AGENDA

1  APOLOGIES for absence: Shitij Kapur
2  Declarations of Interest
3  Minutes of the Board Meeting held on 27th May 2014
4  MATTERS ARISING

QUALITY
5  To discuss Safe Staffing Report
6  To receive the Clinical Audit Annual Report 2013/14

PERFORMANCE AND ACTIVITY
7  To discuss the Finance Report – Month 2
8  To receive Summary Performance Report May 2014

GOVERNANCE
9  To receive a Report from the Chief Executive
10  To receive an Update from the Council of Governors
11  To receive an Update on Kings Health Partners
12  To receive the Mental Health Act Management Annual Report 2013/14
13  To receive Key Points from the Quality Sub Committee and to approve Terms of Reference for the Committee

INFORMATION
14  Director’s Reports
15  Forward Planners
16  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 29th July – 3:00pm, Boardroom, 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 SEVENTY SIXTH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 27TH MAY 2014

PRESENT
Madeliene Long Chair
Dr Martin Baggaley Medical Director
Dr Neil Brimblecombe Director of Nursing
Dr Patricia Connell-Julien Non Executive Director
Robert Coomber Non Executive Director
Harriet Hall Non Executive Director
Gus Heafield Chief Financial Officer
Kumar Jacob Non Executive Director
Prof Shitij Kapur Non Executive Director
Dr Matthew Patrick Chief Executive

IN ATTENDANCE
Alison Baker PA to Chair & Non Executive Directors
Cliff Bean Associate Director Quality and Assurance
Lucy Canning Service Director, Psychosis CAG
Bruce Clarke Clinical Director, CAMHS CAG
Sarah Crack Head of Communications
Eleanor Davies Service Director, B&DP CAG
Jo Fletcher Service Director, CAMHS CAG
Angela Flood Council of Governors
Mark Ganderton Council of Governors
Louise Hall Director of Human Resources
Roy Jaggon Head of Performance Management
Paul Mitchell Trust Board Secretary
Zoë Reed Director of Organisation and Community
Steven Thomas Audit Committee Secretary (from Item 11 onwards)
Noel Urwin Council of Governors
Dr Tom Werner Council of Governors

APOLOGIES
Mark Allen Service Director, Addictions CAG
Steve Davidson Service Director, MAP & Psychological Medicine
Nick Dawe Chief Operating Officer
David Norman Service Director, Older Adults CAG

DECLARATIONS OF INTEREST
Routine declarations were made:

- Madeliene Long declared an interest as an Honorary Fellow of King's College London.
- 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.
• Dr Patricia Connell-Julien declared an interest as a former employee of King’s College London and as a Trustee of Southside Certitude Support.

MINUTES
The minutes of the meeting held on the 29th April 2014 were agreed as an accurate record of the meeting.

BOD 62/14 MATTERS ARISING

1) Risk Management & Assurance Strategy – BOD 48/14
Gus Heafield explained that the RM&A Strategy would be brought back to the Board of Directors meeting in June 2014 once advice from Deloitte had been received.

BOD 63/14 EXPANDING OPPORTUNITIES – INCREASING INVOLVEMENT
Zoe Reed explained that the report set out two proposals to improve the effectiveness and reach of the Trust’s service user and carer involvement mechanisms and structures. The establishment of a new forum, EPIC (Engaging Patients, Involving Carers) to provide trust wide strategic leadership and oversight of service user and carer involvement, along with changes to the Involvement Register to increase equality of access to opportunities and to widen and increase the Involvement Register membership and activity. Zoe Reed explained that discussions had taken place and responses had been received from governors, staff, service users and carers. An annual report would be made to the Board as well as interim progress reports to the Senior Management Team and Trust Executive.

The proposed changes would aim to retain current best practice employed within the Trust, increase the transparency of participation access routes and enhance strategic leadership. It was hoped these changes would enable a more equitable and well functioned structure from which to develop a working strategy/policy around Patient and Public Involvement that would support the Trust’s emerging five year Plan.

The Trust’s aim was to guide and set standards of involvement to ensure consistency and shared purpose. The PPI team, PPI Leaders and EPIC members would play an important role to make sure that everyone within the Trust considered patient experience to be their responsibility and would support and assist them to this end.

Noel Urwin welcomed the ongoing discussions with governors. Madeliene Long commented that this was a helpful detailed report and she welcomed the range of discussions which had taken place to inform the development of the report. Dr Matthew Patrick suggested that the work reflected the changing relationship in the NHS between patients and clinicians.

The Board of Directors approved the changes to the Involvement Register, and approved the creation of the EPIC group.

BOD 64/14 FINANCE REPORT – MONTH 1
Gus Heafield introduced the report which was based on month 1 performance. There was a small adverse variance from plan. The finance and performance
teams were working with the CAGs aiming to ensure absolute clarity in these planning and budgeting issues by month 2, where the position would give a much clearer indication of potential performance issues. The operational plan timetable meant that we were able to ensure clarity in finalised budgets earlier than in previous years.

Teams had been working hard to reduce private sector overspill in line with the plan, with month 1 figures assuming that overspill and internal capacity was funded within the CAG investments and this would be confirmed in terms of the trajectories by month 2. A great deal of work had taken place around delayed discharge within the AMH service and was currently running at the lowest levels since February 2014. The biggest risk outstanding was the NHS England and CCG contracts having yet to be signed off, therefore assumptions had been made as to the ultimate value of these contracts.

Gus Heafield reported that there was an element of the cost improvement programme still unidentified (£5.7m). He was establishing a programme office which would be up and running next month and would report back to the Board of Directors.

Robert Coomber advised that the Board needed to be clear about managing risk and suggested having a clearer view around three of four key areas such as commissioning risks, bed management, CIPs and QIPPS, which could be closely monitored. It would also be helpful to have a list of capital programme schemes and an assessment of how they were performing. Madeliene Long suggested that this be discussed further at a Board away day in July.

Gus Heafield explained that a submission regarding reference costs was required. The Board of Directors needed to approve that the Trust was using the methodology for the calculation of reference costs stated in the guidance. Gus Heafield confirmed to the Board of Directors that this is what was being used.

Progress on the completion of the annual accounts for 2013/14 was noted.

The Board of Directors noted the report, and approved the basis for the completion of the Reference Costs for 2013/14 and noted the progress on the annual accounts for 2013/14.

**BOD 65/14 SUMMARY PERFORMANCE REPORT – APRIL 2014**

Dr Martin Baggaley introduced the first version of this report which brought together a Trust wide view of performance from team to Board level. It was still work in progress and may require some further changes. It would in future be accompanied by supporting data. The performance pyramid would reflect closely what’s happened within the PMR meetings. The second part of the report picked up on issues by CAG.

Dr Neil Brimblecome explained that the national standard for response time to complaints had slipped and we were recently significantly behind, which had been highlighted within this report. Work was ongoing regarding this, and it was hoped to see a significant improvement over the next few months.
An issue was raised regarding the HTT gatekeeping data performance target which was at 85% pending further validation. Dr Martin Baggley reported that clarification was needed and would be reported back to the next meeting.

**Action: Nick Dawe.**

The Board of Directors noted the report.

**BOD 66/14 REPORT FROM THE CHIEF EXECUTIVE**

Dr Matthew Patrick highlighted the major achievement that “Bedlam” had been awarded a BAFTA for the four part documentary series. He offered congratulations to all involved with the programme.

He had attended the CRF launch which had been opened by Dame Sally Davis.

Dr Matthew Patrick had attending a debate on Deconstructing Racism in Psychiatry chaired by Dr Dele Olajide with contributions from a number of SLaM/IoP clinicians.

He had attended the recent AUKUH meeting held in Scotland where one of the topics discussed was the role of LETBs.

The Board of Directors noted the report.

**BOD 67/14 REPORT FROM THE COUNCIL OF GOVERNORS**

Dr Tom Werner presented the report. He highlighted recent changes to the Council of Governors. He confirmed that an updated membership list of the working groups would be brought to the June CoG meeting, along with an update on proposed change to the FT Constitution.

The CoG had unanimously agreed the appointment of two Non-Executive Directors, Lesley Calladine and Alan Downey, who would take up their appointments in June for three year terms.

The Membership development and communications group had met on 14th May where the revised terms of reference were agreed. Progress reports were received on the members’ discount scheme and the planning for the “Happy Heads” festival in July.

Madeliene Long welcomed the increasing involvement of the Governors in the CoG working groups.

The Board of Directors noted the report.

**BOD 68/14 KINGS HEALTH PARTNERS UPDATE**

Dr Matthew Patrick described the work that was taking place around the SLIC programme which was bringing together commissioners, general practice, secondary and volunteer care and other key stakeholders. This had been discussed at the recent KHP Executive meeting where Dr Patrick had been authorised to lead on setting up a programme office for integrated care.

Madeliene Long reported that the new governance arrangements were being implemented. She now chaired the KHP Executive meeting which had now met...
twice. The KHP Board chaired by Prof Sir Rick Trainor had now met for the first time.

Madeliene Long highlighted the KHP annual conference that was taking place on 18th June at The Oval. Simon Stevens, Chief Executive of NHS England will be attending.

The Board of Directors noted the report.

BOD 69/14 VERBAL FEEDBACK FROM SPECIAL AUDIT COMMITTEE MEETING
Robert Coomber tabled a report regarding the Audit Committee’s comments and conclusions regarding the SLaM’s 2013/14 Annual Report and Accounts and the Safer Staffing report. The meeting had been held earlier in the day.

Robert Coomber explained that the Audit Committee were required to make a judgement about the process for finalising the annual accounts. He acknowledged that a huge amount of work and effort had gone into producing the annual accounts in an increasingly tight timescale with increased regulatory requirements each year. This was the first year that the consolidation of the charity’s accounts had taken place. The annual accounts still required some additional work to finalise.

The auditors were satisfied that the accounts were accurate and had not issued any qualifications to the accounts or the quality account.

A discussion had taken place regarding the Safe Staffing report. It was noted that the recommendations would be coming to the Board of Directors meeting in June 2014. Action: Neil Brimblecombe.

The Board of Directors noted the report.

BOD 70/14 DIRECTOR’S REPORTS
- Madeliene Long – reported that this was the last meeting that would be attended by Kumar Jacob and Harriet Hall as Non-Executive Directors. They had both made great contributions, in their different roles, to the development of the organisation. Madeliene thanked them both and wished them all the best for the future.

Harriet Hall replied that she had found the last seven years stimulating and enjoyable. Kumar Jacob replied he had initially spent time on the Audit Committee and latterly he had chaired the Maudsley Charity. He thanked everyone involved for all their support.

BOD 71/14 FORWARD PLANNERS
The Forward planner was noted.

BOD 72/14 ANY OTHER BUSINESS
No other business was considered.
BOD 73/14 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 24th June 2014 – 12:00pm** Maudsley Board room, Maudsley Hospital, Denmark Hill, London, SE5 8AZ

Chair
TRUST BOARD OF DIRECTORS - SUMMARY REPORT:

Date of Board meeting: 24th June 2014  
Name of report(s): Safe Staffing Report  
Author: Neil Brimblecombe – Director of Nursing  
Approved by:  
Presented by: Neil Brimblecombe

Purpose of the report:
This paper summarises the national requirements regarding Safe Staffing in inpatient care settings, the actions taken within SLaM to support Safe Staffing and future plans to monitor and review staffing arrangements.

Recommendations to the Board:
The Board is asked to:
- Note the national guidance on inpatient staffing and implications for reporting, reviewing and Board ownership.
- To support changes in inpatient staffing recommended by the Safe Staffing review
- Consider results from the first month of recording Planned vs. Actual staffing levels and the future reporting of exceptions
- Note actions taken by the Trust to date and future plans to implement processes to ensure safe staffing in both community and inpatient services

Relationship with the Assurance Framework (Risks, Controls and Assurance):
Actions as reported in this paper constitute an action to mitigate against risk 2 - ‘The Trust’s workforce lacks the correct skills in the correct numbers to ensure services are provided in line with best practice.’

Summary of Financial and Legal Implications:
Additional investment has been required to increase staffing in some wards. This is within planned budgets.

Equality & Diversity and Public & Patient Involvement Implications:
None direct

Service Quality Implications:
Ensuring appropriate staffing levels and processes for monitoring and reviewing these are essential to enable inpatient areas to provide safe and therapeutic care.
Safe Staffing in Inpatient Care
Review and Action Plan

Executive Summary

This paper summarises the national requirements regarding Safe Staffing in inpatient care settings, the evidence available to support this process and future planned developments, nationally and locally. Trust boards are now clearly defined as having direct responsibility for agreeing and monitoring nursing staffing levels and ensuring that specific processes are in place that will demonstrate whether Trusts are meeting their planned staffing levels. The processes carried out within SLaM to estimate future staffing needs and current and future arrangements to maximise the effectiveness of ward staff are described.

Key Actions Taken
The need for increases in the number of nursing/support worker posts has been identified on several wards through a series of processes used to check the safety of staffing levels. The most significant planned changes are in:

- Mental health for older adults CAG
- Psychosis CAG, primarily Lewisham and Southward Wards
- Triage wards at night

The costs of staffing increases are within this year's planned budgets. A single 'Relief Rate' has been established for all inpatient averaging 25.1%. This replaces current wide variation between wards. The first monthly publication of planned and actual staff numbers has demonstrated a number of wards have had difficulty in ensuring the expected number of registered nurses are on shift. Plans are in place to deliver on other aspects of Safe Staffing guidance, i.e:

- Exception reports to the Board highlighting significant differences between planned and actual numbers by ward.
- Six monthly reports to the Board reviewing inpatient staffing levels
- Availability on every ward of information regarding planned and actual staffing on a daily basis
- Notices in each bedroom identifying the service user's Named Nurse and Consultant

A range of processes are noted as being in place to support the most effective use of staffing, e.g. leadership development, ward managers being supernumerary to shifts and e-rostering.

Future Actions:
1. Provide six monthly reviews of inpatient staffing to the Board
2. Review the contribution of non-nursing clinical staff in inpatient settings within 6 months
3. Develop methods to evaluate ‘safe staffing’ in community settings within 6 months
4. Provide monthly exception reports and planned actions to the Board where planned staffing rates on individual wards are significantly unmet
5. Create a centralised e-rostering support service and carry out further support worker development activities
6. Data quality of reported staffing levels will be audited
7. Work with partners nationally to develop reliable and valid tools to support Safe Staffing reviews.
Safe Staffing in Inpatient Care  
Review and Action Plan

1. National Context  
1.1 Concerns regarding staffing levels and the skills of staff nationally were highlighted through the series of enquiries concerning the failings of care at Mid-Staffordshire Hospital. In October 2013 the Government published its response, which included a number of requirements for the future monitoring and measurement of staffing levels in all care settings.

1.2 The National Quality Board (NQB) produced ‘How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability’. This guidance seeks to support organisations in making the right decisions and creating a supportive environment where their staff are able to provide compassionate care. Although the guidance highlights the need to take into account the contribution of all disciplines, it is heavily focused on nursing and reporting requirements only relate to nursing (and currently only inpatient care services).

2. Board Responsibilities  
2.1 The NQB guidance emphasises the overarching responsibility of the Trust Board for Safe Staffing, including responsibilities to:

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Review data on workforce, quality of care and patient safety on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients.
- Ensure that decisions being taken at a board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcomes measures.

3. Future National Action  
3.1 NICE has been commissioned to issue evidence-based guidance on safe staffing levels in mental health services. This is unlikely to deliver useful outputs in the very near future.

3.2 Appropriate staffing levels will be included as a core element of the CQC’s registration regime.

3.3 Future requirements to carry out Safe Staffing reviews for non-inpatient settings seem likely

4. National guidance and SLaM  
4.1 The NQB guidance lays out a number of requirements for Trusts. SLaM has met initial requirements and has established systems to continue to do so.

4.2 The Trust has now reviewed staffing levels and reported this to the Board. This process will be repeated at six month intervals.

4.3 The Trust has now published ward level information on its website www.slam.nhs.uk/saferstaffing and will repeat this on a monthly basis. Information will also be available on NHS choices.


