A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND
MAUDSLEY NHS FOUNDATION TRUST
WILL BE HELD ON TUESDAY 24TH NOVEMBER 2015 AT 3:00PM
BUDDY 2&3, LEARNING CENTRE, MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence: Lesley Calladine

2 Declarations of Interest

3 Minutes of the Board Meeting held on 27th October 2015

3.00pm Page 3 Attached

3.05pm Page 10 App A

3.10pm Page 14 App B

3.20pm Page 18 App C

4 MATTERS ARISING/ACTION POINTS REVIEW

QUALITY
5 Discuss – Eliminating Mixed Sex Accommodation

3.10pm Page 14 App B

6 Information – SLaM QI Programme

PERFORMANCE AND ACTIVITY
7 Approve - Finance Report – Month 7

Report to follow 3.25pm App D

8 Approve - Performance Report – November

3.55pm Page 24 App E

STRATEGY
9 Discuss - Centre for Translational Informatics (CTI)

4.05pm Page 57 App F

10 Information – BRC Renewal

4.15pm Verbal

11 Discuss – Arts Strategy

4.20pm Page 73 App G

GOVERNANCE
12 Discuss – Deloitte report and action plan

Report to follow 4.40pm App I

13 Discuss – Risk Action Planning

4.45pm App J

14 Discuss – Draft Risk Management and Assurance Policy

15 Information - Report from the Chief Executive

4.50pm Page 96 App K

16 Information - Update from the Council of Governors

4.55pm Page 99 App L

17 Information - Briefing from the Quality Sub Committee Meeting

5.00pm Page 104 App M

18 Information – Minutes from the BDIC Committee Meeting

5.05pm Page 106 App N

19 Information - Mental Health Act Annual Report

5.10pm Page 113 App O

INFORMATION
20 Director’s Reports

5.15pm Verbal

21 Actions summary from today’s meeting

Verbal

22 Reflections on today’s meeting

Verbal

23 Forward Planner and Draft Agenda for December Board Meeting

Page 126 App P

24 Report from previous Month’s Part II

Page 132 App Q

25 Any other business

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.
Date of Next Meeting: Tuesday 15th December 2015 – 3:00pm, Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ. Please send apologies to Alison Baker 0203 228 4763 alison.baker@slam.nhs.uk

Please note that minutes from this meeting are a public document and will be published on the Internet and may be requested under the Freedom of Information Act (2000). Any attendee that would like their name omitted from the minutes should discuss this with the minute taker. Note that it may not always be possible to oblige as this is dependent on the persons role and the business being discussed.
MINUTES OF THE NINETIETH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 27TH OCTOBER 2015

PRESENT
Roger Paffard Chair
Dr Martin Baggaley Medical Director
Dr Neil Brimblecombe Director of Nursing
Lesley Calladine Non Executive Director
Robert Coomber SID and Deputy Chair
Kristin Dominy Chief Operating Officer
Alan Downey Non Executive Director
Gus Heafield Chief Financial Officer
Dr Julie Hollyman Non Executive Director
Prof Shitij Kapur Non Executive Director
June Mulroy Non Executive Director
Dr Matthew Patrick Chief Executive

IN ATTENDANCE
Mark Allen Director of Estates (item 10 onwards)
Alison Baker PA to Chair & Non Executive Directors
Dr Alison Beck Head of Psychology and Psychotherapy services
Emily Buttrum Commercial Director
Lucy Canning Service Director, Psychosis CAG
Sarah Crack Head of Communications
Steve Davidson Service Director, Psych Med and MAP CAGs
Stephen Docherty Chief Information Officer
Jo Fletcher Service Director, CAMHS CAG
Mark Ganderton Council of Governors
Louise Hall Director of Human Resources
Kay Harwood Head of Planning, Involvement and Equality
Prof Sir Robert Lechler Executive Director, King’s Health Partners
Paul Mitchell Trust Board Secretary
John Muldoon Lead Governor
David Norman Service Director, Mental Health Older Adults CAG
Zoë Reed Director of Organisation and Community
Stephen Thomas Secretary, Audit Committee
Dr Koravangattu Valsraj Consultant Psychiatrist - Croydon
Louisa Woodley Council of Governors

APOLOGIES
Ellie Bateman Service Director, Addictions and B&D CAGs
Angela Flood Council of Governors

DECLARATIONS OF INTEREST
Routine declarations were made:

• Dr Martin Baggaley declared that he occasionally provided consultancy support via Deloitte and occasional chairs meetings for Johnston and Johnston.
Prof Shitij Kapur declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. Prof Kapur advised and consulted with pharmaceutical companies periodically.

Dr Matthew Patrick declared that he was London Mental Health Clinical Director for NHS England London Region and Chair of the London Mental Health Strategic Clinical Network, and Non Executive Director/Clinical Advisor to BigWhiteWall International Board.

**MINUTES**
The minutes of the meeting held on the 15th September 2015, were agreed as an accurate record of the meeting, with the following clarification: **BOD 136/15 Strategy Priority Report no 3.** Last paragraph second line, should read “as when the CQC visit to look at the MHA.”

**BOD 155/15 MATTERS ARISING/ACTION POINTS REVIEW**
The Board of Directors noted the Matters Arising/Action Points Review. It was agreed to review the November agenda. **Action: Roger Paffard/Paul Mitchell.**

**BOD 156/15 KHP UPDATE**
Prof Sir Robert Lechler opened his presentation by explaining that it had been a year since he had last spoken to the Board of Directors. Many exciting developments had taken place with more planned. Added value to the partnership came from the cross cutting programmes.

Prof Lechler updated on research developments, where KCL was now ranked eighth in the world in university rankings. The IoPPN in particular was world leading having overtaken Harvard in the citation index. However the impact of the research needed to improve. In addition, the student satisfaction scores were poor in medicine and nursing.

There had been three sets of agreements agreed over the last 12 months and the KHP Board was now near to signing the agreed Memorandum of Understanding for developing a series of pioneering clinical academic institutes. The contribution from SLaM had been immense. The driving ambition would be international excellence.

Another key challenge ahead was the further integration of mental and physical healthcare so it became ‘business as usual’ for the acute Trusts.

Launching a major fundraising campaign for mental health was a key priority for the next phase of fundraising now that there was a clear vision around the provision of mental health for young people.

The Board of Directors thanked Prof Sir Robert Lechler for his presentation.

**The Board of Directors noted the update.**

**BOD 157/15 PATHOLOGY SERVICE**
Emily Buttrum explained that the Commercial team had led a full OJEU tender process and engaged with key staff to procure a single provider of pathology services. At the September board meeting it had been agreed that Viapath LLP should be awarded the contract, which would delivery cost improvement savings of...
£3.138 million over 7 years associated with significant quality and safety improvements in service delivery.

The mobilisation was underway to go live as from the 1st February 2016. A review of the pathology management arrangements had taken place and a pathology manager would be recruited to oversee the relationship. There would be regular reporting on the KPIs of the contract and the SLaM senior management team would be able to have an oversight of the performance of the contract going forward.

The Board of Directors noted the award of the contract.

**BOD 158/15 RAISING CONCERNS & FREEDOM TO SPEAK UP**
Alison Beck introduced the report and explained that the proposals dovetailed with other quality initiatives. The Quality Sub Committee had recommended that there should be a one year pilot programme.

The Board of Directors supported the one year pilot but asked for greater clarity regarding resource implications and managerial responsibility for the speak up guardian to be brought back to the November Board meeting. **Action: Alison Beck/Martin Baggaley.**

**BOD 159/15 INFECTION CONTROL PROGRAMME 2015/16**
Martin Baggaley introduced the report of the annual programme that had been undertaken this year. Regular progress reports were being made to the Quality Sub Committee.

The Board of Directors ratified the Infection Control programme.

**BOD 160/15 NURSING STRATEGY 2015/19**
Neil Brimblecombe explained that this strategy defined the priorities for nursing in the Trust highlighting specific actions and identified outcomes for nursing within the organisation for the next four years. It outlined how nursing could help the Trust achieve its long term strategy, by ensuring that nursing across the Trust was provided at consistently excellent standards and had the right number of nurses with the right skills to meet service user’s needs. Nursing was also essential to the Trust in meeting its long term strategic aims and to service users in contributing to the provision of excellent care in virtually all areas of clinical practice. The strategy was designed to support and complement the delivery of the Trust Strategy and the Quality Strategy. Clinical academic pathways for nurses would be developed. The nursing executive would lead on the production of detailed yearly action plans and would review the strategy annually. Nursing councils would monitor and support the actions within each CAG, updates and escalations would be provided to the Trust Executive. An annual report would be presented to the Board on all activities surrounding the strategy and achievements. **Action: Neil Brimblecombe.**

Julie Hollyman commented that while she welcomed the strategy, she did not believe the Trust could hold nurses accountable for a 10% reduction in mortality for
people with severe mental health problems. Neil Brimblecombe replied that he would consider those comments.

Matthew Patrick also endorsed the need for the Strategy. He asked that a reduction in safer staffing breaches was built into the strategy. He thanked the heads of nursing for the high standards of leadership displayed during the CQC visit.

The Board of Directors approved the report.

**BOD 161/15 FINANCE REPORT – MONTH 6**
Gus Heafield reported that there had been deterioration in the financial position since Q1 which was driven by activity and management of the adult acute pathway. Ward nursing costs also continued to be above safer staffing establishments, there was also an increase in complex placements activity and shortfalls against planned CIPs.

The Trust was developing a recovery plan which would be presented to the November Board. **Action: Gus Heafield.** This would dovetail with the Trusts Annual Plan for 2016/17 where the main objective would be to achieve a recurring balanced position from 1st April 2016. It was noted that a long and detailed discussion had taken part in the private (Part 2) meeting beforehand.

Monitor had been informed of the Trusts financial performance, the underlying cost drivers and the actions being taken to stabilise and improve the underlying position. The details of the Recovery Plan would also be shared with Monitor and would form the basis for the finalisation of the Q2 Monitor submissions and certificates.

Matthew Patrick reported that bed pressures were a problem for mental health Trusts across the country. CAG leaders and service directors had been working strenuously to manage the situation. Martin Baggaley explained they had approached the bed system problem in number of ways. In the short term they were planning to re-open the beds that had been closed temporarily because of staffing difficulties and decants, it was anticipated with support from Estates these beds will be open in December. They were also planning to expand the PICU capacity. The longer term strategic projects were underway via the respective programme boards.

**The Board of Directors noted the report and agreed that 30 minutes would be set aside at the November meeting to allow for a full discussion.**

**BOD 162/15 PERFORMANCE REPORT - OCTOBER**
Kristin Dominy explained that the presentation and contents of this report differed from previous reports, the Performance Team would continue to develop its approach and the report would continue to evolve. Further work had been implemented in Lewisham regarding Home Treatment Team performance to
address the under-performance, with additional measures being implemented to monitor and manage recording.

Patient Stories – Zoe Reed explained that the PALS service was being revamped. They received 4,000 contacts each year, the majority were information requests. More serious calls were referred to the relevant clinical teams. Zoe Reed presented three vignettes illustrating where a PALS intervention had been instrumental in resolving an issue. The Board of Directors recorded their appreciation for the services efforts.

The Board of Directors approved the report.

**BOD 163/15 REVALIDATION ANNUAL REPORT & SATETEMENT OF COMPLIANCE**
Dr Koravangattu Valsraj explained that the report highlighted outcomes of the 2015/15 appraisal and revalidation cycle. An action plan had been made to strengthen the current processes and fully comply with the regulations over the next year. Julie Hollyman explained she had been briefed regarding the detail of work and the action plan and would encourage the Board to approve. It would be brought back to the Board again next year. **Action: Dr Valsraj.**

The Board of Directors approved the statement of compliance confirming that SLaM as a designated body was in compliance with the regulations.

**BOD 164/15 RISK ACTION PLAN**
Gus Heafield introduced the risk management action plan and described the integration with the Deloitte action plan and the internal auditors’ recommendations to improve risk management governance.

Gus Heafield reported that it had been agreed to align the risks around key work streams and identify leads for each area. It was agreed to cover this in in more detail at the deep dive arranged for the 10th December. **Action Gus Heafield.**

The Board of Directors approved the action plan, with further work taking place at the deep dive.

**BOD 165/15 REPORT FROM THE CHIEF EXECUTIVE**
Matthew Patrick explained that initial feedback had been provided by the CQC, however all the comments were provisional and were liable to change as the CQC would be further reviewing their data and inspection reports. When available, information would be shared with our stakeholders and partners.

The final Deloitte report had been received, it commended the Trust for the progress made over the past year. It also identified a number of areas for improvement with a number of high and medium recommendations that would be brought to the next Board meeting, along with a detailed action plan. **Action: Paul Mitchell.**

Matthew Patrick reported that it was last Board meeting that would be attended by Steve Davidson, Service Director, Psych Med and MAP CAGs. He thanked him on behalf of the Board for the enormous contribution he had made as Service Director over the last 15 years and wished him all the best for the future.
The Board of Directors noted the report.

**BOD 166/15 UPDATE – COUNCIL OF GOVERNORS**

John Muldoon confirmed that this would be his last meeting as Lead Governor and that Chris Anderson would be taking over the role from 1 November 2015.

The process for the appraisal of the Chair had been agreed and was underway with the assistance of an external consultant.

John Muldoon reported that a positive Governors’ Awayday had been held the previous week. Suggested areas for improvement included provision of information to Governors, more resources to support training and development Governors the arrangement of site visits with Non Executive Directors.

Roger Paffard thanked John Muldoon for his support in the role of Lead Governor.

The Board of Directors noted the report.

**BOD 167/15 BRIEFING FROM THE QUALITY COMMITTEE SEPTEMBER MEETING**

Neil Brimblecombe explained that this was a summary of key points discussed at the meeting held on 22 September. At the October meeting Michael Holland had presented trends on suicides, action plans would be brought together and presented to the Board. Neil Brimblecombe explained that a Safer Staffing update would be brought back to the Board in December. **Action: Neil Brimblecombe.**

The Board of Directors noted the report.

**BOD 168/15 MINUTES FROM THE AUDIT COMMITTEE MEETING**

June Mulroy explained that the report contained key issues and draft minutes from the September meeting, along with details of documents signed and sealed on behalf of the Trust. The Quality Committee had given a presentation at the meeting.

The Board of Directors noted the reports.

**BOD 169/15 DIRECTOR’S REPORTS**

No Directors reports were received.

**BOD 170/15 ACTIONS SUMMARY FROM THE MEETING**

Paul Mitchell would circulate the actions from the meeting.

The Board of Directors noted the actions agreed.

**BOD 171/15 REFLECTIONS ON THE MEETING**

Comments included:

- More time to discuss issues
- Preferable having Part II first
- Meeting quite dry
- One report could have been worked on better before coming to the Board
The Board of Directors noted the comments made.

**BOD 172/15 FORWARD PLANNERS**
The Forward planner was noted.

**BOD 173/15 REPORT FROM PREVIOUS MONTH’S PART II**
The report from the previous month’s Part II was noted.

**BOD 174/15 ANY OTHER BUSINESS**
No other business was discussed.

The date of the next meeting will be: **Tuesday 24\textsuperscript{th} November 2015 – 3:00pm Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ**

Chair
<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue</th>
<th>Action</th>
<th>By</th>
<th>When</th>
<th>Status</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>March meeting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Experiment on format of Board meetings.</td>
<td>Review after Board development programme.</td>
<td>RP/PM</td>
<td>Dec</td>
<td>On schedule</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>April meeting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Social care strategy.</td>
<td>Ongoing programme of work. Take forward associated work programme plus specifically consulting with partners relating to parity of esteem for mental health.</td>
<td>CG</td>
<td>Nov</td>
<td>On agenda</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>May meeting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Workforce equality standard.</td>
<td>Publish strategy and action plan to be monitored via QC and add to dashboards.</td>
<td>LH</td>
<td>Dec</td>
<td>On schedule</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>June meeting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>BRC renewal.</td>
<td>Place on forward planner.</td>
<td>PM</td>
<td>Nov</td>
<td>Update rescheduled to</td>
<td></td>
</tr>
<tr>
<td>July meeting</td>
<td></td>
<td></td>
<td>November</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Quality Improvement.</td>
<td>Update at Nov meeting.</td>
<td>NB Nov On agenda</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Show examples from other Trusts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme managers to be responsible for risk identification.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review timetable to ensure stakeholder engagement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior governance structure required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Include as item for CoG agenda.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| September meeting | | | |
| --- | --- | --- | |
| 6 | Communications strategy. | Develop costs for future years. | SC Mar 16 On schedule |
| | | | |
| 7 | PPI strategy. | Bring back with implementation plans. | ZR Jan 16 On schedule |
| | Strengthen strategy relating to individual patient involvement in their own care. | ZR Jan 16 On schedule |
| | Review PPI input into the planning cycle. | ZR Jan 16 On schedule |
| | Review EPIC terms of reference. | ZR Jan 16 On schedule |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>Task Description</th>
<th>Action</th>
<th>Responsible</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Financial position.</td>
<td>Communicate position to the organisation and thank staff for progress made.</td>
<td>GH</td>
<td>Oct</td>
<td>CFO and Head of Comms implementing a strategy for communicating the financial position throughout the organisation.</td>
</tr>
<tr>
<td>9</td>
<td>Board committees’ terms of reference.</td>
<td>Review annual timetable.</td>
<td>PM</td>
<td>Dec</td>
<td>On schedule</td>
</tr>
<tr>
<td>10</td>
<td>Scheme of delegation.</td>
<td>Audit committee to take oversight and bring back implementation plan.</td>
<td>GH</td>
<td>Jan 16</td>
<td>On schedule</td>
</tr>
<tr>
<td></td>
<td><strong>October meeting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Speak up guardian.</td>
<td>SMT to recommend managerial location of the role for next meeting.</td>
<td>NB</td>
<td>Nov</td>
<td>On agenda</td>
</tr>
<tr>
<td>12</td>
<td>Finance report.</td>
<td>Schedule 30 mins discussion at Nov meeting.</td>
<td>PM</td>
<td>Nov</td>
<td>Scheduled</td>
</tr>
<tr>
<td>13</td>
<td>Risk management.</td>
<td>Deep dive on 10 December.</td>
<td>GH</td>
<td>Dec</td>
<td>On schedule</td>
</tr>
<tr>
<td>14</td>
<td>Deloitte review.</td>
<td>Bring to next meeting plus action plan.</td>
<td>PM</td>
<td>Nov</td>
<td>On agenda</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Share with Executive.</td>
<td>MP</td>
<td>Oct</td>
<td>Done</td>
</tr>
</tbody>
</table>

Page 3 of 4
<table>
<thead>
<tr>
<th></th>
<th>Send to Monitor.</th>
<th>MP</th>
<th>Oct</th>
<th>Done</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Brief Council of Governors.</td>
<td>MP</td>
<td>Nov</td>
<td>Summary report to be sent</td>
</tr>
<tr>
<td>15</td>
<td>Mental health commissioning arrangements.</td>
<td>Arrange deep dive in 2016.</td>
<td>RP/PM</td>
<td>Jan 16</td>
</tr>
<tr>
<td>16</td>
<td>Finance committee.</td>
<td>Establish by Jan 16.</td>
<td>RP/PM</td>
<td>Jan 16</td>
</tr>
<tr>
<td>17</td>
<td>November agenda.</td>
<td>Review items.</td>
<td>RP/PM</td>
<td>Nov</td>
</tr>
</tbody>
</table>

**Code:**

- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule

PNJM/October 2015
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 24th November 2015

Name of Report: Eliminating Mixed Sex Accommodation

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

Author: Caroline Sweeney – Nurse Consultant

Approved by: Dr Neil Brimblecombe

Presented by: Dr Neil Brimblecombe

Purpose of the report:
To inform the Trust Board of Directors of: A summary of organisational performance relating to compliance with elimination of mixed sex accommodation, the requirements for declaring compliance with the policy and to report breaches. This report reviews reportable issues related to mixed sex accommodation from 01.10.14 – 01.10.15.

Action required:
To note the report.

Recommendations to the Board:
For discussion and approval

Relationship with the Assurance Framework (Risks, Controls and Assurance):
Eliminating Mixed Sex Accommodation Declaration - Dept of Health 2011

Summary of Financial and Legal Implications:
None

Equality & Diversity and Public & Patient Involvement Implications:
None

Service Quality Implications:
This report forms part of the Assurance framework for Quality
1. Introduction

Same sex accommodation: ‘Your Privacy, Our Responsibility’ was an initiative launched by the Department of Health in January 2009 to provide clearer guidance and support for hospitals. Its aim was to all but eliminate the use of mixed sex accommodation in hospitals, for all patients, at every stage in their journey through care except where it is in the overall best interests of the patient or reflects the patient’s choice.

The Department of Health requires all providers of NHS funded care to confirm whether they are compliant and to commit to audit data quality and publish these results. Thus as part of the Trust Quality Assurance Framework, South London & Maudsley NHS Foundation Trust requires reporting of any breaches in relation to mixed sex accommodation. Commissioners receive copies of the compliance report on an ongoing basis and are systematically notified of any breaches.

Mixed sex accommodation refers not only to sleeping arrangements but also to bathrooms and WCs and the need for patients to pass through areas for the opposite sex to reach their own facilities. There is an additional requirement for mental health and learning disability inpatient units in relation to the availability of same-sex day space, particularly for women who use services.

The Mental Health Act Code of Practice (2015) states: “If in an emergency it is necessary to treat a patient in an environment that does not fully meet their needs, then senior management should be informed, steps should be taken to rectify the situation as soon as possible, and staff should protect the patient’s privacy and dignity against intrusions – particularly in sleeping accommodation, toilets and bathrooms.

SLaM has reviewed the Privacy and Dignity Policy in August 2015 and states the following:

All CAG Executive teams must ensure that they have robust MSA reporting mechanisms and identified leads in their services for implementing the Department of Health’s Eliminating Mixed Sex Accommodation (MSA) policy and for reporting MSA breaches monthly. MSA breaches will be reported to commissioners via clinical quality reporting structures and action plans will be required if breaches occur.

The Trust Equality and Human rights Group have designed guidance for staff in supporting transgender service users who are admitted to in-patient wards and the staff delivering care.

Over the timeframe reviewed there have been no breaches in the Trust’s compliance with MSA requirements.

2. Annual Reports of Breaches

South London & Maudsley NHS Foundation Trust had 22 mixed sex wards in 2014/15.

A table outlining reporting breaches in from 01.10.14 – 01.10.15 as follows:

<table>
<thead>
<tr>
<th>CAG</th>
<th>BREACH REPORT</th>
<th>NUMBER OF OCCASIONS</th>
<th>MANAGEMENT PLAN</th>
<th>TYPE OF BREACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDICTIONS</td>
<td>none</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>B&amp;D</td>
<td>none</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>CAMHS</td>
<td>none</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>MAP</td>
<td>none</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>MHOA</td>
<td>none</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>PSYCH MED</td>
<td>none</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>PSYCHOSIS</td>
<td>none</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
3. Complaints
One complaint was made from Oct 2014 – Oct 2015 specifically relating to mixed sex accommodation. This was a low level complaint made by the family of a female patient on Acorn Lodge regarding a male patient being admitted to the service who then entered a female’s bedroom area and acting aggressively. A management plan was implemented to ensure that the incident was not repeated.

