<td>12</td>
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<tr>
<td>Total</td>
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### Table 4

**Ward Overspend - Monthly Run Rate (% Overspend)**

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<tr>
<th>Directorate</th>
<th>Ward Name</th>
<th>YTD Variance</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Period 3</th>
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<tbody>
<tr>
<td>07. Mhoa And Dementia</td>
<td>Inglemere Road</td>
<td>40.86%</td>
<td>-5.69%</td>
<td>84.25%</td>
<td>44.03%</td>
</tr>
<tr>
<td>07. Mhoa And Dementia</td>
<td>Hayworth Ward</td>
<td>39.12%</td>
<td>24.82%</td>
<td>52.02%</td>
<td>40.52%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Powell Ward</td>
<td>35.93%</td>
<td>82.53%</td>
<td>8.93%</td>
<td>16.32%</td>
</tr>
<tr>
<td>07. Mhoa And Dementia</td>
<td>Chelsham House Brh</td>
<td>20.86%</td>
<td>16.07%</td>
<td>26.40%</td>
<td>20.11%</td>
</tr>
<tr>
<td>05. Psychological Medicine</td>
<td>Woodlands Nursing Home</td>
<td>19.89%</td>
<td>10.05%</td>
<td>30.88%</td>
<td>18.74%</td>
</tr>
<tr>
<td>04. Psychological Medicine</td>
<td>Neuropsychiatry Db1/Lishman Un</td>
<td>19.83%</td>
<td>29.89%</td>
<td>19.12%</td>
<td>10.48%</td>
</tr>
<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>Neurodev Disorder Service</td>
<td>19.79%</td>
<td>15.02%</td>
<td>21.94%</td>
<td>22.42%</td>
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<tr>
<td>04. Psychological Medicine</td>
<td>Eating Disorders - Inpatient</td>
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<td>17.89%</td>
<td>13.67%</td>
<td>21.30%</td>
</tr>
<tr>
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<td>Brook Ward River House</td>
<td>16.32%</td>
<td>19.59%</td>
<td>14.79%</td>
<td>14.56%</td>
</tr>
<tr>
<td>07. Mhoa And Dementia</td>
<td>Al2 (Previously Gresham 1)</td>
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<td>24.50%</td>
<td>17.40%</td>
<td>6.51%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Eileen Skellern 2</td>
<td>15.91%</td>
<td>6.68%</td>
<td>18.88%</td>
<td>22.16%</td>
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<tr>
<td>01. Psychosis</td>
<td>Womens Service</td>
<td>14.25%</td>
<td>10.94%</td>
<td>16.88%</td>
<td>14.92%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Psychology Unit (Fm2)</td>
<td>11.06%</td>
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<td>17.41%</td>
<td>19.90%</td>
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<tr>
<td>06. Child &amp; Adolescent Service</td>
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<td>8.83%</td>
<td>5.02%</td>
<td>19.15%</td>
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<tr>
<td>01. Psychosis</td>
<td>Croydon Westways Ward</td>
<td>10.97%</td>
<td>16.53%</td>
<td>11.59%</td>
<td>4.81%</td>
</tr>
<tr>
<td>06. Child &amp; Adolescent Service</td>
<td>Kent Inpatient - Ash Ward</td>
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<td>14.46%</td>
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<td>Challenging Behaviour Unit</td>
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<td>19.08%</td>
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<td>6.70%</td>
<td>13.21%</td>
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<td>Wharton Ward</td>
<td>8.18%</td>
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<td>-3.77%</td>
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<td>0.92%</td>
<td>12.66%</td>
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<td>Anx Disorders Residential Unit</td>
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<td>15.41%</td>
<td>7.61%</td>
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<td>Mother &amp; Baby Unit - Inpts</td>
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<td>Triage Ward</td>
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<td>3.61%</td>
<td>12.40%</td>
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<tr>
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<td>Ann Moss Domus</td>
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<td>4.67%</td>
<td>-1.89%</td>
<td>14.34%</td>
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<td>3.81%</td>
<td>3.59%</td>
<td>0.12%</td>
</tr>
<tr>
<td>06. Child &amp; Adolescent Service</td>
<td>Bau - Nursing</td>
<td>2.31%</td>
<td>4.48%</td>
<td>5.20%</td>
<td>-2.74%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Gresham Icu Ward</td>
<td>2.04%</td>
<td>-9.39%</td>
<td>-4.32%</td>
<td>20.73%</td>
</tr>
<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>Spring Ward River House</td>
<td>1.31%</td>
<td>1.34%</td>
<td>-0.02%</td>
<td>2.60%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Jim Birley Unit</td>
<td>1.24%</td>
<td>1.17%</td>
<td>3.12%</td>
<td>-0.57%</td>
</tr>
<tr>
<td>06. Child &amp; Adolescent Service</td>
<td>Acorn Lodge - Nursing</td>
<td>1.14%</td>
<td>-2.82%</td>
<td>-2.05%</td>
<td>8.28%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>John Dickson Ward</td>
<td>0.54%</td>
<td>0.46%</td>
<td>-2.86%</td>
<td>4.01%</td>
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<tr>
<td>01. Psychosis</td>
<td>Lambeth Hosp. Eden Ward</td>
<td>-0.77%</td>
<td>-0.05%</td>
<td>2.93%</td>
<td>-4.94%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Nelson Ward</td>
<td>-2.35%</td>
<td>-10.21%</td>
<td>-3.79%</td>
<td>6.94%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Special Needs Heather Close</td>
<td>-2.42%</td>
<td>0.26%</td>
<td>-4.52%</td>
<td>-2.99%</td>
</tr>
<tr>
<td>Directorate</td>
<td>Ward Name</td>
<td>YTD Variance</td>
<td>Period 1</td>
<td>Period 2</td>
<td>Period 3</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------------------</td>
<td>--------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Early Intervention Unit</td>
<td>-2.58%</td>
<td>-0.41%</td>
<td>2.48%</td>
<td>-9.82%</td>
</tr>
<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>Norbury Ward River House</td>
<td>-2.78%</td>
<td>3.97%</td>
<td>-16.08%</td>
<td>3.76%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Eileen Skellern 1</td>
<td>-2.99%</td>
<td>-0.51%</td>
<td>-7.39%</td>
<td>-1.06%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Gresham 1</td>
<td>-3.14%</td>
<td>3.46%</td>
<td>-0.77%</td>
<td>-12.12%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Aubrey Lewis 3</td>
<td>-4.74%</td>
<td>-3.24%</td>
<td>-10.81%</td>
<td>-0.15%</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>Lambeth Hosp. L King Ward</td>
<td>-8.25%</td>
<td>-5.46%</td>
<td>-10.82%</td>
<td>-8.46%</td>
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<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>Chaffinch &amp; Beck Pre-Discharge</td>
<td>-8.79%</td>
<td>-3.80%</td>
<td>-12.05%</td>
<td>-10.52%</td>
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<tr>
<td>08. Addictions</td>
<td>Acute Assessment Unit</td>
<td>-10.77%</td>
<td>-11.86%</td>
<td>-9.88%</td>
<td>-10.56%</td>
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<tr>
<td>CAG/Directorate</td>
<td>Original Plan £'000</td>
<td>YTD Plan £'000</td>
<td>YTD Actual £'000</td>
<td>YTD Variance £'000</td>
<td>Variance From Plan %</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------</td>
<td>----------------</td>
<td>------------------</td>
<td>-------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Psychosis Savings Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure CIPs</td>
<td>851</td>
<td>207</td>
<td>107</td>
<td>100</td>
<td>48%</td>
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<tr>
<td>Income CIPs</td>
<td>50</td>
<td>13</td>
<td>12</td>
<td>1</td>
<td>7%</td>
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<tr>
<td>Behavioural &amp; Dev. Savings Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure CIPs</td>
<td>2,553</td>
<td>179</td>
<td>179</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>Income CIPs</td>
<td>710</td>
<td>34</td>
<td>20</td>
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<tr>
<td>Expenditure CIPs</td>
<td>825</td>
<td>335</td>
<td>320</td>
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<tr>
<td>Income CIPs</td>
<td>86</td>
<td>22</td>
<td>13</td>
<td>9</td>
<td>41%</td>
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<tr>
<td>Psychological Medicine Savings Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure CIPs</td>
<td>393</td>
<td>95</td>
<td>95</td>
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<tr>
<td>Income CIPs</td>
<td>452</td>
<td>102</td>
<td>102</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>CAMHS Savings Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>1,703</td>
<td>426</td>
<td>371</td>
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<tr>
<td>Income CIPs</td>
<td>482</td>
<td>121</td>
<td>111</td>
<td>9</td>
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<td>MHOA Savings Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure CIPs</td>
<td>988</td>
<td>318</td>
<td>195</td>
<td>123</td>
<td>39%</td>
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<td>Addictions Savings Plan</td>
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<tr>
<td>Expenditure CIPs</td>
<td>410</td>
<td>103</td>
<td>65</td>
<td>37</td>
<td>36%</td>
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<tr>
<td>Income CIPs</td>
<td>212</td>
<td>53</td>
<td>20</td>
<td>33</td>
<td>63%</td>
</tr>
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<td>Infrastructure</td>
<td></td>
<td></td>
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<td></td>
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<td>Expenditure CIPs</td>
<td>3,257</td>
<td>721</td>
<td>475</td>
<td>245</td>
<td>34%</td>
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<tr>
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<td>88</td>
<td>22</td>
<td>22</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>Trustwide</td>
<td></td>
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<td></td>
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<tr>
<td>Expenditure CIPs</td>
<td>2,775</td>
<td>694</td>
<td>394</td>
<td>300</td>
<td>43%</td>
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<tr>
<td>Total Directorate CIPS</td>
<td>15,834</td>
<td>3,442</td>
<td>2,501</td>
<td>942</td>
<td>27%</td>
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<p>| Expenditure Variance | 876 | 28% |
| Income Variance      | 66  | 18% |</p>
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<thead>
<tr>
<th></th>
<th>Annual</th>
<th>YTD</th>
<th>YTD</th>
<th>YTD</th>
<th>Notes</th>
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<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
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<tr>
<td>By CAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Psychosis</td>
<td>3,550</td>
<td>408</td>
<td>201</td>
<td>207</td>
<td>reduction in Swk PICU and acute beds not offset by increase in income plus Lew placements overspending</td>
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<tr>
<td>Behavioural &amp; Developmental</td>
<td>279</td>
<td>209</td>
<td>209</td>
<td>0</td>
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<tr>
<td>Mood &amp; Anxiety</td>
<td>250</td>
<td>75</td>
<td>25</td>
<td>50</td>
<td>MPT management costs slippage</td>
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<tr>
<td>CAMHS</td>
<td>200</td>
<td>50</td>
<td>0</td>
<td>50</td>
<td>no plan agreed with Lambeth CCG</td>
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<tr>
<td>MHOA</td>
<td>2,396</td>
<td>412</td>
<td>197</td>
<td>215</td>
<td>Granville Park still incurring estate costs while building retained plus late re-deployment of staff</td>
</tr>
<tr>
<td>Other</td>
<td>222</td>
<td>67</td>
<td>67</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,897</td>
<td>1,221</td>
<td>699</td>
<td>522</td>
<td>risk lies with SLAM (subject to risk share agreements)</td>
</tr>
<tr>
<td>By PCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Lambeth</td>
<td>2,823</td>
<td>140</td>
<td>90</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Southwark</td>
<td>2,259</td>
<td>559</td>
<td>371</td>
<td>188</td>
<td></td>
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<tr>
<td>Lewisham</td>
<td>1,617</td>
<td>472</td>
<td>188</td>
<td>284</td>
<td></td>
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<tr>
<td>Croydon</td>
<td>198</td>
<td>50</td>
<td>50</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,897</td>
<td>1,221</td>
<td>699</td>
<td>522</td>
<td></td>
</tr>
</tbody>
</table>

Note - forecast includes no assumption re savings where plans are still to be agreed.
TRUST BOARD - SUMMARY REPORT

Date of Board meeting: 23rd July 2013

Name of Report: Chief Executive’s report

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

Governance

Author(s): Paul Mitchell, Trust Board Secretary

Approved by (name of Executive member): Gus Heafield, Acting Chief Executive

Presented by: Gus Heafield, Acting Chief Executive

Purpose of the report:
To inform the Board of significant issues arising from Trust Executive meetings, Performance Management meetings, an update on information governance issues, the local health economy and nationally in the NHS and Social Care.