4.4 The Trust board is receiving its first monthly report in this paper that highlights where there is significant difference between planned and actual staffing levels by ward, and exception reports will be received by the Board monthly from this point.
4.5 All SLaM wards will be displaying information easily visible to service users and visitors regarding planned and actual staffing on a daily basis by the end of June. This will be subject to audit.

4.6 Clear written information is now visible in every inpatient service user's bedroom indicating Named Nurse and Responsible Consultant. This will also be subject to audit.

5. The Inpatient Safe Staffing Review Process

5.1 The evidence base in relation to workforce planning and safe and effective staffing within mental health settings is less established than that for acute care settings. There is no single ratio or formula that can calculate nursing requirements in inpatient care and there is little research or robust evidence based tools to inform decision making.

5.2 In the absence of a clear evidence base, SLaM has reviewed its staffing levels through triangulation of a range of information combined with professional judgement, as recommended by national and RCN guidance. Where available, information has included:
   - Comparison with similar wards within the Trust
   - Benchmarking with other organisations
   - Historical patterns of staffing (including use of additional bank/agency)
   - Incident and complaints data
   - Information on specific demands on staffing related to peaks of activity and demand
   - Specific demands related to setting
   - Availability of all disciplines

5.3 This Review process has been applied to all inpatient wards, led by the Director of Nursing and the Heads of Nursing in each CAG, with contributions from other staff. Although a wide range of factors have been considered (as in 5.2 above), in this initial review the primary factors have been:
   - Professional advice regarding particular risk or demand issues
   - Evidence of requirements for staff above that budgeted in the previous year
   - Evidence of inconsistency in staffing across similar wards
   - Specific service user/carer and staff concerns re: staffing

5.4 Future Reviews will become more robust in method as processes are refined, local and national information becomes available and new resources become available, in particular:
   - Local and national benchmarking data
   - Detailed analysis of the level of input from other disciplines by ward
   - Use of a standardised Needs Measurement tool (currently being developed by SLaM and other partners nationally)

6. Changes arising from the Review

6.1 Outcomes identified through the Review process by Ward are reported in Appendix 1. Current planned staffing levels are illustrated at www.slam.nhs.uk/saferstaffing

6.2 The review process has identified a number of wards where additional staffing needs have been identified. The total number of additional posts across the Trust approximates to 41.7 wte. The currently estimated cost of the increased staffing is £1.5 million.

6.3 The most significant planned increases in staffing relate three areas
   - Mental Health of Older Adults – increasing funding to match already established staffing requirements which have been unfunded to date.
   - Psychosis wards in Lewisham and Southwark – increasing staffing where numbers currently benchmark relatively poorly compared to similar wards in other Boroughs.
• Triage Wards – increasing the standard level of night time staffing where these are currently perceived as inadequate in the context of high levels of night-time activity (especially multiple admissions).

6.4 This first Review is part of an on-going process, not the end of it. There will be a six monthly process of review and planning from this point on. Staffing needs may decrease as well as increase over time.

7. Establishing a Standard Relief Allowance for Wards
7.1 The NQB guidance stresses the need to have ‘adequate financial allowance for sickness and other absence’.
7.2 Historically, there has been wide variation between the levels of Relief Allowance available for different types of ward in SlaM. This has prompted a review to establish a single standard allowance across all wards.
7.3 The Relief Allowance has been calculated by estimating averages for annual leave, mandatory training, maternity and other forms of leave. Sickness allowance has been set at 6%, which is lower than the current level in inpatients but above the Trust target of 5%. The new Relief Rate is:
• 25.9% for Registered Nursing Staff and
• 23.3% for Support Workers.
• Equates to 25.1% as a Trust wide average (based on actual wte's in 13/14)
The rate for an individual ward will reflect the ratio of RN to SW staff on the ward.
7.4 The new Relief Allowance exceeds the minimum national expectation of 22.5% (NHS England - verbal) and meets the minimum level proposed by the Royal College of Nursing of 25% (Royal College of Nursing, 2010).

8. Funding for Planned Changes
The Review has identified a number of inpatient areas which have required additional staffing resource in response to specific identified risks, as above. The increases in cost associated with these changes are broadly within the budgets set for this year, with increases having been anticipated in forward planning. The funding for this was added as a new cost within the 2014/15 Monitor Planning process, and has been created in reserves as part of the balanced plan, effectively funded by planned Trust wide savings schemes.

9. Other Actions Taken to Support Safe Care and Safe Staffing
The following table lays out some of the key approaches adopted by the Trust, in line with national guidance, to promote and assure safe and efficient inpatient services. The Director of Nursing is the lead officer for all planned actions.
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Current Position</th>
<th>Further Planned Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Adequate financial allowance for sickness &amp; other absence</td>
<td>Review completed to establish new standard Relief Allowance.</td>
<td>Introduce for all wards End July 2014</td>
</tr>
<tr>
<td>2 Ward managers are supported to supervise staff</td>
<td>All ward managers are not included in shifts</td>
<td>None required</td>
</tr>
<tr>
<td>3 Staff encouraged to speak up if they have concerns regarding staffing</td>
<td>Use of Incident reporting. Whistle blowing policy New Staffing Issues Escalation process agreed (Appendix 2)</td>
<td>Reminder of professional requirement to raise concerns July 2014</td>
</tr>
<tr>
<td>4 E-rostering ensures fair and efficient use of staff resources</td>
<td>E-rostering in place in SLaM since 2010</td>
<td>Develop centralised resource to maximise efficiency and equity Sept 2014</td>
</tr>
<tr>
<td>5 Developing leadership skills in inpatient areas</td>
<td>Range of opportunities eg: Learning to Lead from June 2014 Learning to Manage from May 2014 RCN leadership programme Mary Seacole PgDip programme Individual courses e.g. MBA, MSc</td>
<td>Audit of leadership and managerial development of all ward managers Nov. 2014</td>
</tr>
<tr>
<td>6 Mandatory training</td>
<td>Current inpatient compliance - Over 80% in six areas Below 50% in two areas (one reflects change in requirement)</td>
<td>Follow up low compliance issues in Mandatory Training Log committee Ongoing</td>
</tr>
<tr>
<td>7 Training and preparation of non-professionally qualified staff</td>
<td>Minimum requirement - Level 2 NVQ. Trust and local induction in place and defined mandatory training</td>
<td>Specific support worker training induction package (as per Cavendish Review) to be introduced. Result of bid for clinical skills tutors awaited. Oct 2014 July 2014</td>
</tr>
<tr>
<td>8 Shift timings conducive to good practice and staff well-being</td>
<td>Recent reduction in number of 'long shifts' e.g. 12 hours worked by staff.</td>
<td>General review of shift systems Dec 2014</td>
</tr>
<tr>
<td>9 Trends analysis</td>
<td>Incident data and complaints are formally reviewed by Board’s Quality committee quarterly with an analysis as to whether there are patterns to suggest areas of concern in any particular inpatient service.</td>
<td>Specific quality monitoring to be put in place in relation to monitoring effectiveness of staffing in specified areas. Regular monitoring against this year’s Quality Priorities to go to Board Monitor until Dec. 2015 July 2014</td>
</tr>
</tbody>
</table>


10.1 The first month’s data (May) has now been published by ward and by shift [www.slam.nhs.uk/saferstaffing](http://www.slam.nhs.uk/saferstaffing). 13 wards have not reached the current expected levels of staffing on 20% or more of shifts. Appendix 3 describes the key issues leading to these outcomes and actions planned to mitigate against future occurrences. It is of note that in three cases a clinical decision was made to reduce staffing requirements temporarily due to reduced occupancy. This is a clinically valid reason for
such breaches.

10.2 This month’s data does not take into account planned changes in staffing arising from
the Review process.

10.3 Common issues leading to a staffing shortfall have been short notice sickness, inability
 to fill shifts at short notice by NHSP and some failure to attend booked NHSP staff. Further
work will be taken forward with NHSP in this regard.

10.4 Historic issues in some areas regarding a lack of clarity as to funded staffing levels has
created complexities in reporting data which will be resolved through further work
between the Finance Teams and CAGs.

<table>
<thead>
<tr>
<th>Clinical Academic Group Name</th>
<th>Hospital Site</th>
<th>Ward Name</th>
<th>Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>Maudsley Hospital</td>
<td>Acute Assessment</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unit (AAU)</td>
<td></td>
</tr>
<tr>
<td>Behavioural and Development</td>
<td>Bethlem Hospital</td>
<td>Spring</td>
<td>26%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child and Adolescent Mental</td>
<td>Bethlem Hospital</td>
<td>Acorn Lodge</td>
<td>80%</td>
</tr>
<tr>
<td>Health Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>Bethlem Hospital</td>
<td>Chelsham Unit</td>
<td>33%</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>Bethlem Hospital</td>
<td>Croydon Triage</td>
<td>66%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eating Disorders Unit</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Lewisham Hospital</td>
<td>Ladywell Unit</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lamboth Triage</td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>Bethlem Hospital</td>
<td>Lewisham Triage</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Hospital</td>
<td>Gresham 2</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Heather Close</td>
<td>Heather Close</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Lamboth Hospital</td>
<td>Luther King</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>Bethlem Hospital</td>
<td>Tony Hillis Unit</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>Lamboth Hospital</td>
<td>Bridge House</td>
<td>54%</td>
</tr>
</tbody>
</table>

Denotes no action required as breaches planned due to reduced patient occupancy
Breaches exceeding 20% of total shift per month

11. Future actions

- Provide six monthly reviews of inpatient staffing to the Board
- Review the contribution of non-nursing clinical staff in inpatient settings within 6 months
- Develop methods to evaluate ‘safe staffing’ in community settings within 6 months
- Provide monthly exception reports and planned actions to the Board where planned staffing rates on individual wards are significantly unmet
- Create a centralised e-rostering support service and carry out further support worker development activities
- Audit data quality of reported staffing levels
• Further refining of individual ward budgets modelling between Nursing, Finance, and CAGs: in line with the principles of safe staffing and affordability
• Work with partners nationally to develop reliable and valid tools to support Safe Staffing reviews.
## Appendix 1
Results of Ward Staffing Review by CAG and Ward Type

### Addictions CAG

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NAME</th>
<th>RISKS</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>AAU</td>
<td>No significant risks identified</td>
<td>No changes planned currently. The service will respond to any low occupancy levels by flexing staff numbers downward where safe to do so</td>
</tr>
</tbody>
</table>

### Behavioural and Developmental Psychiatry CAG

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NAME</th>
<th>RISKS</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic</td>
<td>National Autism Unit</td>
<td>No significant risks</td>
<td>No changes planned currently</td>
</tr>
<tr>
<td>Forensic</td>
<td>Ward in the Community</td>
<td>No significant risks</td>
<td>No changes planned currently</td>
</tr>
<tr>
<td>Forensic</td>
<td>Brooke &amp; Effra Ward</td>
<td>Benchmark low against comparable units in direct regular nurse staffing, mitigated by 50k flexible budget provision and commitment to multi-disciplinary contribution</td>
<td>Monitor outcomes through Quality, Performance and Contracting Dashboard. Review urgently if evidence of risk is identified</td>
</tr>
<tr>
<td>Forensic</td>
<td>Norbury; Spring; Thames and Waddon Wards</td>
<td>No significant risks identified</td>
<td>No changes planned currently</td>
</tr>
<tr>
<td>Forensic LSU</td>
<td>Chaffinch Ward</td>
<td>Benchmarks low against comparable units in direct regular nurse staffing, mitigated by 50k flexible budget provision and commitment to multi-disciplinary contribution</td>
<td>Monitor outcomes through Quality, Performance and Contracting Dashboard. Review urgently if evidence of risk is identified</td>
</tr>
</tbody>
</table>
# Child and Adolescent Mental Health CAG

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NAME</th>
<th>RISKS</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Unit</td>
<td>Acorn Lodge</td>
<td>No significant issues identified. Staffing reviewed end 2013 and enhanced</td>
<td>Impact of increased staffing to be monitored</td>
</tr>
<tr>
<td>Kent &amp; Medway Adolescent Unit</td>
<td>Ash and Oak Teams</td>
<td>No significant issues identified. Staffing in line with QNIC standards</td>
<td>No action currently</td>
</tr>
<tr>
<td>Adolescent Unit</td>
<td>BAU</td>
<td>No significant issues identified. Staffing in line with QNIC standards</td>
<td>No action currently</td>
</tr>
<tr>
<td>Adolescent Unit</td>
<td>Snowsfield</td>
<td>No significant issues identified. Staffing in line with QNIC standards</td>
<td>One additional CSW 9am to 5pm</td>
</tr>
</tbody>
</table>

# Mental Health of Older Adults and Dementia

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NAME</th>
<th>RISKS</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>AL1, Chelsham and Hayworth</td>
<td>Long term overspend on staff indicating currently funded establishment insufficient.</td>
<td>Introduce new Relief Rate, increase staffing to 5/5/4.</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>Ann Moss &amp; Inglemere</td>
<td>Financial shortfall of 25% for current staffing. Insufficient staff funding for physically isolated units.</td>
<td>Introduce new Relief Rate, increase staffing to 5/5/4 from 5/4/3</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>Greenvale</td>
<td>Model of care currently under review.</td>
<td>Reconsider staffing levels following review</td>
</tr>
</tbody>
</table>

# Psychological Medicine CAG

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NAME</th>
<th>RISKS</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating Disorders</td>
<td>Tyson West 2</td>
<td>Difficulty meeting needs of newly admitted patients requiring extra mealtime assistance.</td>
<td>1wte RN nurse to provide ‘twilight’ shift</td>
</tr>
<tr>
<td>Neuropsychiatry</td>
<td>Lishman</td>
<td>No significant issues.</td>
<td>Further review in six months to assess effectiveness of Zoning Care Model</td>
</tr>
<tr>
<td>Mother &amp; Baby</td>
<td></td>
<td>Insufficient registered nursing time to support outreach assessments and community linkages.</td>
<td>Additional Band 6 nurse to support outreach work</td>
</tr>
<tr>
<td>Lambeth, Lewisham, Croydon</td>
<td>Triage</td>
<td>Variable level of night cover.</td>
<td>Increase to standard level of 4 RNs for nights</td>
</tr>
<tr>
<td>TYPE</td>
<td>NAME</td>
<td>RISKS</td>
<td>ACTION</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lewisham Acute</td>
<td>Powell, Clare, Wharton</td>
<td>Difficulty in maintaining minimum safe staffing level on ward in daytime and at night due to breaks and emergencies elsewhere on site.</td>
<td>RN and 2 CSWs between 3 wards on weekdays per mid shift. Two RNs between 3 acute and PICU at weekend. Additional RN and SW per night to ‘float’ between 3 acute wards (and PICU) at night.</td>
</tr>
<tr>
<td>Southwark Acute</td>
<td>John Dickson; Jim Burley; ES2; AL3; Ruskin</td>
<td>Difficulty in maintaining minimum safe staffing level on ward in daytime and at night due to breaks and emergencies elsewhere on site.</td>
<td>2RN and 3 CSW per mid shift Monday to Friday between 5 wards. Additional RN and 2 CSWs per night to ‘float’ between 5 acute wards (and PICU) at night.</td>
</tr>
<tr>
<td>Croydon Acute</td>
<td>Gresham 1; Gresham 2 Foxley Lane</td>
<td>Additional temporary demand on staffing due to POS being located remotely (6 months)</td>
<td>Temporary (6 months)additional SW per shift to provide ‘float cover’ between wards 7 day per week</td>
</tr>
<tr>
<td>Lambeth Acute</td>
<td>Luther King, Nelson, Early Intervention</td>
<td>No significant issues</td>
<td>No changes planned currently</td>
</tr>
<tr>
<td>Complex Care</td>
<td>MacKenzie; Tony Hillis; Heather Close; National Psychosis</td>
<td>No significant risks</td>
<td>No changes planned currently</td>
</tr>
<tr>
<td>Complex Care</td>
<td>Westways</td>
<td>Additional demands on staffing when unit moves to Bethlem in May due to Emergency Team and POS</td>
<td>Flexible bank budget to support additional support worker (band 3) 0.75wte and band 6 0.2wte</td>
</tr>
<tr>
<td>PICU</td>
<td>Eden; Johnson; ES1</td>
<td>Frequent closure of Place of Safety due to limited staffing</td>
<td>Flexible budget allowing 10 shifts per week RN across the 3 wards</td>
</tr>
<tr>
<td>Acute (overspill)</td>
<td>Bridge House</td>
<td>No significant Issues</td>
<td>No actions required.</td>
</tr>
</tbody>
</table>
Appendix 2.
Escalation process for staffing related concerns

1. In line with national guidance, escalation processes have been reviewed to ensure information is shared and acted upon at the appropriate level within the Trust

2. Local escalation procedures
   - Where staffing levels do not meet the minimum required standard on a shift a Datix report will be completed and the CAG Head of Nursing will received an automated report via Datix.
   - All minimum staffing level breaches will be escalated verbally to the clinical service lead in the first instance or the site emergency team leader (out of hours).
   - All registered nurses have a professional duty to report any concerns about adverse impact of staffing levels on care standards.