4. Incidents
No serious incidents were reported from Oct 2014 - Oct 2015 relating to mixed sex accommodation.

5. Action Plan

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eliminating mixed sex accommodation is embedded into plans for refurbishments and capital development programmes. EMSA will be embedded and considered when “decanting” wards during refurbishments</td>
<td>Every new build or refurbishment project will encompass EMSA requirements</td>
<td>Mark Allen Estates &amp; capital planning</td>
</tr>
<tr>
<td>Systems &amp; processes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting to commissioners in the CCG &amp; NHSE that includes a system of tracking and auditing any episodes of breach regarding MSA</td>
<td>Any decision to breach mixed sex accommodation will be recorded as an incident on Datix and reviewed within CAG governance structures</td>
<td>CAG Heads of Nursing</td>
</tr>
<tr>
<td>Trustwide policy in place for Privacy &amp; Dignity &amp; Eliminating Mixed Sex Accommodation</td>
<td>Review of Privacy and Dignity policy</td>
<td>Nurse Consultant – Physical Wellbeing</td>
</tr>
<tr>
<td>Service user experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing process of reviewing patient experience</td>
<td>Patient experience surveys and questionnaires include questions relating to EMSA and feeling safe</td>
<td>PPI Lead</td>
</tr>
<tr>
<td>Reports to Board (minimum once per year)</td>
<td>Compliance and breach reporting (including justifications for breach) will be reported to the Board</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Staff Culture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMSA is an integral component of delivering care with privacy and dignity</td>
<td>Privacy and dignity to be included in staff inductions within clinical areas</td>
<td>Heads of Nursing</td>
</tr>
<tr>
<td>Reporting mechanism for nursing staff to report any breach</td>
<td>Heads of Nursing via DATIX and breach reports to Nursing Directorate</td>
<td>Ongoing and to continue</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Mixed sex accommodation will only occur for reasons of clinical justification</td>
<td>Ensure that a full investigation is completed when a breach occurs with a clear action plan.</td>
<td>Heads of Nursing</td>
</tr>
</tbody>
</table>
Date of Board meeting: 24th November 2015

Name of Report: SLaM Quality Improvement Programme

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

Author: Michael Holland

Approved by: Neil Brimblecombe

Presented by: Neil Brimblecombe

Purpose of the report:
To highlight the progress of the QI programme work streams – procurement, recruitment and engagement.

Recommendations to the Board:
To note the progress and the evaluation methodology for the procurement of the external partner.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
This programme relates to improving all areas of quality, patient safety, providing services in line with best practice to improve patient experience, across the organisation. The Business Development and Investment Committee has provided a forum to receive updates on the progress of the procurement and other related updates, ensuring an opportunity for discussion around risks.

Summary of Financial and Legal Implications:
It was agreed that we would hold a financial workshop ahead of the board meeting to clarify the messages on return on investment. A summary of this meeting is included in the report.

Equality & Diversity and Public & Patient Involvement Implications:
This programme will need to directly involve public and patients within the underlying programmes of work to deliver it.

Service Quality Implications:
The primary purpose of the programme is to improve the quality of our service provision, both in the immediate and long term. The procurement of a partner organisation will ensure we have the right expertise and skills to deliver this effectively and safely.
INTRODUCTION

Since the last substantial board update we have made significant progress, drawing us closer to launching the trust wide Quality Improvement (QI) programme and beginning a long term cultural change in the organisation.

This programme will transform care delivery by:

- Engaging our entire workforce and providing uniform quality measurement
- Increasing QI skills in staff at all levels
- Develop organisational capabilities
- Provide support for making improvements across our Trust.

The new ways to support QI include the development of the methodology that will be used to deliver value based healthcare through a QI initiative, training QI Facilitators and engaging mentors to support implementation and develop local experts to help multidisciplinary, cross-departmental frontline teams to redesign care processes and associated infrastructure processes.

Achieving high value for patients is our overarching aim, with value defined as the health outcomes achieved per pound spent. This is what matters for our patients. If value improves, our Trust, patients and commissioners can all benefit while the economic sustainability increases.

We need a partner to support us in the early stages of this transformation and a team to facilitate the work internally. The following report details the updates in these areas, as well as a note on the financial narrative and staff engagement.

PROCUREMENT

We have officially launched our competitive dialogue tender process to procure our quality improvement partner. The timeline below indicates what will be taking place over the next few weeks. **We are on track to secure the partner by the agreed target date of 1 March 2016.**

There are many advantages of using a competitive dialogue process. It allows us to have more engagement with a smaller number of bidders to sense-check our specification, approach and objectives and obtain new ideas and focus. It also allows us to get a feel of how it would be like to work with the partner and understand how they would approach the programme.

Shortlisting criteria is strictly based on clear evidence of delivering these type of projects before. The bidder’s proposals will be reviewed in two stages before and after dialogue. After the dialogue meeting the bidders will have a final opportunity to refresh proposals the highest score will determine the winning partner.

<table>
<thead>
<tr>
<th>Value Based Healthcare Timeline</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Single Stage Invitation to Participate in Dialogue (ITPD) advertised</td>
<td>Friday 23rd October</td>
</tr>
<tr>
<td>2 Deadline for the receipt of clarification questions</td>
<td>Monday 16th November</td>
</tr>
<tr>
<td>3 Target date for responses to clarification questions</td>
<td>Within three working days</td>
</tr>
<tr>
<td>4 Deadline for receipt of single stage ITPD Responses</td>
<td>Monday 23rd November</td>
</tr>
<tr>
<td>5 Evaluation of ITPD Responses</td>
<td>Tuesday 24th November</td>
</tr>
<tr>
<td>Date Range</td>
<td>Event Description</td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Thursday 3rd December</td>
<td>Invitations to Participate in Dialogue issued to up to four organisations</td>
</tr>
<tr>
<td>Friday 4th December</td>
<td>4 hour dialogue session per shortlisted bidder</td>
</tr>
<tr>
<td>Monday 14th December to Thursday 17th December</td>
<td>Invitation to Submit Final Offer (ITSFO) issued</td>
</tr>
<tr>
<td>Monday 21st December</td>
<td>Deadline for the receipt of clarification questions</td>
</tr>
<tr>
<td>Monday 4th January</td>
<td>Target date for responses to clarification questions</td>
</tr>
<tr>
<td>Within three working days</td>
<td>Deadline for receipt of single stage ITSFO Responses</td>
</tr>
<tr>
<td>Tuesday 12th January to Tuesday 19th January</td>
<td>Evaluation of Responses</td>
</tr>
<tr>
<td>Wednesday 20th January</td>
<td>Notification of contract award decision</td>
</tr>
<tr>
<td>Wednesday 20th January to Monday 1st February</td>
<td>Standstill period</td>
</tr>
<tr>
<td>Tuesday 16th February</td>
<td>Sign Contract</td>
</tr>
<tr>
<td>Tuesday 1st March</td>
<td>Contracted partnering services start</td>
</tr>
</tbody>
</table>

Work packages - We have asked bidders to respond with supporting information detailing how they will implement the following work packages.

**FACILITATE**
Setting the target

Agree the organisation wide vision for Value Based Healthcare with the executive team. Data driven diagnostics to identify training needs and quick win project opportunities to identify health improvement initiatives which will deliver the most value.

**LEAD**
Organisational change, training and development

Staff Engagement by rolling out an effective change management process to instil a culture of team work. Staff Training & Development Training and leadership Program for SLaM staff to enable them to deliver.

**LEAD**
Innovation, thought, leadership and continuous development

Ongoing continuous improvement to inspire SLaM about new models and ideas

**SUPPORT**
Data driven intelligence for decision making and performance monitoring of outcomes

Support SLaM QI team to monitor project delivery performance and measure outcomes of the health improvement projects. Feedback results for continuous improvement.

**SUPPORT**
Expert value based healthcare project selection, execution and review support

Supporting SLaM in selecting, scoping and designing the most effective Health Improvements Project initiatives

**Evaluation Criteria**
The evaluation criteria for selecting the winning partner during the dialogue phase

<table>
<thead>
<tr>
<th>Partnering Capability and Capacity Assessment</th>
<th>First stage 60%</th>
<th>Second stage 40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The first stage weighting at 60%, with scores carrying through to the next stage. Second stage is taken up to 40% to reflect importance of experience</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
and track record.

### Proposals Assessment
Re-scoring proposals after dialogue process after bidders have had an opportunity to refine.

<table>
<thead>
<tr>
<th>First stage</th>
<th>Second stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Value for money
Scoring indicates the target is about the right value for money. Weighted to that cheapest bid doesn’t automatically win based on price alone.

<table>
<thead>
<tr>
<th>First stage</th>
<th>Second stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Total

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### RECRUITMENT

Key progress on the QI team recruitment:

- We are currently in the process of recruiting the full QI team. A reminder of the team structure is below.
- The facilitators and programme manager will undergo a series of online competency assessment as well as practical assessment centre.
- Interviews will then be held late November/early December with the goal of having the team in post by March 2016.
- Meetings have been arranged with Chief Information Officer and Director of Estates to discuss the team’s location and agile working options.

### MEDICAL DIRECTOR/DIRECTOR OF NURSING
- Deputy Medical Director
  - Programme Manager
    - QI Facilitator
    - QI Facilitator
    - Programme Support Officer
  - QI Facilitator
  - Statistician
  - QI Facilitator

### FINANCIAL SUMMARY

A financial workshop was held with the Chief Financial Officer, the Medical Director, Deputy Medical Director, Director of Nursing, the Commercial Director and Commercial Project Manager to agree the narrative around the financial expectations of this programme. There was an agreement around the key messages:

1. Main driver for this programme is to improve quality. The savings made will be gained from the overall benefits which are broader than just financial gains.
2. There are many subtle benefits that will have a significant long term impact, for example empowered, engaged clinicians, motivated workforce, and efficiency gains enabling a more productive, motivated workforce.

3. The initial focus will be on building and refining our measurement system. We will be leaders on this in mental health and need to understand our data in order to demonstrate value improvements from year three onwards.

4. One of the main purposes of this team will be to focus on demonstrating the return on investment, and therefore the improvement in value for the organisation. We are aiming for this team to be cost neutral by the end of Year Three.

---

**ENGAGEMENT**

We have created an engagement plan to ensure that by March 2016, we will have undertaken the following:

- Individual conversations with clinical and service directors and heads of profession
- Meetings with all CAG Execs
- Attending all relevant professional and staff meetings to discuss the programme, using the same presentation to highlight the key messages.
- A newsletter set up to share best practice and learning throughout the organisation.

---

**RECENT VISIT TO SALT LAKE CITY**

A team of SLaM staff recently travelled to Salt Lake City to visit Intermountain, a global leader in value based healthcare.

Some key findings worth noting and applying to our model:

- Process design underpins their ability to improve outcomes and reduce costs
- Downstream process improvement allows for reallocation of resource upstream
- Everyone across the organisation talks the same language around improvement
- Long term programme – started 1992, there is a slower approach to change with clear evidence of improved outcomes
- Each year the Board sets a single organisational goal for quality which becomes the focus across the organisation.
- Clear process to lead to standardisation of practice that is led by clinicians
- Some of their improvement has required capital outlay.
- Similar infrastructure in SLaM to Intermountain but markedly different job responsibilities
- Using change facilitators for all programmes
- Framing change as a patient problem rather than an organisational programme

---

**QI EXAMPLES**

The following page highlights three examples of SLaM QI projects already being undertaken.

Demonstrate the potential of what could be achieved if we were running multiple projects across the organisation.

Partner will bring highlight the gaps, to give us a strategy of how to fully organisational approach to deliver.
**Past**

Pilot wards were seeing high levels of violence, lack of implementation of the evidence base to reduce violence. Needs being met reactively rather than proactively leading to violent incidents.

**Present**

We have run pilots which have implemented the evidence base and other process changes. We have worked with facilitators to address local issues within the environment that leads to violent incidents. This has led to **50% reduction in violent incidents**.

**Future**

This programme is being rolled out to every ward over the next two years. We are aiming to reduce violence by 50% across the organisation in that time.

---

**Four steps to safety**

**Deliberate self-harm**

Project run on one ward to deal with very high level of self-harm within a female acute ward with very utilisation of one to one obs. Every other day there was an episode of self-harm.

**Lambeth North**

Project was tested in one community team within Lambeth to see if improvement care delivery processes reduced requirements of inpatient stay.

---

Project led to the implementation of the evidence base to reduce self-harm. One of the interventions was to remove the one to one obs. This led to a rate of self-harm being once every 100 days post implementation. Significantly reduced the amount of obs used and therefore the utilisation of bank staff by this ward.

This led to new processes for review of the current case load and health status of individual patients that leads to earlier identification and prevention of deterioration.

Psychosis CAG are looking at why people are put on one to one obs to develop improvement programmes to reduce this need.

These processes have been embedded into the AMH Programme and are being rolled out as part of that for community teams to follow.
Date of Board meeting: 24th November 2015

Name of Report: Performance Report

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

Author: M Black and S Hamilton, Performance Management

Approved by: Kristin Dominy, Chief Operating Officer

Presented by: Kristin Dominy, Chief Operating Officer

Purpose of the report:
To report the Trusts’ performance against a range of key indicators for 2015/16, identify any major areas of learning and success, identify and analyse underperformance and provide action plans to address such underperformance, taking due account of benchmarking information as appropriate and available.

Recommendations to the Board:
To approve the report noting the ongoing development of the Trust performance reporting.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
The Performance Framework is an operational control with an assurance level of moderate.

Summary of Financial and Legal Implications:
Specified where relevant in the report.

Equality & Diversity and Public & Patient Involvement Implications:
The report identifies performance and activity issues 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 performance and activity and issues that if not resolved may have implications on the Trust’s ability to deliver its quality commitments as set out in the Annual Plan
INTRODUCTION

This report details the Trust performance against key metrics to the end of October 2015 and areas of thematic review.

Please note that the Performance Team will continue to develop its approach to reporting and the report will continue to evolve.

The Key Metrics are:

1. Monitor monthly position
2. Activity and Contracts
3. Quality Priorities

This month’s report also includes:

4. Commissioning for Quality and Innovation (CQUIN)
5. Social Care
6. Safer Staffing
7. Statutory and Mandatory training update
1. Monitor monthly position

Chart 1 – Home Treatment Gatekeeping and 7 Day Follow Up.

Home Treatment Gatekeeping

Following below target performance in September, the Trust has met the 95% threshold in October overall and at LSLC CCG level.

Whilst the out of hours staffing situation in the street triage / crisis line is being resolved, gatekeeping screening continues to be temporarily carried out by the Specialist Registrar on call between the hours of 10pm and 8am.

All community staff have been reminded that all admissions (other than those covered by the Monitor exemptions) must be referred to home treatment as an alternative to admission. Exceptions to this are being followed up by Bed Management via Heads of Pathway.

Delayed Discharges

Table 1 – Delayed Discharges

<table>
<thead>
<tr>
<th>Delayed Discharges</th>
<th>Target</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct (Prov.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Days Lost</td>
<td>7.50%</td>
<td>4.0%</td>
<td>4.2%</td>
<td>3.9%</td>
<td>3.2%</td>
<td>3.1%</td>
<td>3.3%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Overall the Trust wide position is well beneath the Monitor threshold of 7.5%.

Delayed discharges continue to contribute to pressures within Adult Acute pathways and are rising again based on provisional data for October.

There is significant work that has been undertaken in additional data cleansing following local bed management meetings.
Chart 2 - Lost Days & Number of Delays

Chart - 3 Delay Reasons Top 5

Delay Reasons: Top 5 for Lost Days

- E. Awaiting care package in own home
- Awaiting further (non acute) NHS care (including intermediate care, rehabilitation services etc)
- Awaiting nursing home placement or availability
- Awaiting completion of assessment
- Awaiting residential home placement or availability
Actions to manage delays and potential delays are in place through daily monitoring and updates are made to a single source of information and identified action holders. There is quick escalation to Team Leaders/CSLs to ensure priority is focussed on discharge. The escalation process from clinical leads and identified action holders through to Heads of Service and Director is in place, as is weekly access to funding panels for care and support, including identification of appropriate accommodation on discharge. All delays and potential delays are reviewed in full at local weekly bed management meetings. A monthly meeting will review all escalated delays and outcomes within the month that have not been resolved to ensure local governance remains robust.

**CPA 12 Month Review**

Current performance of 88.4% is within the usual tolerance for meeting 95% target at the end of quarter. Performance and outliers and data validation issues are regularly communicated to CAGs to support the process.

This is monitored monthly with increased performance reporting in month for Psychosis given the volume of patients and reviews required. Focused work has been undertaken by the CAG on improving performance with key services.

**Table 2 – Other Monitor Risk Assessment Framework Indicators**

The following measures are reported on a quarterly basis.

<table>
<thead>
<tr>
<th>Monitor Indicator</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting commitment to serve new psychosis cases by early intervention teams (until Q1 16/17)</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Data completeness, MH: identifiers</td>
<td>97%</td>
<td>99.2%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Data completeness, MH: outcomes</td>
<td>50%</td>
<td>80.1%</td>
<td>89.4%</td>
</tr>
</tbody>
</table>

**New Monitor Risk Assessment Framework Measures:**

As highlighted in last month’s report work is on track to deliver the new framework measures.

i. **Early Intervention in Psychosis (EIP)**

   The new measure is that 50% of people experiencing a suspected first episode of psychosis will be treated with a NICE-approved care package within 2 weeks of referral by 1 April 2016. Foundation trusts will be required to report their performance to Monitor from Q4.

ii. **Improving access to psychological therapies (IAPT)**

   Foundation trusts are required to report their performance in respect of improving access to psychological therapies (IAPT) from Q3 2015/16.
The measures are:

- ii.a) People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral: Target 75%
- ii.b) People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral: Target 95%

Performance is currently reported through the national Health and Social Care Information Centre (HSCIC). Due to the retrospective HSCIC reporting process HSCIC has published data for April – July. August performance recorded below is internal provisional data which will be updated in future reports.

Lewisham result for first treatment within 6 weeks was 74.42%, just below the 75% target. This relates to the impact of the number of people on the waiting list prior to the introduction of the targets.

The Trust is also required to capture and monitor waiting times locally for those who have completed treatment. As the waiting list is cleared in services those patients who had longer waits will impact on performance in the short term for completed treatment.

Provisional data for September shared with commissioners indicate Lewisham achieved 78% target in September for completed treatments within 6 weeks.
**CQC Status and Actions**

The CQC carried out a full planned inspection of the Trust in September 2015. The Trust awaits a draft detailed report which is due on 23 November. A two week factual accuracy process will then follow in relation to quality issues.

**Fitzmary 2:**
CQC raised concerns regarding Fitzmary 2’s compliance with actions from a previous inspection in March 2015 concerning: Safeguarding People Who use Services From Abuse; Care & Welfare of People Who use Services (Care planning and risk assessment); and Safety and suitability of premises.

Psychosis CAG has provided an update against all identified actions. The Trust provided evidence of significant progress against the original areas of concern, and noted there would be ongoing Board assurance via the Chief Operating Officer and Director of Nursing for a minimum period of six months.

In support of this, the action plan and progress is reviewed with the team weekly by the Service Director, Deputy Director for Complex Care and the Associate Clinical Director for Complex Care and then progress reported to the CAG’s Care Pathways and Governance Executive monthly. An evidence library is maintained to demonstrate progress.

Overall all actions are either completed, in progress or on track. All actions due for completion have been achieved other than the following:

**Roof Works:** completion date extended to 30 November (previously 30 October), which takes into account additional work related to asbestos that was discovered in the roof. Internal works to damp walls and redecoration will take 6 weeks and will commence once roof works are complete.

**Staffing:** Agreement has been given to backfill PDN time to support care planning 1:1 time with staff - booking of B5 RMN to support this is in progress

**Serious incident investigation:** was due to be completed by 5 November; however this is delayed due to the main witness being on sick leave. The investigators have advised that this can be noted in the limitations within the report.

**Safeguarding Training for staff:** 33 staff have been trained with two staff remaining to be booked. There was initially a delay with training availability; however this is now resolved and booking can proceed.

**Temporary hot/cold water unit:** installed 04/11/15: Installation of a permanent beverage area with fixed units will be completed by the end of November as this is being incorporated into the ongoing refurbishment works, which must meet original completion deadline. The installation is an addition to the works.

**Chelsham House:**
CQC confirmed that Chelsham House ward is now compliant in relation to consent to care and treatment. MHOAD CAG has provided an update confirming completion against all identified actions.
**Care plans and clinical notes:** to ensure consent/capacity is assessed and recorded in the clinical notes before any therapeutic intervention commences the Head of Nursing and Clinical Nurse Specialist review care plans to ensure capacity and consent is considered for all care interventions.

The ward manager and service manager review weekly audits to identify additional training and support staff may need. CNS will be providing coaching to individual staff regarding writing care plans.

The EPJs care plan audit tool has been amended to include specific questions regarding capacity and consent in care plans. Since 2\(^{nd}\) October weekly audits have taken place; if sufficient improvements have been made by 27\(^{th}\) November monthly audits checked by the ward manager will commence.

**Compliance with Deprivation of Liberty Safeguards (DoLS):** the Trust Lead for this has reviewed all current patients with the ward consultant to ensure patients are being treated under the correct framework and the associate clinical director will monitor capacity assessments with ward consultants.

**Mental Capacity Act (MCA):** an assessment tab will be added to weekly exception reports and the Business Manager is liaising with HI to this end.

**Patient profile:** in respect of patients previously admitted without primary diagnosis of dementia, the service manager has conducted a review of patients to ensure there were no risk issues in relation to the environment. Any patients identified with risk in relation to ligatures were transferred to an environment suited to their needs.

Generally patients with an organic diagnosis are admitted to Chelsham. However, one male patient with a functional diagnosis has been admitted as he needed a bed (the risk of non-admission was higher than the risk of an admission to Chelsham House) and he is on enhanced observation to mitigate all possible risks. There is a plan to move the patient as soon as possible. The ward continues to operate at 16 beds, with 4 remaining closed; this has had no adverse impact in bed availability for older people. A reduction in patient numbers has increased the staff-patient ratio, thereby reducing the requirement for additional staffing to undertake enhanced observations to mitigate all possible risks.
2. Activity & Contracts

Adult Acute Pathway Activity

As the Board is aware the Trust has been recruiting to the post of Programme Director for the Adult Acute Pathway programme, as detailed in Dr Baggaley’s report to the Board in September. Lou Hellard has been appointed to the post.

There continues to be significant pressure in the Adult acute pathway with an overspill average of 23.5 patients per day in acute overspill in October. PICU overspill also continues to be high at an average of 14.5 patients per day in October.

Chart 6 - Average Number of Patients in Overspill

![Chart showing average number of patients in overspill from April to October.](chart6.png)

The average daily number of patients went from 37.8 in September up to 39.0 in October. There is an indication of improvement as there has been a decrease in the number of patients throughout the month. The peak was 48 from 30 September - 4th Oct. This fell to 34 between the 5 and 16 October before gradually rising again to 37 by the end of the month.

This can be attributed to a range of pressures including increases in lengths of stay, patient acuity, and reduction in available bed stock due to staff shortages and refurbishment works. There are a broad range of activities targeting these pressures, including project work in reducing length of stay, reviewing patients in external placements, daily monitoring of delays and potential delays and subsequent escalation processes, and ongoing work to strengthen community services and reduce admissions. There are also plans to increase PICU provision in the next calendar year.
Chart 7 - Adult Acute – Average Length of Stay (Excluding Leave)

The average Adult Acute Length of Stay (Excluding Leave) for 2014/15 based on the annual NHS Benchmarking categories indicates the Trust Length of Stay (Excluding Leave) is consistent, albeit slightly higher, with the national mean.