Action required:
To discuss items of concern and where necessary initiate additional assurance action.

Recommendations to the Board:
To note the report.

Relationship with the Assurance Framework (Risks, Controls, and Assurance):
The report highlights issues relating to the Assurance Framework arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.

Summary of Financial and Legal Implications:
The report highlights any financial and legal Implications arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.

Equality & Diversity and Public & Patient Involvement Implications:
The report highlights equality & diversity issues arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.
Chief Executive’s Report

July 2013

1. National issues

NHS ‘faces £60bn funding gap by 2025’
The health service faces a funding gap of £60bn by 2025, according to NHS England. The figure is based on an NHS England forecast that underpins a major recently published report. The document reveals a £30bn funding deficit by 2020. NHS England director of strategy Robert Harris said that the predicted deficit doubled when the timeframe is extended to 2025. The revelation comes as Monitor chief executive David Bennett issued a bleak assessment of the service’s viability, concluding that even if the NHS made all the savings the regulator could conceive of, it would still have a minimum funding gap of £2.5bn in eight years’ time. The projected deficit assumes health service funding remains flat in real terms until 2025 and takes into account rising demand for services resulting from demographic pressures. The report, The NHS belongs to the people: a call to action is expected to say the health service will become unsustainable without a fundamental rethink of service provision, and call for a national debate to help shape a new 10-year strategy.

Competition in the NHS
The Foundation Trust Network has criticised the policy conflicts related to competition in the NHS. NHS England is arguing that mergers are essential to delivering sustainable safer services whilst the Competition Commission says mergers are not in the best interest of patients. This has been highlighted in the process for the proposed merger of the Royal Bournemouth and Christchurch Hospital and Poole Hospital NHS Foundation Trusts.

Connecting to service users and patients
SLaM has been approached and asked to participate in the DH post Francis initiative to connect civil servants to the front line. Eventually all 2,000 DH Civil Servants will participate – currently though they are developing programme for the top 160.

Zoe Reed has met with DH staff recently and discussed a possible approach to developing a programme for SLaM. The aim would be to offer them approx 20 x 1 week placements this financial year in cohorts of about 5 at a time which equates to about 3 or 4 Programmes. Our Programmes would involve them attending the first day of the Trust Induction and then they return to undertake a week’s immersion. We will need to offer a local Induction and debrief to enable them to reflect as part of the week – and the Civil Service also does the same. It would be sensible to obtain DBS clearance and DH will pay for this.

In terms of content and design for the programme, the benchmark of success is when the
participant says they feel part of the service/directorate at the end of their week and that
they have formed meaningful relationships which they can follow up afterwards.

2. National consultations

Monitor calls for views on draft guidance for procuring patient services
Monitor is seeking views on the draft guidance to help commissioners understand how to
comply with new regulations governing procurement, patient choice and competition in the
NHS so that patients receive the best possible health services.

Monitor calls for views on how the NHS payment system can do more for patients
Monitor and NHS England are working together to reform the way NHS services are paid for
following concerns that PbR is not sufficiently patient focussed.

CQC launch consultation on a new regime for quality regulation
CQC’s consultation “A New Start” includes proposals for new fundamental standards, ratings
and a single failure regime.

DH consult on refreshing the mandate to NHS England for 2014/15
The Department of Health is consulting on refreshing the mandate to NHS England for
2014/15. The Mandate sets out the Government’s ambitions for the NHS as well as the
funding available to achieve the kind of care people need and expect.

3. Trust and IoP issues

Mental health pathways – KHP discussion
Mental Health CAG Leaders held a “Vision Session” on 10th July which was attended by the
SLaM Executive and KHP colleagues. This provided an opportunity to assess the mental
health pathways and illustrate how mental health could be at the heart of a future integrated
organisation. Key questions discussed were as follows:

- What are the big opportunities for KHP with regards to Mental Health pathways?
  What are your CAG visions for a more value based, integrated, outcomes focussed
  service? What more do you have to do and how will you achieve this? What help do
  you need across all KHP CAGs and the Partners?
- How might KHP quantify the benefits that achieving your vision would mean for
  patients, research, or education, e.g., lives saved, years of life gained, citations,
  training programmes?
- What are the major barriers preventing or slowing progress in Mental Health
  pathways across SLaM and in your CAG today?
- What are the enablers required to drive forward improvements in the KHP approach
to improved outcomes in MH pathways?
- What national and international opportunities exist, that are untapped or lack
  coherence. How can KHP help?

Care Quality Commission Admission and Assessment Visit
The CQC are carrying out an Admission and Assessment Visit over two days on 30th and
31st July 2013. This will involve a series of meetings with Trust Executive staff, clinical staff,
MHA Department staff, AMHPs, police, ambulance, service users, carers, IMHA services.
They will also visit services e.g. places of safety, a Triage ward, acute admission wards and
meet with any patients who have recently been admitted to hospital. We have been notified
that the visit will not focus on CAMHS, forensic or MHOA services. We await confirmation of whether they will want to meet with the Psychiatric Liaison Services.

**Senior Leaders Group meeting**
I closed the recent meeting of the Senior Leaders Group. As usual this was an interesting and varied programme which included a presentation on value based health care from Professor John Moxham, Director of Clinical Strategy KHP and one on Culture, Quality and Transformation from Zoe Reed, Director of Strategy and Business Development.

**Ward visits**
I have continued my programme of visiting clinical services. Last week I accompanied Jane Sayer to the Ladywell Unit at Lewisham hospital.

**Integrated Care Programme submission**
This was raised in my report last month. I can confirm that the submission has been made.

**4. Chief Executive Performance Management Review**
The July CE PMR meetings will be held after the production of the Board papers. A verbal update on the key themes of the meetings will be made.

**5. Information Governance**
The King's Health Partners Caldicott Group reviewed and updated the King's Health Partners Information Sharing Policy. The policy is the first shared policy in the AHSC and provides guidelines to ensure that sensitive clinical, education and employment records are shared between constituent partners of KHP and its external partner agencies for the purposes of delivering and improving patient care, teaching, research, audit and protecting the public in a lawful, secure and confidential manner. The policy was ratified by the Trust Executive in June. It is going through equivalent ratification processes in the other partner organisations in the KHP.

The Copying Letters to Service Users Policy was ratified by the Trust Executive. The policy sets out the guidelines for providing copies of correspondence to service users in order to provide them with necessary information to enable their involvement in planning and delivery of their care.

The Information Governance Policy, which sets out arrangements, principles and standards around use of clinical and business information and signposts to more specific policies was reviewed by the Trust Caldicott Committee. The revised policy was ratified by the Trust Executive.

The Health and Social Care Information Centre issued a new national reporting process for information incidents in June. The new process introduces online reporting of serious information incidents to external agencies (DH, Monitor, the Information Commissioner’s Office), alongside a new categorisation based on scale and sensitivity of incidents. The Information Governance Team has reviewed and implemented the new process.

**Gus Heafield**
**Acting Chief Executive**
**July 2013**
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 23rd July 2013

Name of Report: Report from the Council of Governors

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

Author: Paul Mitchell, Trust Secretary

Approved by: Gus Heafield, Acting Chief Executive

Presented by: Noel Urwin, Vice Chair, Council of Governors

Purpose of the report: To update the Board on the current areas of Council of Governors’ activity.

Action required: To note.

Recommendations to the Board: To note.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The Council of Governors is an integral component of the Trust’s Constitution as a Foundation Trust.

Summary of Financial and Legal Implications:
Budgetary provision has been made to support the activities of the Council of Governors.

Equality & Diversity and Public & Patient Involvement Implications:
The Council of Governors has a responsibility to ensure that the Trust’s membership is representative of the local populations in terms of diversity and that all members, including those from the patient & public constituencies, are fully involved.
1. Appointment of Dr Matthew Patrick as Chief Executive

The Council of Governors approved the appointment of Dr Matthew Patrick as the new Chief Executive of South London and Maudsley NHS Foundation Trust at a special meeting held on 11th July. Dr Matthew Patrick brings a wealth of experience and expertise to the Board of Directors and SLaM.

Dr Matthew Patrick has been Chief Executive of the Tavistock and Portman NHS Foundation Trust since March 2008. He trained as an adult psychiatrist at the Maudsley and Bethlem Royal Hospitals and for many years combined clinical work and developmental research. Over the past four years Dr Patrick has contributed to national mental health policy and strategy, including the development of the Improving Access to Psychological Therapies (IAPT) programme; the development of the New Horizons mental health policy; and the government's Mental Health Strategy, No Health Without Mental Health. More recently he has led on work around the development of e-mental health and has been actively involved in the development of mental health within Academic Health Science Centres.

2. Elections to the Council of Governors

The result of the elections to fill the current ten vacancies on the Council of Governors will be announced on 26th July. The following nominations have been received:

**Staff (2 vacancies):**
- Yvonne Barrett
- David Blazey
- Iyonie Ranasinghe
- Tom Werner

**Service Users (local) (3 vacancies):**
- Christopher Anderson
- Christopher Collins
- Michael Glyn
- Nashiru Momori

Matthew McKenzie has been elected unopposed as a carer representative.

3. Lewisham Peoples’ Day

This year the key external presence for membership awareness raising will be at the Lewisham Peoples’ Day on 13th July. SLaM HQ staff will be hosting a stall at the large community event at Mountsfied Park in Catford in conjunction with colleagues from the children’s Kaleidoscope service and the Maudsley charity fundraising team.
4. Joint Governors meeting

The next joint Governors meeting will be held on Thursday, 18th July 2013 at the new Maudsley learning centre. The programme will include an update on KHP activity from Prof Sir Robert Lechler and a presentation on diabetes services from Dr Stephen Thomas.