3. If breaches of agreed staffing levels create a potential for negative impact on standards of care then the CAG Head of Nursing must raise this with the Director of Nursing as well as escalate issues within the CAG.

4. The Board will receive a monthly exception report reporting where wards have not met required staffing levels on more than 20% of shifts. Planned actions to reduce future occurrence will be reported.

NB: Expected national guidance regarding the levels at which the number of shifts that are not correctly filled becomes reportable to the Board has not yet been received. The process described here will be reviewed in line with any future guidance.
### Appendix 3
Significant breaches of planned vs. actual staffing: Key reasons and planned actions

<table>
<thead>
<tr>
<th>Ward</th>
<th>Main reasons</th>
<th>Actions</th>
<th>Responsible officer</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Assessment Unit</strong></td>
<td>Clinical decision due to decreased occupancy</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Spring Ward</strong></td>
<td>Clinical decision due to decreased occupancy</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acorn Lodge</strong></td>
<td>NHSP unable to fill Staff vacancies</td>
<td>Meeting with NHSP to review current practice. NHSP agreed to carry out a recruitment drive for CAMHS staff. PDN's on ward to offer training to NHSP staff to ensure they feel supported on the ward and more likely to accept further shifts. Ward to attempt to book NHSP for 'long lines' Recruitment day held by CAG – awaiting start dates</td>
<td>Ward Manager/Practice Development Nurses</td>
<td>July 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ward Manager</td>
<td>July 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ward Manager</td>
<td>Sept 2014</td>
</tr>
<tr>
<td><strong>Chelsham Unit</strong></td>
<td>Increased number of RNs on Mat leave Short notice sickness NHSP unable to fill</td>
<td>Trustwide Recruitment (end June) Apply Sickness/Absence Policy rigorously Escalated concerns re NHSP to Deputy Director HR. He has agreed to raise as an issue in regular contract meeting with NHSP.</td>
<td>Ward Manager Service Manager Head of Nursing Clinical Service Manager</td>
<td>Sept 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ward Manager</td>
<td>June 2014</td>
</tr>
<tr>
<td><strong>Croydon triage</strong></td>
<td>Awaiting new staff to start</td>
<td>Trustwide Recruitment (end June)</td>
<td>Head of Nursing</td>
<td>Sept 2014</td>
</tr>
<tr>
<td><strong>Eating disorder unit</strong></td>
<td>Awaiting new staff to start</td>
<td>Complete recruitment Arrange longer term NHSP fill</td>
<td>Ward Manager and Service Manager</td>
<td>July 2014</td>
</tr>
<tr>
<td><strong>Lambeth Triage</strong></td>
<td>Short term sickness NHSP unable to fill Staff vacancies</td>
<td>Apply Sickness/Absence Policy rigorously Trustwide Recruitment (end June)</td>
<td>Ward Manager and Service Manager</td>
<td>July 2014</td>
</tr>
<tr>
<td><strong>Lewisham Triage</strong></td>
<td>RN vacancies</td>
<td>Trustwide Recruitment (end June)</td>
<td>Ward Manager and Service Manager</td>
<td>Sept 2014</td>
</tr>
<tr>
<td>Location</td>
<td>Issue Description</td>
<td>Action Taken</td>
<td>Responsible</td>
<td>Date</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>Gresham 2</td>
<td>NHSP unable to fill RN posts&lt;br&gt;NHSP issues escalated&lt;br&gt;Improved use of e-rostering</td>
<td>Ward manager CSL</td>
<td>August 2014</td>
<td></td>
</tr>
<tr>
<td>Heather Close</td>
<td>Clinical decision due to decreased occupancy</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luther King</td>
<td>Vacancies NHSP unable to fill&lt;br&gt;Short term sickness</td>
<td>Trustwide Recruitment (end June)&lt;br&gt;Apply Sickness/Absence Policy rigorously&lt;br&gt;NHSP issues escalated</td>
<td>Ward manager CSL</td>
<td>Sept 2014</td>
</tr>
<tr>
<td>Tony Hillis</td>
<td>Short term absence NHSP unable to fill</td>
<td>Apply Sickness/Absence Policy rigorously&lt;br&gt;NHSP issues escalated</td>
<td>Ward manager CSL</td>
<td>August 2014</td>
</tr>
<tr>
<td>Bridge House</td>
<td>Temporary provision – issues with recruitment and NHSP provision</td>
<td>Trustwide Recruitment (end June)&lt;br&gt;NHSP issues escalated</td>
<td>Ward manager CSL</td>
<td>Sept 2014</td>
</tr>
</tbody>
</table>
### TRUST BOARD OF DIRECTORS – SUMMARY REPORT

<table>
<thead>
<tr>
<th>Date of Board meeting:</th>
<th>24th June 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Report:</td>
<td>SLAM Clinical Audit Annual Report 2013/14</td>
</tr>
<tr>
<td>Heading: (Strategy, Quality, Performance &amp; Activity, Governance, Information)</td>
<td>Quality</td>
</tr>
</tbody>
</table>
| Author:                | Rosie Peregrine-Jones  
Assistant Director of Quality and Assurance |
| Approved by: (name of Exec Member) | Neil Brimblecombe |
| Presented by:          | Rosie Peregrine-Jones |

#### Purpose of the report:
To inform the Trust Board of the corporate clinical audit work undertaken in 2013/14 and priorities for 2014/15.

#### Action required:
The Trust Board is asked to comment on the content and suggest further objectives/priorities for inclusion in 2014/15 program.

#### Recommendations to the Board:
As above

#### Relationship with the Assurance Framework (Risks, Controls and Assurance):
The Trustwide Clinical Audit program provides assurance for the following risk in the Assurance Framework: ‘The Trust is unable to demonstrate the clinical quality of its services explicitly’. Audits also provide assurance that other clinical risks in the Corporate Risk Register (e.g. substance misuse, violence, supervised confinement, MHA compliance, etc.) have controls in place etc.

#### Summary of Financial and Legal Implications:
The Trustwide Clinical Audit Program provides assurance that clinical policies are being implemented and improvements are being made. Clinical audit programs are key source of assurance for CQC visits and are required to be declared in the SLaM Quality Account. Audit work also supports monitoring CQUINs and Quality Contract targets.

#### Equality & Diversity and Public & Patient Involvement Implications:
The organisation must ensure that the process for determining choice of clinical audit projects and the manner in which they are drawn up does not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion and belief. Equality data is collected as part of clinical audits in order to determine whether any particular groups of patients are experiencing variations in access or clinical practice.
SLaM Clinical Audit Annual Report
Part 1: Overview of Corporate Audit Program

2013/14

11th June 2014

Clinical Audit & Effectiveness Team
111 Denmark Hill
Maudsley Hospital
Camberwell
SE5 8AZ
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3.</td>
</tr>
<tr>
<td>Corporate Clinical Audit Program Activity in 2013/14</td>
<td>5.</td>
</tr>
<tr>
<td>2.1 Participation in National Audits</td>
<td>5.</td>
</tr>
<tr>
<td>2.2 SLaM corporate audit programme 2013/14</td>
<td>7.</td>
</tr>
<tr>
<td>Impact of the SLaM corporate audit program including re-audits,</td>
<td>7.</td>
</tr>
<tr>
<td>actions taken as a result of audit and dissemination of findings,</td>
<td></td>
</tr>
<tr>
<td>and recommendations</td>
<td></td>
</tr>
<tr>
<td>3.1 Re-Audits:</td>
<td>7.</td>
</tr>
<tr>
<td>3.2 Actions taken as a result of audit findings</td>
<td>9.</td>
</tr>
<tr>
<td>3.3 Impact of CQUIN audits</td>
<td>11.</td>
</tr>
<tr>
<td>3.4 Dissemination of audit findings and recommendations</td>
<td>12.</td>
</tr>
<tr>
<td>3.5 Training delivered</td>
<td>13.</td>
</tr>
<tr>
<td>3.6 Other objectives for the CAET in 2013/14</td>
<td>14.</td>
</tr>
<tr>
<td>Audit Topic Priorities for CAET Corporate Audit Program 2014/15</td>
<td>15.</td>
</tr>
<tr>
<td>Other objectives for CAET in 2014/15</td>
<td>15.</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>Appendix 1: SLaM Corporate Clinical Audit Workplan 13/14</td>
<td>17.</td>
</tr>
<tr>
<td>Appendix 2: SLaM Corporate Clinical Audit Workplan 14/15</td>
<td>20.</td>
</tr>
</tbody>
</table>
1. Executive Summary

Key achievements of the SLaM corporate audit program and related activity over the past year have included: the delivery of the prioritised annual audit plan – 33 projects were completed by end of March 2014 and 5 projects were underway and carried over to 14/15 program. A significant number of projects in 13/14 were monitoring NHS England or LSLC CQUINs or quality contract standards - 20/33 (60%) which was an increase compared to the previous year (45% PCT/CCG contracted audits in 12/13). These projects have successfully contributed to the overall outcome of 100% compliance on CQUIN targets in 13/14 which is a fantastic result for all teams involved. The increase in volume of contracted quality audits, has been offset by a decrease in risk-related audits following the decision by the NHS Litigation Authority (NHSLA) in November 2013 to move away from setting risk management standards and the notice that NHSLA inspections will cease by the end of March 2014. This has allowed us greater freedom to audit other policy areas and audits of new subjects have been undertaken in 2013/14 such as mortality reviews, informal patients rights’, mental capacity act etc. which have successfully highlighted gaps in compliance and areas of good practice.

In terms of impact of the trustwide audit program, some improvements that have been implemented following audits include: i) a new Mental Health Act practice note (no.9) offering guidance to staff on the rights of informal patients, was drafted and circulated to all staff following the informal patients audit ii) following the DNAR and the self-harm NICE audits, a patient information leaflet on cardio-pulmonary resuscitation (CPR) decisions for patients, carers and relatives has been produced by MHOA CAG and self-harm and crisis leaflets for each borough have been produced and disseminated iii) Following the evaluation of causes of deaths of SLaM patients between April 2008-March 2013, the Health Records Department have updated the EPJS help page ‘How to record a death in EPJs’ and have included prompts for clinicians to fill out a Datix form once they are notified of the death of a patient. New guidance has also been produced by the Datix Office to help clinicians’ record deaths on Datix for which no cause of death has been given (i.e. those deaths of ‘active’ patients notified through ONS/CRIS link). A one-page audit summary for staff has been produced and disseminated to all teams which includes links to the new guidance and also a reminder of the physical health standards for community patients iv) finally, since the Psychosis and Co-existing substance misuse Information Audit a recommended list of resources/leaflets has been compiled by the dual diagnosis team leads. It includes: health education information, assessment tools, key working/intervention tools, information about substance misuse services and self-help/mutual aid groups, family/carer support groups, Trust policies, national policies and guidelines. This information has been circulated to teams and is available on the dual diagnosis intranet page. Service User and Carer leaflets on how to access help for drugs and alcohol are being updated and will be disseminated to teams over the summer 2014.
In terms of training delivered, The Clinical Audit & Effectiveness Team (CAET) provided quarterly training workshops throughout 2013/14. These are advertised on the Trust intranet Education & Training site and open to all Trust staff. During 2013/14 a total of 37 staff attended the sessions, with an average feedback score of 3.5/4 (Good/Very Good). In response to feedback, the Clinical Audit & Effectiveness Team collaborated with the Quality Improvement Team (QUIST) to provide a full day workshop in March covering both the Clinical Audit Cycle and the Model for Improvement. This was piloted in March with positive feedback (3.8/4). Dates are set for continuing quarterly training workshops following this new model, with 15 staff booked to attend the June 2014 session.

The team has had success in dissemination of audit results winning an award for the DNAR audit at the pan-London quality improvement network (June 2013). The DNAR project was also selected for poster display and presentation at the International Healthcare forum held in Excel, London in April 2013.

In response to the Francis report and subsequent changes proposed for health care regulation (including the end of NHSLA inspections), some key priorities for the CAET in 14/15 include a Being Open audit and the annual review of SI and Complaints recommendations to aid prioritisation of policy, audit and QI resources. Planned changes to CQC regulation and inspection and introduction of fundamental standards in 14/15 will prompt reviews of existing quality and audit priorities and assurance tools including the Practice Assurance visits. In 2014/15 we plan to build on our existing user involvement work and increase our collaboration with service users/PPI governance structures and the CAET team. Service users will support the team with review of project priorities, advise at project planning meetings with policy leads and assist with interviewing patients. We also plan to increase our use of complaints data in evaluating areas of clinical policy.

Other CAET objectives for 2014/15 include:
- To support staff to learn from audits, introduce quarterly newsletter to include feedback from audits, updates on newly ratified policies and NICE guidance, information on learning events and training available.
- Introduce ‘meet and greet’ and offer regular audit/quality improvement training and support to teams who perform poorly in PAV visits, QUEST, PEDIC surveys etc.
- CAET to review outcomes from QI/Audit pilot project offered to trainee doctors in Southwark in 2014 and consider rolling out pilot trustwide to broaden and strengthen support in undertaking an audits/QI and ensure more reports are completed and trainee doctors contributions are recognised and rewarded.
- Provide continued support to the improvement area of ‘self-harm/suicide prevention’, facilitating strategy, implementation of QI projects and hosting learning events. To include continued work with Network Rail ‘Op Avert’ project which aims to challenge stigma associated with mental health and also
provide information for the public on how to get help for mental health conditions on mainline train stations in the boroughs served by SLAM.

- Continue our collaboration with Kings Health Partners Clinical Governance Teams to hold a Patient Safety Conference and Awards in 2015.

2. Corporate Clinical Audit Program Activity (2013/14)

2.1: Participation in National Audits & Quality Improvement Programmes

National quality accreditation schemes, and national clinical audit programmes are important for a number of reasons. They provide a way of comparing our services and practice with other Trusts across the country, they provide assurances that our services are meeting the highest standards set by the professional bodies, and they also provides a framework for quality improvement for participating services.

During 2013/14, five national clinical audits and two national confidential enquiries covered NHS services that the South London and Maudsley NHS Foundation Trust provides. During that period SLAM participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the SLAM was eligible to participate in during 2013/14 are listed below:

- The national audit of schizophrenia
- The 4 national, Prescribing Observatory for Mental Health - POMH-UK audits:
  i. Monitoring of patients prescribed lithium
  ii. Anti-psychotics in dementia
  iii. Prescribing for ADHD
  iv. Anti-dementia drugs
- The national confidential enquiry into suicide and homicide by people with mental illness
- The national confidential inquiry into maternal and child deaths

The national clinical audits and national confidential enquiries that the SLAM participated in, for which data collection was completed during 2013/14, are listed below.

**Participation in the National Audit of Schizophrenia**

<table>
<thead>
<tr>
<th></th>
<th>Number of cases submitted by SLAM</th>
<th>Number of Cases required</th>
<th>Percentage returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician questionnaire</td>
<td>87</td>
<td>100</td>
<td>87%</td>
</tr>
</tbody>
</table>
The National Audit of Psychological therapies published its second report in December 2013 and the results were reviewed with the MAP CAG Executive team in January 2014. The summary feedback in the Trust level report demonstrated that SLaM performed in the middle range on most of the key standards. Six SLaM teams participated and 3472 cases were submitted. Areas where we performed better compared with the national sample included:

i) A person who is assessed as requiring psychological therapy does not wait longer than 18 weeks from the time at which the initial referral is received to the time that treatment starts.