Chart 8 – National Benchmarking of Adult Acute Length of Stay (Excluding leave)
### 3. Quality Priorities

This table below details mid-year achievement and progress against the nine Quality Priorities set out in the Trust Annual Quality Account. There are no changes to this table on a monthly basis and therefore this will be reported on a quarterly basis.

#### Table 3 – Quality Priorities 2015/16

<table>
<thead>
<tr>
<th>Quality Priority indicators</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Do you feel safe? (inpatients)</td>
<td>90%</td>
<td>79.8%</td>
<td>81.9%</td>
</tr>
<tr>
<td>2 Do you know what to do in an emergency mental health situation? (community)</td>
<td>75%</td>
<td>80.7%</td>
<td>80.9%</td>
</tr>
<tr>
<td>3 Number of eligible inpatients and EI having six key metabolic c-v tests</td>
<td>90%</td>
<td>CQUIN</td>
<td></td>
</tr>
<tr>
<td>4 Do you feel involved in your care?</td>
<td>83.5%</td>
<td>88.3%</td>
<td>86.1%</td>
</tr>
<tr>
<td>5 Number of carers who state they have had a carers assessment</td>
<td>30%</td>
<td>Audit</td>
<td></td>
</tr>
<tr>
<td>6 Improvement in environmental PLACE audit scores from 2014/2015 to over 95%.</td>
<td>95%</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>7 Risk assessment and informing decision making – inpatients and community patients on CPA will have a full document risk assessment</td>
<td>75%</td>
<td>Q4 Audit</td>
<td></td>
</tr>
<tr>
<td>8 Reduce the number of people supported by HTT who required an admission (where the AMH model has been established)</td>
<td>Under 15%</td>
<td>Q4 Audit</td>
<td></td>
</tr>
<tr>
<td>9 Patients with both and AUDIT (identification tool) and a drug and alcohol assessment complete (Adult acute inpatient and adult community)</td>
<td>50%</td>
<td>Q4 Audit</td>
<td></td>
</tr>
</tbody>
</table>

The results for Quality Priorities 1, 2 and 4 have been updated with refreshed data. Following the recent change in supplier for the collection of our patient experience data we have established new internal quality controls for management of paper forms previously undertaken by the supplier. Through this process we have identified a discrepancy in the way the previous supplier was reporting data for one CAG in relation to ‘Do you know what to do in a mental health crisis?’ This has not resulted in a material change in percentage performance for the priority.
4. Commissioning Quality and Innovation (CQUINS)

Further details on CQUIN delivery are detailed in Appendix A.

a) LSLC CQUINS

Lambeth, Southwark, Lewisham and Croydon have agreed the following shared CQUINS:

Table 4 - LSLC CQUINS Summary

<table>
<thead>
<tr>
<th>Scheme</th>
<th>LSLC Shared CQUINS</th>
<th>Q1 Deliverable</th>
<th>Q2 Deliverable</th>
<th>Q3 Forecast</th>
<th>Q4 Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>4a. Physical Health</td>
<td>-</td>
<td>Met</td>
<td>On track</td>
<td>50%</td>
</tr>
<tr>
<td>1.2</td>
<td>4b. Physical Health</td>
<td>-</td>
<td>Met</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>2</td>
<td>Outcomes</td>
<td></td>
<td>Met</td>
<td>On track</td>
<td>85%</td>
</tr>
<tr>
<td>3</td>
<td>In-Patient Experience</td>
<td>Met</td>
<td>Met</td>
<td>On track</td>
<td>45%</td>
</tr>
</tbody>
</table>

The schemes financial weighting is geared towards the end of the year.

b) Local CCG CQUINS

The following CQUINS have been agreed on a single commissioner basis:

Table 5 - Local CQUINS Summary

<table>
<thead>
<tr>
<th>No.</th>
<th>Local CQUINS</th>
<th>CCG</th>
<th>Q1 Deliverable</th>
<th>Q2 Deliverable</th>
<th>Q3 Forecast</th>
<th>Q4 Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>IPSA</td>
<td>Lambeth</td>
<td>-</td>
<td>Ongoing</td>
<td>On track</td>
<td>40%</td>
</tr>
<tr>
<td>5</td>
<td>Personalisation</td>
<td>Lambeth</td>
<td>Timelines being negotiated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dual Diagnosis</td>
<td>Lewisham</td>
<td>-</td>
<td>Met</td>
<td>On track</td>
<td>69%</td>
</tr>
<tr>
<td>7</td>
<td>AMH</td>
<td>Lewisham</td>
<td>-</td>
<td>Met</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>8.1</td>
<td>9.1 MHOA</td>
<td>Croydon</td>
<td>On hold until funding is in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.2</td>
<td>9.2 MHOA</td>
<td>Croydon</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>50%</td>
</tr>
<tr>
<td>9.1</td>
<td>6.1 AMH</td>
<td>Croydon</td>
<td>Met</td>
<td>Met</td>
<td>On track</td>
<td>35%</td>
</tr>
<tr>
<td>9.2</td>
<td>6.3 AMH</td>
<td>Croydon</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>100%</td>
</tr>
</tbody>
</table>

c) NHSE CQUINS

The Trust continues to submit quarterly reports for the following CQUINS and awaits NHSE feedback on whether the requirements have been achieved.

- Carer involvement strategies (supporting carer involvement)
- Physical well-being in Mental Health (Mandatory)
Secure User Engagement: The provision of an active engagement programme to involve all secure service users in a process of collaborative risk assessment and management.

Perinatal Specific Involvement and Support for partners/significant others

Assuring the appropriateness of unplanned CAMHS admissions

Adult Eating Disorders - Outcome measures – Year 2

5. Social Care

There have been significant changes and developments across social care, professional social work and safeguarding adults and children, mainly in response to the inception of the Care Act, which came into force on the 1st April 2015.

In summary:

a. Implementation of the Care Act 2014

A Care Act Implementation Group has been established and an ongoing work programme is under way to ensure compliance with the legislation. The group has focused on: programme management and governance, delegation of local authority functions, assessment and care planning, carer’s assessments, safeguarding adults, workforce and training and the costs of implementation and communication. Since 1st April staff training has continued with care coordinators in community teams and an audit is being undertaken to establish any residual gaps. Additionally, some key legislative changes have been embedded in SLaM corporate induction and mandatory training on safeguarding adults and carers. Other forms of training include: awareness sessions delivered to the Promoting Recovery Pathway and the Medical Advisory Committees; an introductory course to personalisation and the Care Act; and e-learning tools and other resources from Skills for Care available via a Care Act intranet page.

A regular slot for Care Act/social care practice issues is being considered as part of the Promoting Recovery Pathway team practice meetings.

The CPA policy has been updated and will be fully reviewed when the position on carers’ assessments and Section 117 is confirmed (see below).

b. Carers’ assessments.

A working group with carers and carers’ leads has been established to make recommendations on the future use of the SLaM carers’ assessment form and consider changing its use to an engagement or guidance tool which will include the principles of the ‘Triangle of Care’. Once agreed the CPA policy will be reviewed and revised accordingly.

c. Section 117 Policy

The current Section 117 aftercare policy has been reviewed in relation to ordinary residence, definition of aftercare and accommodation and circulated to the Heads of Social Care and clinicians for comment ahead of governance processes for approval. This will provide clear guidance for staff to ensure the Section 117 aftercare needs of service users are recorded, reviewed and discharged appropriately.
It will also enable a ‘register’ of service users who are subject to Section 117 to be held on a borough basis, as recommended by the Code of Practice to the Mental Health Act.

d. SLaM Social Care Strategy

A draft social care strategy was presented to SLaM Trust Board in April 2015, for approval and support to develop this further with borough local authority and CCG colleagues. This was intended to be aligned with existing SLaM and borough mental health strategies to articulate the role of social care in relation to statutory responsibilities and the importance of integrated health and social care interventions in achieving good outcomes for service users and carers. It has outlined high level key priorities which are being reviewed with the Chief Operating Officer and will form the basis of a more detailed work plan for 2015/16.

e. Section 75 agreements

The Director of Social Care is in negotiation with Lambeth, Lewisham and Croydon local authorities to progress the individual Section 75 agreements. Template agreements for Care Act compliance are agreed and each borough is populating the schedules with staffing and resource detail and consulting their respective legal departments. An internal Section 75 task and finish group has been set up and the Director of Social Care will work with the CAG operational teams towards final sign off.

Section 75 reporting arrangements have been reviewed and recommendations are being made to establish a robust governance framework to give performance assurance on social care to local authority partners.

Southwark local authority’s engagement was delayed owing to the Southwark Mental Health Social Care Review. The report has now been shared with SLaM and negotiations will now take place to discuss the details of the proposals and agree next steps.

f. Social Care Performance

SLaM is required to provide social care activity data undertaken within the Trust on behalf of the local authorities in discharging the delegated statutory duties. This includes Short and Long Term support (SALT) returns and other social care indicators which local authorities are required to report and monitor under the Adult Social Care Outcomes Framework. The Director of Social Care is working with the Performance Team to build a social care performance dashboard which will report to Trust Board quarterly.
6. Safer Staffing

The report for October indicates 15 wards breached the 20% of shifts threshold. The full report is detailed in Appendix B.

Chart 9 - Safer Staffing

Safer Staffing: Wards Breaching 20% of Shifts

7. Statutory and Mandatory training

The Trust has seen significant improvements in mandatory training compliance over 2015 and is very clear that continued progression to full compliance in all areas is a priority. The challenge of balancing the assurance of a well-trained workforce with not adversely impacting on staffing levels and patient care is recognised and therefore all Clinical Academic Groups (CAGs) have submitted trajectories showing completions required to reach full compliance by April 2016; these figures will be monitored by the Chief Operating Officer through monthly Operational Performance meetings and CAG performance review meetings to identify and remedy early underperformance.

CAGs will require teams to instruct staff members to schedule bookings and commit protected learning time for e-learning modules to meet these targets. The Education and Training department is reviewing face to face provision of all courses until March 2016 to ensure that training resources match these expectations.

Staff are encouraged and supported to review their own mandatory training in a number of ways: all mandatory training without a physical skills element is available as e-learning to give greater flexibility; staff can access the WIRED system online which shows their personal requirements; and mandatory training compliance is included as a core component of the Trust's performance development process.
Table 6 - Snapshot of Mandatory Tier 1 Level Training Compliance

The following table represents reported performance on WIRED on a given day. The WIRED system is updated weekly.

<table>
<thead>
<tr>
<th>Tier 1 Level A Training - Subjects</th>
<th>Trust</th>
<th>Addictions</th>
<th>BDP</th>
<th>CAMHS</th>
<th>Psych Med</th>
<th>Psychosis</th>
<th>MAP</th>
<th>MHOAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Safeguarding Alerters (All Non Clinical Staff)</td>
<td>84.5%</td>
<td>100.0%</td>
<td>85.7%</td>
<td>85.6%</td>
<td>79.7%</td>
<td>85.7%</td>
<td>86.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Adult Safeguarding Alerters Plus (All Clinical Staff)</td>
<td>78.6%</td>
<td>86.7%</td>
<td>80.4%</td>
<td>72.9%</td>
<td>81.3%</td>
<td>79.0%</td>
<td>80.9%</td>
<td>76.0%</td>
</tr>
<tr>
<td>Child Safeguarding Level 1 (All Non Clinical Staff)</td>
<td>87.8%</td>
<td>100.0%</td>
<td>96.8%</td>
<td>90.0%</td>
<td>81.4%</td>
<td>89.5%</td>
<td>92.1%</td>
<td>76.3%</td>
</tr>
<tr>
<td>Child Safeguarding Level 1 and 2 (All Clinical Staff)</td>
<td>87.0%</td>
<td>90.2%</td>
<td>89.6%</td>
<td>88.1%</td>
<td>89.5%</td>
<td>85.4%</td>
<td>90.8%</td>
<td>86.4%</td>
</tr>
<tr>
<td>Child Safeguarding Level 3</td>
<td>91.3%</td>
<td>96.2%</td>
<td>88.5%</td>
<td>91.8%</td>
<td>93.5%</td>
<td>89.4%</td>
<td>94.6%</td>
<td>90.7%</td>
</tr>
<tr>
<td>PSTS Team work inpatient staff</td>
<td>72.0%</td>
<td>-</td>
<td>70.2%</td>
<td>70.2%</td>
<td>75.7%</td>
<td>76.9%</td>
<td>-</td>
<td>53.8%</td>
</tr>
<tr>
<td>PSTS Awareness / Conflict Resolution</td>
<td>92.7%</td>
<td>96.3%</td>
<td>100.0%</td>
<td>96.4%</td>
<td>79.8%</td>
<td>33.3%</td>
<td>92.9%</td>
<td>91.3%</td>
</tr>
<tr>
<td>PSTS disengagement</td>
<td>62.8%</td>
<td>65.0%</td>
<td>59.6%</td>
<td>62.7%</td>
<td>60.6%</td>
<td>60.4%</td>
<td>67.4%</td>
<td>66.6%</td>
</tr>
<tr>
<td>Basic Life Support Level 1 (All Non Clinical Staff)</td>
<td>90.4%</td>
<td>100.0%</td>
<td>88.9%</td>
<td>95.6%</td>
<td>85.7%</td>
<td>93.2%</td>
<td>91.2%</td>
<td>92.3%</td>
</tr>
<tr>
<td>Basic Life Support Level 2</td>
<td>76.9%</td>
<td>62.0%</td>
<td>69.5%</td>
<td>76.4%</td>
<td>83.6%</td>
<td>77.9%</td>
<td>79.7%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>74.1%</td>
<td>70.0%</td>
<td>68.7%</td>
<td>62.5%</td>
<td>82.1%</td>
<td>75.9%</td>
<td>84.3%</td>
<td>84.0%</td>
</tr>
<tr>
<td>Infection Control (Levels 1 &amp; 2)</td>
<td>78.1%</td>
<td>85.7%</td>
<td>73.8%</td>
<td>79.7%</td>
<td>75.2%</td>
<td>73.4%</td>
<td>79.1%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>69.3%</td>
<td>72.1%</td>
<td>71.2%</td>
<td>71.7%</td>
<td>74.4%</td>
<td>60.3%</td>
<td>71.6%</td>
<td>75.4%</td>
</tr>
<tr>
<td>Health, Safety &amp; Welfare</td>
<td>84.8%</td>
<td>83.7%</td>
<td>86.7%</td>
<td>83.9%</td>
<td>86.5%</td>
<td>83.2%</td>
<td>85.2%</td>
<td>80.2%</td>
</tr>
<tr>
<td>Equality, Diversity &amp; Human Rights</td>
<td>80.1%</td>
<td>80.3%</td>
<td>82.1%</td>
<td>80.1%</td>
<td>83.2%</td>
<td>74.5%</td>
<td>83.8%</td>
<td>77.5%</td>
</tr>
<tr>
<td>Moving &amp; Handling Loads</td>
<td>72.1%</td>
<td>65.7%</td>
<td>72.5%</td>
<td>60.0%</td>
<td>73.0%</td>
<td>73.0%</td>
<td>72.4%</td>
<td>74.2%</td>
</tr>
<tr>
<td>Moving &amp; Handling Patients</td>
<td>54.1%</td>
<td>-</td>
<td>57.4%</td>
<td>41.0%</td>
<td>59.4%</td>
<td>55.5%</td>
<td>-</td>
<td>55.3%</td>
</tr>
<tr>
<td>Fire Safety Awareness</td>
<td>79.3%</td>
<td>87.8%</td>
<td>77.4%</td>
<td>79.2%</td>
<td>78.2%</td>
<td>77.5%</td>
<td>82.3%</td>
<td>81.0%</td>
</tr>
</tbody>
</table>
Tier 1 Level B training has been added to WIRED in this financial year and is being developed to incorporate other essential training standards relevant to CAGs. There is further development underway in consultation with the CAGS regarding additional training and applicability of particular training subjects to the CAG staff groups.

Table 7 - Snapshot of Tier 1 Level B Training Compliance

<table>
<thead>
<tr>
<th>Tier 1 Level B Training</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Risk</td>
<td>69.86%</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>53.82%</td>
</tr>
<tr>
<td>Immediate Life Support - DSN</td>
<td>91.74%</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>90.57%</td>
</tr>
<tr>
<td>Mental Health Act Training</td>
<td>70.45%</td>
</tr>
<tr>
<td>MEWS</td>
<td>50.07%</td>
</tr>
<tr>
<td>PSTS Team Work - DSN</td>
<td>88.07%</td>
</tr>
</tbody>
</table>

Education and Training (E&T) is utilising the trajectories to inform capacity planning and training programme delivery and have started emailing staff directly to advise them of subjects in which they require a refresher and have seen a high response rate to these. This is also reducing the need for E&T to cancel courses due to low numbers of delegates.

CAGs have highlighted differences between team data and WIRED data following the cleansing exercise. Leavers and transfers should be updated through the Trust’s existing change form process. However, feedback from CAGs indicates delay in changes being reflected on the system – this is being addressed.

Report Conclusion

In summary monthly performance against Monitor is on course to meet target at the end of Quarter 3.

CQUIN achievement is of particular importance as we approach Q4. Significant project and infrastructure work has been invested and forecast for delivery in Quarter 3 is on track.

There continues to be significant pressure on the Adult Acute pathway, and although provisional data indicates that there is a reduction in the number of patients currently in overspill beds it is too soon to establish if this constitutes a trend.

The performance report content will be further developed for December Board.

Martin Black
Stephanie Hamilton
Performance Management
Appendix A
Commissioning Quality and Innovation (CQUINS)

1) LSLC CQUINS Delivery

Physical Health

Physical Health 4A: An audit report was completed for baseline performance for all LSLC wards in Quarter 2. The audit selected 100 cases meeting the diagnosis criteria in Quarter 2 which identified whether the physical health parameters were assessed and interventions offered.

The target of 90% compliance was met for 3 of the 6 physical health assessment parameters. These were: Blood pressure (97%), Lifestyle (95%), Smoking status (90%) Parameters below target were Body mass index (85%), Glucose regulation (78%) and Blood lipids (76%).

The target of 90% compliance physical health interventions offered was met for Glucose Regulation (95.5%). The other parameters had the following scores: Smoking status (89.5%), Blood pressure (84.6%), Body mass index (81.8%), Lifestyle (75.0%), Blood lipids (72.0%).

Systematic feedback to clinical teams is in place to prompt completion and clinical training programmes developed.

Physical Health 4B: Relates to communications with General Practitioners. The target is that 75% of patients from selected community teams should have either an updated CPA i.e. a care programme approach care plan or a comprehensive discharge summary shared with their GP. This should contain 7 key elements.

The audit of 100 cases found in 67.0% of the cases the GP has been sent a review letter resulting from the latest CPA review. However, only a small proportion (11.0%) cases had a review letter sent to the GP resulting from the latest CPA review which contained all relevant components. Most commonly, GPs were being sent care plans containing 5 of the components.

The audit has highlighted the need for improvement in all areas especially with regards to the inclusion of mental health diagnosis ICD codes (41.0%), all physical health diagnosis/concerns (40.0%), monitoring requirements of prescribed medications (40.0%) and offered smoking intervention/smoking status recorded where non-smoker (21.0%).

Outcomes

The Trust has successfully met the deliverables for Quarter 2, including establishing a baseline report of performance for Health of the Nation Outcomes (HoNOS) and a workshop with commissioners. The targets set by commissioners are for HoNOS completion rates in Closed Episodes of care. In Quarter 3 Paired HoNOS performance is to reach 35% across the Trust, rising to 40% during Quarter 4.
In-Patient Experience

A survey was undertaken to identify need by gathering feedback from families and carers and wards to ask for suggestions to improve family / carer experience. Alongside this research to identify other areas of good practice was undertaken. Generally respondents answered the questions positively although the narrative comments were generally less positive.

Key issues that emerged were timeliness of being given ward information, the need for privacy when visiting, ensuring that visitors with disabilities were appropriately catered for, the physical environment and more information at the point of discharge. In the next quarter a number of borough-based events will be held and wards will be developing action plans based on the feedback provided in Quarter 1 and 2.

2. Local CCG CQUINS

MHOAD: 9.1 (Treatment in Community)
The CQUIN is on hold, pending confirmation of funding from commissioners.

Personalisation:
Timelines are being finalised. A project group including the Trust, external partner and commissioners will meet November to review timings and milestones.