Paul Mitchell
Trust Secretary
July 2013
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 23rd July 2013

Name of Report: KHP Board Update

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

Governance

Author:

Approved by: (name of Exec Member)

Presented by: Madeliene Long

Purpose of the report:
To inform the Board of Directors on the progress made on the development of SLaM/IoP Mental Health Clinical Academic Groups and the wider developments across King's Health Partners

Action required:
To receive the verbal report

Recommendations to the Board:
The verbal report is for information.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
One of the purposes of the King’s Health Partners Executive is to ensure that the impact of the development of King’s Health Partners is positive with regard to each constituent organisation’s risks and controls

Summary of Financial and Legal Implications:
The current report does not contain any legal implications. As the work develops, any significant legal or financial implications will be brought to the Board of Directors for consideration. There are resource requirements to ensure that the Trust contributes to delivery within the King's Health Partners Strategic Framework 2010-2014

Equality & Diversity and Public & Patient Involvement Implications:
A key purpose of King’s Health Partners is to improve the health and wellbeing of local people. In developing their strategies, the CAGs are specifically required to state how they will address the health inequalities reflected in the “heat map”. This of necessity requires that service users and their carers are actively involved in their own care and the developments within services. It also requires that no service user receives less favourable services or outcomes as a result of their ethnicity, gender, disability, sexuality, faith or age.
**TRUST BOARD OF DIRECTORS – SUMMARY REPORT**

<table>
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<tr>
<th><strong>Date of Board meeting:</strong></th>
<th>23rd July 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Report:</strong></td>
<td>Mental Health Act Management Annual Report 2012-13</td>
</tr>
<tr>
<td><strong>Heading:</strong></td>
<td>Governance</td>
</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Kay Burton</td>
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<tr>
<td><strong>Approved by:</strong></td>
<td>Jane Sayer, Executive Director and Dr Patricia Connell-Julien, Non-Executive Director</td>
</tr>
<tr>
<td><strong>Presented by:</strong></td>
<td>Jane Sayer, Acting Director of Nursing and Education</td>
</tr>
</tbody>
</table>

**Purpose of the report:**
To inform the Trust Board of Mental Health Act developments, activity and areas of concern for the year 2012-13

**Action required:**
To receive the report and raise any queries on the report at the Board.

**Recommendations to the Board:**
To approve the report.

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**
Report contains information about incidents which have resulted from breaches in the use of the Mental Health Act and recommendations for action by the Care Quality Commission following their visits to Trust services. These incidents and Commission reports are reviewed at the local Directorate MHA Forums where actions taken following the recommendations made are monitored.

**Summary of Financial and Legal Implications:**
The concerns highlighted within the Report, if unchecked, result in continuing poor compliance with the MHA in some areas and may result in litigation against the Trust.

**Equality & Diversity and Public & Patient Involvement Implications:**
The report contains information about the use of section by ethnic group.
MENTAL HEALTH ACT MANAGEMENT
ANNUAL REPORT

APRIL 2012 TO MARCH 2013

Prepared by: Kay Burton
Head of Mental Health Act Office
28 June 2013
Introduction
This is the fourteenth Mental Health Act Annual Report of South London and Maudsley NHS Foundation Trust (formerly South London and Maudsley NHS Trust). Included within this report is both qualitative and quantitative information relating to Mental Health Act activity and issues which have occurred during 2012/13. This includes a summary of service development, information on training, policy development, new initiatives, operational issues, Care Quality Commission reports and Associate Hospital Managers’ activity plus statistical information and data.

Service Development
Operational
The collection of data moved from manual to electronic, with MHA activity data captured from the ePJS system. Data for hearings continued to be managed manually.

The stronger approach seen in 2012-13 by the Tribunal to ensure reports are provided within the statutory timescale continued with an increase in the number of Directions and Orders to Answer Questions issued. A general improvement in the timeliness of report provision was seen which would appear to be due to the stronger management within the CAGs to follow up on outstanding MHA actions identified in the weekly monitoring tables.

The joint monitoring of Associate Hospital Managers decision forms by the MHA Management Team and the AHM Leads continued through the year. Results from this informed the training topics for the sessions delivered to the AHMs through the year.

The Key Performance Indicators for the MHA team were reviewed and revised. A system was implemented to record the data centrally electronically with reports reviewed quarterly at the MHA Team Meetings to monitor performance.

The Head of MHA and the MHA Training Manager continued to observe Associate Hospital Managers hearings using a checklist to measure criteria at the hearings. Feedback was given immediately after the hearing to the panel and also at the annual reviews to individual AHMs. The system was received positively and will continue through 2013-14.

Links with External Groups
The MHA Department continued its link with the Pan London MHA Network with staff and the Non-Executive Director with responsibility for the MHA attending the quarterly meetings and sharing ideas for new initiatives and current good practice.

The Head of Mental Health Act continued to be a member of the Mental Health Advisory Group at the Administrative Justice and Tribunals Council (AJTC), attending the quarterly meetings. In the summer the group disbanded and a new group was formed, namely the Mental Health Jurisdictional Stakeholders Meeting. This group is chaired by the Deputy Chamber President and the membership comprises representatives from legal firms, Tribunal panel members, and operational managers from the MHT, MHA Administrator representatives and representatives from the Legal Services Commission. Membership of the group has allowed the Head of MHA to raise issues that have given cause for concern, namely panel members not arriving, members arriving without reports which have previously been sent, lack of Tribunal Assistants and communication difficulties with the MHT Secretariat. The Head of Mental Health Act also continued as
a member of a smaller operational working group to explore practical administrative difficulties with the Tribunal, the group being lead by the Head of MHT Secretariat.

The link with the Full Time President(s) at the Tribunal Service, Dr. Martin Baggaley and the Head of MHA continued to follow up and resolve issues of late reports and the quality of Tribunal accommodation.

**New Initiatives**

**The Maze – second edition**
The Maze which was published in April 2010 was further revised, a second edition published in April 2012. Further revisions were undertaken with a view to a third edition to be available from April 2013. An e-book version was also developed and will be available in the summer of 2013.

**Paper reviews for uncontested hearings by Associate Hospital Managers (AHMs)**
A six month pilot to manage uncontested renewal hearings by the Associate Hospital Managers began in March 2013. This is aimed at renewals of Section 3/37 and CTOs. This followed a period of consultation and joint working with clinicians, AMHPs, MHA Co-ordinators and the Lead AHMs. The process was developed to include safeguards for patients and will be monitored and evaluated during the pilot.

**MHA E-learning package**
The e-learning package to train staff in the Mental Health Act was launched during the year. This was a joint initiative between the MHA Team and the Training Department. Work continued to develop a similar package for use by external mental health trusts and acute general hospitals.

**Service Level Agreement – acute trusts**
In May 2013 the Service Level Agreement for SLaM to provide MHA Administration to Kings Healthcare NHS Foundation Trust began. The success of the SLA lead to a further term being contracted for 2013-14. Discussions continued with Guys and St. Thomas’ to provide a similar arrangement.

**Supervised Confinement**
In November 2012 a Trustwide Supervised Confinement Workshop was held, where staff across all areas of the Trust were invited to attend to review the current policy and identify issues that need to be resolved. Representatives from clinical services, Estates and Facilities and the Mental Health Act Management Team participated. Following this an action plan was developed which has been reviewed every six weeks at a Supervised Confinement Workstream meeting. The work of this group will inform the revised Supervised Confinement Policy to be launched in 2013-14.

**Community Treatment Order pathway**
Following the processed used in the previous year to explore the MHA pathway for patients admitted to hospital, a similar project was started to look at the pathway for CTO patients. This has involved joint work with Dr. Christina Kyriakidou and Dr. Ros Ramsay to examine the process and blocks along the way which lead to errors in the administration and operation for patients on a CTO. The work will continue into the following year.

**Mental Health Act Administration Training for other providers**
The MHA Administration training programme was commissioned by a large mental health Trust in the midlands for the whole of their MHA Administration Team, at their local site. The standard package was tailored to meet their specific needs. It is hoped that further such training sessions will be undertaken in the future.

**PAN London AHM Training**
The PAN London MHA Network set up a small project group to take this initiative forward. During the year the group developed a syllabus which includes core topics for Associate Hospital Managers. A workshop was arranged involving all London mental health trusts and representatives of their Hospital Managers groups and administrative leads. The first phase of the project was completed to be further discussed at the first PAN London MHA Network meeting in 2013-14.

**PAN London MHA Data Review and MHMDS**
The Head of MHA joined a group comprising Data Analysis from other London MH Trusts, social care leads, Heads of MHA Administration. The group was set up by a Project Manager at the Department of Health whose task is to improve the recording of MHA data across London. She had been delegated the task from the PAN London Chief Executives group. Initial work was carried out with a report taken to the March 2013 meeting of the CEO Group. As a development of this group, the Head of MHA was invited to attend the Health and Social Care Information Centre in Leeds where a review of the MHMDS is ongoing.

**Training**

**Medical Staff**
The Trust continues to run both Approved Clinician and Introductory s12 courses both of which are accredited by the London Approval Panel. The courses meet the needs of doctors within SLaM and are also a source of income generation when non-SLaM doctors attend. Three of each course are held each year. One feature unique to the SLaM Approved Clinician course is that day one can serve as a stand alone s12 Refresher course and day two as a stand alone Approved Clinician refresher course. This flexibility is appreciated by the London Approval Panel and is helpful for clinicians so as to avoid them not attending unnecessary training.

The Trust is very grateful for the core group of trainers who offer their expertise to provide training which is of a very high standard as reflected in the consistently high evaluations which are received.

**Nursing and other disciplines**
MHA training continued to be offered throughout the year with one day courses delivered at both the Lambeth and Bethlem training centres. The courses continued to be very well evaluated and the increased use of case studies assisted participants to broaden their knowledge base and be more confident practitioners as mental health law becomes more complicated. Over 250 Trust staff attended; mainly nurses but also occupational therapists, social workers, psychologists and support workers.

One problem with the one day course is the widely varied knowledge base of attendees. The introduction of e-learning, as an alternative to the one day course, enables someone seeking a very basic overview of the MHA to obtain that from the e-learning package.
As Community Treatment Orders have been increasingly used it had become clear that dedicated training for clinical staff involved in their use was essential. Half day courses were introduced and seven have already been held attended mainly by Care Co-ordinators and Responsible Clinicians. These courses address the points highlighted within the CQC annual report which had identified than non-AMHPS working as Care Co-ordinators for CTO patients needed to acquire new skills e.g. obtaining s135 warrants.