SLAM score: 98% vs. Total national sample 91%

ii) The therapy provided is in line with that recommended by the NICE guideline for the service user’s condition/problem

SLAM score: 91% vs. Total national sample 79%

In terms of service user experience, we performed similar to the national sample:

iii) Service users report a high level of satisfaction with the treatment that they receive.

SLAM: Access 82% & Experience 81% vs. Total national sample: Access 82% Experience 80%

Areas our Trust did less well compared to the national sample were:

iv) Treatment for high intensity psychological therapy is continued until recovery or for at least the minimum number of sessions recommended by the NICE guideline for the service user’s condition/problem.

SLAM score: 54% vs. Total national sample 57%

iv) Therapists are delivering therapy under supervision and have received formal training to undertake the therapy.

SLAM score: 74% vs. Total national sample 80%

The majority of responses in this category were from our IAPT services, which provide psychological therapies in primary care. The NICE guidelines address psychological service in secondary care where more sessions are usually indicated. We will review this provision in 2015 and also the level of supervision opportunities available to our therapists.
2.2 SLaM Corporate Audit Programme 2013/14:

By end of March 2014, the SLaM 13/14 Corporate Clinical Audit Programme had 33 completed projects and 5 projects were underway and carried over to the 14/15 program. A significant number of projects 20/33 (60%) were monitoring NHS England or LSLC CQUINs or quality contract standards which was an increase compared to the previous year (45% PCT/CCG contracted audits). Some of the topics included (for full list of audits undertaken please see Appendix 1):

- **Patient Safety**: completed projects include audits of: mortality review of SLAM patients over a 5-year period; themes from SI Investigations in 12/13; Supervision policy audit; consultant appraisal audit; suicides in SLAM and DNAR.

- **Clinical Effectiveness**: This included the National Audit of Schizophrenia data collection; Reasons for re-admission for service users with Bipolar Disorder audit and CQC Nutrition standards audit.

- **Patient Focus**: Completed audits include: Informal Patient Rights: Consent To Treatment & Leave; Mental Capacity Act documentation audit; Patient Information, Bed Management audit – admissions to multiple wards and themes from Complaint Investigations in 12/13.

- **CQUIN’s/Quality Contracted Audits**: This included quarterly audits on: Inpatient Physical Health Checks; Support and Recovery Care Plan audits including self-defined recovery goals in care plans, discharge letters to GPs, reasons for re-admission within 28 days and smoking cessation audits.

3. Impact of the SLaM corporate audit program including re-audits, actions taken as a result of audit and dissemination of findings, and recommendations.

3.1 Re-audits

The SLaM Corporate Audit Program is now in its sixth re-audit cycle. There were fewer re-audits in 13/14 program, compared with the previous year largely due to the decision by the NHS Litigation Authority (NHSLA) to move away from setting risk management standards and notice that NHSLA inspections will cease by the end of March 2014. This has allowed the CAET more freedom to audit other policy areas and new audit topics have been undertaken in 2013/14 such as mortality reviews, informal patients, mental capacity act audits etc. In the 3 re-audits undertaken, demonstrable improvements have been shown across criteria in 2013/14. These include:

i) **Clinical Supervision**: The questionnaire was sent to all clinical staff and the response rate was 828/1969 (42.1%). Overall, the results of the audit were very positive and indicated that performance had slightly improved compared to the previous audit in 2010. Three quarters of the respondents had clinical supervision in the last month (75%) and those that did felt it helped them to do their job better (90%), along with
making them feel valued (90%). Supervision was also written up in the majority of cases (77%).

ii) **Patient Information**: In terms of recording in the notes that patient information has been delivered, the audit showed that there has been a small general improvement when the 2011 and 2013 audit results are compared: less people have been given no information at all. The 2011 audit showed 22/105 (21.0%) patients were given no information whereas in the 2013 audit this has dropped to 3/90 (3.3%). The average amount of information given to patients has risen. In 2011 the average amount of information given to a patient was 2.6 items, this has risen to 3.9 items in 2013.

In terms of availability of patient information on the wards, generally wards are achieving medium compliance with CQC and policy standards with regards to information availability on the ward. With regards to CQC 1G: Providing information about what patients’ rights are. Regarding MHA rights leaflets, 24/35 (68.6%) wards visited had a version of the “Guide to the 1983 Mental Health Act (for detained service users) leaflet or poster and 23/35 (65.7%) wards visited had some version of the “Being an informal patient” leaflet or poster. 30/36 (83.3%) wards visited had some version of the complaints and compliments leaflet. However, of those complaints leaflets found, 11/30 - 36.7% were out of date (predating the Care Quality Commission) and these need to be removed from wards and replaced with new ones. 24/36 (66.7%) wards visited provided service description leaflets. With regards to CQC 2E: People who use services are provided with information about: alternative options for the care, treatment and support and the risks and benefits of each, compliance was medium. 28/36 (77.8%) wards had information about treatments i.e. psychological therapies and 24/36 (66.7%) wards had signposting for medication information or medication information available. One area in need of improvement included both the “Drug and alcohol: information for service users” (16/36 – 44.4%) and “Drug and alcohol: information for carers” (14/36 – 38.9%) leaflets. A program of updating relevant drug and alcohol leaflets and informing teams of resources has been undertaken by nurse consultant in dual diagnosis in 2014 in response to this finding.

iii) **DNAR**: Overall the results of the audit were very positive. Every standard apart from one fell within high compliance and there have also been significant improvements since the April 2011 audit. Areas of high compliance included:
- In 57/57 (100%) of the cases there was a DNAR alert in EPJs
• 53/56 (95%) of service users had the Trust DNAR form scanned into EPJs
• In 53/57 (93%) the rationale for DNAR decisions was clearly stated either on the DNAR form or elsewhere in EPJs
• Where the service user had relatives/friends in 52/55 (95%) of cases there was evidence they were involved in DNAR decisions
• 40/43 (93%) of the forms had the names of the members of the multidisciplinary team documented that contributed to the decision

Area of medium compliance:
• 24/30 (80%) of DNAR forms were completed by a Consultant

3.2 Actions taken as a result of audit findings
In reviewing the impact of the audit program, the reports of 33 Trust wide clinical audits were reviewed by our Quality Governance Committee in 2013/14 and a number of actions undertaken to improve the quality of health care provided. Here are descriptions of some of them:

• Suicide Prevention - following publication of a review of SLAM suicides in August 2013, a suicide prevention working party was convened and action plan developed. A literature search of international suicide prevention research was conducted and there are plans to develop small pilots of high impact interventions in community and inpatient settings in 2014/15. The SLAM suicide prevention strategy has been reviewed and now includes training for staff, reviewing care pathways (e.g. crisis care, affective disorders and personality disorders) to ensure better detection and management of suicide risk, improving access to dual diagnosis (drug users with mental illness) workers in Assessment and Treatment Teams and implementation of NICE guidelines for long term management of self-harm.

• Rights of Informal Patients – Following an audit on the rights of informal patients, a new Mental Health Act practice note (no.9) offering guidance to staff, was drafted and circulated to all staff. A summary of the audit findings and recommendations to teams was also sent trust wide encouraging teams to provide all informal patients with the ‘Being an Informal Patient leaflet’ and document discussions about rights in health records, to clearly display the Informal Patient Poster in an accessible way for patients on wards, and include the Leave for Informal Patients Policy in the local induction for all
staff. These and other recommendations will be evaluated in a re-audit in 2014.

- **Nutrition** - A Mealtime Standards working group have undertaken a number of actions since the Nutrition audit was reported in October 2013. Ordering guidelines are being developed and work is being carried out on computerised ordering so as to simplify the process. The menu is currently under review. The menu will be displayed for the week in addition to the menu on the day. The new nutrition screen has been added to the health record which now includes cultural, religious and health related needs. Nutrition screening/care planning training has been delivered to wards starting in February 2014.

- **Do not Attempt Resuscitate Decisions** – following the audit, a patient information leaflet on cardio-pulmonary resuscitation (CPR) decisions for patients, carers and relatives has been produced by MHOA CAG.

- **Mortality review of SLAM patients over a 5 year period** – following the evaluation of causes of deaths of SLaM patients between April 2008-March 2013, a list of all deaths of ‘active’ patients notified via the CRIS link to ONS is now sent by Health Records Dept. to CAG Business managers weekly who are encouraged to inform the Care Co-ordinator and prompt them to update EPJs and complete a Datix Form. The Health Records Department have updated the EPJS help page ‘How to record a death in EPJs’ to also include prompt for clinicians to fill out a Datix form once they are notified of the death of a patient. New guidance has also been produced by the Datix Office to help clinicians’ record deaths on Datix for which no cause of death has been given. A one-page audit summary for staff has been produced and disseminated to all teams which includes links to the new guidance and also a reminder of the physical health standards for community patients.

- **Patient Information EPJs and ward observation audit** – Following the audit a powerpoint presentation highlighting out of date and up to date patient information leaflets was produced and circulated to team leaders encouraging removal of out of date leaflets and replacement them with the correct versions. Teams without service description leaflets were followed up and all of those that didn’t have any leaflets available at the time of the audit have now all made them available.

- **Psychosis and Co-existing substance misuse Information Audit** - Since the audit, a recommended list of resources/leaflets has been compiled by the dual diagnosis team leads. It includes: health education information, assessment tools, key working/intervention tools, information about substance misuse services and self-help/mutual aid groups, family/carer
support groups, Trust policies, national policies and guidelines. This information has been circulated to teams and is available on the dual diagnosis intranet page. Service User and Carer leaflets on how to access help for drugs and alcohol are being updated and will be disseminated to teams over the summer. A poster that should be displayed on wards that use drug detection dogs if there is no other similar signage, a copy of a poster to put up in each bedroom to remind people that alcohol, drugs and smoking are prohibited and a copy of the process for dissemination of alerts is attached have also been circulated to team leaders.

### 3.3 Impact of CQUIN audits

The SLaM Corporate Audit Team has also been responsible for providing quarterly audit reports on a number of CQUIN and Quality Contract targets. CQUIN stands for “Commissioning for Quality and Innovation” and is a bonus of 2.5% of the contract value paid to NHS trusts. They are payments made by Clinical Commissioning Groups (CCGs) to Provider Trusts for improving quality in services. For 2013-14, the CQUIN money was approximately £5.3 million for SLaM. This includes CQUIN for both our core contracts (Lambeth, Southwark, Lewisham, Croydon – most of our Adult and Older Adult services) and our prescribed services (commissioned by NHS England). The Contracts Team have announced that we achieved 100% of CQUIN – this means we achieved all targets for all indicators. Compared to the previous year 12/13, gains have been made in achievement of the physical health checks on inpatients on admission, discharge plans to GPs and the Recovery Care Plan standards (targets were not met in the latter 2 CQUINs in 12/13).

A progress report for LSLC CQUINS 2013/14 is as follows:

- **Physical Health – New Admissions**; (Q4 target 75%) achieved 92%
- **Physical Health – Antipsychotics** (Q4 target 85%) achieved 88.2%
- **Recovery** (no. of CPA patients that have a Recovery & Support plan completed on EPJs). Q4 target is 50% of CPA patients having a plan – achieved 54%. This CQUIN is continuing for 14/15. Existing services will have a higher Q4 target (proposed 80%); rolled out to new services (CAMHS, MHOA, Community Forensic and Community LD) – these services will have a lower Q4 target (proposed 50%).
- **‘Easy In Easy Out’ Integrated Discharge Recovery Planning** (patients on or have been on CPA in past 6 months that have been discharged back to primary care with discharge documentation containing the following criteria:
Medication, Relapse signatures/Early relapse interventions/Early warning signs/Crisis plans, Goals – long and short term, Contact details (SLaM and Patient); being sent to the GP within 7 working days. (Q4 target 55%) – achieved 55%. This CQUIN is continuing for 14/15. Existing services will have a higher Q4 target (proposed 80%); rolled out to new services (CAMHS, MHOA, Community Forensic and Community LD) – these services will have a lower Q4 target (proposed 50%).

3.4 Dissemination of audit findings and recommendations:

**Internal within SLAM**

i) Following presentation at the Quality Governance Committee (QGC), relevant corporate audit reports and recommendations have been included as agenda items on CAG clinical exec committees. CAG clinical exec committees are encouraged to scrutinise their results and develop their own local action plans to improve performance.

Presentations have also been given of audit findings at various trustwide quality committees related to the audit/policy area. These have included the Physical Health Committee, MHA Forum, the Prevention of Violence and Aggression Committee, the Patient Information Strategy Group, the Equality and Human Rights Committee to name a few. This ensures that learning from the audits is taken forward by those directly involved and those leading policy and strategy in these areas.

ii) ‘Learning Lessons from Clinical Audit/Purple light bulletin. In order to spread Trustwide the results and recommendations from audit, the CAET team have produced one-page summaries of audit findings and key recommendations aimed at clinical staff. These have been distributed in the SLAM e-news bulletin and been sent via e-mail Trustwide to team leaders and senior clinical staff. Bulletins have been issued on the following audit subjects in 13/14: Substance misuse and psychosis, clinical supervision, self-harm long term management, informal patients, patient information and mortality 5-year review. There are also links to the policy and education resources available.

**Kings Health Partners (KHP) links**

Planning meetings for the KHP Safety Connections Conference held on 14th May 2014 – a collaboration between SLaM, Guys and St Thomas and Kings and took place late 2013 and early 2014. The conference included speakers and workshops led by SLAM staff and a quality improvement poster competition for projects relating to service improvements was also arranged to promote high quality improvement projects and reward successful work.
External Conferences and Awards
The Do Not Attempt Resus (DNAR) audit poster won a pan-London quality improvement network (HQIP) poster competition on 7th June 2013, held at St. Pancras Hospital. The judges commented that the poster was very high quality and they commended the use of rapid cycle audit and direct feedback to consultants as a quality improvement method.

3.5 Training Delivered

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</tr>
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*Change in format – Combined QI and Audit training delivered

The Clinical Audit & Effectiveness Team provided quarterly training workshops throughout 2013/14. These are advertised on the Trust intranet Education & Training site and open to all Trust staff. During 2013/14 a total of 37 staff attended the sessions, with an average feedback score of 3.5/4 (Good/Very Good). The training workshops for the first three quarters were half a day long and focused on clinical audit (similarly to previous years). In response to feedback, the Clinical Audit & Effectiveness Team collaborated with the Quality Improvement Team (QUIST) to provide a full day workshop in March covering both the Clinical Audit Cycle and the Model for Improvement. This was piloted in March with positive feedback (3.8/4). Dates are set for continuing quarterly training workshops following this new model, with 15 staff booked to attend the June 2014 session.

Training is delivered through both theoretical presentations and practical exercises, with each delegate completing a project proposal form by the end of the session.

Corporate Induction
‘Market stalls’ were held each month at the SLaM Corporate Induction. These provide every new employee with a brief introduction to clinical audit and the process within the Trust.

Trainee Doctors
In July 2013 the team collaborated with trainee doctors to evaluate the knowledge, training and undertaking of clinical audit and improvement projects by trainee doctors across the trust. In response to the findings the team contributed to a pilot of bi-monthly training/supervision sessions for the trainee doctors working in SLaM Southwark services. These trainees have been invited to present their projects at a
prize day, organised for the end of the current rotation. The trainees will be surveyed again at the end of the intervention to inform any roll-out of support to trainee doctors across the Trust in 2014/15.

**Ad-hoc Training**
The Clinical Audit & Effectiveness team provide training on request in skills such as data analysis to support numerous clinical audit, quality improvement, research and other projects throughout the Trust. During 2013/14 these have included projects on dual diagnosis, staff awareness of physical health, complex PTSD intervention, adult safeguarding and clinical support worker skills. Training has also been delivered on poster design to present and promote service improvements.