Q1 and Q2 deliverables:
A request from Lambeth for additional information about the Inpatient Experience Quarter 1 report was responded to. In Quarter 2 Lambeth raised some queries, primarily relating to minor clarifications, but no issues which will challenge the delivery of the CQUINs.
### Staffing Levels in Inpatient Wards - October 2015

#### South London and Maudsley NHS Foundation Trust

#### Appendix B - Safer Staffing: October report

<table>
<thead>
<tr>
<th>Clinical Academic Group Name</th>
<th>Hospital Site</th>
<th>Ward name</th>
<th>Breach %</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioural and Developmental Psychiatry</strong></td>
<td>Wandsworth Prison</td>
<td>Addison Ward</td>
<td>19%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Brook Ward</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Chaffinch Ward</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Effra Ward</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>National Autism Unit (NAU)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Norbury Ward</td>
<td>34%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Spring Ward</td>
<td>42%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Thomas Ward</td>
<td>25%</td>
<td>Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse</td>
</tr>
<tr>
<td></td>
<td>Bethlem Royal Hospital</td>
<td>Waddon Ward</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lambeth Hospital</td>
<td>Ward in the Community (WIC)</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

| **Child and Adolescent Mental Health Services** | Bethlem Royal Hospital | Acorn Lodge Children’s Unit | 46% | 23% of total breaches planned due to decreased patient occupancy. Breaches due to short notice sickness and NHSP unable to fill. |
| | Woodland House | Ash Adolescent Unit | 17% |  |
| | Bethlem Royal Hospital | Bethlem Adolescent Unit (BAU) | 38% | Breaches due to NHSP unable to provide staff |
| | Woodland House | Oak Adolescent Unit | 6% |  |
| | Maudsley Hospital | Snowfields Adolescent Unit | 10% |  |
| | **MIHCA and Dementia** | Maudsley Hospital | Aubrey Lewis 1 Ward (AL1) | 0% |  |
| | | Bethlem Royal Hospital | Cheekham House | 4% |  |
| | | Voss Court | Greenside Specialist Care Unit | 6% |  |
| | | Ladywell Unit | Hayworth Ward | 9% | Breaches due to NHSP unable to provide staff |
| | | Lambeth Hospital | Lambeth Triage | 65% | 3% of total breaches planned due to decreased patient occupancy. Majority of breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Bethlem Royal Hospital | Eating Disorders Unit (EDU) | 15% | Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Ladywell Unit | Lewisham Triage | 49% | Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Bethlem Royal Hospital | Lishman Unit | 8% | 4% of total breaches planned due to decreased patient occupancy. |
| | | Bethlem Royal Hospital | Mother and Baby Unit (MBU) | 17% |  |
| | | Maudsley Hospital | Aubrey Lewis 3 Ward (AL3) | 1% |  |
| | | Lambeth Hospital | Bridge House | 53% | Majority of breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Ladywell Unit | Clare Ward | 2% |  |
| | | Lambeth Hospital | Eden Ward | 4% |  |
| | | Maudsley Hospital | Eileen Skellern 1 Ward (ES1) | 0% |  |
| | | Maudsley Hospital | Eileen Skellern 2 Ward (ES2) | 15% |  |
| | | Foyle Lane | Foyle Lane | 0% |  |
| | | Bethlem Royal Hospital | Gresham 1 Ward | 14% |  |
| | | Bethlem Royal Hospital | Gresham 2 Ward | 6% |  |
| | | Heath Close | Heath Close Rehabilitation Inpatient Ward | 3% |  |
| | | Maudsley Hospital | Jim Briley Unit (JBU) | TBC | Pending confirmation |
| | | Maudsley Hospital | John Dickson Ward | 0% |  |
| | | Ladywell Unit | Johnson PCU | 1% |  |
| | | Lambeth Hospital | Lambeth Early Onset Ward (LEO) | 4% |  |
| | | Lambeth Hospital | Luther King Ward | 35% | Majority of breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Lambeth Hospital | McKenzie Rehabilitation Inpatient Ward | 20% | Majority of breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Bethlem Royal Hospital | National Psychosis Inpatient Ward (Florinry I) | 62% | Majority of breaches due to NHSP unable to provide staff |
| | | Bethlem Royal Hospital | Nelson Ward | 27% | Breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Ladywell Unit | Powell Ward | 17% |  |
| | | Maudsley Hospital | Rooker Ward | 2% |  |
| | | Lambeth Hospital | Tony Hills Unit | 42% | Majority of breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Bethlem Royal Hospital | Winstead Rehabilitation Inpatient Ward | 52% | Majority of breaches due to NHSP unable to provide staff and support worker covering for qualified nurse |
| | | Ladywell Unit | Whiston Ward | 11% |  |
New Items of Focus:

Issue Log:

<table>
<thead>
<tr>
<th>Indicator No</th>
<th>Indicator Name</th>
<th>Actions / Trajectory</th>
<th>Status</th>
<th>Responsible Owner</th>
<th>First Reported</th>
<th>Planned Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Number of Adult Acute Patients in Private Beds</td>
<td>There continues to be significant number of patients in Acute Adult over spill with an average of 25.9 patients per day in September. September Board discussed and reviewed the pressures within adult services and the actions being undertaken to mitigate these issues. This includes project work targeting at reducing length of stay, reviewing patients in external placements, daily monitoring of delays and potential days and subsequent escalation processes and ongoing work to strengthen community services and reduce admissions. Plans to increase PICU provision in the next financial year is underway.</td>
<td>Sep 2015 QSC</td>
<td>QSC</td>
<td>Sep 2015 QSC</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Physical Health: Communication with GP CQUIN</td>
<td>The external National Audit by the Royal College of Psychiatrists is underway for patients who were on the wards in the months of August and September 2015. A further data collection and submission is scheduled over December and January. The Trust has been undertaking internal audits prior to this to feedback to teams and support improvement and continues to do so. A range of activity has been undertaken to support physical health improvement including:</td>
<td>Physical Health Care Nurse Consultant &amp; CQUIN Lead</td>
<td>April 2015 QSC</td>
<td>April 2015 QSC</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Discharge communications to GP - AMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Discharge communications to GP - Non AMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Do you feel safe? (on the ward) target &gt;90% (2014/15 result was 81%)</td>
<td>The Trust continues to experience difficulty in reaching the 90% target. This measure relates to inpatient wards. Performance continues to track at levels similar to 2014/15. Initiatives with the potential to impact on this measure include: Four Steps to Safety: The first cohort comprising four wards (Lithoson, Acorn Lodge, Powell, and Lex) started in September. The wards are being visited twice a week to identify support in implementing the changes. Monitoring of outcomes and training uptake, incident levels, and effective implementation is underway. The second cohort, comprising Tony Hills, ES2, Heather Close, and Lewisham Triage, has been recruited to. A collaborative meeting of Cohort 1 and 2 is being scheduled for January. Recruitment: The targeted recruitment programme continues. Anti-ligature works: Most Level 2 ligature reduction works are scheduled to complete by the end of November 2015 with some in December. One is scheduled for completion end of March as part of a wider refurbishment programme. The anti-ligature furniture installation programme and works within the Triage Wards were completed by the 31 August.</td>
<td>AP / MH</td>
<td>April 2015 QSC</td>
<td>April 2015 QSC</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Wards where patients are expected to queue for medication. Target = 0</td>
<td>There has been feedback that patients are choosing to queue as opposed to being required to. Re-audit is underway, ward visits have been undertaken and the results will be compiled. The CAET bulletin and recommendations has been circulated.</td>
<td>MOD</td>
<td>April 2015 QSC</td>
<td>Sep 2015 QSC</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Wards where patients are expected to queue for meals. Target = 0</td>
<td>Current reported compliance with Tier 1 mandatory training increased by 11.8% since the start of the year. CAGS have submitted trajectories for meeting compliance where RAG rating is Red or Amber. Compliance will be addressed Operational Performance meetings in addition to the Trust wide Education and Training committee.</td>
<td>CAG Leads</td>
<td>Feb 2015 QSC</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>Mandatory Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Child Need Risk Screening</td>
<td>Performance is consistently below target - the policy has been updated and ratified at the QSC and disseminated to staff.</td>
<td>PPI</td>
<td>Feb 2015 QSC</td>
<td>Ongoing monitoring</td>
<td></td>
</tr>
<tr>
<td>1, 2, 43,48,49</td>
<td>Patient Experience Reporting (PEDIc and Family and Friends)</td>
<td>The reporting flow has been re-established earlier this year and regular reports are being received. The contract has been re-tendered and a new contractor has been awarded the contract. The transition is going well.</td>
<td>PPI</td>
<td>Feb 2015 QSC</td>
<td>Ongoing monitoring</td>
<td></td>
</tr>
</tbody>
</table>

Closed issues:

<table>
<thead>
<tr>
<th>Issue No</th>
<th>Indicator Name</th>
<th>Issue Description</th>
<th>Closure Date</th>
<th>Reasons for closure</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Safer Staffing</td>
<td>The number of wards reporting that over 20% of shifts were breached. The vast majority of breaches continue to be the result of support workers covering for qualified nurses.</td>
<td>April 2015 QSC</td>
<td>A 6 month staffing review has been completed and was reported to the Board. Safer staffing continues to be reported monthly to the Trust Board. To address safer staffing breaches in the main the priority is improved recruitment and to ensure that recruitment processes are continuous.</td>
</tr>
<tr>
<td>10</td>
<td>Four Steps to Safety</td>
<td>Additional funding has been secured to support the delivery of this work.</td>
<td>April 2015 QSC</td>
<td>Funding of £0.5 million has been secured from the Health Foundation. The 1st cohort started in September and the 2nd cohort has been recruited.</td>
</tr>
</tbody>
</table>
### Safety

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td>1</td>
<td>Do you feel safe (In-Patients)</td>
<td>Quality Priority 1</td>
<td>90%</td>
<td>81%</td>
<td>76.8%</td>
<td>81.9%</td>
<td>80.9%</td>
<td>79.8%</td>
<td>76.1%</td>
<td>86.1%</td>
<td>83.9%</td>
<td>81.9%</td>
<td>Improvement</td>
<td>80.9% YTD following data refresh</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Do you know what to do in an emergency mental health situation (Community)</td>
<td>Quality Priority 2</td>
<td>75%</td>
<td>79%</td>
<td>80.6%</td>
<td>78.3%</td>
<td>82.4%</td>
<td>80.7%</td>
<td>80.6%</td>
<td>80.0%</td>
<td>83.1%</td>
<td>80.9%</td>
<td>Improvement</td>
<td>80.9% YTD updated following DQ assurance process</td>
<td></td>
</tr>
<tr>
<td><strong>Use of private beds</strong></td>
<td>3</td>
<td>Number of Adult Acute Patients in Private Beds (average per day for Month)</td>
<td>Safety monitoring</td>
<td>TBC</td>
<td>5.0</td>
<td>9.6</td>
<td>6.3</td>
<td>13.2</td>
<td>-</td>
<td>26.4</td>
<td>20.6</td>
<td>25.9</td>
<td>-</td>
<td>Stable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Number of Adult Patients in PICU Private Beds (average per day for Month)</td>
<td>Safety monitoring</td>
<td>TBC</td>
<td>6.0</td>
<td>7.3 (5.1)</td>
<td>6.8 (4)</td>
<td>10.8 (5.4)</td>
<td>-</td>
<td>13.4 (5.8)</td>
<td>15.6 (7.2)</td>
<td>14.9 (4.4)</td>
<td>-</td>
<td>Improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Follow up</strong></td>
<td>5</td>
<td>Seven Day Follow Up</td>
<td>Monitor</td>
<td>95%</td>
<td>97.4%</td>
<td>96.0%</td>
<td>96.8%</td>
<td>95.8%</td>
<td>96.2%</td>
<td>97.7%</td>
<td>99.1%</td>
<td>98.0%</td>
<td>98.2%</td>
<td>Deterioration</td>
<td>11.5 YTD. Refer to issues log</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>New Serious Incidents</td>
<td>Safety monitoring</td>
<td>SPC Trend</td>
<td>14/15 Aug-6</td>
<td>9</td>
<td>5</td>
<td>11</td>
<td>25</td>
<td>9</td>
<td>7</td>
<td>9</td>
<td>25</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Reported incidents % harm (categories A-C)</td>
<td>Safety monitoring</td>
<td>SPC Trend</td>
<td>27.60%</td>
<td>31.5%</td>
<td>28.0%</td>
<td>31.3%</td>
<td>30.2%</td>
<td>27.8%</td>
<td>23.50%</td>
<td>26.50%</td>
<td>25.90%</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Sts Violence &amp; aggression - patient physical assault on staff (categories A-C)</td>
<td>Safety monitoring</td>
<td>SPC Trend</td>
<td>14/15 Aug-21.1</td>
<td>12</td>
<td>13</td>
<td>16</td>
<td>41</td>
<td>23</td>
<td>14</td>
<td>16</td>
<td>53</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Sts Violence &amp; aggression - patient physical assault on patient (categories A-C)</td>
<td>Safety monitoring</td>
<td>SPC Trend</td>
<td>14/15 Aug-16.2</td>
<td>13</td>
<td>13</td>
<td>10</td>
<td>36</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td>41</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Four Steps to Safety (Care Delivery System)</td>
<td>Quality Priority 1 Link</td>
<td>100% IP by Q4 16</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>17</td>
<td>17</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Incidents</strong></td>
<td>11</td>
<td>Safer Staffing (Number of wards with 20% or higher of shifts breached)</td>
<td>Safety monitoring</td>
<td>&lt; 20%</td>
<td>13.6</td>
<td>14</td>
<td>15</td>
<td>9</td>
<td>12.7</td>
<td>13</td>
<td>15</td>
<td>13</td>
<td>13.7</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Absent - Detained (formerly recorded as AWOLs)</td>
<td>Safety monitoring</td>
<td>-</td>
<td>-</td>
<td>55</td>
<td>78</td>
<td>71</td>
<td>204</td>
<td>59</td>
<td>85</td>
<td>62</td>
<td>206</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safeguarding</strong></td>
<td>13</td>
<td>Brief &amp; Full Risk Screen</td>
<td>Safety monitoring</td>
<td>80%</td>
<td>91.22%</td>
<td>92.44%</td>
<td>92.59%</td>
<td>92.58%</td>
<td>-</td>
<td>93.08%</td>
<td>92.70%</td>
<td>-</td>
<td>-</td>
<td>Improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Child Need Risk Screen</td>
<td>Safety monitoring</td>
<td>96%</td>
<td>92.3%</td>
<td>91.5%</td>
<td>91.2%</td>
<td>91.3%</td>
<td>-</td>
<td>91.93%</td>
<td>92.34%</td>
<td>92.70%</td>
<td>-</td>
<td>Improvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Graphs

- **Safer Staffing: Wards Breaching 20% of Shifts**
- **Violence (Physical Assaults by Patient on Patient (A-C))**
- **Incidents (Categories A-C)**
## Effectiveness

### Monthly Indicator

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Delayed Discharges</td>
<td>Monitor</td>
<td>7.5% Monthly</td>
<td>3.1%</td>
<td>4.0%</td>
<td>4.2%</td>
<td>3.9%</td>
<td>4.0%</td>
<td>3.2%</td>
<td>3.1%</td>
<td>3.3%</td>
<td>3.2%</td>
<td>A: 7.5-10%</td>
<td>-</td>
<td>Q2 Monitor target met. Performance has improved in October.</td>
</tr>
<tr>
<td>17</td>
<td>HTT Gatekeeping</td>
<td>Monitor (and CCG Sanction)</td>
<td>95% Monthly</td>
<td>95.6%</td>
<td>96.7%</td>
<td>96.4%</td>
<td>96.2%</td>
<td>96.4%</td>
<td>96.1%</td>
<td>93.5%</td>
<td>95.4%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>19</td>
<td>Inpatient annual Physical Health Screen</td>
<td>CCG Sanction</td>
<td>90%</td>
<td>93.3%</td>
<td>93.2%</td>
<td>94.4%</td>
<td>92.9%</td>
<td>-</td>
<td>94.4%</td>
<td>93.3%</td>
<td>91.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20</td>
<td>Percentage of New Patients with the Ability to Consent that are Admitted to AMH Inpatient Services Offered an HIV Test (500K Penalty)</td>
<td>CCG Sanction</td>
<td>30.00%</td>
<td>M12: 43.2%</td>
<td>32.7%</td>
<td>37.0%</td>
<td>51.3%</td>
<td>41.6%</td>
<td>52.1%</td>
<td>42.5%</td>
<td>47.4%</td>
<td>48.3%</td>
<td>A: 30-40%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Settled Accommodation Assessment Completed (CPA patients)</td>
<td>Contracts</td>
<td>95%</td>
<td>93.3%</td>
<td>93.0%</td>
<td>92.9%</td>
<td>92.8%</td>
<td>-</td>
<td>92.5%</td>
<td>90.2%</td>
<td>90.7%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>26</td>
<td>Employment Assessment Completed (CPA patients)</td>
<td>Contracts</td>
<td>95%</td>
<td>93.8%</td>
<td>93.5%</td>
<td>93.3%</td>
<td>93.1%</td>
<td>-</td>
<td>92.9%</td>
<td>90.2%</td>
<td>90.7%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>27</td>
<td>Total of wards with total QUeSTT score at level 2 and 3, where level 1 is good</td>
<td>QUeSTT Indicator</td>
<td>-</td>
<td>6</td>
<td>6 (15)</td>
<td>8 (15)</td>
<td>7 (15)</td>
<td>-</td>
<td>6 (15)</td>
<td>4 (15)</td>
<td>8 (15)</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following indicators are reported on either a quarterly, bi-annual or annual basis.

### Quarterly Indicator

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>Reduce the number of people supported by HTT who required an admission (where the AMH model has been established)</td>
<td>Quality Priority 8</td>
<td>&lt; 15%</td>
<td>17%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>29</td>
<td>Patients: No of eligible patients having six key metabolic c/v tests CQUIN (4a)</td>
<td>Quality Priority 3 &amp; CQUIN</td>
<td>90% by Q4 - Each 90%</td>
<td>83%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Early Intervention: No of eligible patients having six key metabolic c/v tests CQUIN (4a)</td>
<td>Quality Priority 3 &amp; CQUIN</td>
<td>80% by Q4 TRC</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Physical Health Communication with GP CQUIN (4b)</td>
<td>Quality Priority 3 &amp; CQUIN</td>
<td>75% by Q4 - Each 75%</td>
<td>24%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Discharge communications to GP</td>
<td>Internal target</td>
<td>C@NHL</td>
<td>59.6%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Discharge communications to GP</td>
<td>Internal target</td>
<td>C@NHL</td>
<td>37.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Patients with both an AUDIT (identification tool) and a drug and alcohol assessment completed (Adult acute inpatient and adult community teams)</td>
<td>Quality Priority 9</td>
<td>50% (Audit)</td>
<td>18% Audit completion &amp; D&amp;A assessment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Assuring the appropriateness of unplanned CAMHS admissions (Tier 4) - number of reviews held within 5 working days of unplanned admissions</td>
<td>CQUIN (NHSE)</td>
<td>60% improvement</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Adult Eating Disorders - Outcome measures – Year 2</td>
<td>CQUIN (NHSE)</td>
<td>Year 2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Dual Diagnosis Themes 1-4 SI Network</td>
<td>CQUIN (Lewisham)</td>
<td>New</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>AMH Service Redesign &amp; GP Network</td>
<td>CQUIN (Croydon)</td>
<td>New</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>AMH Model</td>
<td>CQUIN (Lewisham)</td>
<td>New</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Outcomes</td>
<td>CQUIN (LSLC)</td>
<td>New</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Smoking Cessation Training: 85% of clinical staff will be trained to Level 1 and have annual refresher</td>
<td>Internal target</td>
<td>85%</td>
<td>New</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Smoking Cessation Training: 85% of Site Based Advisors will have completed Level 3 training</td>
<td>Internal target</td>
<td>85%</td>
<td>New</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
### Caring

#### Monthly Indicator

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Do you feel involved in your care? (IP &amp; Community)</td>
<td>Quality Priority 4</td>
<td>Increase on 14/15</td>
<td>83.50%</td>
<td>87.6%</td>
<td>89.9%</td>
<td>87.7%</td>
<td>88.3%</td>
<td>84.3%</td>
<td>88.2%</td>
<td>90.6%</td>
<td>88.1%</td>
<td></td>
<td></td>
<td>YTD 87.9% following data refresh.</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>CPA Formal Review within 12 months</td>
<td>Monitor</td>
<td>Q4: 97.15%</td>
<td>95%</td>
<td>97.1%</td>
<td>-</td>
<td>-</td>
<td>95.5%</td>
<td>-</td>
<td>-</td>
<td>95.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Copies of Care Plan given (%) (% of patients given copies of their CPA care plan</td>
<td>LSLC Contracts report all CAGS</td>
<td>95%</td>
<td>95.1%</td>
<td>95.0%</td>
<td>94.4%</td>
<td>-</td>
<td>95.2%</td>
<td>95.3%</td>
<td>95.1%</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>New Complaints</td>
<td>National Standard</td>
<td>SPC Trend</td>
<td>Avg. PM 45</td>
<td>31</td>
<td>47</td>
<td>43</td>
<td>121</td>
<td>38</td>
<td>35</td>
<td>27</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Friends and Family Score</td>
<td>National Standard</td>
<td>Trend</td>
<td>-</td>
<td>84%</td>
<td>86%</td>
<td>82%</td>
<td>84%</td>
<td>78%</td>
<td>83%</td>
<td>85%</td>
<td>83%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Number of Friends and Family Responses</td>
<td>National Standard</td>
<td>Trend</td>
<td>-</td>
<td>858</td>
<td>685</td>
<td>728</td>
<td>2271</td>
<td>2777</td>
<td>777</td>
<td>915</td>
<td>795</td>
<td>2487</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following indicators are reported on either a quarterly, bi-annual or annual basis

#### Quarterly Indicator

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Risk Assessment &amp; informing decision making - Inpatients and Community Patients on CPA will have a full documented risk assessment</td>
<td>Quality Priority 7</td>
<td>75% (Q4 Audit)</td>
<td>65.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Number of carers who state they have been offered a carer's assessment</td>
<td>Quality Priority 5</td>
<td>30% (Audit)</td>
<td>20%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Personalisation</td>
<td>CQUIN</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>In-Patient Experience</td>
<td>CQUIN (LSLC)</td>
<td>Milestones</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>-</td>
<td></td>
<td>Met &amp; 1 &amp; 2 Deliverables achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Secure Service Users Active Engagement Programme (MH01)</td>
<td>CQUIN (NHSE)</td>
<td>Milestones</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td></td>
<td>Qtr 2 submission made - Pending NHSE response.</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Perinatal specific involvement and support for partners/significant others (MH06)</td>
<td>CQUIN (NHSE)</td>
<td>Milestones</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td></td>
<td>Qtr 2 submission made - Pending NHSE response.</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Mental health carer involvement strategies (MH08)</td>
<td>CQUIN (NHSE)</td>
<td>Milestones</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td></td>
<td>Qtr 2 submission made - Pending NHSE response.</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Wards where patients are expected to queue for medication</td>
<td>14/15 Quality Priority</td>
<td>24.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>A: 10-25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Wards where patients are expected to queue for meals</td>
<td>14/15 Quality Priority</td>
<td>32.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>A: 10-25%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Do you feel involved in your care?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>87.6%</td>
<td>89.9%</td>
<td>87.7%</td>
<td>88.3%</td>
<td>84.3%</td>
<td>88.2%</td>
<td>87%</td>
<td>85.8%</td>
<td>86%</td>
<td>84.7%</td>
<td>88%</td>
<td>85.8%</td>
<td>86%</td>
<td>84.7%</td>
<td>88%</td>
<td>85.8%</td>
<td>86%</td>
<td>84.7%</td>
<td></td>
</tr>
</tbody>
</table>

#### New Complaints

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>37</td>
<td>38</td>
<td>41</td>
<td>33</td>
<td>37</td>
<td>33</td>
<td>41</td>
<td>33</td>
<td>37</td>
<td>33</td>
<td>37</td>
<td>33</td>
<td>41</td>
<td>33</td>
<td>37</td>
<td>33</td>
<td>37</td>
<td>33</td>
<td>41</td>
</tr>
</tbody>
</table>
### Responsiveness

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>59</td>
<td>&lt;18 week wait time AMH services</td>
<td>TBC</td>
<td>-</td>
<td>92.8%</td>
<td>91.4%</td>
<td>90.5%</td>
<td>-</td>
<td>89.2%</td>
<td>91.7%</td>
<td>90.3%</td>
<td>TBC</td>
<td>CCG Reporting</td>
<td>2015/16 Target to be agreed with CCG. Will be replaced by new EI national standard. - reporting due Q4 2015/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>Monitor</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>-</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Stable</td>
<td>TBC</td>
<td>New national requirement - reporting in Q4 2015/16. Shadow reporting commenced 1 November.</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>Early intervention in Psychosis (EIP), 1st Episode Psychosis treatment within 2 weeks and concordance with NICE guidance</td>
<td>Monitor</td>
<td>95%</td>
<td>(Q4 onwards)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Deterioration</td>
<td>-</td>
<td>New national requirement - reporting in Q3 2015/16. PAVE figures for LSLC IAPT for First Treatment.</td>
</tr>
<tr>
<td>62</td>
<td>IAPT Waiting Times within 6 weeks (First treatment)</td>
<td>Monitor</td>
<td>75%</td>
<td>(Q3 onwards)</td>
<td>-</td>
<td>81.2%</td>
<td>85.0%</td>
<td>88.0%</td>
<td>84.7%</td>
<td>88.70%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Deterioration</td>
<td>-</td>
<td>New national requirement - reporting in Q3 2015/16. PAVE figures for LSLC IAPT for First Treatment.</td>
</tr>
<tr>
<td>63</td>
<td>IAPT Waiting Times within 18 weeks (First treatment)</td>
<td>Monitor</td>
<td>95%</td>
<td>(Q3 onwards)</td>
<td>-</td>
<td>98.4%</td>
<td>98.9%</td>
<td>98.5%</td>
<td>98.6%</td>
<td>98.90%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Stable</td>
<td>-</td>
<td>New national requirement - reporting in Q3 2015/16. PAVE figures for LSLC IAPT for First Treatment.</td>
</tr>
</tbody>
</table>

The following indicators are reported on either a quarterly, bi-annual or annual basis