A number of one day ‘bespoke’ training courses have been held where the MHA Adviser/Policy Lead delivers the one-day course either on wards or at team bases. One advantage of this new trend is that it enables the content of the day and the case studies used to focus on the specific needs of those attending. Several days enable participants to meet their needs for an MCA update.

Though not achieved in all areas there has been an increased amount of ward-based training delivered by Senior MHA Co-ordinators which address very practical needs for guidance about form filling and administrative procedures at ward level. The sessions are also a good way for stronger links to be built between the MHA Offices and wards which are part of the Departmental objective of improving customer relations.

A session on Mental Health Law (incorporating the Mental Health Act and Mental Capacity Act) is part of Corporate Induction programme and the session is jointly delivered by the MHA Adviser/Policy Lead and a service user.

**MHA Staff**
Training for staff within the Department continued to be offered by the MHA Adviser/Policy Lead. The training for the new Band 3 and 4 staff included the reintroduction of elements of the Competency Programme Workbook as a way for them to acquire key competencies. To broaden their understanding of how the MHA works staff have been encouraged to attend ward rounds which has proved to be very beneficial for them.

**Associate Hospital Managers (AHMs)**
The programme of training for AHMs continued to be refined in response to training needs identified during their annual review cycle. Sessions continued to be offered on Cultural Diversity, Risk, Forensic Risk, Safeguarding Children, Safeguarding Adults, De-escalation, the MHA, medication and Child and Adolescent Services. A new course on Substance Misuse was introduced during the year. The distinction between Intermediate and Advanced MHA Training was felt to be artificial and was replaced during the year by the need for a MHA update every two years. The frequency of training was reviewed in conjunction with the training department and a more helpful and realistic timescale for updates was agreed.

The Trust is very grateful for the core group of trainers who offer their expertise to provide training which is of a very high standard as reflected in the consistently high evaluations which are received.

**External training**
Two external courses focusing on MHA administration were held. One was held in London with participants attending from different organisations. The second course was delivered as bespoke training for a Trust in the midlands. It is hoped these courses will prove to be an important source not just of income-generation in the future.
but also of raising the profile of the Trust. Plans for an advanced course are being developed.

**MHA Policy Development**
The way in which MHA policies are reviewed, revised or developed changed during the year and the regular MHA Policy Forum ceased. Where work on a policy is required the MHA Adviser/Policy Lead will invite key people are who needed to assist in completing the policy. During the year the Correspondence policy was completed and implemented and – following feedback from both staff and service users - changes were made to the Leave for Informal Patients policy. Work continued during the year on refining the AWOL Policy.

**Associate Hospital Managers**
Through the year 13 new AHMs were recruited and completed their training during the year. The recruitment process was changed and involved applicants attending an assessment day where their skills were tested, culminating in a short interview at the end of the day. The assessors included representatives from the AHM Group Leads, service users and carers and staff from the MHA Management Team. Applicants who were successful at this stage progressed to a formal interview with the Director of Nursing and the Non-Executive Director/Chair of the Trustwide MHA Committee.

During the year the Hospital Managers received 128 appeal applications (this shows a reduction on the previous years), with a further 293 renewal hearings (decrease) and 17 Barring Order reviews (an increase). Of these, 231 (53%) were heard, with 11 (5%) discharged by the Managers; the number discharged is higher than previous years. The number of renewal hearings occurring within the target of one week either side of the expiry date remains low.

Of the 438 hearings to be arranged during the year, 142 (32%) were cancelled. This is a lower number of cancellations compared to the previous year when 37% were cancelled in 2011/12 and 44% in 2010/11. There were 37 (9%) patients transferred to a bed outside of the Trust before the hearing was held. There were 8 (2%) hearings adjourned, a further reduction on previous years. Reasons for adjournments included non-attendance of professionals at the hearing, panel member’s non-attendance and one where reports were received late.

**Mental Health Tribunals**
During the year there was an increase in the number of appeal applications to the Tribunal, with 1303 submitted and a further 155 referrals by the Hospital Managers under Section 68 of the Act. The number of appeals was an increase on the previous year. Of the 1271 Tribunals to be arranged, 515 (40%) were heard with 51 (11%) discharged, 429 (83%) not discharged and 30 (6%) granted a conditional discharge.

Of the 1458 hearings to be arranged during the year, 752 (51%) were cancelled – a decrease on the previous year. There were 153 (10%) of hearings cancelled due to the patient being transferred to a bed outside of the Trust before the hearing was held. There were 39 (3%) cases adjourned for reasons including patient absent without leave; late production of reports; non-attendance of professionals; non-attendance of Tribunal panel members. The number of adjournments was lower than previous years.
Care Quality Commission Mental Health Act Monitoring Visits
On a number of visits the visiting Commissioner commented favourably about ward atmosphere, activities, interactions between patients and staff and positive feedback received from patients. Visiting Commissioners were able to access the clinical records using the electronic Patient Journey System.

The main issues raised were in the following areas. These issues did not occur at all visits and reflect the main points rose across the Trust taking account of all visits. Many of the issues raised have been noted at visits in previous years and the CQC began to link these to criteria for compliance and registration.

Consent to Treatment
- Recording by Responsible Clinicians (RCs) in the case notes of the discussion with the patient relating to capacity to consent - Code of Practice Paragraphs 24.16 to 24.17. While, commissioners were, in some areas, unable to find clear evidence that this is occurring and improvement was seen as noted in some reports.
- The Commissioners noted that RCs do not record details of discussion and assessment of capacity when patients are first treated under the Mental Health Act. Code of Practice 23.37. Again some improvement with this was seen, reflecting the changes of practice for RCs to record this on ePJS regularly at ward rounds.

Section 132
- Repeating the giving of rights to patients who may not have understood on the first occasion is not happening in some areas – Code of Practice Paragraph 2.24 to 2.25.
- A slight increase in the number of concerns raised by visiting Commissioners about the giving of Rights, repeating these and informing patients about the IMHA services. This is against the recent trend where improvements in this area were seen.
- A revised section 132 Rights policy was launched in the year to give clear guidance to staff about the giving of rights and the frequency of this.

Access to IMHA services
The Commissioners found at a number of visits that patients were unaware of the IMHA service and were unable to find evidence that patients had been informed of this. All patients detained under the MHA have a right to an IMHA and improvement is needed to ensure that the Trust is compliant with paragraph 20.12 of the MHA Code of Practice.

Care Planning
The Commissioners continue to place a high focus on patient involvement in the care planning process, this to be more than patients just being given a copy of their care plan. As in previous years Commissioners continue to comment that it was not possible to find evidence of full patient involvement. Improvement is required to ensure that the Trust can demonstrate compliance with paragraph 1.5 of the Code of Practice in relation to the Participation Principle.

Untoward Incidents
There were 94 incidents during the year resulting from breaches of the Mental Health Act. This is a small increase on the previous year when 90 were recorded. For all incidents of C category or above a Fact Finding report was completed and a decision taken as to whether these should be regarded as Serious Untoward Incidents. There were no incidents reported within category A or B as defined by the Trust Incident
Policy. A summary of MHA breaches is presented to the quarterly Trustwide MHA Committee and more detailed analysis of these at the site MHA Fora. The number of breaches in 2012/13 represents a very small percentage (2%) against the number of Sections used in the Trust for the year, the breaches being identified on scrutiny by the Mental Health Act Co-ordination Team. The breaches that resulted in the most incidents were (a) Other MHA paperwork error - 33; (b) Other MHA Trust error – 32 and (c) non-rectifiable paperwork errors – 16 cases. Figure 1 displays the categories for the year. There was a decrease in the number of errors reported relating to medication administered not covered by Section 58. This appears to reflect improved practice following recommendations being made following audits of the use of Section 58 and increased vigilance by staff working in clinical areas.

![Figure 1: Chart to show categories of MHA breaches - 2012-2013](image)

**Clinical Governance**
During the year a Trustwide audit of Supervised Confinement, Community Treatment Orders and the Informal Patient were carried out. The findings from these audits were presented to the Clinical Effectiveness Committee and the Trustwide MHA Committee. The recommendations will form the action plan for improvements to be followed up through the site MHA Fora during 2013/14. It is planned to audit the use of the Mental Capacity Act during the coming year.

**Use of the Act**
During the year 2012-13 the Trust had 4959 admissions of which 1361 were formal (27.45%).
sections 136, SCT, 2, 5(2) and 5(4) and a reduction in the use of all other sections. A breakdown of Section use by CAG can be seen in Table 1 below. These figures do not include those patients detained in overspill placements.

<table>
<thead>
<tr>
<th>Section by Directorate</th>
<th>Psychosis</th>
<th>B&amp;D</th>
<th>Psych Med</th>
<th>MAP</th>
<th>CAMHS</th>
<th>MHOA</th>
<th>TOTAL</th>
</tr>
</thead>
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<tr>
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<td>29</td>
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<td>66</td>
<td>21</td>
<td>2</td>
<td>1</td>
<td>677</td>
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<tr>
<td>Section 17a (CTO)</td>
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<td>19</td>
<td>9</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>203</td>
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<tr>
<td>Section 2</td>
<td>678</td>
<td>5</td>
<td>533</td>
<td>10</td>
<td>46</td>
<td>79</td>
<td>1351</td>
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<td>Section 3</td>
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<td>22</td>
<td>43</td>
<td>963</td>
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<td>Section 37N</td>
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<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Section 37/41</td>
<td>3</td>
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<td>1</td>
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<td>0</td>
<td>0</td>
<td>21</td>
</tr>
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<td>Section 4</td>
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<td>0</td>
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<tr>
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<td>142</td>
<td>16</td>
<td>26</td>
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<tr>
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<td>11</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>30</td>
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<tr>
<td>TOTAL</td>
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<td>97</td>
<td>955</td>
<td>50</td>
<td>100</td>
<td>139</td>
<td>3909</td>
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</table>

Figure 2 shows the percentage of MHA use across the Trust by CAG.

![Figure 2: Chart to show percentage Section use by CAG - 2012/2013](image-url)
The number of patients admitted directly to a Trust bed under a Section of the Mental Health Act can be seen by Directorate in Table 2. This shows the number of MHA Admissions by CAG, compared to the total of all admissions and the percentage under the Mental Health Act. The number of admissions directly to hospital under the Mental Health Act 1983 was higher than in the previous two years when 1287 and 1242 were admitted direct respectively.