### 3.6 Other objectives for the Clinical Audit & Effectiveness Team in 2013/14:
- Completion of the Trustwide programme of audits to assist with CQC assurances, CCG Quality Contract & CQUIN requirements and NICE quality standards. **Achieved**
- CAET to provide supervision and support to QI project underway to improve the support offered to junior doctors undertaking an audit to ensure more reports are completed and trainee doctors contributions are recognised and rewarded. **Achieved**
- Continue our collaboration with Kings Health Partners Clinical Governance Teams to hold a Patient Safety Conference and Awards in 2014. **Achieved**
- Provide continued support to CAET ‘Mind the Gap’ community project which aims to challenge stigma associated with mental health and also provide information for the public on how to get help. **Achieved**
- Quality Governance Committee (QGC) terms of reference review of function to ensure fundamental (CQC) standards of care are reviewed for compliance and action planned. **Achieved**
- CAET Team review to include: development of team mission statement, review of clinical audit project prioritisation process to ensure projects are action-focused, cost-effective and relevant to patients’ and The Trust Board’s quality concerns. Review to consider whether CQC proposed fundamental standards and themes from SLAM complaints, incidents and claims should be covered prior to undertaking audits of enhanced quality standards (e.g. NICE and NHSLA standards) and service evaluations. **Partially achieved (achieved review of annual audit plan prioritisation in line with proposed CQC fundamental standards and review of Sis and complaint themes).**
- Building our user involvement capacity and increase our collaboration with service users and the CAET team. Service User involvement activity to include review of priorities, support on project planning meetings with policy leads, interviewing patients and increasing our use of complaints data in evaluating area of clinical policy. **Partially achieved (awaiting outcome of PPI strategic review).**
- Re-establish a quarterly CAG Quality Governance and Audit SLAM network meeting **Partially achieved** - re-established quarterly meeting but low attendance and feedback from attendees has led to closure of the meeting.

- Consultation on setting up a QGC/clinical audit Patient Advisory panel to aid prioritisation of quality areas for review, monitor and drive improvements. Patient Advisory panel to develop secondary evidence that audit actions have been implemented (e.g. service user/'mystery shopper' spot checks). **Not achieved** – (awaiting Trustwide PPI strategic review)

- CAET team review to include consultation on whether a statement of assurance (limited, partial, significant, full assurance) should be given on clinical policy areas following publication of audit findings. **Not achieved**

4. **Audit Topic Priorities for SLaM Corporate Audit Programme in 2014/15**

The selection of topics for the 14/15 audit programme has been influenced by a recent themed analysis of SLAM SI and Complaint recommendations which have highlighted several areas for audit, CQC/MHA relevant topics (e.g. Being Open), quality contract/CQUIN monitoring requirements and requests from Policy/Audit lead clinicians. The draft list was consulted with CAG service and clinical directors and Heads of Profession in April 2014 who were invited to submit further suggestions for topics. In terms of participation in national audits in 14/15, SLaM will be participating in the Prescribing in mental health services (POMH-UK) national pharmacy audit program as usual. For further information on the prioritised corporate audit work program in 14/15 please see appendix 2.

5. **Other objectives for the Clinical Audit & Effectiveness Team in 2014/15:**

- Provide monitoring evidence to support external and internal quality priorities and drive improvement in patient care i.e. completion of the Trustwide programme of audits to assist with CQC assurances, CCG Quality Contract & CQUIN requirements, NICE guidance and SLAM Quality Account priorities. Continue to carry out themed reviews of serious incidents and complaints and other patient feedback to highlight future quality priorities and direct the trust Quality Strategy, priorities and allocation of resources.

- Building our user involvement capacity and increase our collaboration with service users. Consultation on setting up a clinical audit Patient Advisory panel to aid prioritisation of quality areas for review, monitor and drive improvements. Service User involvement activity to include review of priorities, support on project planning meetings with policy leads, interviewing patients and increasing our use of complaints data in evaluating area of clinical policy.
• To support staff to learn from audits, introduce quarterly newsletter to include feedback from audits, updates on newly ratified policies and NICE guidance, information on learning events and training available.

• Introduce ‘meet and greet’ and offer regular audit/quality improvement training and support to teams who perform poorly in PAV visits, QUEST, PEDIC surveys etc.

• CAET to review QI/Audit pilot project offered to trainee doctors in Southwark in 2014 and consider rolling out pilot trustwide to broaden and strengthen support to junior doctors undertaking an audits/QI and ensure more reports are completed and trainee doctor’s contributions are recognised and rewarded.

• Provide continued support to the improvement area of ‘self-harm/suicide prevention’, facilitating strategy, implementation of QI projects and hosting learning events. To include continued work with network rail ‘Op Avert’ project which aims to challenge stigma associated with mental health and also provide information for the public on how to get help on mainline train stations in the boroughs served by SLAM.

• Continue our collaboration with Kings Health Partners Clinical Governance Teams to hold a Patient Safety Conference and Awards in 2015.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 24th June 2014

Name of Report: Finance Report

Heading: Performance & Activity

Author: Tim Greenwood, Mark Nelson
Finance Directorate, BRH

Approved by: Gus Heafield
(name of Exec Member)

Presented by: Gus Heafield

Purpose of the report:
The Finance Report provides an analysis of the financial position of the Trust as at 31st May 2014 (month 2 of the new financial year).

We have included a section on capital at the end of the analysis section this month as requested.

We have changed the format of the report slightly this month to include the key issues and actions more prominently at the front of the report and moved the more detailed analysis towards the end to be referred to as required. This is work in progress on the reporting and comments would be appreciated.

Action required:
To note the contents of the report and the financial position together with risks and early indications of pressures and for the members of the Board of Directors to satisfy themselves that actions are appropriate to address them in order to ensure that the Trust meets its financial targets for Q1 and the next 12 months in line with the operational plan.

Recommendations to the Board:
That the Trust Board of Directors approves the report on the financial position for the year to date as at the end of May 2014

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The report is a key component of the assurance framework in terms of the effective and efficient management of resources.

Summary of Financial and Legal Implications:
The Trust must make the best possible use of public money and meet regulatory requirements and deliver to plan.
**Equality & Diversity and Public & Patient Involvement Implications:**

The report identifies activity and financial pressures that if not resolved may have implications on the Trust’s ability to deliver its equality, diversity and patient involvement commitments as set out in the Annual Plan.

**Service Quality Implications:**

The report identifies potential activity and financial pressures that if not resolved may have implications on the Trust’s ability to deliver its quality commitments as set out in the Annual Plan.
Income and Expenditure

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<tr>
<td>EBITDA</td>
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Expenditure Financial Position

- Capital spend against plan: £0.1m
- Net surplus (£0.5m adverse variance from current plan ytd)

Forecast year-end Variance

- EBITDA: £2.4m (£0.4m adverse variance from current plan ytd)

There remain on-going issues that need to be addressed and which are causing the current position to be off Plan:

- Ward nursing costs/budgets (£286k off Plan). Additional funding has been set aside to increase nursing establishments in certain areas following a Director of Nursing led review. However this funding does not fully cover the current rate of overspend and implies that the overspend is not solely a funding issue.
- Although interim transitional support has improved the financial positions in Psychosis and B&D, they remain significantly overspent:
  - Psychosis (£0.8m adverse variance ytd): overspends on placements (£0.3m), drugs (£0.1m), ward and community staffing (£0.2m) and unmet CIPs (£0.2m).
  - B&D (£0.4m adverse variance ytd): overspends on placements (£0.1m), pay costs on NAU (£0.1m) and low activity on ADHD and Behavioural Genetics services. The position includes £3.6m of transitional funding leaving further work to be undertaken by the CAG to close trading gaps on Offender Health, ADHD, Behavioural Genetics, NAU and Croydon LD.
- Estates directorate overspent by £0.1m in the month (£0.2m ytd) with a number of appointments to unfunded posts or use of agency staff.

Key Financial Drivers

- Cash
  - Cash at bank and in hand: £67.6m
  - Cash in non-GBS bank deposit: £0m
  - PDC funding: £0m

Working Capital

- Working Capital: £30m

Capital expenditure < 85% or > 115% original plan

- Estates directorate overspent by £0.1m in the month (£0.2m ytd) with a number of appointments to unfunded posts or use of agency staff.
South London and Maudsley NHS Foundation Trust

Finance Report 2014/15 – May 2014 (month 2)

1. Headlines

Year to date
- £0.1m net surplus (£0.5m adverse variance from current plan) – see Table 1
- £2.4m EBITDA (£0.42m adverse variance from plan) – see Table 1
- The Operational Plan performance was a Continuity of Service Rating of 3 based on a liquidity rating of 4 based on liquidity of 34 days operating expenditure and a debt service ratio of 2 based on our planned EBITDA for Q1 of £3.2m. We expect to hit the performance targets at Q1 although there are still risks unresolved as described in the report.

Forecast
- We are forecasting that the Trust will hit its financial targets within the Operational Plan for 14/15 (CoSRR of 4 and EBITDA £16m and net surplus of £1m) but we must maintain our focus on the delivery of the plan and resolution of the issues emerging within the operational services.

2. Trust Summary Issues and Actions

The Trust Executive and CAGs are focussed on delivery to the financial plan for Q1. Significant progress has been made to establish appropriate budgets within the CAGs following the finalisation of the Operational Plan, although there are some remaining budgets to be finalised – particularly ward establishment budgets. This will be completed by the time of publication of the month 3 results.

The Trust and CAGs have been reviewing non-essential expenditure and additional controls in order to ensure the stabilisation of the financial position in this first quarter. Some additional measures and schemes have been put in place. As discussed last month this is often one of the most challenging periods given the significant changes in financial budgets and targets between the financial years.

In particular the Trust needs to make progress in the following areas:

- Finalisation of contracts with local CCGs and NHS England particularly for forensic services, clarification of QIPP requirements, and outstanding issues between NHS England and NHS Southwark. Meetings are scheduled between the parties to seek resolution and we should seek to finalise the results for Q1.
• Finalisation of the bed trajectory and AMH programme metrics for the year. Significant progress has been made in mapping current trajectories with the investment from CCGs and our plans for reductions in internal capacity before the end of the year. We have assumed that overspill costs will be covered by the funding and our risk arrangements within the contracts. **This should be completed and signed-off by Q1**

• There has been some impact on the pressure in the remaining placements budgets this is still running at a level which is unsustainable (£0.4m at month 2). The Trust has been seeking to mitigate the internal pressures while negotiations with commissioners have been ongoing. **The CAGs are expecting a decision this month on resolution with the commissioners.**

• The work on safer staffing is expected to have concluded to enable us to establish new ward budgets in time to feed into the month 3 position. It is apparent from the month 2 figures that other factors outside the agreed staffing and funding are driving a financial pressure and we are working with the CAGs and Nursing and Finance team to address individual issues going forward. **I expect us to have worked up action plans to address the performance and operational issues to report to the Board next month.**

• Psychosis, and BDP CAGs have been working up their action plans to address the underlying issues identified below. Progress with the actions is being tracked through the refreshed performance regime and Executive. **We are working with BDP on the review of the long term viability and sustainability of those service currently not covering their costs including NAU to report back to the Board next month.**

• The MHOA position is driven primarily by ward staffing issues in the specialist care units and the wards. The budgets for the individual units are being established this month. Discussions are underway with the commissioners on the Specialist care provision in order to mitigate these costs overruns. There have been particular issues in the inpatient services which have now been stabilised. Additional savings are expected to deliver within the CAG to offset the ytd position post Q1.

• We are working with the budget holders on the pressures within the infrastructure budgets and expect these services to hit their budgets for the year and be in recurrent balance by the end of Q1.

• There has been significant slippage in the capital programme as at month 2 and we will need a revised and re-scheduled programme for the year to deliver in line with the operational plan (further detail at the end of the analysis section) by the time we finalise the Q1 reports and returns to Monitor.

3. **Further Information and Updates**

**Movements in Central Budgets between Month 1 &2**

As described in the month 1 report in a number of areas we have adjusted local budgets to reflect the local implications of the operational plan. A total of £13.6m held centrally has been allocated in this way to fund –

• Pay and non-pay inflation
• An adjustment to the Psychosis acute and PICU bed plan
- Interim transitional support to 3 CAGs – Psychosis (£2.1m), B&D (£3.6m) and Addictions (£0.5m) – pending further review and agreement to new financial targets
- An adjustment to the planned income position pending agreement with NHSE
- Investments in ICT and delivery of the Smoke-Free initiative across the Trust

Within the remaining centrally held budgets funding is set aside for the nurse establishment review and for further adjustment of community budgets in line with the AMH plan.

We expect to have made all of the central allocations to local budgets by the time we report on the quarter 1 results.

Risks Identified in the Plan

The income and expenditure account includes a number of assumptions/risks which were described last month and unless indicated otherwise have not been amended -

- There remains a gap in the CIP plans required to deliver a balanced financial plan; £2.25m of CIPs were not identified in the Plan and are impacting on the month 2 position by £0.4m. Additional Trustwide CIPs of £1.7m which were identified still have detailed plans to be developed. These are not impacting at month 2 but will do so later in the year if these plans do not deliver as expected. Current CIPs total £15.9m. Some additional CIP schemes have been identified and will feed into the position after Q1. The programme office is being established and additional schemes are being identified through the Executive and SMT.

- There remains a gap in the Lambeth, Southwark and Lewisham CCG QIPP plans; workshops have been held with all 3 CCGs in early June to establish the exact position and what other options exist to close the gaps.

- The contract with NHS England is in the late stages of negotiations but has yet to be finally agreed; there are still some significant risks although the positions are much closer and final discussions are underway to address the outstanding issues and reach agreement asap.

- The Plan assumed £2.2m of funding from Southwark CCG, which is not currently included the latest Southwark CCG offer; a meeting has been arranged with Southwark Chief Finance Officer in early July to resolve this issue.

- The Plan assumed £5.2m of funding from Croydon CCG to deal with the bed pressures in the borough, but agreement has yet to be reached about how this funding should be utilised and how much is committed to the purchase of additional bed capacity versus investment in community services to prevent admission and improve discharge; a meeting was arranged for 17th June to resolve this, pending a follow up meeting between the respective CEOs.

- The Plan assumed Lewisham CCG support for the AMH model, but he CCG have stated their intent to put no further funding into this beyond the £300k
invested in 2013/14; further discussions are underway with the CCG re the AMH model and how it is to be funded.

Financial Performance Issues

There remain on-going issues that need to be addressed and which are causing the current position to be £0.7m off Plan -

- Ward nursing costs/budgets remain an issue - £286k off Plan in month 2. The overspend relates mainly to MHOA, particularly continuing care homes. Additional funding has been set aside to increase nursing establishments in certain areas. This funding is currently held centrally (although feeding through to the bottom line position) and will be allocated to specific wards/units once final agreement is reached. However this funding does not fully cover the current rate of overspend and implies that the overspend in all units. Reviews are underway with the CAGs and Nursing and Finance teams to agree next steps to resolve the underlying issues.

- The Trust retains secondary commissioning responsibility for many non forensic placements in Lambeth, Southwark and Lewisham. At month 2 these placements were £0.4m overspent – an unsustainable level of activity – with Southwark Local Authority are seeking a further £0.75m reduction in cost that is not factored into the figures stated here.

- Although interim transitional support has improved the financial positions in Psychosis and B&D, they remain significantly overspent at month 2 -

  - Psychosis (£0.8m adverse variance ytd): overspends on placements (£0.3m), drugs (£0.1m), ward and community staffing (£0.2m) and unmet CIPs (£0.2m) are helping to drive the position
  
  - B&D (£0.4m adverse variance ytd): overspends on placements (£0.1m), pay costs on the NAU (£0.1m) and low activity on ADHD and Behavioural Genetics services. The position includes £3.6m of transitional funding leaving further work to be undertaken by the CAG to close trading gaps on Offender Health, ADHD, Behavioural Genetics, NAU and Croydon LD.