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>64</td>
<td>Certification - requirements regarding access to healthcare for people with a learning disability (L)</td>
<td>Monitor</td>
<td>Compliance</td>
<td>Met</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Met</td>
<td>Cleanliness 99.5%, Food 90.5%, Privacy, Dignity and Well Being 94.5%, Condition, Appearance and Maintenance 96.25%, Dementia 98.4% (new domain) PLACE lite assessments on a selection of wards each month on Food and Hydration are planned. Trust cleanliness audits are undertaken on a monthly basis for in the region of 60 wards per month.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>PLACE results quality of the environments IP</td>
<td>Quality Priority 6</td>
<td>95%</td>
<td>Annual</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3 of 5 over 95%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Works to 5 wards completed comprising Nalion, Luftor King, Willey 2, Leo, Evans Ward (JBU relocated from Douglas Bennett House). Gresham PICU contractor progressing refresh works. Gresham 1 - Refurb and Ascom installation - progressing on site. Ladywell Ground floor phase 3 and entrance - completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>Monitor progress of redecorate/refurbishment plan</td>
<td>Linked to Quality Priority 6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Works within the Triage Wards were completed by the 31st August. Most Level 2 ligature reduction works are scheduled to complete by the end of November 2015 (apart from BRH River House and Westways which will complete early December 2015). Gresham 2 is not scheduled to complete until March 2016 because the ligature works are included as part of a larger refurbishment project.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Well Led

### Workforce Monthly Indicator

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>68</td>
<td>Staff Sickness rate % (rolling year %)</td>
<td>Workforce</td>
<td>&lt; 5.12%</td>
<td>5.15%</td>
<td>5.21%</td>
<td>5.11%</td>
<td>5.07%</td>
<td>-</td>
<td>5.06%</td>
<td>5.09%</td>
<td>5.03%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Vacancy Rate (WTE)</td>
<td>Workforce</td>
<td>TBC</td>
<td>19.5%</td>
<td>20.0%</td>
<td>19.7%</td>
<td>20.7%</td>
<td>-</td>
<td>22.2%</td>
<td>20.1%</td>
<td>20.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>Appraisal Workforce</td>
<td>Workforce</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>86%</td>
<td>97%</td>
<td>99%</td>
<td>-</td>
<td></td>
<td>HR is validating with CAGS where there is not a record of completion and reasons for this.</td>
</tr>
</tbody>
</table>

### Workforce Clinical Risk

- **Level 2 Training**
  - Target: 65.3%
  - 2014/15 Q4: 66.1%
  - Apr-15: 68.7%
  - May-15: 70.3%
  - Jun-15: 72.6%
  - Jul-15: 72.4%
  - Aug-15: 76.9%
  - Sep-15: 77.7%

### Workforce Mandatory Training

- **Basic Life Support Level 1 (Non Clinical Staff)**
  - Target: 85%
  - 2014/15 Q4: 84.1%
  - Apr-15: 84.8%
  - May-15: 87.9%
  - Jun-15: 87.5%
  - Jul-15: 87.8%
  - Aug-15: 89.4%
  - Sep-15: 90.4%

- **Immediate Life Support**
  - Target: 85%
  - 2014/15 Q4: 50.3%
  - Apr-15: 52.5%
  - May-15: 54.4%
  - Jun-15: 61.9%
  - Jul-15: 68.3%
  - Aug-15: 66.5%
  - Sep-15: 76.8%

- **Infection Control (Levels 1 & 2)**
  - Target: 85%
  - 2014/15 Q4: 65.6%
  - Apr-15: 67.8%
  - May-15: 70.1%
  - Jun-15: 84.2%
  - Jul-15: 73.1%
  - Aug-15: 74.0%
  - Sep-15: 78.1%

- **Health, Safety & Welfare**
  - Target: 85%
  - 2014/15 Q4: 75.7%
  - Apr-15: 76.1%
  - May-15: 78.5%
  - Jun-15: 78.8%
  - Jul-15: 79.7%
  - Aug-15: 80.8%
  - Sep-15: 83.0%

- **Equally, Diversity & Human Rights**
  - Target: 85%
  - 2014/15 Q4: 57.1%
  - Apr-15: 58.6%
  - May-15: 62.3%
  - Jun-15: 65.6%
  - Jul-15: 69.3%
  - Aug-15: 72.4%
  - Sep-15: 76.7%

- **Moving & Handling Loads**
  - Target: 85%
  - 2014/15 Q4: 59.0%
  - Apr-15: 60.2%
  - May-15: 60.4%
  - Jun-15: 65.9%
  - Jul-15: 67.1%
  - Aug-15: 68.6%
  - Sep-15: 71.7%

- **Moving & Handling Patients**
  - Target: 85%
  - 2014/15 Q4: 33.1%
  - Apr-15: 33.2%
  - May-15: 33.3%
  - Jun-15: 41.4%
  - Jul-15: 43.7%
  - Aug-15: 46.4%
  - Sep-15: 53.5%

- **Fire Safety Awareness**
  - Target: 85%
  - 2014/15 Q4: 67.5%
  - Apr-15: 68.5%
  - May-15: 71.8%
  - Jun-15: 73.3%
  - Jul-15: 73.9%
  - Aug-15: 73.9%
  - Sep-15: 80.2%
Transformation Programmes Dashboard

The dashboard reports delivery of the transformation programmes identified within the Operational Plan 2014/16 and is designed to provide assurance and challenge at Board level.
## Summary

### AMH Programme

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Target</th>
<th>Performance</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBDs excluding leave (of people known to the AMH teams)</td>
<td>-28%</td>
<td>2732</td>
<td></td>
</tr>
<tr>
<td>Referrals into our services from primary care (accepted referrals to A&amp;L)</td>
<td>-</td>
<td>308</td>
<td>↑</td>
</tr>
<tr>
<td>Transfers back to primary care (discharges from MAP treatment teams and PRTs)</td>
<td>10%</td>
<td>195</td>
<td>1</td>
</tr>
</tbody>
</table>

### Workforce

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Target</th>
<th>Performance</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness Absence</td>
<td>5.12%</td>
<td>5.00%</td>
<td>↓</td>
</tr>
<tr>
<td>Appraisal compliance</td>
<td>100%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Bank and agency utilisation and recruitment: CPN Bank &amp; Agency usage</td>
<td>-20%</td>
<td>92.9</td>
<td>↓</td>
</tr>
</tbody>
</table>

### ICT

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Target</th>
<th>Performance</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service desk open calls at the end of the month</td>
<td>-</td>
<td>1599 New 1292 Closed</td>
<td></td>
</tr>
<tr>
<td>PCs replaced at the end of the month</td>
<td>2100 FY</td>
<td>367</td>
<td>1</td>
</tr>
<tr>
<td>Number of users of Health Intelligence products count during the month</td>
<td>-</td>
<td>234</td>
<td></td>
</tr>
</tbody>
</table>

### Estates: Capital and Facilities

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Target</th>
<th>Performance</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce number of community properties and related operating costs</td>
<td>-</td>
<td>Refer to commentary</td>
<td></td>
</tr>
<tr>
<td>Capital project achievement against plan</td>
<td>Cost &amp; Time</td>
<td>Green: 5/4 Amber: 1/2 Red: 0/0</td>
<td></td>
</tr>
<tr>
<td>Year on year improvement on PLACE scores</td>
<td>3 of 4 domains</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Quality Improvement

Our vision is to create and sustain a culture with continuous quality improvement.

We aim to become an organisation with a culture of improvement that is based on service users, carers, staff and key partners working together to improve the delivery of care to deliver the outcomes that matter to our service users.

We are seeking a partner to help us deliver a trust wide quality improvement programme to achieve this vision over the next three years, embedding this culture in our organisation permanently and ensuring value for money in everything we do. The partner will support us to deliver a programme that will be service user focused, flexible in delivery and provide economies through standardisation of our methods and continuous efficiency improvement.

### Key Processes

<table>
<thead>
<tr>
<th><strong>Key Processes</strong></th>
<th><strong>Timelines</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Procurement of a partner with the right expertise to deliver this model.</td>
<td>Start Sept Go Live Mar 2016</td>
</tr>
<tr>
<td>Recruiting a QI team – in place Feb 2016</td>
<td>In place Feb 2016</td>
</tr>
<tr>
<td>Scoping and training exercises 2016</td>
<td>2016</td>
</tr>
</tbody>
</table>

### Commentary

- It has been agreed that until the Trust have a partner in place and a defined set of KPIs agreed with them, this programme will remain as a narrative update. A more detailed update is provided within this meeting.
- Key performance indicators:
  - Procurement process has officially begun.
  - Recruitment ads are live, we aim to have a programme team in place by February 2016, including a programme manager, a programme support officer and five facilitators.
  - The quality improvement internal project board refreshes the governance structure and maintains robust oversight of the procurement and implementation of this programme.
  - The new partner is selected and the contract is awarded in March 2016.
  - There will be subsequent phases including a scoping exercise, implementation including staff training and guidance on system changes. These phases and their timeframes will be agreed with our preferred partner over the course of the procurement exercise and the scoping phase. We will provide regular updates to the board and relevant stakeholders when there is more detail around these key stages in the programme.
  - To reach a better understanding potential scale of savings associated by March 2016.
  - To provide details of a defined project board with terms of reference by November 2015.
KPI Targets

<table>
<thead>
<tr>
<th>KPI</th>
<th>Targets</th>
<th>Previous (Month)</th>
<th>Performance (Oct)</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBDS excluding leave (of people known to the AMH teams)</td>
<td>28% Reduction</td>
<td>2751</td>
<td>2732</td>
<td></td>
</tr>
<tr>
<td>Referrals into our services from primary care (accepted referrals to A&amp;L teams)</td>
<td>-</td>
<td>255</td>
<td>308</td>
<td></td>
</tr>
<tr>
<td>Discharges back to primary care (discharges from all MAP teams and PRTs)</td>
<td>10% reduction in caseload</td>
<td>204</td>
<td>195</td>
<td></td>
</tr>
</tbody>
</table>

**AMH Programme**

**Commentary**

• Accepted referrals and Transfers to Primary Care: The number of referrals into the services have increased this month and discharges reduced therefore the numbers within each of the Treatment Teams (MAP and PRTs) continues to rise. This is not causing a significant problem to services at present except the MAP treatment team in Lewisham. The MAP treatment team in Lewisham has a very high caseload per Care Co-ordinator which has caused a cost pressure within the team. This is being discussed with the CCG.

**Reporting Details**

• OBDS – OBD by CMHT AMH report – activity relates to AMH Lambeth and Lewisham. HI validation has been completed and the data has been re-run.
• Accepted referrals - Activity relates to the Assessment & Liaison Teams within MAP CAG in Lambeth and Lewisham. System has been revised to exclude any rejected referrals.
• Discharge figures are based on discharges back to GP from the Promoting Recovery services within the Psychosis CAG and the Assessment & Liaison Teams and MAP treatment teams within MAP CAG in Lambeth and Lewisham.
Workforce

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Previous (Month)</th>
<th>Performance (Oct)</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness Absence</td>
<td>5.12%</td>
<td>5.03%</td>
<td>5.00%</td>
<td></td>
</tr>
<tr>
<td>Appraisal completion</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Bank and agency utilisation and recruitment</td>
<td>-20% CPN Bank &amp; Agency usage</td>
<td>112.6 WTE</td>
<td>92.9 WTE</td>
<td></td>
</tr>
</tbody>
</table>

**Commentary**

- Work has been ongoing for several years to reduce staff sickness. A level of 5.00% in October 2015 demonstrates the lowest level of sickness since records have been kept in this particular way since June 2009. The cost of sickness in 2013/14 to the Trust was calculated as c £6,525,000 PA. A reduction of 0.35% in sickness equates to £450K. Current performance is well ahead of 5.12% target.
- Appraisal Completion: Significant increase on 2014/15 completion rates. This is unlikely to alter until the next Appraisal season in April – June 2016. Alternative metrics are being considered to replace this.
- Bank and Agency utilisation: Bank and Agency CPN reduction from 124WTE in October 2014 and to 92.9 WTE for CPN is a 25% reduction and ahead of target. There was an expected increase in September but this has fallen in October as recruitment processes are completed and new members of staff start in post.

**Reporting Details**

- Absence: Sickness levels rolling year: The total cumulative sickness for the service (in the preceding 12 months). Source: HR Dashboard using ESR.
- Appraisal Compliance - Completion rates for staff, excluding medical staff.
- Bank and agency utilisation and recruitment: CPN Usage October.
Estates: Capital and Facilities

<table>
<thead>
<tr>
<th>KPI</th>
<th>Targets</th>
<th>Previous (Month)</th>
<th>Performance (Oct)</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce number of community properties and related operating costs</td>
<td>-</td>
<td>GIA 129,077 sq m</td>
<td>Refer to commentary</td>
<td></td>
</tr>
<tr>
<td>Capital project achievement against plan</td>
<td>Cost &amp; Time</td>
<td>Green: 4/4 Amber: 2/2 Red: 0/0</td>
<td>Green: 5/4 Amber: 1/2 Red: 0/0</td>
<td></td>
</tr>
<tr>
<td>Year on year improvement on PLACE scores</td>
<td>Annual</td>
<td>-</td>
<td>3 of 4 domains</td>
<td></td>
</tr>
</tbody>
</table>

Capital projects achievement against plan: This indicator is reporting on key projects.

<table>
<thead>
<tr>
<th>Projects</th>
<th>Cost</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Ligature programme</td>
<td>G</td>
<td>A</td>
</tr>
<tr>
<td>Centralised Place of Safety</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Trust Wide Staff Attack Alarms</td>
<td>G</td>
<td>A*</td>
</tr>
<tr>
<td>Ladywell Phase 3 and Entrance**</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Work Hubs - Maudsley</td>
<td>A</td>
<td>G</td>
</tr>
<tr>
<td>Douglas Bennett Refurbishment</td>
<td>G</td>
<td>G</td>
</tr>
</tbody>
</table>

Note: Anti-ligature window replacement programme will be reported separately.

Commentary

- Benchmarking is under development to chart progress in identifying properties for disposal, reporting occupancy utilisation, and factoring in organisational growth.
- Capital planning: Attack alarms Time Amber rating due to Gresham 2. Ladywell Phase 3 and Entrance now complete.
- Patient-Led Assessments of the Care Environment (PLACE): There has been year on year improvement in three of four domains. The Trust scores are all above the National averages. PLACE Assessments are annual in 16/17 these will be carried out Feb - Jun. Hotel Services are planning to undertake PLACE Lite assessments Nov-Dec as a practice assessment in readiness.

Reporting details

- GIA (Gross Internal Area): Freehold properties
- Capital projects achievement against plan comprises Key projects - RAG rating status for achievement against planned time and cost.
### ICT

**KPI**

<table>
<thead>
<tr>
<th>KPI</th>
<th>Target</th>
<th>Previous (Month)</th>
<th>Performance (Oct)</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service desk open calls at the end of the month</td>
<td>-</td>
<td>1662 New 1850 Closed</td>
<td>1599 New 1292 Closed</td>
<td>🚀</td>
</tr>
<tr>
<td>PCs replaced at the end of the month</td>
<td>2100 FY</td>
<td>347</td>
<td>367</td>
<td>🚀</td>
</tr>
<tr>
<td>Number of users of Health Intelligence products</td>
<td>-</td>
<td>236</td>
<td>234</td>
<td>⇠</td>
</tr>
</tbody>
</table>

**Commentary**

- PC and mobile replacement programme is currently amber. Consolidated Project Managers (Mobile PM & PC Replacement PM) from two to one. Tender is in progress for new laptops/tablets.
- No target is set for users of Health Intelligence Products this is an initial metric to monitor trends.

**Reporting Details**

- ICT Balanced Business Scorecard – this will be issued to Executives on a monthly basis.
### TRUST BOARD OF DIRECTORS – SUMMARY REPORT

**Date of Board meeting:** 24 November 2015

**Name of Report:** Centre for Translational Informatics (CTI)

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

**Author:** Stephen Docherty / Tanya Hardy

**Approved by:** Matthew Patrick

**Presented by:** Stephen Docherty

### Purpose of the report:
To inform the Board on progress of the establishment of the Centre for Translational Informatics and to discuss an official launch date.

### Recommendations to the Board:
To note the progress to date and approve an official CTI launch at the end of February 2016

### Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
This report has no relationship with the Assurance Framework

### Summary of Financial and Legal Implications:
No financial or legal implications at this point. Funding for projects will be pursued on a case-by-case basis.

### Equality & Diversity and Public & Patient Involvement Implications:
Considered but there are no specific implications.

### Service Quality Implications:
CTI will continue to evolve the framework to allow ideas to be brought forward and developed that could exploit Technology & Data, bring about new insights through the use of analytics, and therefore delivering benefit to patients and clinicians.
WHO WE ARE AND WHAT WE DO

- Increases the value to patients, clinicians and SLaM through the use of existing and new data systems
- Increases the volume, rigour, timeliness and relevance of analyses using current data resources
- Provides an environment for development, robust testing, implementation, dissemination and support of e- and m-therapies (the use of mobile/devices based technologies)
- Provides a focus for the promotion of KHP IP and streamlining of commercialisation opportunities
KEY OUTPUTS

- Addressing clinical priorities
- Data enrichment
- Data integration
- Post processing

- Pipeline assembly
- Device design
- Prototype development

- Prototype implementation
- Evaluation
- Dissemination and export

- Patient participation
- Commercial partnerships
The Maudsley Digital Ecosystem embraces CTI & SLaM IT within its creative development process, product & service design, development & implementation.

**CTI (Centre for Translational Informatics)**
- big data architecture
- discovery and analysis tools
- insight generation
- idea generation
- scientific underpinning
- quality assessment

**SLaM IT**
- IT architecture & design
- information governance
- management information BI
- idea generation, test bed for new products & services, quality assessment

**IoPPN Academia**
- primary partners for commercialisation incl. Maudsley International & Learning brand management

**SLaM & KCL Commercial**

**SLaM Operations**

**Patients & Community**

**Strategic partnership**

**Supplier relationship**

**Technology partners**

**Venture partners**

THE MAUDSLEY DIGITAL ECOSYSTEM ENCOMPASSES CTI & SLaM IT
CTI MAKES UP ONE HALF OF THE MAUDSLEY DIGITAL ECOSYSTEM
THE VISION

To be recognised as the world’s leading institution in mental health informatics

Why?
Better care through the use of information

How?
Working collaboratively across institutions and divisions

What?
Insight generation
Tools for research
Data architecture
CTI PROJECTS

- **Dev environment**: An environment has been created to enable agile development, implementation and dissemination of mental health apps by providing access to a snapshot-ed version of the electronic medical record.

- **CRIS & NLP**: Pseudonymised version of the SLaM electronic medical record is available for research through the CRIS project.

- **Protect**: The PROTECT Study will gather data and support innovative research to improve our understanding of the ageing brain and why people develop dementia.

- **MHL 2.0**: Next iteration of MHL PHR - prototype and Beta release. Deliver a Personalised Health Record (PHR) on a platform with an application and database for the benefit of patients, carers, clinicians and researchers.

- **Imparts**: Integration of mental and physical healthcare in research.

---

Additional text:

**Dev environment**: An environment has been created to enable agile development, implementation and dissemination of mental health apps by providing access to a snapshot-ed version of the electronic medical record.

**CRIS & NLP**: Pseudonymised version of the SLaM electronic medical record is available for research through the CRIS project.

**Protect**: The PROTECT Study will gather data and support innovative research to improve our understanding of the ageing brain and why people develop dementia.

**MHL 2.0**: Next iteration of MHL PHR - prototype and Beta release. Deliver a Personalised Health Record (PHR) on a platform with an application and database for the benefit of patients, carers, clinicians and researchers.

**Imparts**: Integration of mental and physical healthcare in research.
CTI PROJECTS

Sleep Sight
Remote monitoring of sleep in Schizophrenia to test feasibility for predicting relapse.

RADAR
Remote access and passive monitoring to detect changes that are predictive of disease prevention.

K-Connect
An EU H2020 project to enable EHR semantic annotation and search capability with literature integration.

Name TBC
Implement a process (likely to be agents) to automatically identify injectors and randomise the ultrasound scanning to put the test on a more formal trial footing.

Anika
Feasibility work around EHR literature integration.

Remote monitoring of sleep in Schizophrenia to test feasibility for predicting relapse.
Remote access and passive monitoring to detect changes that are predictive of disease prevention.
An EU H2020 project to enable EHR semantic annotation and search capability with literature integration.
Implement a process (likely to be agents) to automatically identify injectors and randomise the ultrasound scanning to put the test on a more formal trial footing.
Feasibility work around EHR literature integration.
Developing ideas and connecting them with the appropriate people / teams, using user-led design techniques.

Developing quickly into a POC or prototype.

Driving implementation.

Evaluating the technology and patient impact.

Idea from anywhere.

Idea.
SLaM IT has arranged a series of workshops to build in-house skills in data visualisation, delivered by local data expert David McCandless - enabling attendees to begin conveying and delivering information graphically and visually.
## PLANS AND DELIVERABLES

<table>
<thead>
<tr>
<th>Framework</th>
<th>Funding</th>
<th>Pipeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement and evolve the framework to allow people to come forth with ideas.</td>
<td>To optimise the level of funding for tech projects from the following:</td>
<td>To establish and develop the pipeline for idea generation.</td>
</tr>
<tr>
<td>Create the Maudsley Digital eco-system.</td>
<td>• Research</td>
<td></td>
</tr>
<tr>
<td>Create an advisory function to assist with validating digital interventions</td>
<td>• Government and Charity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Data related funding from UK sources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Corporate partnerships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Philanthropic funding</td>
<td></td>
</tr>
</tbody>
</table>
## Engagement

Close cooperation with SLaM, Service Users, Clinicians, Carers

Dev environment to be delivered (complete) and maintained

## Partnerships

- Digital Industries
- Cross-Trust
- Academic
- Healthcare
- Life sciences
- Pharma
- Biotech

## Space

A space for the CTI and Maudsley Digital eco-system to operate
KEY DATES

NEXT STEPS
Conference to launch CTI, showcasing and telling our story

Four possible themes:
- Data Visualisation,
- Wearables,
- IG/Security,
- Self Management and Autonomy

Promoting of the use of technology and data

Internal and external audience to include:
clinicians, researchers, patients, carers, CIO’s, DH, NHS England, HSCIC, Commissioners, Primary Care, LA, IG and tech community, NOCRI, MRC, Wellcome, FARR, CRICK, MQ, BRC Scientific Advisory Board.
### Purpose of the report:

To demonstrate the effectiveness of the SLAM Arts Strategy initiative and the evidence to make a case for the mainstreaming of the central resource comprising the co-ordinating role – Head of Arts Strategy and the networks and systems that have been developed. The current funding arrangements from the Maudsley Charity cover the costs of the project until the end of March 2016.

### Recommendations to the Board:

The demonstrated effectiveness of the initiative and the evidence presented above make a strong case for the mainstreaming of the central resource comprising the co-ordinating role and the networks and systems that have been developed.

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

None

### Summary of Financial and Legal Implications:

The cost of maintaining the post and its associated activity is approximately £75,000 per year.

Over the last three years, well over £3,500,000 has been levered in from a variety of sources to support arts and cultural activity for the benefit of SLaM service users, such as GSTT and Maudsley Charity. Many of these have been supplemented by allocations from mainstream budgets so that the total value of the activity is considerably higher. KHP fundraising team have begun supporting the activities of the SLaM Arts Strategy.