Table 2: Admission Direct to Hospital under MHA – 2012-13

<table>
<thead>
<tr>
<th>Section by Directorate</th>
<th>Psychosis</th>
<th>B&amp;D</th>
<th>Psych Med</th>
<th>MAP</th>
<th>CAMHS</th>
<th>MHOA</th>
<th>TOTAL</th>
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<td>420</td>
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<td>1008</td>
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<tr>
<td>s3</td>
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<td>2</td>
<td>104</td>
<td>0</td>
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<td>264</td>
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<tr>
<td>s4</td>
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<td>s37</td>
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<td>0</td>
<td>4</td>
</tr>
<tr>
<td>s37/41</td>
<td>3</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
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<tr>
<td>s47; s47/49</td>
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<td>0</td>
<td>28</td>
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<tr>
<td>s48; s48/49</td>
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<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>693</strong></td>
<td><strong>36</strong></td>
<td><strong>533</strong></td>
<td><strong>3</strong></td>
<td><strong>29</strong></td>
<td><strong>67</strong></td>
<td><strong>1361</strong></td>
</tr>
<tr>
<td><strong>TOTAL ALL ADMISSIONS</strong></td>
<td><strong>1908</strong></td>
<td><strong>84</strong></td>
<td><strong>2239</strong></td>
<td><strong>82</strong></td>
<td><strong>332</strong></td>
<td><strong>314</strong></td>
<td><strong>4959</strong></td>
</tr>
<tr>
<td><strong>Percentage of MHA admissions</strong></td>
<td><strong>36.32%</strong></td>
<td><strong>42.86%</strong></td>
<td><strong>23.81%</strong></td>
<td><strong>3.66%</strong></td>
<td><strong>8.73%</strong></td>
<td><strong>21.34%</strong></td>
<td><strong>27.45%</strong></td>
</tr>
</tbody>
</table>

Figure 2 shows a comparison between the total admissions for the year 2012/13 and of those, the number admitted direct to hospital under a Section of the Mental Health Act 1983. 27.5% of admissions were under the MHA 1983.
Figure 4 shows the comparison by Clinical Academic Group admitted directly to a bed under Section and the number of total Sections applied during the year.

A comparison between the uses of the Mental Health Act within the Trust since the year of the merger (1999) and 2011/12 can be seen in Figure 5. The use of the MHA in 2012/2013 was the highest seen since the Trust was first formed.
Ethnicity
The breakdown of patients detained under the Mental Health Act during the year, in terms of broad ethnic groupings is shown at Table 3. The ethnicity data for this year’s annual report has been taken from ePJS. The highest number of detentions fell within the Black or Black British group at 1949 (46%) with those in the White group the second largest group at 1673 (39%). This represents the same percentage of those detained in the Black or Black British category, and a higher percentage in the White group, last year showing 37%. In the Asian group there were 158 (4%) same as previous year, Mixed Background 124 (3%) an increase on the previous year and Other Ethnic Group 208 (5%), a decrease on the previous year. Of the total 82 (2%) were shown as ‘Not stated’, this represents an increase.

The ethnicity breakdown in this annual report is based on the number of Sections used across the Trust and includes those patients transferred into the Trust from external organisations. Figure 6 shows a graphical representation of the data in Table 3.
Figure 6: Chart to show breakdown by section and ethnic group - 2012/13
Table 3: Ethnicity of Detained Patients using Broad Ethnic Categories – 2012-13

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Sec 2</th>
<th>Sec 3</th>
<th>Sec 45(2)</th>
<th>Sec 45(4)</th>
<th>Sec 37/37</th>
<th>Sec 47/49</th>
<th>Sec 48/49</th>
<th>Sec 135</th>
<th>Sec 136</th>
<th>Sec 37</th>
<th>Sec 36</th>
<th>Sec 38</th>
<th>Sec 47</th>
<th>TOTAL</th>
</tr>
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<td>White</td>
<td>585</td>
<td>371</td>
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<tr>
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<td>202</td>
<td>10</td>
<td>12</td>
<td>20</td>
<td>3</td>
<td>21</td>
<td>131</td>
<td>23</td>
<td>227</td>
<td>3</td>
<td>0</td>
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<tr>
<td>Mixed Background</td>
<td>39</td>
<td>34</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>20</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>83</td>
<td>47</td>
<td>23</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>39</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>208</td>
</tr>
<tr>
<td>Not Stated</td>
<td>26</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>82</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>1472</td>
<td>1082</td>
<td>38</td>
<td>516</td>
<td>30</td>
<td>17</td>
<td>23</td>
<td>7</td>
<td>33</td>
<td>228</td>
<td>29</td>
<td>353</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

Figure 7 shows the ethnic groupings for the main Sections used in the Trust compared to the local Trust population (Sections 2, 3, 4, 5(2) and 136).

Figure 7: Chart to show ethnicity by main sections 2012-13

Proposed MHA Developments for 2012/13
- Produce a guide to the Mental Capacity Act in the same format as The Maze.
- Finalise the e-learning package for internal use and expand this for external marketing.
- Continue to provide courses in MHA Administration, developing an advanced course to run alongside the introductory course.
- Extend current MHA training to be available in the external market.
- Finalise the process map the pathway for Community Treatment Order patients.
- Develop the MHA float team to provide flexibility across the service.
- Develop a simulation training model for MHA training for staff and Associate Hospital Managers.
• Finalise the Supervised Confinement and Restriction of Free Movement Policies.
• Evaluate the pilot paper reviews by AHMs for uncontested renewals.
• Work with the EPJS team to further develop the reporting functionality to meet MHA Department purposes.
• Develop EPJS reporting systems to produce the KP90 stats return to the Department of Health.
• Work with the EPJS team to increase the number of electronic MHA forms.

Kay Burton
Head of Mental Health Act Office
July 2013
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 23 July 2013
Name of Report: Assurance Framework Report
Heading: Governance
Author: Jenny Goody, Governance Manager
Approved by: Nick Dawe
Presented by: Nick Dawe

Purpose of the report:
To present the principal risks that have been identified by the Trust’s operational management that are thought to most threaten the achievement of the Trust’s objectives in 2013/14. To understand the actions and progress with the actions designed to mitigate and control the principal risks.

Action required:
The Board of Directors is asked to review the attached report to ensure that all principal risks are identified and to confirm that actions to mitigate these risks are comprehensive and appropriate.

Recommendations to the Board:
Accept the attached Assurance Framework Report, subject to any changes agreed by the Board of Directors. Note the significant and growing risks to patient quality and financial stability arising from the fact that (in two boroughs) actual activity is significantly exceeding contracted and funded activity.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
This paper forms the basis of the on-going process that ensures risk identification; mitigation and management comply with the requirements of the Assurance Framework.

Summary of Financial and Legal Implications:
The Assurance Framework underpins the statutory requirement to produce an Annual Governance Statement, which confirms that the Trust is appropriately and effectively governed and managed.

Equality & Diversity and Public & Patient Involvement Implications:
The Assurance Framework enables the Board to assess and manage the organisation’s principal risks and ensure that the Trust’s strategic aims are achieved.
Board Assurance Framework 2013/14

Introduction

The identification and management of risk forms a key part of the governance of the Trust. By the very nature of the services that the Trust provides and the reputation, scale and complexity of the Trust, the number of risks facing the Trust is large, with several of the risks being significant. It is not only important that the Trust identifies these significant risks, it is critical that the Trust has a realistic risk appetite that supports innovation, change and the capacity and capability to manage and mitigate risks.

Methodology

The list of principal strategic risks currently facing the Trust was ratified at the April meeting of the Board of Directors. Proposed sources of assurance have now been identified, which will be used to evidence that the planned actions are on track to mitigate the risk to an acceptable level.

The next step was to ensure that the key actions identified by the Trust Executive were reasonable from a CAG and Directorate perspective and begin to understand how they are progressing. To achieve this, another column has been added to the Assurance Framework report specifying progress to date, which is reported by one of five colours, namely:

- BLUE: Completed & working; identified benefits realised;
- GREEN: Progressing to plan; delivering to expectations;
- AMBER: Slight delay in progress; uncertainty that identified benefits will be realised;
- RED: Amber status for more than one reporting period, i.e. late and not delivering as expected;
- PURPLE: Failure in timing and/or results; reconsider if this action is appropriate.

CAGs were asked to review the key actions on the Assurance Framework report, amending and/or adding actions so that they are specific to their CAG or Directorate, and an indicative progress rating was also requested. Future reports will compare previous and current ratings to identify the ‘direction of travel’. Where progress ratings are Blue, Green or Amber, the predominant rating will be reported. If any Action is reported as being Red or Purple for any CAG or Directorate, this will be the rating reported to the Board, with full supporting details.

Progress

Responses have been received from all CAGs and the Estates & Facilities Directorate. The Assurance Framework report at Attachment 1 details the full list of principal risks, the consequences should they be realised, current risk ratings, key actions to mitigate them, possible sources of assurance and aggregate indicative progress ratings.

Key changes: Risk 5, Activity and capacity, with the certainty that activity volumes will now run well in excess of contracted and funded levels with a spending pressure of circa £6m, the score of this risk has moved from 12 to 20.

This is a major area of concern that impacts on quality, safety and the ability to deliver objectives such as a balanced financial out-turn and an improved estate.

Key successes: None reported.

Key issue: Demand pressures and at a secondary level, actions to support the Psychosis Learning Difficulties Plan are not delivering as expected.
# Board Assurance Framework 2013/14

**Objective:** The service user is the centre of all we do

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Area</th>
<th>Risk Description</th>
<th>Consequences (Reason for Inclusion)</th>
<th>Risk Rating</th>
<th>Trust Lead(s)</th>
<th>Key Actions</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Offer people the quality of service they require / deserve</td>
<td>Insufficient attention is given to quality issues in strategic and operational decision making and practice.</td>
<td><strong>Service Users:</strong> Service users fail to thrive and improve; failure to embed a caring and compassionate culture. <strong>Service:</strong> Service users choose to go elsewhere. <strong>Business:</strong> Failure to comply with regulatory requirements and/or evidence Monitor's Compliance Framework.</td>
<td>5 4 20</td>
<td>Trust Board and Executive collectively, co-ordinated by Medical and Nursing Directors</td>
<td>Ensure the Trust’s Quality Plan for 2013/14 contains specific quality targets and baselines. <strong>Key metric:</strong> Disseminate the Quality Strategy throughout the Trust. <strong>Key metric:</strong> Ensure mechanisms for patient, carer and staff satisfaction are regular and robust and respond appropriately. <strong>Key metric:</strong> Ensure that quality implication statements appear on all decision papers at CAG, Executive and Board level. <strong>Key metric:</strong></td>
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<p>| 2.   | Safety of patients, staff and public | Heightened levels of violent and aggressive behaviour. | <strong>Service Users:</strong> Injury; unsatisfactory in-patient experience. <strong>Service:</strong> Injury to staff; poor staff morale; sickness absence. <strong>Business:</strong> Backfill costs; damage to Trust property and premises; litigation. | 4 4 16 | CAG Service Directors, co-ordinated by Medical and Nursing Directors | Address the problem of an aging/less fit workforce and their capability to use and train in PSTS techniques. <strong>Key metric:</strong> Implement improved alarm system. <strong>Key metric:</strong> | |</p>
<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>3.</td>
<td>Safety of patients, staff and public</td>
<td>Unexpectedly high levels of Serious Incidents and Complaints.</td>
<td><strong>Service Users</strong>: High level of patient mortality. <strong>Service</strong>: Lack of awareness of key performance indicators and inability to respond appropriately. <strong>Business</strong>: Litigation.</td>
<td>4 3 12</td>
<td>CAG Service Directors, co-ordinated by Medical and Nursing Directors</td>
<td>Develop agreed benchmarks and a mechanism to raise awareness, identify issues and respond appropriately. <em>Key metric:</em></td>
<td></td>
</tr>
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</table>
Objective: Provide effective and efficient services that meet the needs of our service users