Gus Heafield
Chief Financial Officer
June 2014
Finance Report 2014/15 – May 2014 (month 2)

Financial Summary and Analysis (some adjustments to new-year budgets particularly nursing to be completed by Q1 reporting)

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Full Year Live Budgets (£)</td>
<td>Current Month Actual (£)</td>
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<tr>
<td>01. Psychosis</td>
<td>98,982,000</td>
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<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>0</td>
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<td>03. Mood, Anxiety, Personality</td>
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<td>04. Psychological Medicine</td>
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<td>05. Child &amp; Adolescent Service</td>
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<td>07. Addictions</td>
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<td>08. Clinical Support Services</td>
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<tr>
<td>10. Corporate Income</td>
<td>(99,762,800)</td>
<td>(7,888,000)</td>
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| Operational Deficit | 54,507,200 | 5,031,900 | 139,000 | 10,789,200 | 1,673,500 |

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<td>Corp Income</td>
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<td>(201)</td>
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<td>Use of Contingency</td>
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<tr>
<td>Total EBITDA</td>
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<td>(141)</td>
<td>(5,890)</td>
<td>(146)</td>
<td>(280)</td>
<td>(426)</td>
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</table>
3. Key Cost Drivers

Performance against the main cost drivers is detailed below –

- **Acute/PICU Overspill**

Overall, 23 beds were used outside the Trust in May, a decrease of 11 compared to the previous month. The number of beds used outside the Trust has continued to fall such that at the beginning of June the use of such beds was down to single figures. This would be in line with Trust expectations following a number of measures taken to address the overspill issue (as outlined in the April Board Report). Continuation of the current zero £ variance is reliant upon external placements being maintained at this low level and reaching agreement on outstanding contractual issues with our local CCGs.
• **Ward/Unit Nursing Costs (Table 2)**

At month 2 ward nursing costs were overspent by £416k, an increase of £286k in the month. The movement reflects an increase in bank usage in the month of £260k which is spread across a number of wards but particularly impacting Psychosis, Psychological Medicine and MHOA.

• **Complex Placements**

Forensic placements transferred to NHS E at the start of the year having overspent by £2.3m in 2013/14. The Trust remains the secondary commissioner for other placements in Lambeth, Southwark and Lewisham. In month 2 these placements overspent by £145k (£358k year to date). The majority of the overspend (64%) relates to Southwark where the Council is intending to reduce its funding contribution by £750k. Discussions continue with the CCG/Council to establish an appropriate level of funding. Small risk shares are in place in Lambeth and Southwark.
**Cost per Case/Cost and Volume**

The position remains slightly below Plan (0.4%) but a large improvement on 2013/14 following the closure of the AED and NDS units. Provisional transitional funding (£0.47m) has been allocated to support the Addictions Assessment Unit which remains a loss making service with low forecast occupancy levels and prices that do not cover the full cost of providing the service.

The Trust is yet to conclude discussions with NHS E regarding the price/volume and terms and conditions for a range of specialist services in 2014/15.
4. **Cost Improvement Programme (CIP) & CCG QIPP**

**a) Trust CIP (Table 4)**

The Trust is reporting an overall adverse variance of £352k (17%) against its original identified plan of £15.9m at month 2.

The main areas of variance are highlighted and explained in Table 4. This includes both a delay in closing Gresham PICU and a possible requirement to utilise the savings to fund external placements, continuing pay overspends in MAP A&T teams which were planned to be addressed by month 1 and expected pay savings in B&D not yet materialising. These adverse variances have been partly offset by savings that have been delivered ahead of plan in MHOA.

Outside of CAG and Directorate specific CIPs there remain both unidentified CIPs (£2.25m currently feeding into the bottom line position of the Trust) and Trustwide CIP schemes (£1.7m which are being developed but which are due to start delivering in the second half of the year). These 2 areas of CIP totalling £4m remain a significant risk unless addressed with specific schemes.

**b) CCG QIPP (disinvestment) - Table 5**

There was an estimated shortfall of £350k against the CCG QIPP target attributable to SLaM. However none of this shortfall is included within the month 2 position as the detailed plans to meet the QIPP targets have yet to be agreed. In total £3.9m of QIPP savings have yet to be agreed/identified (out of a total QIPP target of £6.2m) although removed from the block contracts. The Trust will not sign up to savings plans that cannot be delivered and alternative approaches will be sought if the current proposals are not feasible. Further detail is provided in section 5 below.

5. **Local CCG Contract Positions**

Contracts with our 4 local CCGs have yet to be signed. The main outstanding financial issues are largely to do with QIPP (and whether the plans to remove funding are reasonable or not) and investment in the AMH model –

- Lambeth - c£1.5m of QIPP schemes remain to be agreed.
- Southwark – c£1.3m of QIPP schemes remain to be agreed. In addition the council are intending to reduce their contribution to the placements budget - an already overspending budget. No agreement has yet been reached with the CCG regarding the 13/14 transfer of funding to NHS E for specialist services
- Lewisham - c£1m of QIPP schemes remain to be agreed. In addition the CCG have stated their intent to put no further funding into the AMH model beyond the £300k invested in 2013/14. This would leave a gap of c£900k for the Trust to deal with which was not built into the Trust Plan. Further discussions are required to agree a way forward.
- Croydon – although a provisional investment of £5.2m was included in the CCG offer to deal with the bed pressures in the borough, agreement has yet to be reached about how this funding should be utilised and how much is committed to the
purchase of additional bed capacity versus investment in community services to prevent admission and improve discharge.

6. Capital Expenditure

Last year Monitor retained a risk indicator for capital expenditure – the risk indicator being triggered by capital expenditure being +/- 15% against Plan.

Capital expenditure at month 2 is £1.5m against planned expenditure of £2.6m. This represents a 42% variance from plan. The main variances from plan are -

- £500k slippage on ward refurbishment programme
- £385k slippage on the EDU move to Maudsley AL2
- £196k slippage on staff alarms
- £167k slippage on capital maintenance
- Less £167k provision for slippage

Ward Refurbishment programme – The original intention was an allowance of £500k for six wards across the Trust, however just prior to the start of the FY it was decided that a better intention would be to complete a building as a whole, so the team are currently reviewing Douglas Bennett House to refurbish this in the second half of this financial year.

Staff Alarms – There was a degree pressure of the availability of decant wards at the start of this calendar year which prevented a number of ASCOM projects from commencing as planned. However, this has since been re-planned, and the projects are now re-mobilised. The delay has enabled us to include a degree of essential ward refurbishment as part of the ASCOM works whilst the wards are decanted. This has extended the contracts slightly which then indirectly impacts the roll-out progress, but facilitates an improvement in the environments whilst avoiding some of the potential disruption to the clinical services.

EDU – McKenzie ward is undergoing a period of essential refurbishments whilst it is decanted which has extended the programme – as a result the service are remaining in AL2 slightly longer than planned, which is the eventual EDU ward. However, the works programme has been reviewed by the capital team and they expect to deliver the project by Christmas as planned, but with a shorter site programme.

Capital maintenance – Some initial start-up problems within the project management arrangements in capital planning have been resolved and the programme is being rescheduled by the Estates team.

In 2014/15 £17.3m is allocated to individual projects with the exception of £1m of capital maintenance of which £0.7m remains at month 2. Provisional allocations comprise -

- £3m for the ward refurbishment programme & £3m in 15/16
• £2m for Croydon community cluster
• £1m for Lewisham community cluster and £1m in 15/16
• £2m for Lewisham inpatients and £4m in 15/16 (financed by the development reserve)
• £1m for ICT development and £1m in 15/16
• Less £1m allowance for slippage from 14/15 to 15/16

Gus Heafield
Tim Greenwood
Mark Nelson
June 2014
Date of Board meeting: 24th June 2014

Name of Report: Summary Performance Report, May 2014

Heading: Performance

Author: Roy Jaggon, Head of Performance Management

Approved by: Nick Dawe, Chief Operating Officer

Presented by: Nick Dawe, Chief Operating Officer

Purpose of the report:
To report the Trusts’ performance against the Operational Plan 2014/16 targets, identify any major areas of learning and success, identify and analyse underperformance and provide action plans to address such underperformance.

Action required:
To review the progress being made with the Operational Plan 2014/16, consider the robustness and timing of actions to address issues and to quantify areas where a more detailed report will be required at the end of the first quarter of the year.

Recommendations to the Board:
To approve the report noting that this is the second report reflecting the new performance framework and observations around layout and level of detail would be welcome.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report – none, low, moderate, high:

Key operational control, assurance level moderate.

Summary of Financial and Legal Implications:

No additional financial implications or benefits identified.

Equality & Diversity and Public & Patient involvement implications:

None.

Service Quality Implications:

None.
Summary Performance Report, May 2014

Introduction

This report is the second version of reporting reflecting the new performance framework and brings together a Trust wide view of performance from team to Board level. This month we have included the Trust Board summary level performance pyramid in support of this report and the Red, Amber, Green performance flags. We will progress this further next month by including milestones for IT and Workforce Strategies. Please note that this report is written in advance of the Operational Management Performance meetings with CAGs that take place on 20th June 2014 and therefore will require a degree of update at the Board meeting.

OVERALL PERSPECTIVE

Compared to last month the Trust position remains Amber. However within this assessment there have been significant improvements in performance as well as improvements in the robustness and reporting of information.

QUALITY PERSPECTIVE

The Quality agenda is being progressed and the Quality subcommittee of the Board met earlier this month to lead this work. The content of the quality dashboard has been defined pending agreement with the new chair of this committee. We continue to make progress with the Quality Account priorities and the Francis Report recommendations.

PROGRAM PERSPECTIVE

We continue to make progress with programs as described in the Trust Operational Plan. This includes clarity around deliverables and milestones. In particular the AMH program continues to deliver to milestones and in particular to time. The community team realignment (MAP) has been completed with recruitment on going. The Forensic program is also progressing well focussing on a complete review of services including skill mix and staff numbers with the aim of closing the contractual gap with NHSE and keeping within budget. The CAMHS ‘Turn-a-round’ project which reviews all teams in terms of quality, activity, skill mix and staff numbers is progressing as anticipated.

OPERATIONAL PERSPECTIVE

The overall position is considered red because although total activity, capacity and overspill fall within planned and expected levels there is however one major national performance measure which is being failed, HTT gatekeeping and a growing concern around the availability of the Section 136 suites.

- HTT gatekeeping performance: performance continues to be below target c. 85% ytd. It is clear that we will not meet this target for the Q1 Monitor return. The PSYMED
CAG has implemented a series of actions which are included in an action plan (for submission to Monitor) which is enclosed (appendix II).

- **Activity:** the over performance in IP activity reported last month has reduced to 1% which is within the tolerance assumed in the annual plan (finance and capacity) of variations between plus/minus 5%.

- **Section 136 suites:** the most significant capacity pinch point the Trust has are its four (one per borough) Section 136 (place of Safety) suites. No availability is a significant quality issue and causes reputational damage with the Police. Unavailability is normally due to their being insufficient staffing available on the host ward. Immediate action to improve staffing levels has been actioned and plans to increase the number of individual rooms and consider consolidation of location and other operational improvements is under way.

- **Overspill activity:** has reduced since the last Board meeting and at the time of writing there are 6 placements for acute (current target 8) and 7 for PICU (current target 6). This continues to be under review as does the use of Bridge House. The Board are reminded that there were some 60 plus overspill placements as recently as last November.

- **Complaints:** this was reported as a specific issue for Psychosis CAG last month. Action over the last month has indicated a more system / process issue in that some complaints are completed by the CAG but are delayed elsewhere in the system. Some action has already been taken to update Datix (the complaints information system) records when a complaint is complete and returned to the complaints team.

- **7 DFU and CPA 12m review:** reported as potential areas of underperformance have now been resolved and targets have been met for the month.

**RESOURCE PERSPECTIVE**

**Estates:** progress on the compliance programme is to plan but there is a lag in progress with two key projects on the capital programme, essentially due to a change in approach and capacity constraints impacting on capital spend in the first quarter and the start of the ward major refurbishment programme.

**IT and Workforce:** requires work to establish milestones and these must be in place for the June report as success with both strategies is vital to the delivery of the Trust’s annual plan.

Finance is subject of a separate report.

The overall colour is deemed to be amber but if absence of agreed milestones in the critical areas of IT and Workforce continue next month the rating will default to red.
INDIVIDUAL CAG PERSPECTIVE

A number of the issues reported last month have been covered above. An update will be provided post the Operational Performance Management meetings 20\textsuperscript{th} June 2014.

FURTHER DETAIL

The Performance Pyramid is enclosed as appendix I. The figures and analysis supporting this report are available on request.

Roy Jaggon
Head of Performance Management

19\textsuperscript{th} June 2014
Our quality priority this year is to work to increase the number of patients who feel safer when in our hospitals.

We will stop the transfer of acute patients to private sector hospital beds outside the Trust.

We will make it easier for patients to access help in a crisis. No one should experience being turned away when in a crisis.

We will improve the quality of the environments within our in-patient wards.

We will ensure that all patients receive an individual service at medication and mealtimes when in hospital.

We will improve the way we involve patients in their care planning and make sure patients understand their care plans.

• Waiting Times
  - To increase the number of people who when asked say they feel safe in our services
  - To reduce the number of times that patients are physically restrained
  - Measure the number of patients transferred to acute overspill beds outside the Trust
  - Community patients to respond positively to the question, “Have you been offered a crisis plan for emergency mental health situations?”

• Improvement in PLACE environmental audit scores
  - No patient will queue for medication or meals when in hospital
  - All new CPA referrals to have completed S&R plan

• Assessing, documenting and acting on six key cardio metabolic test results recorded for patients
  - Increase the number of smokers offered intervention NRT or counselling
  - See more patients at home and in primary care settings for first contact

Francis Report: ACTION PLANS
Programs

Transform
- Specialist

Transform
- Local

Innovate

-child & Adolescent Psychiatry

Addictions

Forensics

CAMHS

MHOA

AMH Programme

Value Based Healthcare

Prevention & Wellbeing

LEAN Integration

Digital

Assessment by Time, Quality, Resources

Projects that will deliver

60 of 102
Operations Assessment by Time, Quality, Resources

- Regulatory / Compliance / Legal
- Contracts
- CIP / QIPP
- RAF
- CQC Inspection
- CQUIN
- Sanctions

Assessment by Time, Quality, Resources
Operations

Contracts

Activity / Capacity Management

Sanctions

CQUIN

- OBD’s – Over-Performance
- Copy of Care Plan
- Physical Health Checks

- Delayed Discharges
- 7 DFU
- Physical Health: Improving Physical healthcare to reduce premature mortality in people with Severe Mental Illness

- Discharge
- PbR
- Recovery

Assessment by Time, Quality, Resources

Individual Projects / Operational Teams

Project Exec (SRO) / CAG Exec

SMT / Executive

BOARD
• Delayed Discharges – Monitor YTD
• CPA 12 Month Review
• HTT Gatekeeping
• 7 Day Follow-up
• Early Intervention
• LD Access
• Data Completeness- Identifiers
• Data Completeness- Outcomes

RAF (SQIR – Report)
CQC Inspection
Operations

Assessment by Time, Quality, Resources

Productive

CIPs PLANNED

- Addictions
- BDP
- CAMHS
- MAP
- MHOAD
- PSYMED
- PSYCHOSIS
- Trust-Wide
- All Others
Resources

Finance

- Income
- EBIDTA
- Vacancy Rate
- Sickness Rate
- Expenditure
- Bank and Agency Rates

Assessment by Time, Quality, Resources

BOARD

SMT / Executive

Project Exec (SRO) / CAG Exec

Individual Projects / Operational Teams

Staffing
Resources

Operational Effectiveness

- Mobile working technologies
- Cloud-based productivity applications

- My Health Locker
- Robust Data
- Report Writing
- Governance Arrangements
- Data Quality
- MHMDS Analysis
Date of Board meeting: 24 June 2014

Name of Report: Chief Executive’s report

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

Author(s): Paul Mitchell, Trust Secretary

Approved by (name of Executive member): Dr Matthew Patrick, Chief Executive

Presented by: Dr Matthew Patrick, Chief Executive

Purpose of the report:
To inform the Board of significant issues arising from 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 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 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 the local health economy and nationally in the NHS and Social Care.

Service Quality Implications:
A number of the national issues listed in the report will have an impact on the quality of services provided by the Trust.
1. National issues

NHS Confederation
Along with the Chair I attended the recent NHS Confederation annual conference.

The balance of patient and political leaders on the main stage gave different perspectives and some of the most powerful insights at the conference. Commissioning was visibly on the agenda through NHS Clinical Commissioners and Simon Stevens' first major speech at conference. Provider issues were well served, with everything from the Dalton review to the future of the Foundation Trust pipeline, and a communal meeting of the chief inspectors.