### Equality & Diversity and Public & Patient Involvement Implications

Many arts projects/programmes have been created with the ongoing support and liaison of the PPI Leads i.e. Journeys of Appreciation Programme (JOAP), MHOAD, which also supports anti ageism and recovery based, work. JOAP has been very successful in public facing awards and has been selected as a case study for national and international reports, conferences, and the AESOP arts and health showcase at the Royal Festival Hall.
The activities are reported to the Social Inclusion and Recovery Board and there is much evidence of how the arts in mental health challenge stigma and discrimination for example by supporting service users in building identities and roles with high-level achievement - as an artist, producer, exhibiter, performer etc. The activities support SLaM in meeting the challenges for a recovery-focused organisation (ImRoc). The arts strategy was coproduced with service users and all of the activities foster service user and carer engagement and involvement.

The role of the SLAM Arts Strategy has been very important to the high profile and strategic patient and public work of partners i.e. Guys and St Thomas Charity’s arts and mental health funded programmes, the Culture at Kings programme, KCL medical school and for example SLAM arts have been accepted as a Tate Exchange (TEX) Associate (the new extension and programme at Tate Modern). There is only one other hospital arts TEX Associate.

It is clear that this role is having a notable impact on enhancing the reputation of SLaM’s work in this arena, and ensuring that a coherent approach is sustained with innovative activity being constantly channelled towards connecting with and influencing mainstream provision across the life course, with the most positive effect being the provision of opportunities for service users that promote their social inclusion and recovery and providing a conduit from supported provision within Trust services to participation in recovery-orientated arts projects in the voluntary sector and ultimately to participation as active citizens in mainstream arts and cultural organisations.

**Service Quality Implications:**

These activities are either well embedded within service provision, or provide valuable enhancements to routinely available activities. They complement one-to-one arts psychotherapies, support recovery, wellbeing and promote social inclusion.

For example one of the activities cited in the report is The Alchemy Project, which offers a radical dance-led intervention model that provides transformational opportunities for young adults accessing Early Intervention in Psychosis Services. The evaluation of the dance intervention showed it delivered clinically significant results in the wellbeing of participants, specifically a 10-point increase in their WEMWBS scores. The evaluation also showed that this intervention acted as powerful catalyst for the recovery of mental health service users and impacted positively on the Early Intervention Service itself.
Review of the Impact of SLaM’s Arts Strategy

Introduction and Executive Summary

The current post (Head of Arts Strategy) has grown from its original Southwark focus to comprehensive coverage that is now Trust-wide and beyond.

In 2013, funding was sought from and awarded by the Maudsley Charity for a three-year pilot designed to implement and embed the Arts Strategy that had been ratified by the Trust Executive. As part of this implementation, the post was moved from a temporary hosting in Psychosis CAG to Corporate OT / Social Inclusion and Recovery.

The Charity-funded implementation and embedding phase has achieved all of its objectives and more, by high profile participation in, and development and support of, comprehensive networks of Arts and Health providers and time-limited partnership projects on local, national and international scales.

The project has made a significant impact on raising the profile of arts participation as activity with therapeutic value, and as complementary to the specific arts psychotherapies provided by the Trust.

In the course of a three-year fixed-term project, the Arts Strategy has become firmly embedded across the Trust and has been influential in building on and developing relationships with many relevant organisations and facilitating their connection and collaboration with SLaM clinical services for the benefit of its users, carers and staff. The Arts Strategy supports the wide spectrum of arts in mental health, encompassing all art forms and the formal treatment of Arts Therapies and the therapeutic and vocational arts practice facilitated in hospitals, community and mainstream arts and cultural settings, such as museums, galleries, theatres, arts centres, festivals and arts fairs.

The Head of Arts Strategy is often called upon to maintain / sustain and promote projects in times of transition of infrastructure, funding and development: e.g. the Alchemy Project, Journeys of Appreciation programme, SLaM AdArt. Also increasingly we have been contacted and referenced as the “to go to place/first port of call” for advice, signposting and expertise for organisers of significant national events and initiatives: e.g. Cultural Commissioning Programme, accepted as an associate for the new Tate Exchange, Age Friendly Museums Network, AESOP Arts and Health showcase at Royal Festival Hall and the Changing Minds Festival at Southbank, All Parliamentary Party Group on Arts, Health and Wellbeing, and academic institutions such as Goldsmiths, Kings College London (KCL) and University of the Arts London (UAL).

The SLaM Arts Strategy is effectively coupled in a strategic collaboration with Guy’s and St Thomas’ Charity Arts Strategy, with their expressed specific focus on mental health arts projects, and with KCL with the Culture at Kings programme and Arts in Medical Education initiative.
The Head of Arts Strategy constantly identifies and communicates opportunities and connections for this network of stakeholders. An important element that has emerged from many testimonies is that of trust between the organisations and individuals concerned, which has led to an unprecedentedly high level of productive cooperation and flourishing through mutual understanding, support and enhanced connectedness.

Over the last three years, well over £3,500,000 has been levered in from a variety of sources to support arts and cultural activity for the benefit of SLaM service users. Many of these have been supplemented by allocations from mainstream budgets so that the total value of the activity is considerably higher.

The cost of maintaining the post and its associated activity is approximately £75,000 per year.

Current funding arrangements cover the costs of the project until the end of March 2016.

It is clear that this role is having a notable impact on enhancing the reputation of SLaM’s work in this arena, and ensuring that a coherent approach is sustained with innovative activity being constantly channelled towards connecting with and influencing mainstream provision across the life course, with the most positive effect being the provision of opportunities for service users that promote their social inclusion and recovery and providing a conduit from supported provision within Trust services to participation in recovery-orientated arts projects in the voluntary sector and ultimately to participation as active citizens in mainstream arts and cultural organisations.

Recommendation

The demonstrated effectiveness of the initiative and the evidence presented in more detail below make a strong case for the mainstreaming of the central resource comprising the co-ordinating role and the networks and systems that have been developed.

Rationale for Establishing an Arts Strategy Management Post in SLaM

Establishment of the Arts Strategy post responded to identified needs within SLaM, which has a long history of therapeutic arts participation. The original stated purpose of the three-year pilot was

To provide a strategic Arts and Culture role to work across the South London and Maudsley Trust, the Maudsley Charity, Bethlem Royal Archives and Museum and the Bethlem Gallery, to ensure that optimal benefit is achieved for service users, carers and staff through implementation of the SLaM Arts Strategy 2013-2018 and to build on its potential links and integration with King’s Health Partners & GSTT Charity’s Arts Strategy.

The need for the post was expressed thus:
Across the Trust and the Charity there are a number of projects embracing Arts and Culture that are at various stages in their development. There are many historical areas of provision, including specific arts therapies, and therapeutic arts involving all art forms which make use of the Arts and Culture in various ways, but that exist in isolation and suffer from a lack of co-ordination and strategic direction. The need to address this has been identified through the recently launched Trust Arts Strategy that has been ratified by the Trust Executive. There is now a need to bring the Trust’s many and diverse strands of artistic and cultural activity together in ways that improve the experience of people using services and promote mental health and wellbeing for all. The Trust needs to promote and sustain its reputation as the leader in the field of Arts and mental Health.

At the time it was proposed to pilot the initiative with Charitable Funding, SLaM was in the process of embedding the KHP CAG structure. Without an obvious place within that structure, it was decided that the project would have a home within Corporate Occupational Therapy / Social Inclusion and Recovery and that it would develop a Trust-wide presence with early emphasis on developing relationships with services within CAGs and with known local voluntary-sector providers of arts and cultural activity. Because this meant that there was no immediately identifiable mainstream funding source to support the activity, the Maudsley Charity was approached to support a three-year pilot to demonstrate the effectiveness of the scheme, with a view to SLaM mainstreaming it if the proposed objectives were achieved.

The envisaged beneficiaries and benefits were as follows:

- **Service users** – through active participation and aesthetic appreciation
- **Carers and families** – through mood stabilisation effects of arts participation, positive changes in self-perception and personal status of their loved ones
- **Staff** – through effects described above, improvements in motivation, skills, knowledge, participation, volition and general wellbeing
- **Local authority and public health bodies** – joint working with their agendas i.e. Southwark, Lambeth and Lewisham culture and sports and wellbeing strategies.
- **Arts bodies** – arts institutions and forums, and artist’s involvement
- **Public** – tackling stigma and discrimination by demonstrating achievement
- **Environment** – through contributions to and enhancements of built and natural spaces
- **Trust and Charity** – enhanced reputation as organisations in a different orbit from the average equivalents
- **Maudsley Charity associate organisations** (Bethlem Gallery, “Museum of the Mind”, Maudsley Learning Company, Maudsley International – there is the potential for strong links to be developed with each of these and for the Arts Strategy to provide significant enhancements to the activities of each.

It was proposed that
Through the four goals of the Trust wide arts strategy the Head of Arts Strategy will orchestrate the implementation of the Arts Strategy to address the needs and issues as reported in the consultation. www.slam.nhs.uk/arts:

1. Build on the SLaM infrastructure;
2. Develop the SLaM ambassadors and champions;
3. Expand connectivity and partnerships;
4. Raise staff awareness.

The main outcomes expected from the three-year funded project are listed below. How these have been achieved is shown in the narrative that follows, drawn from reports to the SIR Board, testimony from the many people and organisations involved, areas discussed and recorded in supervision and appraisal.

- **Scoping exercise** in which all provision will be mapped, a gap analysis will be carried out and solutions to challenges of filling gaps will be identified.
- Identification of appropriate tools to measure the effectiveness of individual Arts and Culture interventions
- There will be close working with partners through stakeholder meetings/forums
- A communication strategy will be developed.
- Developing provision that ensures identified gaps are filled for the benefit of all, effectively addressing stigma and discrimination.
- Data gathered to evidence effectiveness of individual interventions and the Arts Strategy as a whole.
- Promotion via all appropriate media and events
- Signposting via Trust Arts Strategy Lead coordinating the arts opportunities directory, SLaM and KHP website, ebulletins, TWIG Ops, outreach, networking, raising staff awareness
- Co-ordination via Head of Trust Arts Strategy, the Trust Arts Therapies adviser (Jo Van Den Bosch) and the steering group
- Leading to a report including analysis of effectiveness of the Arts Strategy.

Arts and Health Connections

The simplified diagram below demonstrates the dynamic range of relationships and opportunities with and between partners providing and supporting arts and cultural activity that benefit SLaM service users. It cannot adequately express the organic growth in complexity and the catalytic richness of the relationships involved.
Variety of Activity

Networking and engagement with individuals and organisations has supported and facilitated the following wide range of activities:

- Promoting volunteer-led arts activity within SLaM clinical provision and potentially in wider contexts. Over the last three years, approximately 105 people have volunteered in the provision of arts activity within SLaM and Bethlem Museum and Gallery.

- Building the infrastructure, champions and connections:
  - Arts in Addictions- 1 new p/t post created to support the arts coordinator; JOAP- 1 new p/t post created as community development worker; Salome gallery- evaluator for the publication;
  - Volunteers; Connectors and Champions

- Exhibitions
  - Salome Gallery at SHARP;
  - Long Gallery, Maudsley;
  - Adamson Collection;
Main corridor Maudsley: the Alchemy project, Healing Arts Team (HAT);
GV Art: partnership with Salome gallery for World Mental Health 2014, with artist Susan Aldworth on Reassembling the self
WMH 2012, 13, 14, 15: SLaM AdArt at Tate Modern
Bethlem Gallery also curating at ORTUS and Long Gallery
Bethlem Museum of the Mind

- Participatory social arts partnership projects
  - Peckham Platform; Playing on with AL3 ward for Anxiety 2014;
  - Creative Families at South London Gallery with the SLAM Parental Mental Health Team

- Festivals and Fairs – SLaM as key partner and collaborator
  - Impact Art Fair 2013 (in Brixton)
  - Adamson Collection festival
  - Anxiety Festival - Arts and Mental Health in London 2014
  - Changing Minds, Southbank February 2016

- Museum and Gallery partnerships

- Performances:
  - Laura Jane Dean, Manual Oracle, Song in the City- Creative Madness in Song,
    The Alchemy Project, Anatomy of Melancholy, Wishbone Theatre-Mountain
    High Valley Low

- Publications and Evaluation and research

- Interdisciplinary learning and exchange and debates and consultation

- Conferences (HS presenting unless otherwise stated):
  - International conference Culture, Health and Wellbeing 2013. Presented the JOAP poster and screened the Thou Art Film
  - Diversity in Heritage London network 2014 - presented JOAP
  - Panel speaker at Power of Art at House of Lords for Anxiety 2014
  - National Symposium on Older Adults and Isolation and the Arts, Albany 2014
  - Independent Theatre Council (ITC) conference Dec 2014,
  - Hosted Outreach Europe Conference, ORTUS, April 2015 Outreach Europe
  - Key note speaker presenting JOAP at the Health, Wellbeing and Museums Conference in Northern Ireland at the Ulster Folk and Transport Museum 6th October 2015, for Age Friendly Museums Network, led by British Museum.
  - Panel for Making it Together Conference 3rd December 2015 at Goldsmiths

---

### Arts Projects and Funding

Over the last three years, well over £3,500,000 has been levered in from a variety of sources to support Arts and cultural activity for the benefit of SLaM service users. Many of these have been supplemented by allocations from mainstream budgets so that the total value of the activity is considerably higher. Local health charities have been mobilised and convinced of the value of arts-based interventions.
The considerable match-funding, cash and in-kind, elements provided by SLaM and community partners is not represented here. Many projects have included valuable evaluation learning demonstrating the power of these interventions in helping to keep people well and to promote their acceptance and inclusion within local communities. The next phase of this work should include close engagement with health and social care commissioners to encourage more commissioning within mainstream provision so that there is not a constant reliance on charitable funds and the unstable status quo that this produces.

A number of other proposed initiatives that will attract further funding are currently in development. These include:

- KHP Fundraising commitment to supporting fundraising for the arts strategy
- Guy’s and St Thomas’ Charity for enhancing the healing environment with arts. Link with Places and spaces.
- Guy’s and St Thomas’ Charity for a CAMHS project with Ovalhouse Theatre

Consequences of the Activity

An extremely important aspect of this work is the organic way in which networks of influence and productive relationships have been developed. This includes many instances in which new opportunities for SLaM are tapped into through regular meaningful contact with existing and emerging partners. The result is a halo effect from the coalition of stakeholders working together, enabling better cross fertilisation, exchange, and return on investment and collaboration of expertise, knowledge and assets.

Significant Recent Arts Initiatives

The ways in which arts activity is valued is best expressed through the narratives of the example testimonies in the project descriptions and quotes below.

The Alchemy Project with Early Intervention in Psychosis (Dance as part of an integrated recovery model in Early Intervention in Psychosis) Funded by GSTT and Maudsley Charities

Summary of key points

- The Alchemy Project offers a radical dance-led intervention model that provides transformational opportunities for Young Adults accessing Early Intervention in Psychosis Services and has to date delivered clinically significant results in the wellbeing of participants, specifically a 10 point increase in their WEMBS scores
- The intervention acts as powerful catalyst for the recovery of mental health service users. Key factors in the effectiveness of the intervention are:
  - It does not define participants by their illness or their deficits and instead provides a focus, structure and process that enables them to work beyond
the typical lived experience of this constituency and challenge their expectations of themselves

- The physical activity of dancing addresses symptoms of mental health illness and/or medication such as apathy, lethargy and lack of motivation and rebalances the mind-body relationship.
- It creates social and physical connections between individuals and counteracts the feelings of isolation and fragmentation characteristic of populations with mental health problems.

- The intervention impacts positively on the Early Intervention Service itself
  - The intensity of the intervention i.e. that it looks after clients for a period of 4 weeks relieves workload pressure for Care Coordinators
  - It raises the bar in regard to Care Coordinator’s (and Clinician’s) expectations of their clients/service users
  - Care Coordinators who have participated in training or in sessions themselves note it as a powerful contributor to their own mental wellbeing and a positive experience in their own development.

**Journeys of Appreciation Programme - JOAP**

The Journeys of Appreciation Programme (JOAP) is a museum and gallery partnership with in-patient clinical services for older adults with mental health problems and dementia. Funded by the Maudsley Charity, JOAP works with Tate Modern, Tate Britain, the Cinema Museum, the Horniman Museum and Gardens and Dulwich Picture Gallery. The experience seems to be a turning point in the health worker-patient relationship. JOAP has been a catalyst for new creative and cultural projects, partnerships and opportunities, and encouraging the enhancing of the hospital ward environment and application of life story work.

- JOAP is the chosen case study for the Outreach Europe project [http://outreach-europe.eu/](http://outreach-europe.eu/)
- JOAP has also been selected as the case study on Cross sector partnerships for the British Museum report *Exploring the impact of population ageing on museums* by Dr Kate A. Hamblin, Senior Research Fellow, Oxford Institute of Population Ageing, University of Oxford
- JOAP has been selected for the AESOP National Arts in Health Celebration and Showcase in February 2016 at the Royal Festival Hall. 1 of 24 by AESOP, Southbank Centre, and Dr Michael Dixon, Chair of the NHS Alliance.

**Service User Support for the Arts**

**Visual Artist and Creative Practitioner**

I cannot emphasise enough how significant the impact of the Arts Team at SLaM has been in my life. I have experienced compassion, belief and endorsement most especially from Helen Shearn at SLAM, and Beth Elliott and Sam Curtis at Bethlehem Gallery. They have supported
my development as an artist in my own right, with my own voice and story. Through their help I have found a way to weave lived experience and creativity into something powerful to help others. After a nervous breakdown and period of severe depression, I resigned from a full time position. Slowly I have moved fully into a new life as a freelance artist, and much of my professional development in this journey happened gently over a number of years, supported by passionate and kind SLaM staff. I frequently use lived experience as an advocate to destigmatise mental illness and I share my story to help educate and share hope with others. I was proud to support colleagues in the launch of the new Bethlem Gallery with BBC Breakfast and international press.

Liz Atkin
Liz was also supported to travel recently to the USA to speak at UCLA on her art and recovery.

SLaM Clinical Staff Support for Arts
Adult Mental Health Psychiatrist and SLAM Arts Strategy Champion

The Trust’s ambitious Art Strategy has not only survived but expanded significantly in the last three years through the indefatigable efforts of Helen Shearn who seems to have a natural facility for networking and enthusing others on various projects.

There is an increasing recognition of the significance of art and culture in the healing and rehabilitative process of those who experience mental illness and thankfully, SLaM is at the vanguard of this exciting movement. Art and Culture have the potential to rebuild/reawaken the sense of self shattered by mental illness and compounded by alienation from society. In the Playing On drama project we saw the transformation of acutely psychotic patients embarked on a six-week workshop which led to a coproduction and performance of Hearing Things at the Ortus Learning Centre and The Albany Theatre. The highlight for me was when the audience was not able to recognise professional actors from patients or the members of staff. The accelerated discharge from hospital of several of the patients was for me, a proof of the efficacy of art and culture as an integral tool in the curative process of the mentally ill.

Dr Dele A Olajide Consultant Psychiatrist

Support from Partner Organisations
Guy’s and St Thomas’ Charity

I am writing with some thoughts from the Charity’s point of view on working with SLAM’s Arts Strategy. In short we value our relationship with Helen Shearn very highly indeed and look forward to continuing to work closely together in the future. As you know, arts in mental health is a priority area for us under our new arts strategy so there is a big focus for us here and I’m pleased to say the projects we have invested in over the last three years are
yielding some very promising early results. However, this is challenging work and to help these projects towards future sustainability (a key aim for us at the Charity) we all need to pull together. Since I began at the Charity three years ago I have been working closely with Helen to link up where we can in supporting mental health projects – this seemed to make absolute sense in terms of sharing expertise and making the most of our resources. In the same spirit, David Blazey and I have endeavoured to jointly fund where we have seen an opportunity to do so and the Alchemy project and the Dragon Café are good examples of this. This brings additional money to the table but also helps us work more closely in partnership to support the projects once they are ‘live’.

Nicola Crane Head of Arts Strategy

Conclusion

It will be seen from the above account that the SLaM Arts Strategy (and the post-holder within the project) has increasingly been referenced as the “to go to place/first port of call” for advice, signposting and expertise for organisers of significant national events and initiatives.

It is clear that this role is having a notable impact on enhancing the reputation of SLaM’s work in this arena, and ensuring that a coherent approach is sustained with innovative activity being constantly channelled towards connecting with and influencing mainstream provision across the life course, with the most positive effect being the provision of opportunities for service users that promote their social inclusion and recovery and providing a conduit from supported provision within Trust services to participation in recovery-orientated arts projects in the voluntary sector and ultimately to participation as active citizens in mainstream arts and cultural organisations.

Recommendation

The demonstrated effectiveness of the initiative and the evidence presented above make a strong case for the mainstreaming of the central resource comprising the co-ordinating role and the networks and systems that have been developed.

Dr David Blazey
Head of Social Inclusion and Recovery Projects

Helen Shearn
Head of Arts Strategy

November 2015
Purpose of the report:

The final report has been received from Deloitte. It commends the Trust for the progress made over the past year. In particular it highlights some very positive developments in the Trust Board over the last 12 months with the Board coming together, driving Board strategic direction and increase Board visibility and influence internally and externally.

The report also identified a number of areas for improvement. The most material areas are in relation to the governance of risk management; connectivity between the corporate level of the organisation and the CAGs; and Board Committee coverage of financial performance.

It includes a number of high and medium recommendations that have been brought together here along with a detailed action plan.

Recommendations to the Board:

To note the recommendations and agree the action plan.

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

The governance of risk management is one of the areas identified for improvement. The action plan details progress being made.

Summary of Financial and Legal Implications:
No immediate implications.

Equality & Diversity and Public & Patient Involvement Implications:
No immediate implications.