<table>
<thead>
<tr>
<th>Ref.</th>
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<th>Risk Lead(s)</th>
<th>Key Actions</th>
<th>Progress</th>
</tr>
</thead>
</table>
| 4    | Forward Plan| Failure to deliver the Forward Plan (CIPs and QIPPs). | **Service**: Inability to deliver the service that is fit for purpose. **Business**: The Trust is not operationally viable. | 4 3 12      | Executive and CAG Service Directors | Improve ‘SMART’ monitoring of CIP and QIPP delivery.  
*Key metric:* Manage performance of CIP and QIPP delivery, holding managers to account at Board meetings. |          |
| 5    | Activity    | Demand for services exceeds capacity and contracted levels. | **Service Users**: Non responsive or inappropriate care; unacceptably long waiting lists; patient safety compromised (community and in-patient). **Service**: Unacceptably high bed occupancy and community caseloads. **Business**: Cost of overspill (patients going to private sector). | 5 5 20      | CAG Service Directors          | Improve capacity and demand forecasting.  
*Key metrics:*  
- Waiting lists  
- Emergency beds commissioned  
Establish bed management office and monitor performance.  
*Key metric:* Agree how best to use £3m demand contingency monies set aside for additional capacity and/or placements. |          |
<table>
<thead>
<tr>
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<th>Consequences (Reason for Inclusion)</th>
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<th>Risk Lead(s)</th>
<th>Key Actions</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>AMH transformation</td>
<td>Insufficient capacity &amp; capability to deliver the AMH transformation programme (due to its scale and experimental nature).</td>
<td>Service Users: Don’t receive a modern and applicable service. Service: Loss of market share, through commissioners or service users choosing to go elsewhere. Business: Unaffordable business model that does not meet demand; failure to comply with regulatory requirements.</td>
<td>4 3 12</td>
<td>AMH CAG Service Directors</td>
<td>Produce SMART Business Case. Identify and train implementation project team. Monitor progress against plan and report to Board.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Forensics transformation</td>
<td>Insufficient capacity &amp; capability to deliver the Forensics transformation programme (due to its scale and experimental nature).</td>
<td>Service Users: Don’t receive a modern and applicable service. Service: Loss of market share; through commissioners choosing to go elsewhere. Business: Unaffordable business model that does not meet demand; failure to comply with regulatory requirements.</td>
<td>4 3 12</td>
<td>B&amp;DP CAG Service Directors</td>
<td>Produce SMART Business Case. Identify and train implementation project team. Monitor progress against plan and report to Board.</td>
<td></td>
</tr>
</tbody>
</table>
**Objective:** Retain the position of a leading MH Trust, with proven clinical and business success

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Area (Reason for Inclusion)</th>
<th>Consequences (Reason for Inclusion)</th>
<th>Risk Rating</th>
<th>Risk Lead(s)</th>
<th>Key Actions</th>
<th>Progress</th>
</tr>
</thead>
</table>
| 8.   | Organisational and Operational Position | Service: Insufficient management capacity / capability to deliver or support the delivery of clinical services; prolonged uncertainty and inability to act. Business: Failure to comply with regulatory requirements and/or evidence Monitor's Compliance Framework. | 3 4 12 | Chief Executive | Identify and manage gaps proactively. *Key metric:*
Identify and develop leadership skills. *Key metric:*
Recruit to key Director and other senior posts. *Key metric:*
| 9.   | Estates responsive and proactive service (Condition of premises stock and backlog maintenance need) | Business: Rapid repairs; inability to deliver approved projects; failure to comply with regulatory requirements. | 4 3 12 | Finance and HR Directors (pro temps) | Initiate rapid response arrangement and create buffer stock of key estate components and decant facilities. *Key metric:*
Improve operational, programme and project management arrangements. *Key metric:*
Ensure proactive approach to statutory testing and remedial works programme. *Key metric:*
Delivery of procurement process and % completion of works programme. |
<table>
<thead>
<tr>
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<th>Key Actions</th>
</tr>
</thead>
</table>
| 10   | Decision support            | Lack of timely and accurate performance information (clinical, contractual, bed, etc.). | Service: Inability to make correct operational and strategic decisions.  
Business: Under recovery of income (including PbR), fines, contract sanctions and inability to implement zero based budgeting. | 4 3 12      | Medical, Strategy and Finance Directors, supported by Director of ICT Strategy | Identify information requirements, establish data supply (source and timetable) and monitor performance.  
*Key metric:*                                                                                                                                                          |
|      |                             | Source of Assurance:  
• Balanced scorecard reported to Board                                                |                                                                                                 |             |                                                                               |                                                                                                                                                                                                          |
| 11   | Business Retention          | Failure to retain and develop our business (retain/expand market share, expand into new markets and respond to commissioner needs, policy and intentions). | Service: The need for further efficiencies that are increasingly difficult to achieve.  
Business: Loss of market position/influence, loss of income of brand equity. | 3 4 12      | Medical, Strategy and Finance Directors                                        | Ensure that SLaM's models of care are seen to be innovative and credible.  
*Key metric:*  
Identify prospective customers, review their requirements and provide appropriate response.  
*Key metric:*                                                                                           |
<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Area</th>
<th>Risk Description</th>
<th>Consequences (Reason for Inclusion)</th>
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<th>Risk Lead(s)</th>
<th>Key Actions</th>
</tr>
</thead>
</table>
| 12   | New NHS   | Failure to develop robust relationships with CCGs, SCGs and Local Authorities, in light of commissioning changes and the introduction of Payment by Results. | **Service Users:** New commissioning plans may not be perceived as patient focussed.  
**Service:** Service users choose to go elsewhere.  
**Business:** Delays / changes in commissioning intent; reduced income. | 4 3 12 | Strategy Director and CAG Service Directors | Refresh marketing strategy and commit to a market share defence / expansion plan.  
*Key metric:* Improve relationships with key GPs, commissioners and boroughs through targeted contact, information provision and support.  
*Key metric:* Review 4Ps (product, placement, price and promotion) approach to service offering to community, GPs and commissioners.  
*Key metric:* |
Date of Board meeting: Tuesday 23rd July 2013

Audit Committee (‘AC’):

Name of Report:
(a) draft minutes of meeting held 25.Jun.2013
(b) signed and sealed report (Mar.13 to Jun.13)

Heading: Governance

Author: Steven Thomas (AC Secretary)

Approved by:
(name of Exec Member) Robert Coomber (AC Chair and Non Executive Director – ‘NED’)

Presented by: Robert Coomber (AC Chair and NED)

Purpose of the reports:

AC draft minutes. To inform the Board about proceedings at the AC meeting held on 25.Jun.2013
Signed and sealed report. To inform the Board about documents signed and sealed on behalf of the Trust in the period Mar. 2013 to Jun.2013

Action required:
Review the documentation presented.

Recommendations to the Board:
Note the documentation presented.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The AC’s role includes consideration of the Assurance Framework

Summary of Financial and Legal Implications:
No specific significant implications identified.

Equality & Diversity and Public & Patient Involvement Implications:
No specific significant implications identified.

KEY ISSUES SUMMARY (references are to the AC minutes attached)
(The AC Chair may wish to expand or amend the following at the Board meeting)
At its 25.Jun.2013 meeting, the AC concluded that no matters required escalation for the attention of the Board (14.1 refers). However the AC considers that the Board should be kept aware of the AC’s concerns about the following issues.

- Competitive marketing/benchmarking As flagged in the AC’s minutes for Mar.13, the new environment means that SLaM needs to understand competitive marketing/benchmarking (including commissioners’ needs) and internal audit is seeking to adjust the focus of their audit work to allow them to comment on this (10.1 refers).

- Estates and Facilities GH updated the AC on progress in addressing these issues, including addressing capacity and capability issues and the prioritisation of works.
NOTES
The AC Chair decides on the appropriate order in which to take agenda items at AC meetings, and this is not necessarily the order shown below. The minutes focus on recording the information and assurances provided in the meeting, in response to questions from AC members and otherwise, rather than on the questions themselves.

1. UNMINUTED SESSION
1.1 RC, PCJ, SK, ND, KL, NM, MH, AF and ST held a session pre-agreed to be unminuted. All agreed that attendees would make their own notes as appropriate. The meeting discussed key issues faced by NHS bodies, and by Mental Health Trusts in particular, and SLaM’s responses thereto.

2. APOLOGIES FOR ABSENCE
2.1 RC opened the meeting. Attendees introduced themselves as appropriate. ST noted that ND had arranged for TG and MN to attend in his stead for those parts of the meeting that he was unable to attend. After due discussion the AC noted this agenda item.
3. DECLARATIONS OF INTEREST
3.1 RC asked all present to declare any relevant interests. Routine declarations were made. PCJ declared an interest as a former employee of King’s College London and as Trustee of Southside Certitude Support. SK declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. SK advises and consults with pharmaceutical companies periodically. After due discussion the AC noted these declarations.

4. MINUTES OF PREVIOUS AC MEETING(S)
4.1 The AC considered the final draft minutes of the AC meeting held on Tuesday 21st May 2013. PCJ advised that her declaration of interest in 3.1 should show her as a former employee of King’s College London. After due discussion the AC approved the minutes with that amendment.

5. ACTION POINTS (‘APs’) FROM PREVIOUS AC MEETINGS
5.1 The AC considered the AP list. After due discussion the AC noted the AP list. Post meeting note: with the AC Chair’s agreement ST has updated the AP list to reflect information received during the AC meeting and subsequently

6. MATTERS ARISING (IF ANY)
6.1 No other matters arising were reported. The AC noted this agenda item.

7. KEY POINTS FROM RECENT SQISC MEETING(S)
7.1 JG presented this report based on the most recent meeting of the Service Quality Improvement Sub Committee (‘SQISC’). The following points in particular were amongst those discussed in the AC meeting:
(a) the meeting discussed Monitor’s Quality Governance Framework and the Francis Report, referred to in the first paragraph of the SQISC report. KL advised that he considered the Framework a useful document that he used in Board workshops. MH advised that Deloitte had been involved in writing the Quality Governance Framework. RC noted the SQISC’s request that Cliff Bean should arrange a formal review of SLaM’s compliance with the Framework, and was surprised that SLaM had not already done this (the Framework was issued in July 2010). KL advised that relevant points from the Framework and the Francis Report were built into internal audit workplans as appropriate;
(b) JG discussed the metrics used to evidence progress against each action logged in the Assurance Framework;
(c) JG outlined the discussions between the Council of Governors and Deloitte about selection of a performance indicator for audit review purposes (AP.355 refers). MH reported that the Council of Governors had commented that their meetings with Deloitte were useful, and the next such meeting was scheduled for July 2013; and
(d) after due discussion the AC noted the report.