Equality and diversity were in play with more diverse panels, dedicated sessions on black and minority ethnic issues and women leaders, and a strong focus throughout.

To quote Rob Webster, the new CE of the NHS Confederation – “Last week, the system experienced a real shift in tone – towards hope, and cautious, realistic optimism. This will be essential as we make the case for our burning ambition for health and care and demand the changes needed to get there. At stake is something of which we are immensely proud. Something that defines us as a nation. The NHS.”

Hospitals receive £250m to reduce waiting lists
Hospitals have been given £250m to help NHS providers clear their planned care waiting list backlogs. The DH also said there would in 2014/15 be a £400m fund for “winter pressures”, £250m of which was announced last year by NHS England, aimed at addressing pressure in accident and emergency departments.

Memory loss discovery raises hopes of drug for Alzheimer's
Scientists at Penn State University have reported findings on why people with dementia cannot form new memories. It was previously thought a build-up of plaques in the brain prevented neurons from firing but drugs to clear plaques have so far failed to bring any improvement to sufferers. A team led by Prof Gong Chen have now reported that the plaques may be triggering overproduction of a chemical known as GABA neurotransmitter, which causes memory loss by preventing a key part of the brain from functioning. The discovery has raised hopes that a drug that deactivates the chemical could halt memory loss.

2. Trust issues

Lambeth
Lucy Canning, Cath Gormally and I met with senior social care staff from Lambeth Council on 16th June. We made presentations on SLaM’s Lambeth services, our organisational direction of travel and the social care agenda in SLaM. We, in turn, heard about the Lambeth AMHP service and Hospital Social Work Service. The meeting was very positive, not least because of a strong sense of shared challenge and a shared vision of direction of travel.
Visits
I have continued with my programme of visits to services. This month I included a visit to the Evelina children’s hospital based at St Thomas’ hospital and the SLaM services located on the St Thomas’ site.

3. Congratulations

Nursing Times awards
Director of Nursing at SLaM, Dr Neil Brimblecombe, has been honoured in the prestigious Nursing Times Leaders list. The award recognises Neil’s work on safe staffing and his contribution to mental health strategy.

The list recognises individuals who have demonstrated strength across the five key areas of leadership outlined by the NHS Leadership Academy Healthcare Leadership Model. The five key areas are: leadership, influence, impact, role model and legacy. A list of over 200 people was put before a judging panel, and Neil was one of forty six people who made the final inaugural list.

Dr Matthew Patrick
Chief Executive
June 2014
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

**Date of Board meeting:** 24 June 2014

**Name of Report:** Report from the Council of Governors

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

**Author:** Paul Mitchell, Trust Secretary

**Approved by:** Dr Matthew Patrick, Chief Executive

**Presented by:** Noel Urwin, 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.

**Service Quality Implications:**
The Council of Governors’ bids programme specifically welcomes bids which “improve the patient experience”.
The Council of Governors met on Thursday, 12th June 2014. The following issues were discussed:

1. **Development of the Trust strategy**

   The governors received a presentation from Matthew Patrick, Gus Heafield and Nick Dawe relating to the strategic plan, the economic plan and implementation respectively.

   Governors then had the opportunity to raise questions related to the presentation. This is all part of the ongoing development of the strategic Plan which needs to be submitted to Monitor by 30 June 2014.

2. **Report from the Nominations Committee**

   As previously reported, Kumar Jacob and Harriet Hall have stepped down after serving for a number of years as NEDs. They were both thanked for the huge contribution they have made to running of the organisation at their last Board meeting.

   Steps are now being taken to find a replacement NED.

3. **Report from working groups**

   The refresh of the membership of all the working groups is nearing completion. Revised terms of reference have been agreed by the Quality, Planning and strategy and Membership Development and Communications groups.

   **3.1 Quality group**

   The Quality Group met on Tuesday, 20th May 2014. The final draft of the Quality Account was discussed. A statement was produced following the meeting for inclusion in the Quality Account.

   **3.2 Planning and strategy**

   The Planning and Strategy group met on 15th April and 10th June. This provided an opportunity for an update and discussion on the development of the annual plan and strategic plan.
3.3 Bids

The group met on 5th June.

The current round of the bids scheme is called Smile for Health and launched on 8th April. By mid-June 230 expressions of interest had been received. Bids close on 4th July.

Surgeries have been held in each of the four boroughs with mixed attendance.

3.4 Membership development and communications group

The group met on Wednesday, 14th May 2014. Revised terms of reference were agreed.

Progress reports were received on the members’ discount scheme, implementation of Plain English and the planning for the “Happy Heads” festival in July.

The development of a membership marketing strategy will be considered further at the next meeting.

3.5 Representative on Social Inclusion and Responsibility Board

Stephanie Correia has attended meetings of the Trust’s Social Inclusion and Responsibility Board. Chris Collins has offered to act as a reserve should Stephanie not be available.

4. Lead Governor

The role of the Lead Governor is to act as a point of contact with Monitor should the regulator have concerns regarding the Trust’s performance. The current Lead Governor, Noel Urwin, has indicated that he will not be standing for re-election later in the year.

It was agreed that an election process be established later in the summer to ensure that a new Lead governor is in place prior to Noel’s departure.

5. FT Constitution

The FT Constitution will need to be amended to reflect changes in legislation. Discussions with legal advisers have already commenced. Final changes have to be agreed at the annual members’ meeting in September. In the meantime it would be useful to re-establish the CoG Constitution Review group as a means of ensuring governor input to the review.

It was agreed at the CoG meeting that the Trust Secretary should convene a meeting of the Constitution Review group to work through any outstanding issues.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 24th June 2014

Name of Report: KHP Board Verbal 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:
The Board of Directors is asked to approve 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.

Service Quality Implications:
A key driver of the AHSC is the improvement of the quality of the services offered to local people and beyond. This has recently been tested via the accreditation process. Of specific importance to mental health is the closer integration and parity with physical health care.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

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<th>24th June 2014</th>
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<tr>
<td>Name of Report:</td>
<td>Mental Health Act Management Annual Report 2013-14</td>
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<td>Heading:</td>
<td>Governance</td>
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<tr>
<td>Author:</td>
<td>Kay Burton</td>
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<tr>
<td>Approved by:</td>
<td>Neil Brimblecombe, Executive Director and Patricia Connell-Julien, Non-Executive Director</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Kay Burton</td>
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**Purpose of the report:**
To inform the Trust Board of Mental Health Act developments, activity and areas of concern for the year 2013-14.

**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) and level of assurance provided by the report - none, low, moderate, high:**
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. Provides high assurance to the Trust.

**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.

**Service Quality Implications:**
The report outlines the way the MHA is monitored in the Trust through robust administrative processes and review of MHA issues at site based quarterly MHA Fora and the quarterly Trustwide MHA Committee.
MENTAL HEALTH ACT MANAGEMENT
ANNUAL REPORT
APRIL 2013 TO MARCH 2014

Prepared by: Kay Burton
Assistant Director of Mental Health Legislation
16 June 2014
Introduction
This is the fifteenth 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 2013/14. 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 continued to be reviewed quarterly at the MHA team meetings and revised. A system was implemented to record the data electronically with reports reviewed quarterly at the MHA Team Meetings to monitor performance.

Community Treatment Order pathway
The project to review the pathway for management of patients on Community Treatment Orders continued, and was piloted in a Community Mental Health Team in Lewisham. Further work on this project following completion of the pilot will continue into 2014-15.

The Assistant Director of Mental Health Legislation and the MHA Advisor and 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 2014-15.

The six month pilot to manage uncontested renewal hearings by the Associate Hospital Managers which began in March 2013 concluded in September 2013. This was evaluated and a paper discussed at the January Board of Directors meeting where approval was given for this to continue. The Board agreed the plan to undertake a review of the full implementation of the process, with a report back to the Board in the summer of 2014.

Service Level Agreement – acute trusts
The Service Level Agreement for SLaM to provide MHA Administration to Kings Healthcare NHS Foundation Trust continued and was renewed for a further year.
**Supervised Confinement**

The Supervised Confinement working group continued through the year, focusing on review of the policy and reviewing the environment of the supervised confinement rooms. The revised policy was drafted although not ratified, pending further work on the documentation and estates matters. This work will be carried over into 2014-15. The term *Supervised Confinement* was replaced with *Seclusion* in line with that used in the MHA Code of Practice. Regular reports on the use of Seclusion are presented at the quarterly Trustwide MHA Committee meetings.

**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 Assistant Director of Mental Health Legislation continued to be a member of 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, operational managers from the MHT, MHA Administrator representatives and representatives from the Legal Services Commission. Membership of the group has continued to enable the Assistant Director of Mental Health Legislation 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 link with the Full Time President(s) at the Tribunal Service, Dr. Martin Baggaley and the Assistant Director of Mental Health Legislation continued. This facilitated the follow up and resolution of issues of late reports and the quality of Tribunal accommodation.

**Mental Health Act Administration Training for other providers**

The MHA team continued to organise external courses in MHA Administration throughout the year. These were popular and well attended, with positive evaluation.

**PAN London AHM Training**

This work continues to be progressed by the PAN London MHA Network, which set up a small project group in 2012 to complete the training package. The project had progressed with each participating organisation taking responsibility for designing a specific module. A tester module is to be delivered to a future meeting of the PAN London MHA Network.

**PAN London MHA Data Review and MHMDS**


**New Initiatives**

**The Maze – third edition**

The Maze which was published in April 2010 was further revised, a second edition published in April 2013. An e-book version was also developed and will be available from April 2014.
MHA E-learning package
The e-learning package to train staff in the Mental Health Act which was launched during 2012-13, was developed for marketing to the external market. The package is suitable for both mental health and acute general hospitals.

Service Level Agreement – acute trusts
In March 2014 discussions for the Service Level Agreement for SLaM to provide MHA Administration to Guys and St. Thomas’ NHS Foundation Trust were concluded, to start with effect from May 2014. Discussions were also held during the year with University Hospital Croydon and University Hospital Lewisham to set up similar arrangements. These discussions will continue into 2014-15.

Mental Health Act Roadshows
The MHA Department ran a series of MHA awareness road shows at the four Trust sites. These were well attended and gave an opportunity for staff, service users and carers to meet with the local MHA team and raise queries. Further similar roadshows are planned to be held regularly through 2014-15.

Service Users and Carers Event
A dedicated event was organised and facilitated by Mr. Bob Lepper, MHA Adviser, focussing on service users’ and carers’ awareness of mental health law matters. This was well attended and received positive evaluation.

Electronic Section 17 Leave Form
Work began to develop an electronic section 17 leave form to further reduce the reliance on paper forms. A vital element of this is to ensure that only the Responsible Clinician can grant and authorise leave and methods to achieve this were explored. A pilot is to be carried out on one ward in Lambeth during 2014-15 to inform further development of this.

AHM Competency Framework
A revision of the AHM Competency Framework began which will result in each AHM maintaining their own portfolio, which will be reviewed at the annual review. This will include a training record, record of hearing panels attended and issues that have arisen at hearings; the portfolio should act as an aide memoir when discussing matters with their peers and at their annual reviews.

AHM Structure Review
A consultation began to review the group structure of the AHMs. This included (a) having a central pool of AHMs from which hearing panels are booked and (b) moving away from the four Borough group structure to have one group overseen by the Non-Executive Director with support from deputies who would be experienced AHMs. Consultation period due to end in May 2014 with further discussion thereafter.

Mental Health Tribunal Simulation Project
The MHA team worked collaboratively with the Trust Simulation Team to hold a simulation training day for doctors, care co-ordinators and nursing staff. This involved a Judge, a medical and a lay member from the Tribunal Service who formed the panel. The aim of the course was to train staff in both report writing and presenting at a Tribunal. The session was held in March 2014, and is to be evaluated with a view to deciding if further such training days can be organised.
MHA Float Team
The MHA Department reviewed its staffing established and developed a float team from existing resources. The aim of this was to provide more flexibility in the administration team to provide support across the MHA offices at times of increased need.

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 use of case studies assist 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. Those working with the MHA can now access e-learning as an alternative to their initial training though the update course required every two years needs to be classroom based.

Take up for the half day Community Treatment Order course was disappointingly low despite the clear need for training amongst Trust staff. It is likely that future CTO training will need to be delivered within community team bases.

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) was part of the Corporate Induction programme with the session jointly delivered by the MHA Adviser/Policy Lead and a service user. Corporate induction has been reorganised which means this session will no longer be held but the same service user is now co-training on the one day course where he is able to bring his thoughtful and challenging insights into how the MHA is used in practice.

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 both comprehensive and popular. Identified Sessions continued to be offered on Cultural Diversity, Risk, Forensic Risk, Safeguarding Children, Safeguarding Adults, De-escalation and a MHA update. 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.

The main development has been the introduction of a one day course on Report Writing/Chairing skills. Two courses have already been held which are jointly facilitated by the MHA Policy Lead and AHMs. This is a very positive development as the use of skills and knowledge within the existing pool of AHMs better meets the needs of AHMs (particularly those new to the role) than the use of external facilitators.

External training

One external course for staff working within MHA administration took place. Further courses are planned for 2014/15.

MHA Policy Development

The main development was the finalisation of a s117 policy. We are grateful to the Service Director of Psych Med CAG and the Borough AHMP leads who led on this piece of work.

Associate Hospital Managers

There were no additional AHMs recruited during the year. The number of active AHMs will be reviewed during the 2014-15 with further recruitment if required.

During the year the Hospital Managers received 146 appeal applications (this shows an increase on the previous year), with a further 290 renewal hearings (decrease) and 28 Barring Order reviews (an increase). Of these, 276 (59%) were heard, with 11 (4%) discharged by the Managers; the number discharged is the same as the previous year. The number of renewal hearings occurring within the target of one week either side of the expiry date remains low. The introduction of paper reviews is aimed to improve this.

Of the 464 hearings to be arranged during the year, 142 (30%) were cancelled. This is the same number although a lower percentage of cancellations compared to the previous year when 32% were cancelled in 2012/13, 37% cancelled in 2011/12 and 44% in 2010/11. There were 31 (6%) patients transferred to a bed outside of the Trust before the hearing was held. This was a lower number than the previous year. There were 8 (2%) hearings adjourned, the same number and percentage as the previous year. 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 1076 submitted and a further 142 referrals by the Hospital Managers under Section 68 of the Act. The number of appeals was a reduction on the previous year. Of the 1458 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 1218 hearings to be arranged during the year, 543 (44%) were cancelled – a further decrease on the previous years. There were 90 (7%) of hearings cancelled due to the patient being transferred to a bed outside of the Trust before the hearing was held, this
represents a reduction. There were 41 (3%) cases adjourned for reasons including patient absent without leave. This is a marginal increase on the previous year. Reasons included 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
There were 29 CQC MHA Monitoring visits to the Trust in 2013-14. In addition there was a focussed Admission and Assessment visit in July 2014 which took place over two days and involved a review of inter-agency working between social services, the police, ambulance service, Independent Mental Health Advocacy Services, service users and carers groups. Representatives of all of these groups met with the Commissioners in private during the visit. The findings of the CQC MHA Commissioners are reported quarterly to the Trustwide MHA Committee. The action plan following the Admission and Assessment visit has also been reviewed at the Trustwide MHA Committee. 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 it is not always possible to find evidence that Statutory Consultees have recorded their conversation with the Second Opinion Appointed Doctor (SOAD) – Code of Practice Paragraph 24.54.

Section 132
- A further 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 in previous years.
- 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.

Section 17 leave
The Commissioners reported that section 17 leave forms are not always given to patients or carers – Code of Practice Paragraph 21.21. They further reported that on some wards due to staff shortages patients were not always able to utilise their section 17 leave.

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 – Code of Practice Paragraph 20.12.
Care Planning
As seen in previous years, the MHA 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. This was noted at a number of visits. 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.

Section 117 Aftercare
Concerns were raised at one visit regarding the lack of ‘step down’ facilities for patients on the forensic wards.