Service Quality Implications:
No immediate implications.
DELOITTE WELL LED REVIEW – ACTION PLAN

A. HIGH PRIORITY

<table>
<thead>
<tr>
<th>No</th>
<th>Recommendation (H/M)</th>
<th>Action</th>
<th>Lead</th>
<th>When</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>In regard to risk management arrangements across the Trust:</td>
<td>Work Ongoing on Risk Action Plan as reported to the Board October 2015. 4 workstreams to address the recommendations in 4 and 5 (below)</td>
<td>DoN/CFO</td>
<td>Update to QSC 17 Nov 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>− Review the risk register access rights for ward and team managers, and ensure that staff at all levels of the organisation receive regular risk management training appropriate to their roles and responsibilities;</td>
<td></td>
<td></td>
<td>Board Report for endorsement 24 Nov 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>− Introduce rolling audits of risk registers to ensure current and future risks are appropriately captured; and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>− Clearly define roles and responsibilities for all levels of staff in appropriate strategies, policies and job descriptions. H</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The Board needs to further review a number of areas in regard to risk and namely:</td>
<td>See narrative above</td>
<td>DoN/CFO</td>
<td>Update to QSC 17 Nov 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>− The presentation and format of the BAF and Corporate Risk Log;</td>
<td>Datiix functionality for linking risks and generating the BAF is under review, including the production of trend data of risk/assurance</td>
<td></td>
<td>Board Report for endorsement 24 Nov 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>− The role of the Committees in relation to strategic risks;</td>
<td>Risk appetite will be discussed following the conclusion of RAR review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>− More frequent discussion and referencing to the risk appetite and the introduction of a risk profile at Board and in Committees; and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>− Ownership of the BAF and Corporate Risk Log, including resourcing requirements. H</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Recommendation (H/M)</td>
<td>Action</td>
<td>Lead</td>
<td>When</td>
<td>RAG</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>-----</td>
</tr>
<tr>
<td>7</td>
<td>Relaunch the Trust guidance for assessing the impact on quality of service changes and ensure compliance. In particular, all schemes should be assessed post implementation. <strong>H</strong></td>
<td>Review being set up by NB/MB and performance team.</td>
<td>DoN/MD</td>
<td>Dec 15</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>The new COO should fundamentally refresh the mechanisms in place for considering operational interdependencies including the operations executive, performance management reviews and regular interaction with Service Directors. <strong>H</strong></td>
<td>Review of operational exec and performance complete and about to commence in November. New TOR and timetable agreed.</td>
<td>COO</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>The Board should consider scope for enhancing corporate level engagement with CAG leaders through their participation in a selection of Board development sessions, away days or other forums. <strong>H</strong></td>
<td>Being considered as part of planning of board/seminar/development programme for 2016. Diary dates are being set.</td>
<td>Chair/CE</td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Introduce a Board forum that scrutinises operational financial performance through the creation of a new Committee or by extending an existing Committee. Also consider the need to formally include a focus on operational performance and workforce in either the Quality or the Finance Committee (if established). <strong>H</strong></td>
<td>Agreed. An initial set up meeting has been arranged for 9 Nov 15. Interim arrangements of two separate committees have been established for six months conjoined with common membership. Diary dates are being set.</td>
<td>Chair</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>The Trust should introduce an accountability framework which clearly sets-out: •the respective accountabilities of Service Directors, Clinical Directors and Academic Directors. Ensure this is applied consistently across the CAGs; •the respective accountabilities and responsibilities of support functions across the CAGs; and •the parameters under which CAG governance arrangements should operate, ensuring that the framework is developed by bringing together the best of practices currently in place across the CAGs. <strong>H</strong></td>
<td>A framework template has been sourced and is being populated to describe the recommended accountability arrangements.</td>
<td>TBS</td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Recommendation (H/M)</td>
<td>Action</td>
<td>Lead</td>
<td>When</td>
<td>RAG</td>
</tr>
<tr>
<td>----</td>
<td>----------------------</td>
<td>--------</td>
<td>------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>18</td>
<td>The Board should consider the need to further explore the appropriateness and sustainability of the current distribution of CAGs in terms of both scale and number. <strong>H</strong></td>
<td>A wider infrastructure review is underway as part of the business planning process for 2015/16 which will have an impact on this issue.</td>
<td>Chair/CE</td>
<td>Apr 16</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>The Board should see some causal factor analysis for complaints, incidents, and claims to ensure key themes are being addressed, lessons learned and changes in practice sustained. <strong>H</strong></td>
<td>A recommendation has been made and agreed regarding a revised process.</td>
<td>DoN</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>The Trust should revisit the format of the performance management reviews to ensure that they enable the right balance of corporate support and executive scrutiny. <strong>H</strong></td>
<td>A review of performance management team and function has been commissioned alongside the development of a performance framework which will underpin process and structures for reporting and management.</td>
<td>COO</td>
<td>Complete</td>
<td></td>
</tr>
</tbody>
</table>
| 28 | The Trust should consider a number of areas for enhancing its Board/Committee reporting to include:  
  - streamlining Board level performance information to capture the comments made in this report;  
  - increasing CAG focus of reported information; and  
  - Executive Directors presenting performance information to the Board. **H** | Board level performance and quality report has been reviewed and refined. New structure presented at October Board which incorporated CAG reporting for exceptions. This will continue to iterate and will also develop further to capture Social Care performance measures. | COO | Jan 16 |   |

**B. MEDIUM PRIORITY**

<table>
<thead>
<tr>
<th>No</th>
<th>Recommendation (H/M)</th>
<th>Action</th>
<th>Lead</th>
<th>When</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Recommendation (H/M)</td>
<td>Action</td>
<td>Lead</td>
<td>When</td>
<td>RAG</td>
</tr>
<tr>
<td>----</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-----------------------</td>
<td>-----</td>
</tr>
<tr>
<td>1</td>
<td>More clearly communicate the strategic objectives of the Trust and ensure alignment between the 2 year plan, 5 year strategy and the BAF. Also consider a refresh of the Trust’s vision and values (commitments) in conjunction with the communications initiatives that are referred to in the Communications Strategy. M</td>
<td>To be considered as part of the Annual Planning Process for 2016/17; a series of engagement events are planned which will provide the opportunity to ensure alignment and decide if we need to re-fresh vision and values. If so this will be brought to the Board for approval. This will be linked to the Comms Strategy.</td>
<td>DOC</td>
<td>Nov and Dec 15</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>The executive strategy meeting should be more engaged in the development and on-going evolution of individual CAG strategies, and there should be provision for more regular presentations on these to this forum. Terms of Reference for the strategy and operations executive meetings need to be reviewed to ensure the purpose of each is clear and that appropriate value is derived by all attendees. M</td>
<td>Strategy Executive to look at this recommendation and the work undertaken by Kris Dominy/SDs to draw up timetable of meetings and clarify purpose and work plan across all meetings including the Strategy Executive. TOR for operation meeting drafted for approval.</td>
<td>COO</td>
<td>Dec 15</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Ensure key stakeholders are engaged in the strategic planning process and are appropriately appraised of the Trust strategy and methods of implementation. M</td>
<td>As is customary we will be holding a key stakeholder event as part of the annual planning process 2016/17.</td>
<td>DOC</td>
<td>Mar 16</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Review Committee briefing reports and consider the introduction of assurance based reports which RAG rate the issues discussed. M</td>
<td>Agreed – to be considered further in discussion with the board committee chairs.</td>
<td>Chair/TBS Comm chairs</td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Formally discuss and capture succession planning for all Board member and senior leadership positions. M</td>
<td>This is already underway for NEDs via the Nominations Committee. The CE and HRD review succession planning for the Executives throughout the year on an ongoing basis and it is formally reviewed by Chair/TBS CEO/HRD</td>
<td>Chair/ TBS CEO/HRD</td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Recommendation (H/M)</td>
<td>Action</td>
<td>Lead</td>
<td>When</td>
<td>RAG</td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------</td>
<td>-------</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td>the Remuneration committee at a minimum of twice a year. This includes retirements,</td>
<td>career progressions, role expansions or changes, the need for new recruitment and for performance. The senior roles are reviewed in the light of Trust requirements and changes as well as personal circumstances. The CE and HRD also consider the wider executive talent pool to identify development needs and opportunities to operate at a higher level in readiness for a more senior role.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Appraisals and mandatory training need to be phased throughout the year and monitored to allow early understanding of areas of underperformance. M</td>
<td>The Trust has seen significant improvements in mandatory training compliance over 2015 and is very clear that continued progression to full compliance in all areas is a priority. The challenge of balancing the assurance of a well-trained workforce without adversely impacting on staffing levels and patient care is recognised and therefore all Clinical Academic Groups (CAGs) have submitted trajectories showing completions required to reach full compliance by March 2016; these figures will be monitored by the Chief Operating Officer through monthly Operational Performance meetings and CAG performance review meetings to identify and remedy early underperformance. CAGs will require teams to instruct staff members to schedule bookings and commit protected learning time for e-learning modules to meet these targets. The Education and Training department are reviewing face to face provision of all courses until March 2016 to ensure that training resources match these expectations.</td>
<td>HRD</td>
<td>Mar 16</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Recommendation (H/M)</td>
<td>Action</td>
<td>Lead</td>
<td>When</td>
<td>RAG</td>
</tr>
<tr>
<td>----</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-------</td>
<td>-----</td>
</tr>
<tr>
<td>12</td>
<td>Ensure clinical and non-clinical staff have access to a range of quality performance information and can also see how other comparable local and national services are performing.</td>
<td>Staff are encouraged and supported to review their own mandatory training in a number of ways: all mandatory training without a physical skills element is available as elearning to give greater flexibility, staff can access the WIRED system online which shows their personal requirements and mandatory training compliance is included as a core component of the Trust’s performance development process.</td>
<td>COO</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Consider further opportunities to increase cross divisional learning such as open forums to discuss live case studies and ensure learning is an agenda item at ward and team meetings.</td>
<td>Through the development of dashboards with IT and BI, performance development is in hand and operations are fully engaged in this process.</td>
<td>DoC/DoN/HRD</td>
<td>Mar 16</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Ensure that good practice and terms of references are complied with in relation to the alignment of the Board Committees and that cross representation is introduced.</td>
<td>The Strategy Executive will be taking forward. Lessons from the CQC inspection and Schwarz rounds will be included.</td>
<td>TBS</td>
<td>Dec 15</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>The Trust should be more explicit regarding the appraisal of Academic Leaders.</td>
<td>The academic leaders’ reviews are led by KCL. The MD will feed into this process.</td>
<td>MD</td>
<td>Mid 16</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Thresholds for quality performance should be revisited and expectations for compliance clearly articulated to Executive and CAG leads so that they can be held to account for delivery.</td>
<td>This will be captured through the performance framework detailed above and the monthly performance reviews.</td>
<td>COO</td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Recommendation (H/M)</td>
<td>Action</td>
<td>Lead</td>
<td>When</td>
<td>RAG</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------</td>
<td>-----</td>
</tr>
<tr>
<td>21</td>
<td>Review the governance resource for each of the CAGs and ensure appropriate roles are in place to support effective management of complaints, claims, incidents and audit. Establish a forum where corporate and CAG governance leads can meet to ensure alignment of systems and processes. M</td>
<td>This will be brought together with the infrastructure review being led by CFO where CAG and corporate functions will be reviewed and aligned.</td>
<td>CFO/COO</td>
<td>Apr 16</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>CAG clinical audit arrangements need to be reviewed to ensure consistency of approach and appropriate oversight at CAG executive and Board Committee levels. This will help to ensure that recommendations are progressed in a timely manner and that lessons learned are shared across the Trust. M</td>
<td>This will be taken forward and reviewed by the Quality Committee in the new year. There has been an initial discussion with the CAG CDs.</td>
<td>MD/DoN</td>
<td>Feb 16</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Opportunities for engagement should be consistent across the CAGs and feedback co-ordinated to ensure service improvements are optimised. M</td>
<td>As part of the review of Strategy Exec ToR and purpose within whole suite of meetings to consider addressing this aspect.</td>
<td>COO/DOC</td>
<td>Dec 15</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Ensure that staff and service users are made aware of changes that have resulted from their feedback. Engage hard to reach staff in focus groups or surveys in order to better inform communication methodologies. M</td>
<td>Board papers September 2015 “Partnerships: with people who use our services, their friends, family, carers and communities” sets out the approach to achieving this recommendation for service users – update report on implementation to January 2016 Board. Staff meet the Chair/CE monthly sessions – capture their feedback and then publish follow up actions in eNews.</td>
<td>DOC</td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Key meetings should be rotated across the Trust sites or conferencing facilities made available to ensure attendance.</td>
<td>Previously agreed by Board. Agree scheduling in December.</td>
<td>TBS</td>
<td>Dec 15</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Recommendation (H/M)</td>
<td>Action</td>
<td>Lead</td>
<td>When</td>
<td>RAG</td>
</tr>
<tr>
<td>----</td>
<td>----------------------</td>
<td>--------</td>
<td>------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>M</td>
<td>Increase the availability of quality, performance and patient experience information on the Trust website. M</td>
<td>Through the development of the dashboards identified above, this information will aggregate to Trustwide indicators of performance which can be accessed on the Trust website.</td>
<td>COO</td>
<td>Jan 16</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Introduce data quality kite marks / metrics to performance reports and ensure information can be traced to source. M</td>
<td></td>
<td>CIO</td>
<td>Mar 16</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Ensure that the Board receives appropriate assurance on governance arrangements and controls for data quality via clearly defined reporting routes. M</td>
<td>The recommendations from the Information Review project initiated by the CIO have recently been agreed, including the upgrading of the current Health Intelligence Platform, the formation of an Information Analyst network and the establishment of the new Business Intelligence Group (BISG). This is chaired by the CIO with attendance by the COO &amp; CIO, and representation from Health Intelligence, Performance &amp; Contract teams, and CAGs. Meeting monthly, this group will ensure Data Quality standards are enforced throughout the Trust, as set out in the ToR for the group. Output and reports will be made available to the Trust board where required. The BISG will agree the priorities for information &amp; data quality requirements of the Trust, coupled with a roadmap of improvements aligned to the strategic objectives of the Trust.</td>
<td>CIO</td>
<td>2nd November-first meeting of BISG. Information Analyst Network first meeting 26th October. Balanced Scorecard has been in place</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Recommendation (H/M)</td>
<td>Action</td>
<td>Lead</td>
<td>When</td>
<td>RAG</td>
</tr>
<tr>
<td>----</td>
<td>---------------------</td>
<td>--------</td>
<td>------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The CIO has also now set up a Balanced Scorecard for IT, and one of the metrics is to measure data quality and consistency checks on systems e.g. replication of data, batch runs, report generation.</td>
<td>since May 2015 but has data from January 2015 to present.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Code:
- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule
<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12/10/15</td>
<td>Paul Mitchell</td>
<td>Draft to Board.</td>
</tr>
<tr>
<td>2</td>
<td>02/11/15</td>
<td>Paul Mitchell</td>
<td>Including comments from lead directors.</td>
</tr>
<tr>
<td>3</td>
<td>08/11/15</td>
<td>Paul Mitchell</td>
<td>Additional comments from directors.</td>
</tr>
<tr>
<td>4</td>
<td>11/11/15</td>
<td>Paul Mitchell</td>
<td>Updated following consideration at SMT.</td>
</tr>
<tr>
<td>5</td>
<td>14/11/15</td>
<td>Paul Mitchell</td>
<td>Version for Board.</td>
</tr>
</tbody>
</table>
TRUST BOARD - SUMMARY REPORT

Date of Board meeting: 24 November 2015

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.

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.
Chief Executive’s Report
November 2015

1. Trust issues

CQC visit
At the time of writing we are waiting for our CQC inspection report to go through Quality Assurance, and are expecting to receive it on Monday 23rd, the day before our Board meeting. Services have been written to regarding the CQC factual accuracy process that will be initiated on receipt of the draft CQC report. This is absolutely vital to ensure that the Trust is judged on correct information and can make a significant difference in the final outcomes of the inspection and hence the way that the Trust is viewed by service users, carers, commissioners and our staff for a considerable time to come. Regardless of the final outcome I would like to take the opportunity to thank all staff for their commitment to the quality of our services, and their commitment to working with service users and local people to support the best possible outcomes for those with mental health difficulties.

2. National issues

Events over the past weekend
Again at the time of writing we are all still reeling from the terrible events in Paris and in other places around the world, including Lebanon and Kenya. Our thoughts are with those impacted. As always in such tragic circumstances we must also pay tribute across national boundaries to the dedication of all staff who work in emergency services.

“Mental health under pressure”
Over the past two decades, mental health providers have led the way in transforming how we deliver services in the NHS – replacing long-stay institutions with care in the community, diversifying services to focus support on people with specific needs, and extending access to evidence-based mental health treatment to those in primary care. In recent years, a new wave of transformation programmes has emerged that focus on the principles of recovery, with services and the workforce redesigned to reflect that focus. We have, therefore, done much to drive transformation in pursuit of better outcomes and experience. The King’s Fund’s new briefing, Mental health under pressure, now calls on the sector to focus on using evidence to improve practice and reduce variations in care, but says it is essential that this is underpinned by stable funding. They argue that mental health providers are now facing sustained underinvestment in their services, compounded by substantial cuts in wider public services and a lack of investment in the data and information infrastructure. It is worth noting that the delivery of evidence based practice, using quality improvement to reduce variation and investment in informatics are all core components of our strategy.

High profile backing in call for mental health equality
Not linked directly to the King’s Fund report but overlapping in spirit, over 200 celebrities have supported a campaign calling for an increase in funding for mental health services in England. NHS Providers chair, Dame Gill Morgan, and NHS Providers board members John Lawlor, chief executive of Northumberland, Tyne and Wear NHS Foundation Trust and Tom Cahill, chief executive of Hertfordshire Partnership NHS Foundation Trust, are also signatories of the letter. The push for mental health to be treated as seriously as other illnesses was launched by former mental health minister Norman Lamb, Conservative MP
Andrew Mitchell and Alastair Campbell. While the government increased overall mental health funding to £11.7bn in 2014/15, the campaign states that people with mental ill health do not receive the same right to access treatment on a timely basis compared to the general population and not enough is being done to address this continuing inequality in care standards and funding.

**Consultation on national price caps for agency working in the NHS**

Monitor and the TDA announced a four week consultation on proposals to cap the rates for agency staff and to encourage workers back into substantive and bank roles. The proposals include the following principles:

- An overall rationale to bring agency pay in line with substantive pay by April 2016.
- Price caps would apply to all doctors, nurses and all other staff in NHS Trusts and Foundation Trusts.
- Rules will apply to all NHS organisations.
- There will be a phased approach to implementation with break clauses in place for local managers and clinical leaders to override the rules under exceptional circumstances in the interests of patient safety.
- Ceilings and frameworks for agency nursing still apply. There are plans for agency expenditure ceilings to be extended across all staff groups from 2016/17.

Three examples of the concerns that have already been raised are:

- How to support those Trusts with particular recruitment and retention challenges whose only current way of providing safe staffing levels is to pay agency staff a significant premium
- How to successfully introduce a rate limit over a winter period when demand for agency staffing is traditionally at its highest
- How system leaders will support Trust leaders faced with an immediate staffing shortage on whether they break the rate limit or operate with a sub optimal staffing ratio.

3. And Finally….  
I’m delighted to report that the Trust won two categories at the recent Royal College of Psychiatrist awards. One of our specialist CAMHs team has won psychiatric team of the year and Prof Sukhi Shergill (Consultant Psychiatrist at the IoPPN/SLaM in psychosis) has won academic researcher of the year. Well done also to our other three teams for their nominations.

- Psychiatric Team of the Year (working-age adults): Eating disorders outpatients and day care team
- Psychiatric Team of the Year (non-age specific): Channi Kumar mother and baby unit and linked community perinatal mental health teams
- Psychiatric Team of the Year (outstanding contribution to sustainability): The healing environment project

**Dr Matthew Patrick**  
**Chief Executive**  
**November 2015**

U / Board / Chief Exec report November 15
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 24 November 2015

Name of Report: Report from the Council of Governors

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

Author: Paul Mitchell, Trust Secretary and CoG working group chairs

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

Presented by: Chris Anderson, Lead Governor

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

Recommendations to the Board:
To note the report.

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 has an active role in the development of the quality of services via the CoG working group and the observer status on the Board’s QSC. The CoG bids programme specifically welcomes bids which “improve the patient experience”.
1. **Deputy Lead Governor**

Congratulations to Jenny Cobley on her election as Deputy Lead Governor, with effect from 10 November 2015.

2. **Governors’ away day**

An away day was held on 20 October chaired by the Deputy Chair/Senior Independent Director. The morning session comprised of group work which focussed on three areas:

**Message to Board**

Three key issues were brought forward:

- The need for prompt and reciprocal responses.
- The opportunity to understand current service provision via the arrangement of joint visits.
- Ongoing training and support to Governors.

**What worked well last year**

- Greater transparency.
- Introduction of governor observers on Board committees.
- Awareness of current estates issues and plans for the future.
- Training programmes for governors.
- Transition to the new Board.

**What can be improved?**

- Holding of NEDs to account.
- Briefings for governors.
- Understanding of other corporate areas - HR, IT.
- Resources to support and develop governors.
- Greater engagement with governors across KHP.
3. Governance sub-committee (Chris Anderson)

Report on meeting held on 16 October 2015.

Members of the committee received a summary of actions reported as open, including a summary of action taken as at 5 October 2015. The committee reviewed the status of all 19 outstanding actions of which 7 were reported to be rated as red i.e. action recorded as not complete that required immediate attention. Matters discussed included:

a. Proposals for governors to visit Clinical Academic Groups (CAGs) and meet with CAG Executive members.

b. Election of Lead and Deputy Lead Governors

c. Corporate induction for governors

d. Proposals for holding Non-Executive Directors (NEDs) to account that included plans to link governors to NEDs and establish links between NEDs, governors and trust committees.

e. Plans for undertaking an evaluation of the Council of Governors (CoG), self-assessment for individual governors and a governor’s skills audit.

f. Development of a protocol for providing information to governors.

Matters discussed and corresponding action taken at the meeting included the following items;

Governors Handbook – Discussion took place on the first draft of the SLaM Governors Handbook. Members agreed the handbook should be finalised and available for the next intake of new governors. It was also noted the Membership Officer would support oversight of the document’s development and in the longer term its continuing development and implementation.

Code of Governance – Those present discussed a report on the Trusts’ response to questions raised in relation to the NHS Foundation Trust Code of Governance, the SLaM Constitution and Monitors' reference guide for FT Trust governors.

As previously reported at the meeting on 7 September 2015, work to respond to questions raised by AB would help to inform future development of the SLaM Constitution, provide assurance on how the Trust met its obligations with regard to provisions within the Code and identify areas where governors required further support and development. Such work would not require the Trust to develop its own code of governance however it was noted there would still need to be a requirement to describe local arrangements when the Trust was not compliant with the FT Code or any other published guidance.

Mentoring and Governors’ Training Programme - Tom Werner, elected member representing SLaM staff, introduced an update on Mentoring and the Governors’ Training Programme. The Trust had agreed to financially support the mentors development programme over 8 weeks and there would be monthly meetings with mentors.
Disclosure and Information Governance - With Dr Murat Soncul, Head of Information Governance in attendance, discussion took place in relation to Information Governance following requests for the disclosure of information held by the Trust. The meeting noted the advice received from Dr Soncul and agreed governors should receive Information Governance Training. The meeting also noted the Trust should clarify the level of information it would disclose to governors.

4. Planning and strategy (Angela Flood)
The group last met on 6 October, the final meeting of 2015. An update report was included in the papers for the Board meeting which took place on 27 October.

Members of the group have been involved in the planning of the Council of Governors’ cross-borough Annual Members and Public meetings. The first meeting took place in Croydon on 9 November at MIND Croydon. The large number of participants included SLaM Members, members of the public, Governors and staff. The information gathered from the break-out groups will be collated and circulated to participants as well as used to inform service improvement and strategy development. A follow-up meeting will be held in May 2016. Meetings in the other three boroughs (Lambeth, Lewisham and Southwark), will also take place in 2016.

Members of the group also attended the SLaM Annual Planning 2016/17 Stakeholder Event on 12 November where priorities for the forthcoming year were identified and discussed.

The first PSWG meeting of 2016 will take place on Tuesday 16th February when Louise Hall, Director of HR, will give a presentation on the SLaM workforce strategy and related plans.

5. Bids Group (Roger Oliver)
Meetings
This may be my last report as it depends on the results of the current Council of Governor election, but in any event there will be another Governor appointed to Chair this group if I don’t succeed.

The group meets quarterly, and there has not been a meeting since the last report to the Board. – the next meeting will take place on Monday 30th November in the Maudsley Boardroom, 3:30pm until 5pm.

Smile for Health Scheme (Nov. 2014 – 31st December 2015) Update
Further to recent reports, which is near to its closure, the following update is reported:-

Three (3) bids have not been completed due to a number of reasons, e.g. due to project being undertaken by SLaM Estates, funding placed in NHS account “lost” due to the “time rule” in which means that the funding has to be used by the end of the financial year (31st March), proposed project’s facilitator unable
to work within a forensic ward’s system and delays due to Procurement process.