7.2 Action/(timescale). KL will ensure that internal audit workplans include a review of the Board’s role in monitoring actions from the Francis Report (Sep.2013).

8. REPORTS FROM AND DISCUSSIONS WITH SLaM MANAGEMENT (OTHER THAN FINANCE)
8.1 Discussion with CAG/service leader re data quality, change management and commissioning
8.1.1 JF introduced herself as Acting Service Director of the Child and Adolescent Mental Health Services (‘CAMHS’) Clinical Academic Group (‘CAG’). JF tabled and presented two reports, discussion of which is noted below.

CAMHS’s structure, finances and commissioning
8.1.2 The following points were covered in discussions based on this report:
(a) JF commented that resource cuts had affected CAMHS. GH advised that CAMHS had experienced one of the largest such cuts;
(b) JF advised that the increase in funding of National and Specialist service (2009/10: £10m and 2013/14: £19m) was due mainly to success in tendering for new contracts, in particular the Kent contract which is less risky for SLaM as SLaM’s income is not volume-dependent. SK noted that this 87% increase in income required only a 40% increase in Whole Time Equivalents (‘WTEs’), so CAMHS is relatively efficient. JF flagged good working relationships with commissioners as key to this, and noted that SLaM needed to focus on building these again now that commissioners are more distant. JF noted that CAHMS’s move to home treatments rather than bed-based treatment had improved financial
performance, and confirmed that SLaM's agreements with PCTs had eliminated commissioning risks as regards patients who go to the private sector;

(c) JF advised that benchmarking showed CAMHS’s costs to be in the lowest third of the group of Trusts;

(d) JF advised that a financial risk in outpatients had arisen because the service had grown but a block contract was in place;

(e) JF reported that CAMHS is developing a small team, with academic links in the CAG, to work with young people in schools to identify potential problems at an early stage and so facilitate resolution; and

(f) TG noted that new services had been costed, existing services were re-based about three years ago and JF noted that a full-scale exercise was underway, the most recent such prior to this being 15 years ago. RC and GH stressed that pricing of services must fully reflect market-based information, not solely the cost of provision.

CAMHS’s performance: monthly performance indicator trends since July 2011

8.1.3 JF presented this report, which the meeting discussed, and:

(a) JF noted the trends shown and in particular the increase in attended appointments per WTE (for Southwark this is 1.4 in July 2011, and 2.1 in March 2013), indicating an increase in efficiency;

(b) JF noted that SLaM wished to benchmark performance against other (non-competing) Trusts so as to check if performance, whilst improved, is reasonable;

(c) GH confirmed that other CAGs were adopting the approach reflected in the report; and

(d) JF stressed the major 'peak' bed management issues faced by SLaM, as a preferred service provider, advising that use of private sector bed resources to manage 'peaks' was problematic given the variable quality of such beds. JF advised that in Kent the root issue is excessive bed-based treatment admittances, not a lack of beds.

Other issues

8.1.4 The meeting discussed some other issues:

(a) JF advised that CAMHS was seen within mental health services as the service dealing with young people, rather than seen within services for young people as the service dealing with their mental health issues

(b) JF advised her view that, to date, KHP potential merger discussions had been dominated by physical/acute health issues;

(c) JF advised that CAMHS had recently started to review the pros and cons for CAMHS of the KHP merger, and noted links with the work done by McKinsey & Company. SK stressed that CAMHS should report its views as soon as possible to the Board, to allow the Board to form an overall view; and

(d) after due discussion the AC noted the agenda item, and thanked JF for an excellent presentation.

8.2 Estates-related issues: feedback from discussions with GH

8.2.1 GH reported on this matter and in particular:

(a) That management and staffing issues were being addressed appropriately and urgently in-line with Trust policies and procedures.

(b) That the interim management arrangements (Mark Drewe and Kevin Leader) were enabling the Trust to make rapid progress with backlog maintenance, statutory and strategic issues.

(c) That a recent re-prioritisation of the capital programme had ensured must do issues, such as, Chaffinch Ward increased capacity was addressed and that qualitative issues around ward hygiene, decor and safety were given the utmost attention.

(d) After due discussion the AC noted the agenda item.

8.3 KHP-related issues: effect of KHP and other changes on senior management and update re advice from external consultant

8.3.1 The AC agreed that this agenda item had been dealt with as appropriate during discussion of other agenda items.

9. EXTERNAL AUDIT

9.1 Update to 2012/13 audit reports

9.1.1 MH and AF presented the reports, advising that these were updated versions of the reports considered at the previous AC meeting held on 21.May.2013. After due discussion the AC noted the agenda item.
9.1.2 Action/(timescale). Deloitte will update, and report to the AC on, the benchmarking information presented in the appendix to their ‘Report on the financial statement audit for the year ended 31 March 2013’ (Dec.13).

9.1.3 Action/(timescale). ND will circulate a briefing note summarising the implications for SLaM of external audit’s 2012/13 reports and how SLaM has and will respond, with particular reference to external audit’s qualified opinion on the SLaM’s quality accounts, including the background to the issues giving rise to that opinion (Sep.13).

9.2 Report on change management: lessons learned from other clients
9.2.1 MH reported on this matter, and:
(a) MH and SK noted the relatively large number of senior staff at SLaM who are in ‘interim’ or ‘acting’ roles. KL stated that this could result in issues of corporate ‘memory loss’. However MH stated that everything in SLaM appeared to be running as it should, in all material respects and confirmed that external audit had no concerns other than those already raised formally in their reports;
(b) ND commented that SLaM did not have issues in dealing with risks on a short and medium term (on the scale of days, weeks and years) but there were issues in managing strategic risks of a longer term nature. ND considered that there were benefits in having a significant number of ‘interim/acting’ senior staff, in that corporate memory can sometimes act as a block to progress; and
(c) after due discussion the AC noted the agenda item.

10. INTERNAL AUDIT (INCLUDING ICT AUDIT AND CLINICAL AUDIT IF RELEVANT)
10.1 Progress report (key changes to be highlighted per AP.346)
10.1.1 KL and NM presented this agenda item, and in particular:
(a) NM advised that the internal audit plan had been recently agreed, and now linked specifically with the assurance framework to show what risks internal audit work would address;
(b) NM advised that the risks dealt with in the Assurance Framework are considered to be higher level than those, such as CAG-related risks, which are not thus recorded. NM considered that such risks required coordination/consolidation and suggested that JG could be tasked to work on this;
(c) the meeting discussed commissioning risk. KL considered that the NHS was becoming more commercial and KL and RC noted that this could mean that SLaM takes on more commissioning risk, and needs greater skill in marketing and cost management. NM stated that it would not be necessary to amend internal audit work to cover these aspects, but a change in the focus of internal audit work would be required; and
(d) after due discussion the AC noted the agenda item.

10.1.2 Action/(timescale). KL and NM will discuss with ND how the focus of internal audit work might be amended to allow reporting on: (a) the appropriate level of commissioning risk that SLaM should accept; and (b) whether SLaM is making appropriate progress in gaining marketing and commissioning skills (Sep.13).

10.2 Closure of audit agreed actions (and Computer Audit update per AP.347)
10.2.1 NM presented this report, forming sections 3.1 and 5.2 of the Progress Report and in particular:
(a) NM advised that SLaM had implemented 3 further medium priority recommendations since the report was drafted;
(b) NM confirmed that SLaM staff do take internal audit recommendations seriously, and (especially as regards IT audits) often do not simply accept recommendations without further discussion and sometimes amendment of the recommendation. The aim is to agree the wording of any recommendations as part of finalising each draft internal audit report;
(c) KL confirmed that an appropriate escalation protocol was in place to deal with old agreed actions that remained open; and
(d) after due discussion the AC noted the agenda item.

10.3 Update re 2013/14 internal audit plan
10.3.1 KL and NM presented the 2013/14 internal audit plan and:
the AC queried whether sufficient audit time has been allocated for the reviews entitled ‘Learning lessons from internal incidents and complaints’ and ‘Developing corporate efficiency programmes’ (14 days planned for each), especially given that SLaM is seeking to improve its agility as organisation. NM commented that those two audits and others were linked, and so total audit time allocated is considered sufficient;

NM advised that internal audit had amended the planned phasing of audits across the year, seeking to spread audits more evenly;

after due discussion the AC noted the agenda item and agreed the updated internal audit plan 2013/14.

10.4 Feedback on liaison with Paul Grady
10.4.1 KL reported on internal audit’s discussions with Paul Grady (‘PG’ – Head of Internal Audit at Imperial College Healthcare NHS Trust) about how he addressed issues faced by that AHSC. KL stated that PG’s main comment was on the difficulties caused by the clash of corporate cultures that had surfaced after the merger of bodies to form Imperial College Healthcare NHS Trust. After due discussion the AC noted the agenda item.

11. LOCAL COUNTER FRAUD SPECIALIST (‘LCFS’)
11.1 Summary cover sheet
11.1.1 DK presented the summary cover sheet. The AC considered that this was a useful report, and should be presented at each AC meeting. After due discussion the AC noted the agenda item.

11.2 Progress report 2013/14
11.2.1 DK presented the report, and in particular:

(a) DK outlined the strategic objectives introduced by NHS Protect, relating these to the previous ‘generic areas’ (section 2.1);
(b) DK flagged the e-learning package developed by LCFS with Trust staff (section 3.7);
(c) DK flagged potential risk areas (section 3.14) including handwritten prescriptions;
(d) DK confirmed that historically, retention of Trust mobile phones by ex-staff had been an issue, and would be added again into the 2013/14 workplan. MN advised that managers did receive reports on Trust mobile phones relating to staff about to leave SLaM’s employment and ex-staff, but stated that managers sometimes did not act upon such reports;
(e) DK confirmed that LCFS’s work on case PAA5784 (Absent without leave) was preparatory work prior to Human Resources (‘HR’) taking action on the case; and
(f) After due discussion the AC noted the agenda item.

11.3 Annual report 2012/13
11.3.1 DK presented the report and in particular flagged:

(a) section 3 (qualitative assessment) which reported SLaM as achieving ‘level 3 – organisation performing well’ as regards its counter fraud service. The only higher level is level 4;
(b) section 4 (fraud liaison), which shows a list of bodies with which LCFS has liaised to date;
(c) section 6.14, which shows the protocols reviewed/agreed with Trust staff; and
(d) after due discussion the AC noted the agenda item.

11.4 Workplan 2013/14
11.4.1 DK presented the workplan, advising that it was similar to that adopted for 2012/13. After due discussion the AC noted the agenda item.

11.5 Fraud QA presentation
11.5.1 DK drew attention to the hard copy slides from a recent presentation on the Counter Fraud QA process that is being adopted for 2013/14. After due discussion the AC noted the agenda item.