Unward Incidents
There were 76 incidents during the year resulting from breaches of the Mental Health Act. This is a decrease from the previous two years when 94 and 90 were recorded respectively. 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 2013/14 presents a very small percentage (1.9%) 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 - 35; (b) Other MHA Trust error – 18 and (c) non-rectifiable paperwork errors – 10 cases. Figure 1 displays the categories for the year. The number of errors reported relating to medication administered not covered by Section 58 remained the same as the previous year. This would appear to support the improved practice following recommendations being made following audits of the use of Section 58 and increased vigilance by staff working in clinical areas.
Clinical Governance
During the year a Trustwide audit of Section 58 Consent to Treatment and a Mental Capacity Act documentation audit were carried out. The findings from both were presented to the Quality Governance Committee and the Trustwide MHA Committee.

A further audit was carried, prior to the development of the Trust’s Street Triage project, to explore the differences in the characteristics of patients assessed under section 136 and what part these may play in them being further detained or discharged. The recommendations will form the action plan for improvements to be followed up through the site MHA Fora during 2014/15.

A junior doctor, supported by an Associate Clinical Director, audited the quality of medical reports prepared for Associate Hospital Managers and Mental Health Tribunal hearings, the findings of which were presented to the Trustwide MHA Committee. Following this work continued to develop a template and checklist to assist medical staff in preparing high quality reports for hearings.

It is planned to audit the knowledge staff have of the Mental Capacity Act during the coming year and to audit the timeliness of patient assessments in the Places of Safety

Use of the Act
During the year 2013-14 the Trust had 5561 admissions of which 2224 were formal (40%). This represents and increase on 2012-13 when the percentage was 27.45%.

The Trust has used the Act on 3847 occasions in 2013-14 (Table 1). This was a reduction of 1.5% on 2012/13 when it was used 3909 times. The highest use of the MHA was seen in the Psychosis CAG (63%) followed by Psych Med (26%). Section 2 continues to be the most used section, in line with the trend since the 2007 MHA Amendments and in line with a National trend. Section 2 uses accounted for 78% of the total use, with section 3 accounting for 15%. This represents a percentage increase in the use of section 2 against overall section use. There was an increase in the use of sections 135, 136, 2, 37, 37/41 and 38. A reduction in the use of all other sections was seen. 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 1: Use of Section by Directorate – 2013-14

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<tr>
<th>Section by Directorate</th>
<th>Psychosis</th>
<th>B&amp;D</th>
<th>Psych Med</th>
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Figure 2 shows the percentage of MHA use across the Trust by CAG.

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**Figure 2: Chart to show percentage Section use by CAG - 2013/14**

![Figure 2: Chart to show percentage Section use by CAG - 2013/14](image)
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 three years when 1361, 1287 and 1242 were admitted direct respectively.

![Figure 3: Chart to show comparison of total admissions against admissions under the MHA - 2013/14](image)

Table 2: Admission Direct to Hospital under MHA – 2013-14

<table>
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<th>Section by Directorate</th>
<th>Psychosis</th>
<th>B&amp;D</th>
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<tr>
<td>TOTALS</td>
<td>630</td>
<td>40</td>
<td>648</td>
<td>1</td>
<td>44</td>
<td>82</td>
<td>1445</td>
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| TOTAL ALL ADMISSIONS   | 1435      | 74  | 2248      | 65  | 309   | 279  | 4410  |

| Percentage of MHA admissions | 44% | 54% | 29% | 1.5% | 14% | 29% | 33% |

Figure 3 shows a comparison between the total admissions for the year 2013/14 and of those, the number admitted direct to hospital under a Section of the Mental Health Act 1983. 33% of admissions were under the MHA 1983. This represents an increase on the previous year.
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 2013/14 can be seen in Figure 5. There was a small reduction in use during the year.
**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 1874 (45%) with those in the White group the second largest group at 1615 (39%). This represents a 1% reduction in those detained in the Black or Black British category compared to the previous year, and the same percentage in the White group as the previous year. In the Asian group there were 183 (4%) same as previous year, Mixed Background 137 (3%) same as the previous year and Other Ethnic Group 238 (6%), a slight increase on the previous year. Of the total 82 (2%) were shown as ‘Not stated’, this represents the same as last year.

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.
**Table 3 : Ethnicity of Detained Patients using Broad Ethnic Categories – 2013-14**

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<td>290</td>
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<td>7</td>
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<td>0</td>
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<td>183</td>
</tr>
<tr>
<td>Black or Black British</td>
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<td>523</td>
<td>8</td>
<td>178</td>
<td>7</td>
<td>11</td>
<td>28</td>
<td>4</td>
<td>10</td>
<td>128</td>
<td>14</td>
<td>240</td>
<td>0</td>
<td>0</td>
<td>1874</td>
</tr>
<tr>
<td>Mixed Background</td>
<td>49</td>
<td>31</td>
<td>0</td>
<td>19</td>
<td>3</td>
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<td>0</td>
<td>20</td>
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<td>0</td>
<td>137</td>
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<td>4</td>
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<td>4</td>
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<td>0</td>
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<td>82</td>
</tr>
<tr>
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<td>960</td>
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<td>391</td>
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<td>27</td>
<td>816</td>
<td>1</td>
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</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).

**Proposed MHA Developments for 2014/15**

- Produce a guide to the Mental Capacity Act in the same format as The Maze.
- Produce a smaller version of the Maze to be called the Mini-Maze.
- 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 a simulation training model for MHA training for staff and Associate Hospital Managers.
- Finalise the Seclusion Policy.
- Evaluate further 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 and clinical teams to develop the electronic section 17 leave form and develop an electronic form for section 132 rights.
• Develop a Mental Capacity Act forum in light of caselaw – Cheshire West – to ensure that the Trust meets the changed legal requirements.
• Informed by the findings of the consultation, implement the revised group structure for Associate Hospital Managers.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 24 June 2014
Name of Report: Key Points from and Terms of Reference of the Quality Sub Committee
Heading: Governance
Authors: Neil Brimblecombe
Approved by: Neil Brimblecombe
Presented by: Neil Brimblecombe

Purpose of the report:
To present a brief summary of the key points discussed at the preparatory meeting of the Quality Sub Committee of the Board held on 11 June 2014.
To present the Terms of Reference of the Quality Sub Committee, that have been updated in response to these key points (updates highlighted in blue text).

Action required:
The Board of Directors is asked to note this report and decide whether any further action or briefing is required.

Recommendations to the Board:
Approve the updated Terms of Reference of the Quality Sub Committee at Attachment 1.

Trust-wide risk(s) affected by this report and the level of assurance provided (none, low, moderate, high):
The Quality Sub Committee provides assurance to the Board that the principal risks to service quality, recorded within the Assurance Framework and Corporate Risk Log, are being correctly identified, judged and classified and, most importantly, are being actively managed and mitigated by named staff.

Service Quality Implications:
The primary objective of the Quality Sub Committee is to ensure that there are processes in place to monitor service quality effectively.

Summary of Financial and Legal Implications:
The Audit Committee carries out an annual review of the Annual Governance Statement; the work of the Quality Sub Committee informs this review.

Equality & Diversity and Public & Patient Involvement Implications:
Equality & Diversity and Public & Patient Involvement are reviewed by the Quality Sub Committee.
Key points from the meeting of the Quality Sub Committee  
held on 11 June 2014

Introduction
Attendees were welcomed to this first, preparatory, meeting of the Quality Sub Committee (QSC). The purpose of this meeting was to confirm the Terms of Reference, quality indicators and forward planner that will form the basis of the committee's agendas over the coming year and provided an opportunity to shape the future of the committee and set the scene to ensure its success.

Purpose of the Committee
There needs to be a central forum where senior clinicians can engage with Board members on issues of clinical quality. The Trust's governance structure has been streamlined to reduce the number of committees that senior managers are expected to attend and the aim of the QSC is to provide a single robust line of communication between CAGs and the Board. Meetings of the QSC will be held monthly, with timely escalation of any quality issues to the Board. The QSC incorporates the functions of several former committees; meetings need to be run on an exception basis, comprising less process and more meaningful discussions.

CAG Engagement
The Terms of Reference (ToR) of the QSC were reviewed to ensure that there is a clear link between CAGs and the Board of Directors: there needs to be robust oversight of quality issues within each CAG that is reflected in the QSC and vice versa. Each CAG will be asked to provide a highlight report comprising any successes, lessons learned, risks or issues that have been identified in the last month. Quality issues identified by Performance Management will also be brought to the attention of the QSC. CAG quality meetings may have similar aims but different processes; it was agreed that their ToR should be reviewed and aligned to those of the QSC. The chart of relationships to other meetings was reviewed in detail and updated as required. It was agreed that, as a minimum, all subsidiary committees will provide quarterly exception reports and an Annual Report.

Membership
The members of the QSC were reviewed in detail and it was proposed that a pool of service users should be identified and one asked to attend each meeting; they will need to be suitably supported by the PPI Strategy Lead. The option of inviting a specific nurse representative and a representative from SLaM Partners will also be considered and representation negotiated from the Board of Governors via the Chair of the Trust.
It was noted that QSC membership comprises a core group that will attend every meeting, supplemented by specialists that will attend one of the three themed meetings of the QSC (Safe Services / Caring & Responsive Services / Effective Services).

Quality Indicator Dashboard
Monitor expects a single dashboard of quality indicators covering all levels of the Trust, from Board to wards and teams. A definitive list of quality indicators has been proposed, incorporating the quality priorities set out in the Quality Account for 2014/15, QUeSTT, safe staffing, patient safety, patient experience, clinical outcomes and mandatory training indicators. These indicators will be presented to the QSC every month, where they will be refined before a subset is presented to the Board later in the month. In the past it has been difficult for the Business Intelligence team to prioritise this work due to the pressure of other commitments. Once the content of the QI Dashboard is agreed, additional resources will need to be found to implement this solution.

Policy Ratification
Policy ratification is a key function of the QSC; it was agreed that a summary report should be provided for each policy, including the key changes and its consultation process: the people involved in its development and the forums where it has been discussed and agreed.
A prioritised list of clinical policies in need of urgent review was agreed by the committee; there is the potential for a 3 month lag if policies are ratified by the most appropriately themed QSC meeting and so it was agreed that they will be ratified at the next QSC, regardless of theme.

1 Non-clinical policies will be ratified by the Executive Operations Committee
Quality Sub-Committee  
of the Trust Board of Directors  

Terms of Reference  
June 2014

Overall Purpose: The main role of the committee is to provide assurance to the Board of Directors on the delivery of the Trust’s Quality Strategy. It will have a role in examining where there have been failures in service or clinical quality and monitor progress against action plans to address them.

Key objectives:  
- Develop the Trust’s strategy for service and clinical quality.  
- Monitor progress against the Trust’s strategic quality goals, the quality priorities as published in the annual Quality Account and other quality targets, such as CQUINs.  
- Monitor service performance against the Care Quality Commission’s essential standards of quality.  
- Examine where there have been failures in service quality and monitor progress against action plans to address them.  
- Identify risks related to service and clinical quality and provide assurance to the Board that the principal risks threatening quality are being managed appropriately at all levels within the Trust.  
- Seek assurance that major service transformation and significant QIPP and CIP programmes will not have a detrimental impact on service quality as patients experience it.  
- Ensure that Quality Improvement support resources are targeted where they are most needed.  
- Ensure that there are processes in place to monitor quality effectively.  
- Receive and consider national policy and strategy as it impacts on safety, effectiveness and patient experience within the Trust.  
- Receive & monitor Social Care data relating to quality.  
- Receive reports from 3rd parties, such as Healthwatch, and address & monitor any issues raised.  
- Approve Trust policies relating to all aspects of quality.  
- Ensure that senior clinical staff, including senior nurses, play a key role in quality strategy development and monitoring.  
- Promote an organisational culture that enables high quality and compassionate care, using the Trust’s five commitments and four Francis elements to guide behaviour and decision making.  
- Consider any issues escalated by the committees accountable to the Quality Sub-Committee.

Chair: Non-Executive Director
**Members:**
- Non-Executive Director (in addition to the Chair)
- Director of Nursing – Executive lead
- Medical Director
- Director of Social Care
- Chief Operating Officer
- Associate Medical Director
- Clinical Directors x 7
- Heads of Profession x 2 (OT and Psychology)
- Associate Director Quality & Assurance
- Head of Performance Management
- Clinical Audit & Effectiveness Manager

For every **Safe Services** meeting:
- Director of Pharmacy & Pathology
- Head of Patient Safety

For every **Caring & Responsive Services** meeting:
- PPI Strategy Lead
- Head of Complaints & PALS

For every **Effective Services** meeting:
- Director of Research & Development
- Assistant Director of Nursing (physical & public health)

All members are expected to attend every meeting or nominate a delegated representative.

Other Trust directors, managers and clinicians will be required to attend to address specific issues as they arise.

The Chief Executive, Chief Financial Officer, Director of Organisation & Community and HR Director will be expected to attend at least one meeting per year.

**Responsible to:**
Trust Board of Directors

As a minimum, a report of the principal topics discussed at each Quality Committee will be presented to the Board of Directors annually.

A summary of each themed review will be presented to the Board of Directors the following month.

**Accountable for:**
Refer to Chart of Relationships to Other Meetings and also to Appendix A.

As a minimum, these committees are required to escalate any concerns relating to quality to the Quality Sub Committee and provide an Annual Report; they are also required to present areas of specific interest or concern at the request of the Committee.

**Frequency of Meetings:**
The Committee will meet monthly (**ten times per year**).

**Quorum:**
The meeting will be quorate when there are a total of **two** Board Directors present, including one Non-Executive Director.

**Record Keeping:**
The minutes and papers of meetings will be kept and archived by the Committee Secretary.
Terms of reference review: The Chair and Responsible Executive will review the effectiveness of the committee after each meeting.

The Terms of Reference will be reviewed annually; (next review date: June 2015).

Chart of relationships to other meetings:

```
Board of Directors

Quality Committee (Safe Services)
- PMVA (Prevention & Management of Violence & Aggression)
- Drugs & Therapeutics
- Medicines Safety
- Medical Devices
- Safeguarding Adults
- Safeguarding Children
- Health, Safety & Fire
- Infection Control
- ECT
- KHP Clinical Biological Safety
- Education & Training

Quality Committee (Caring Services)
- EPIC (Engaging Patients Involving Carers)
- Patient Information
- TPAC (Psychology & Psychotherapy Advisory Committee)
- Education & Training

Quality Committee (Effective Services)
- Physical Health
- Education & Training
```
Appendix A: Topics and themes

For every meeting:
- Quality Priorities (Quality Indicator dashboard)
- Regulatory compliance issues, including CQC
- Trust-wide operational risk review (Corporate Risk Log)
- Strategic risk review (Assurance Framework)
- Policy ratification

For every Safe Services meeting:
- Violence & Aggression
- Serious Incidents

Annual themed review at one quarterly Safe Services meeting:
- Safeguarding Adults / Children
- Self-Harm / Suicide
- Medicines Management

For every Caring & Responsive Services meeting:
- Patient Experience (including PALS, access to services and carer feedback)
- Complaints

Annual themed review at one quarterly Caring & Responsive Services meeting:
- Care Environment (PLACE)
- Francis Action Plan
- Safe Staffing Review (six-monthly)

For every Effective Services meeting:
- CQUINS
- Integrated Care Pathways
- Clinical Audit
- NICE Guidelines
- Education & Training
- Research & Development (From Bench to Bedside Report)

Annual themed review at one quarterly Effective Services meeting:
- AMH Transformation
- Forensic Transformation
- Physical Health / Nutrition
- Mental Health Legislation

At the end of each agenda item, the following questions should be asked:
- Is the committee assured that this item is being dealt with appropriately?
- Is there anything more that needs to come to a future meeting?
- Is there anything that needs to be brought to the attention of the Board of Directors?

The committee will agree a Forward Plan that will schedule agenda items over the year and will include the publication of key documents and annual reports on key areas of governance.

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2 As they relate to Safe, Caring & Responsive or Effective services
Trust leads will be asked to provide a highlight report on the areas covered by each Quality Committee meeting, comprising lessons learned, successes and issues, with the potential to present an agenda item if deemed appropriate.
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<td>Lucy Canning/Fran Bristow/ Matthew</td>
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