12. RISK MANAGEMENT AND FINANCE
12.1 Report from Director of Finance on items 12.2 onwards
12.1.1 On ND’s behalf, TG and MN reported as appropriate within agenda items 12.2 to 12.4 below.

12.2 Update on consolidation of charitable funds/impact
12.2.1 MN updated the AC about this, reporting that whilst the dispensation to exclude charitable funds from consolidation ended on 31 March 2013, it remained unclear whether consolidation was now required. After due discussion the AC noted the agenda item.

12.3 Report/update on risk management compliance
12.3.1 JG presented this report, and in particular:
(a) JG advised that Finance Department now has a programme of regular risk reporting and update meetings;
(b) JG advised that HR will review their Risk and Assurance Register at each HR managers’ meeting;
(c) JG confirmed that she has now received evidence of review of the Strategy and Business Development Risk and Assurance Register; and
(d) after due discussion the AC noted the agenda item.

12.4 Assurance Framework, including update on proposed ‘integrated report’ and refocusing of management’s responsibilities
12.4.1 JG presented the Assurance Framework, outlining the new format and progress colour-rating adopted, and in particular:
(a) JG explained the meaning of the multi-coloured text shading in the ‘progress’ column (it shows mixed progress in dealing with points);
(b) JG stated that the Risk Management Committee wishes the document to show assurances;
(c) JG stated that considerably more education about the Assurance Framework was required before it could be said to be used properly;
(d) GH stated that the change in form and content of the Assurance Framework had encouraged staff to adopt a more thoughtful and thorough approach. However GH considered that the document remained rather ‘process-driven’ whereas the key to its efficient and effective use was the prompting of risk discussions around the Trust, and the quality of the resulting risk judgments; and
(e) GH confirmed his view that the Assurance Framework captured all key issues faced by SLaM.

12.4.2 JG presented the report on serious incidents, prepared as a means of testing the completeness and accuracy of the Assurance Framework, and in particular:
(a) JG confirmed that all items on the list had been reported nationally, but stated that in the absence of an analogous Trust to SLaM it was difficult to benchmark the numbers of incidents reported;
(b) JG expanded on the issue regarding restraint of patients by Police called to an incident. JG and GH advised on the difficulties in deciding when to engage the Police and in managing them once they are engaged (rather strangely SLaM appears to have some responsibility even though the Police are at that point in control); GH advised that restraints were relatively frequent at the Bethlem Hospital, occurring about once per week, and SLaM is seeking to identify reasons for this;
(c) JG advised that the ‘Patient Information’ incident was a data security incident, relating to information that went astray; and
(d) after due discussion the AC noted the Assurance Framework

12.5 Signed and sealed documents, SFI breaches and STAs
12.5.1 TG and MN presented the ‘signed and sealed’ report, the ‘single quote/tender action submissions (‘STA’)’ report, and the ‘breaches of Standing Financial Instructions (‘SFIs’)’ report. After due discussion the AC noted the agenda item and approved the proposal that the signed and sealed report be appended to the draft minutes of the AC meeting when these are taken to the Board of Directors for information.

13. AC-RELATED MATTERS
13.1 AC workplan for the year ahead
13.1.1 ST presented the workplan. After due discussion the AC approved the workplan, subject to any updating required to reflect points raised in the meeting.

14. CPD NEEDS, ESCALATION OF MATTERS TO THE BOARD AND ANY OTHER BUSINESS
14.1 After due discussion the AC concluded that all agenda items and supporting agenda papers had received due consideration, that no significant training (Continued Professional Development – ‘CPD’) needs had been identified for AC members, and that (except where otherwise noted in these minutes) no
matters required escalation for the attention of the Board. There being no further AC business, **RC closed the meeting.**
15. DATES OF NEXT MEETINGS
15.1 The next quarterly meeting will be held in Autumn 2013 (precise date, time and location to be confirmed).

ACTION POINT (‘AP’) LIST
Excluded from the AP list below are actions previously agreed by the AC as completed and actions agreed by the AC Chair as completed.

<table>
<thead>
<tr>
<th>Date arising</th>
<th>AC action point</th>
<th>Action lead</th>
<th>Date to complete</th>
<th>Notes/evidence that completed (or ref to relevant agenda item)</th>
<th>AC Chair sign off</th>
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<tbody>
<tr>
<td>26.03.13</td>
<td>368 10.4.3 ND and RC will liaise to consider engaging an external consultant to report on issues arising from the KHP process and to advise on addressing these</td>
<td>ND, RC</td>
<td>Apr.13 To be confirmed</td>
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<tr>
<td>26.03.13</td>
<td>369 12.2.2 RC will discuss with GH and ND how best to ensure that infrastructure groups achieve appropriate risk management process % compliance targets, and SLaM management (not JG): (a) takes responsibility for the judgments involved in updating the assurance framework; and (b) presents the assurance framework itself. The purpose is to provide the Board with proper assurance</td>
<td>RC, GH, ND</td>
<td>Apr.13 To be confirmed</td>
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<tr>
<td>25.06.13</td>
<td>370 7.2 KL will ensure that internal audit workplans include a review of the Board’s role in monitoring actions from the Francis Report</td>
<td>KL</td>
<td>Sep.13</td>
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<td>25.06.13</td>
<td>371 9.1.2 Deloitte will update, and report to the AC on, the benchmarking information presented in the appendix to their ‘Report on the financial statement audit for the year ended 31 March 2013’</td>
<td>MH, AF</td>
<td>Dec.13</td>
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<td>25.06.13</td>
<td>372 9.1.3 ND will circulate a briefing note summarising the implications for SLaM of external audit’s 2012/13 reports and how SLaM has and will respond, with particular reference to external audit’s qualified opinion on the SLaM’s quality accounts, including the background to the issues giving rise to that opinion</td>
<td>ND</td>
<td>Sep.13</td>
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<td>25.06.13</td>
<td>373 10.1.2 KL and NM will discuss with ND how the focus of internal audit work might be amended to allow reporting on: (a) the appropriate level of commissioning risk that SLaM should accept; and (b) whether SLaM is making appropriate progress in gaining marketing and commissioning skills</td>
<td>KL, NM</td>
<td>Sep.13</td>
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<td>102</td>
<td>27/03/2013</td>
<td>Contract in respect of the sale of land on the North East side of London Road, Croydon (former Croydon General site) (1 copy)</td>
<td>SLaM</td>
<td>London Borough of Croydon</td>
<td>Gus Heathfield</td>
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<tr>
<td>103</td>
<td>27/03/2013</td>
<td>Deed of Release in respect of 843 London Road, Thornton Heath (The Oaks) (2 copies)</td>
<td>SLaM</td>
<td>London Borough of Croydon</td>
<td>Gus Heathfield</td>
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<td>104</td>
<td>27/03/2013</td>
<td>Transfer (TP1) Form in respect of the land to the North East Side of London Road, (Former Croydon General site) (2 copies)</td>
<td>SLaM</td>
<td>London Borough of Croydon</td>
<td>Gus Heathfield</td>
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<td>21/03/2013</td>
<td>Finance Facility in respect of the Cycle to Work Scheme for a 12 month period to expire on 3rd June 2013</td>
<td>SLaM AFM Solutions</td>
<td>Zoe Reed</td>
<td>Louise Norris</td>
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<tr>
<td>312</td>
<td>21/03/2013</td>
<td>Research Consultancy Contract in support of preparing for the 2013/2014 contracting and budgeting round (2 copies)</td>
<td>SLaM RAND Europe</td>
<td>Gus Heafield</td>
<td>Nick Dawe</td>
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<td>313</td>
<td>21/03/2013</td>
<td>Clinical Trials Agreement in respect of the Atlas Trial led by Rob Howard (3 copies)</td>
<td>SLaM King's College London and Surrey and Borders Partnership NHS FT</td>
<td>Nick Dawe</td>
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<td>314</td>
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<td>Clinical Trials Agreement in respect of the Atlas Trial led by Rob Howard (3 copies)</td>
<td>SLaM King's College London and Northumberland Tyne &amp; Wear NHS FT</td>
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<td>315</td>
<td>05/04/2013</td>
<td>Variation Agreement relating to the Learning and Development Agreement (2 copies)</td>
<td>SLaM King's College London and Health Education England Special Health Authority</td>
<td>Martin Baggaley</td>
<td>Nick Dawe</td>
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<td>316</td>
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<td>Clinical Trials Agreement in respect of the Atlas Trial led by Rob Howard (3 copies)</td>
<td>SLaM King's College London and Oxleas NHS FT</td>
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<td>Nick Dawe</td>
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<td>317</td>
<td>15/04/2013</td>
<td>Revised Agreement (RMSA) in respect of Research led by Dr Paul Morrison (3 copies). See No. 305 for original entry. Statement of Agreement (revised) in respect of the above (3 copies) A1</td>
<td>SLaM King's College London and GI Pharma Ltd</td>
<td>Gus Heafield</td>
<td>Zoe Reed</td>
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<td>29/04/2013</td>
<td>Mutual Confidentiality Agreement (1 copy)</td>
<td>SLaM Guy's and St Thomas NHS FT King's College Hospital NHS FT King's College London</td>
<td>Zoe Reed</td>
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<td>Clinical Trials Co-sponsorship Agreement relating to the MADE Trial led by Rob Howard (3 copies)</td>
<td>SLaM King's College London</td>
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<td>Agreement in respect of the Cycle to Work Scheme (1 copy of the Rental Schedule and 1 copy of the Conditions)</td>
<td>SLaM AFM Solutions</td>
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<td>322</td>
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<td>Tripartite Clinical Trials Agreement for Pharmaceutical and Biopharmaceutical industry sponsored research in NHS Hospitals, led by Simon Lovestone</td>
<td>SLaM King's College Hospital NHS FT and Hoffmann-La Roche Ltd Quintiles Ltd</td>
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<td>Variation to Contract in respect of the MADE trial (see entry 320) for main contract</td>
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<td>Public Health Services Contract (2013/14) for the provision of Public Health Services in respect of Substance Misuse (2 copies)</td>
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<td>326</td>
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<td>Clinical Trials Agreement in respect of the Atlas Trial led by Rob Howard (3 copies)</td>
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<td>Clinical Trials Agreement in respect of the study trial in the treatment of Cognitive Deficits in Schizophrenia in non-smokers led by Sukhi Shergill (4 copies)</td>
<td>SLaM King's College Hospital NHS FT Abbvie Ltd</td>
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<td>Sub-contract Agreement for the provision of psychiatric input to the Isle of White Prisons (2 copies)</td>
<td>SLaM Southern Health NHS FT</td>
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<td>332</td>
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<td>Variation Agreement in respect of the South London and South East Mental Health Hub (3 copies)</td>
<td>SLaM Department of Health</td>
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<td>333</td>
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<td>Research Contract in respect of the effectiveness and cost effectiveness of Perinatal Mental Health Services (Ref: RP-PG-1210-12002) (2 copies)</td>
<td>SLaM Secretary of State for Health</td>
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<td>10th Sept</td>
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