41 bids have been completed and sent in receipts

36 projects have sent in feedback reports, which have shown that there is an average score of 3.7 out of 4 for project achievement (scoring 1 = Not at all successful, 2 = Partially successful, 3 = Successful and 4 = Very successful).

Eleven (11) visits have been made by members of the Bids Steering Group to projects, one (1) of which was undertaken this month. We are aiming to carry out some more visits before the end of this scheme.

We will be planning a one-off “Best Practice and Feedback” event for both successful and unsuccessful bidders to be held in February/March 2016. Potential bidders will also be invited.

**Future of the “Make me Smile” Bids Scheme Funding**
As previously stated we will be making application to the Trust Charity for funding for the next scheme by the end of December, and the form has been drafted and awaits final approval by the Steering Group. The next scheme could be planned to run from October, 2016 until 31st December 2017.

6. **Membership development and communications** (Dele Olajide)

The main items discussed at the meeting on 5 November were:

- Options for the allocation of SLaM e-mail addresses for governors. This will be brought back to the next meeting for a decision.

- An update on the election of governors for 2015. The results will be announced on 17 November.

- An update on the planning for the first of the Council of Governors' cross-borough Annual Members and Public meetings. Details of the meeting are reported in section 4 above.

Paul Mitchell
Trust Secretary
October 2015

U: / board / cog update report Oct 15
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 24th November 2015

Name of Report: Briefing from Quality Sub Committee

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

Author: Dr Neil Brimblecombe, Director of Nursing

Approved by: (name of Exec Member) Dr Neil Brimblecombe, Director of Nursing

Presented by: Dr Neil Brimblecombe/ Lesley Calladine

Purpose of the report:

To present a brief summary of key points discussed at the meetings of the Quality Sub Committee of the Board held on 15th October 2015 drawing the Board’s attention to key points for consideration.

Recommendations to the Board:
The Board of Directors is asked to note this report and decide whether any further action or briefing is required in relation to the key issues raised.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - 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, correctly judged and classified and, most importantly, are being actively managed and mitigated by named staff.

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 on a regular basis.

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.
Key points

The Quality Sub Committee draws the following items to the attention of the Board for noting and for consideration as to whether further briefing is required.

Meeting of the Quality Sub Committee – 15th October 2015

1. Safer Staffing

The Committee discussed the monthly safer staffing reporting arrangements to NHS England. Currently the Trust measures actual staffing levels against minimum agreed staffing levels. This does not take into account, enhanced levels of observation or acuity and dependency of the service user group. It was recognised by the committee that these are important measures to include. A number of test sites in the Trust will be piloting the use of the ‘Hurst Tool’, which will enable teams to measure levels of acuity and dependency. An evaluation of this pilot will be presented to the board. The planned roll out of the e-roster module ‘Safe Care’ will enable the Trust to capture enhanced levels of observation data as well as information from the Hurst tool on acuity and dependency levels.

2. Thematic review - Suicide Prevention

A paper was presented to the committee which outlined the findings from the National Confidential Inquiry into Suicide and Homicide (NCISH). The committee discussed the NCISH report and reviewed local incident data on suicides. The Trustwide action plan was presented outlining plans to support the reduction in suicides within SLaM. It was highlighted that there is some very successful work taking place internationally which aims to reduce suicides to zero, specifically the work in Detroit was presented to the committee.

Discussion with our local commissioners has taken place to look at how we can work collaboratively in reducing suicide within our local population. The committee agreed that suicide prevention groups would be set up within individual CAGs to review the NCISH report, local data and the Trustwide action plan.

An update on progress with the action plan will be presented to the committee in January 2016.

3. Policies for review

There were no policies ratified at this committee

Next meeting: 17th November 2015
Date of Board meeting: 24th November 2015
Name of Report: BDIC Update Report
Heading: - (Strategy, Quality, Performance & Activity, Governance)
Strategy
Author: Emily Buttrum, Olivia Howarth
Approved by: Matthew Patrick
Presented by: Emily Buttrum

Purpose of the report:
To inform the board of the key issues discussed at the Business Development Investment Committee.

Recommendations to the Board:
To note the report

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
The Business Development Investment Committee provides support and challenge to the development and implementation of the Trust’s commercial strategy. It is responsible for approving major investment decisions including proposals for new business and for scrutinising the strategy for the improvement of efficiency and productivity in order to enable delivery of the Trust’s strategic and operational objectives.

The key items discussed in this meeting relevant to the assurance framework were the international commercial opportunities and the proposed ethics committee. The risks and mitigations around the Abu Dhabi service were discussed. The nature of the ethics committee would be to mitigate potentially ethical risks to the Trust.

Summary of Financial and Legal Implications:
International opportunities – all three topics were subject to financial consideration to the committee. Regarding the Abu Dhabi opportunity the committee would welcome further updates on the financial situation and felt the board would welcome an update at this meeting in person from Jo Fletcher given the significance of the opportunity.

Intellectual property policy – an updated trust policy would incur modest costs. There needs to be further discussion on the financial implications of international trademarks.

Equality & Diversity and Public & Patient Involvement Implications:
All items of discussed in the meeting were required to provide assurance that the E&D and PPI implications had been considered.

Service Quality Implications:
The Abu Dhabi service has recently launched and therefore subject to a close scrutiny around service quality and potential risks.
Business Development and Investment Committee

Sub Committee of the Board

19 October 2015, 12.30pm in the Boardroom, Maudsley Hospital

Attendees:  
Emily Buttrum (EB)  
Stephen Docherty (SD)  
Kristin Dominy (KD)  
Alan Downey (Chair) (AD)  
Olivia Howarth (OH)  
Adam Pryce (AP)  
Martin Baggaley (MB)  
Gary Hitching (GHI)  
Angela Flood (AF)  
Zoe Reed (ZR)  
Jo Fletcher (JF)  
Tracey Power (TP)  
Jonathan Rolfe (JR)

Apologies:  
Matthew Patrick  
Gus Heafield

ITEM

Meeting administration
The minutes of the last meeting were agreed as an accurate record.

Updates:
- A prison bid – we are presenting to the commissioner this week and will feedback to the committee when we have any update.
- Pathology services – we have awarded contract with the intention of signing soon. Mobilisation meetings with SLaM/Viapath teams are going well. *The contract has since been signed.

Abu Dhabi

Jo Fletcher updated the committee on progress of the service which has now opened and is providing clinical service.

Overview
- Service opening delayed from 20th April to June due primarily to delays with professional registrations and slippage with finalising the clinic renovations.
- During a Ministerial Visit to the CAMHS CAG, Rt Hon Alistair Burt MP, voiced interest in the
Abu Dhabi service having previously undertaken the role of Minister for the Middle East.
- Staff are now in accommodation. Soft launch went ahead.

Costings
- The financial situation was discussed now the service has launched. The committee would welcome a further update on the financial situation further into the running of the service.

Risks
The key risks highlighted were around:
- Information governance
- Market
- Income/activity
- Demand management and delivery
- Cultural differences
- Abu Dhabi law

Conversation on the appropriate actions taken to mitigate these was discussed and a risk register provided assurance in the paper.

Summary and comments
- There were comments on the bureaucratic obstacles in setting up services in Abu Dhabi and on the importance of sharing learning, as there are many helpful lessons to be learned from the experience of this contract so far.
- A report to this committee when the finances have been updated would be welcome.
- Agreed to update the trust November board as a stand alone item. We will ask to extend the BDIC update section. Jo Fletcher to attend and present.

China
Zoe Reed updated on result of the Wei Fang opportunity in China and other potential areas for commercial ventures, with a recommendation that we partner with the China-Britain Business Council (CBBC).

Finances
- The financial situation was discussed post completion of the training and observational placements.

Key points
- Regarding the MOU, there are four elements, of which only one has been agreed. It seems unlikely now that we will proceed with the others. If we do proceed, we will negotiate fees accordingly.

Comments
- There was a reminder of the agreement that we should adopt a ‘waterfall’ approach to overseas opportunities: pursuing further opportunities in China could be a distraction, but developing and maintaining relationships now could deliver future benefits.
- The potential sensitivities of association with China were noted.
Summary and actions

- It was agreed that this would be an appropriate board discussion. The committee would request a board development session to talk about international strategy in general and to seek clarity over which opportunities to pursue.

Maudsley International (MI)

Tracey Power updated the committee on the recent work of MI.

The overall financial position was discussed. There are limited resources to invest in marketing. Previously new work has been developed mostly by relationships and word of mouth. But the market is changing and procurement is becoming more formal and bureaucratic.

There is a need now to reposition in order to make sure MI can operate profitably in a changing market. It may be necessary to target an increase in the value of contracts and this will present a number of challenges.

Comments

- Noted that a new Chief Executive of the Maudsley Charity has been appointed – would be beneficial to have a discussion with MI and BDIC.

Ethics committee

Alison Beck led the discussion on the proposal for the trust to set up a committee to consider the ethical and reputational implications of commercial and other service developments in SLaM. The purpose of the committee would be to consider developments which:

1. Conflict with the aims and objectives of the organisation
2. May reduce willingness of patients, carers and communities to use SLaM services
3. May alienate staff, supporters and other stakeholders (including reducing likelihood of other business developments)

The goal is that ethical issues would be dealt with in a timely and organised way, and there are clear and consistent messages around these issues. There is also a need to be clear what the risks are and how they are being mitigated.

Currently, we do not have a standard process or forum in which we think about working with different countries or organisations who have different values than ours, and the potential reputation implications.

The following options were discussed:

Option 1: A Trust-wide committee will meet three times a year for 1 hour. Representation on the committee will come from across the CAGs and include the Communications Team. The Committee will need to include very senior staff who have the authority to hold the CAGs to account.
**Option 2:** BDIC will provide the function of an Ethics Committee as and when necessary

**Option 3:** Ethical committee review will be required at CAG level

**Option 4:** Do nothing

**Comments**

- There is an important distinction between tricky clinical decisions and ethical issues of the kind that are under consideration here.

**Summary**

1. EB/AD to have initial conversation with Matthew Patrick
2. It was agreed to add ethical issues as standard due diligence to our assessment of overseas opportunities which would ensure discussion at this committee.
3. AB would investigate other NHS trusts to compare good practice.

**Intellectual property (IP)**

EB presented the report on IP, there is currently a gap in our management of IP and related areas. The commercial team have drafted a report of the current situation and where the recommended improvements are.

**Key points**

- Agreement to update the trust-wide IP policy which would incur modest costs. It is also essential to communicate with staff what this means and how to seek IP guidance.
- The Commercial Development Meeting receives and discusses IP related issues, which if necessary will feed back to this committee – this function is working well so far.
- There was a discussion around KHP and the need to align with their IP governance.
- The trust Board has recently agreed we need a brand strategy.
- Agreement to trademark our brand in the UAE and incur associated costs. EB to discuss with Jo Fletcher

**Commercial Governance – communications plan**

Following on from the presentation of the commercial governance paper at the previous meeting, it was suggested that a communications plan demonstrating how to communicate this to staff would be welcomed.

The commercial team followed up with the communications team and drafted a proposed plan that was presented.

**Comments**

- Agreed that the best form of communication was in person and through word of mouth, therefore effective engagement will take time.
- It was worth noting that teams may not be aware this is a ‘free’ service. We will emphasise we offer support without charge.
- Be sure to include borough services who may be less aware of the commercial function.
- Change in infrastructure - people may not be clear around service promotion, would be helpful to share how we work with clinical teams.
**Summary**
The communications plan was approved and the commercial team will follow up with the communications team to begin planning.

**SLaM Quality Improvement Programme**
OH updated the committee on the progress of the SLaM QI Programme procurement.

The key workstreams that were updated were procurement, recruitment and engagement. It was noted that a full board item would be presented in the November meeting.

**Next meeting** – forward planner was agreed as follows:

- Abu Dhabi update – pricing update
- Commercial Development Meeting report
- Education and training strategy
- NHSE genomics labs tender
- Croydon APA agenda - next two agendas
- CDM ToRs to ratify
- Tender lessons learned
- Recovery services sustainability

Olivia Howarth, October 2015
International opportunities

**Abu Dhabi**
The committee discussed progress of the service which has now opened and is providing clinical service. There were comments on the bureaucratic obstacles in setting up services in Abu Dhabi and how to share learning, of which there are many helpful examples. The committee has requested a further report when the finances have been updated. Given the importance of this service to the trust, the committee requests an item on the agenda of the next Board meeting, in addition to the standard BDIC report, and that Jo Fletcher should update the board in person.

**China**
The committee discussed the outcome of the Wei Fang opportunity in China and other potential areas for commercial ventures. It was agreed that this would also be an appropriate item for a board discussion. The committee will request a board development session to talk about international strategy in general and to seek clarity over which opportunities to pursue.

**Maudsley International**
A general update on progress was discussed. There is a need now to reposition MI and possibly to increase the average size of contracts, as the market has changed: it is more difficult to win business by word of mouth, as the approach to procurement has become more formal and bureaucratic. It was noted that a new Chief Executive of the Maudsley Charity has been appointed – it would be beneficial for her to have a discussion with MI and the Commercial Team.

**Ethics committee**
The committee discussed a proposal for the trust to set up a committee to consider the ethical and reputational implications of commercial and other service developments in SLaM. The Commercial Director will have an initial conversation with the Chief Executive Officer about the best strategy, and in the meantime BDIC will investigate good practice in other NHS organisations.

**Intellectual property**
A report on IP was presented highlighting the current gap in our management of IP. The commercial team has drafted a report of the current situation, identifying where improvements need to be made.

**Commercial Governance – communications plan**
When the commercial governance paper was presented at the previous meeting, it was agreed that a communications plan should be prepared. The commercial team followed this up with the communications team and drafted a plan which was discussed at BDIC.

Olivia Howarth, October 2015
**TRUST BOARD OF DIRECTORS – SUMMARY REPORT**

**Date of Board meeting:** 24\(^{th}\) November 2015

**Name of Report:** Mental Health Act Annual Report 2014-15

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

**Author:** Kay Burton

**Approved by:** Neil Brimblecombe, Executive Director and Julie Hollyman, Non-Executive Director

**Presented by:** Neil Brimblecombe

---

**Purpose of the report:**

To inform the Trust Board of Mental Health Act developments, activity and areas of concern for the year 2014015.

---

**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 Trustwide Mental Health Law Committee and local Directorate MHA Fora 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 Mental Health Law Committee.
Executive Summary

The Mental Health Act Management Report for 2014-15 includes information for the Board about the following topics:

Developments linked to the Mental Health Act (MHA) during the year including new initiatives, work to address the changes in the MHA Code of Practice from April 2015; a review of the way Associate Hospital Managers (AHMs) hearings are organised and their competencies to fulfil the role; a summary of the training that has been delivered both internally for staff and AHMs and external to the Trust including the well evaluated Section 12 and Approved Clinician courses; a summary of MHA Monitoring visits by the Care Quality Commission (CQC) to the Trust; MHA policies reviewed during the year; summary of MHA audits; data on numbers of hearings held by the Mental Health Tribunal and Associate Hospital Managers with the outcomes; activity data for the use of the MHA during the year. For the first time in a MHA Annual Report a comparison of MHA use with other London mental health trusts and a breakdown of use of the MHA by ethnic background benchmarked against the Borough populations as defined in the Census 2011 has been included. At the end of the report a summary of the developments planned for 2015-16 can be seen.
MENTAL HEALTH ACT MANAGEMENT ANNUAL REPORT

APRIL 2014 TO MARCH 2015

1. Introduction
This is the sixteenth 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 2014/15. 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.

2. Service Development
Operational
The stronger approach which began 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. Compliance with target dates was monitored at the quarterly Mental Health Law Committee.

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.

The management of renewal hearings by Associate Hospital Managers using a paper based system for some cases continued with a further evaluation of the process during the year. The evaluation included feedback from service users, clinicians and Associate Hospital Managers. The findings were presented to the Board of Directors in January 2015 when it was agreed that the paper based process should continue while being kept under review.

The MHA Float Team became established and was able to provide more flexibility in the administration team to provide support across the MHA offices at times of increased need.

Community Treatment Order (CTO) pathway
The project to review the process for management of CTOs continued. Having identified aspects of the process that needed improvement and streamlining a pilot was proposed to be carried out within a community team. While the benefits of the system were acknowledged within the team it was recognised that the process to manage CTOs would need to be locally adapted and not be applicable to all Trust teams. While the momentum to achieve a ‘consensus’ view across the Trust was not achieved, the key processes for managing CTOs was continued in flowcharts which were distributed to teams. Evidence during the year showed there were less operational issues raised about the management of CTOs than previously leading to a belief that the project had been successful in achieving smoother operation of CTOs.

Observation of Associate Hospital Managers hearings
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 2015-16.

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. Two new SLAs were set up with partner acute Trusts. One with Guys and St. Thomas’ NHS Foundation Trust which started in May 2014 and one with Lewisham and Greenwich NHS Trust which started in October 2014.

Seclusion
The Supervised Confinement working group completed its review of the policy with a revised Seclusion Policy approved in December 2014. 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. Work has developed with a decision made to record training DVDs for AHMs to enable them to remotely access training. This is to be supplemented by classroom based training using London wide materials.

3. New Initiatives
The Maze – fourth edition
The Maze was first published in April 2010 and work began on the fourth edition which would take account of changes in the MHA Code of Practice due for release in April 2015. An e-book of the Maze was available during the year.

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.

Electronic Section 17 Leave Form
An electronic section 17 leave form was developed and piloted. Feedback on the form was received and further development work continued with the Electronic Patient Journey (EPJS) team with a view to extending the pilot on other wards to fully evaluate the effectiveness.

**AHM Competency Framework**

A AHM Competency Framework review was completed. A training and MHA activities portfolio document was developed which would start from 1st April 2015 and enable AHMs to keep their own records of training and numbers of hearings attended.

**AHM Structure Review**

A consultation begun to review the group structure of the AHMs concluded. It was agreed to retain the four local groups with a change in approach to the booking of hearings. This became central from November 2014 with all AHMs stating their site preferences and groups of AHMs set up for each site. This had the benefit of widening the pool of AHMs for each site thereby reducing the likelihood of patients meeting the same AHMs at their hearings.

**Mental Health Tribunal Simulation Project**

The MHA team continued to work 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. There were two further sessions arranged during the year with a decision to make this a regular course throughout the following year.

**4. Training**

**Medical Staff**

The Trust continues to run both Approved Clinician and s12 courses which are accredited by the London Approval Panel. For those seeking Approved Clinician or s12 status for the first time a two day course is offered. For those needing s12 or Approved Clinician re-approval a one day course is offered. The courses meet the needs of doctors within SLaM and are also a source of income generation when non-SLaM doctors attend. The introduction of the stand-alone re-approval courses is a move away from the somewhat unsatisfactory practice of either the first or second day of a two day Approval course acting as a refresher for the person attending. This change anticipates the Department of Health plans for the future. For the first time a s12 introductory course was offered for internal doctors only – this met the organisation’s need for SLaM trainee doctors to be approved at the same point in time. 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.

Three Mental Capacity Act master classes were held during the year. Though open to non-doctors they were principally attended by consultant psychiatrists within the Trust and facilitated by solicitors from DAC Beachcroft. These master classes proved an invaluable way for participants to present real life cases and to gain clarity in which legal framework(s) to use in what is often an area of confusion and ambiguity.

**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 200 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 a classroom based refresher every three years is required. The training is enhanced by the participation of a service user whose insights into the real life experiences of a detained patient are a challenging (yet positive) highlight of the day. Plans were made for the MHA one day course to be revamped with the day being split between the MHA and Mental Capacity Act. This plan was abandoned and the MHA Policy Lead/Adviser now offers a one day standalone MCA course.
Bespoke training has taken place on several occasions where the MHA Policy Lead/Adviser has offered the training at team bases. This meets the practical difficulty in releasing staff from their workplace and does mean the training can be focused on the needs of the service in question. The training is accredited as meeting the standard to count as both a MHA and MCA refresher.

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 – probably in the context of bespoke training (see above). Though not achieved in all areas ward-based training delivered by Senior MHA Co-ordinators continues. This training focuses on 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.

MHA Staff
There has been some slippage in the delivery of the Competency Programme Workbook for the Band 3 and 4 staff but three separate work streams are currently being run which means all staff will have completed the programme in the forthcoming yearly cycle.

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 relatively new course of Report Writing / Charing Skills was run on one occasion. 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 2015/2016

5. MHA Policy Development
The following policies have been reviewed and updated during the year.
- Mental Capacity and Deprivation of Liberty Safeguards (now combined in one policy)
- Leave for informal patients
- Leave for detained patients
- Information for detained patients

Work on a reviewed Community Treatment Order policy is near completion.

6. Associate Hospital Managers
There were no additional AHMs recruited during the year.

During the year the Hospital Managers received 106 appeal applications (this shows a decrease on the previous year), with a further 264 renewal hearings (decrease) and 11 Barring Order reviews (a decrease). Of these, 225 (59%) were heard, with 9 (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. This is predominantly due to delays in clinical teams providing dates for the hearings or the renewals happening close to the renewal date.

Of the 381 hearings to be arranged during the year, 114 (30%) were cancelled. This is the same percentage as seen in the previous year and below that seen in 2012/13 when 32% were cancelled, with 37% cancelled in 2011/12 and 44% in 2010/11. There were 45 (12%) patients
transferred to a bed outside of the Trust before the hearing was held. This was an increase on the previous year. There were 11 (4.5%) hearings adjourned, the an increase on 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.

During the year there were 49 paper review sessions held which reviewed 147 renewals of section. Of these 135 were not discharged; five adjourned due to either inadequate reports or further information requested; seven referred for a full hearing.

7. Mental Health Tribunals
During the year there was an increase in the number of appeal applications to the Tribunal, with 1132 submitted and a further 155 referrals by the Hospital Managers under Section 68 of the Act. The number of appeals was an increase on the previous year. Of the 1287 Tribunals to be arranged, 623 (48.5%) were heard with 55 (9%) discharged, 459 (74%) not discharged and 109 (17.5%) granted a conditional discharge. The number of conditional discharges was an increase from the previous year.

Of the 1287 hearings to be arranged during the year, 694 (54%) were cancelled – an increase on the previous years. There were 135 (20%) of hearings cancelled due to the patient being transferred to a bed outside of the Trust before the hearing was held, this represents an increase. There were 177 (25.5) withdrawals prior to the Tribunal. There were 59 (8.5%) cases adjourned for reasons including patient absent without leave. This is an increase on the previous year. Reasons included late production of reports; non-attendance of professionals; cancellation by the Tribunal service.

8. Care Quality Commission Mental Health Act Monitoring Visits
There were 29 CQC MHA Monitoring visits to the Trust in 2014-15. The findings of the CQC MHA Commissioners are reported quarterly to the Trustwide MHA Committee.

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. References to the MHA Code of Practice in this report are quoting the Code in operation during 2014-15.

Consent to Treatment
Recording by Responsible Clinicians (RCs) in the case notes of the discussion with the patient relating to capacity to consent both when first detained and at three months following the start of treatment - Code of Practice Paragraphs 24.16 to 24.17. While, commissioners were, in some areas, unable to find clear evidence that this is occurring an improvement was seen as noted in some reports.

Section 132
• Visits during the year again highlighted a number of concerns raised by visiting Commissioners about the initial giving and repeating of Rights - 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.

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.

Approved Mental Health Practitioner (AMHP) Reports
At a number of visits the MHA Commissioners were unable to locate a copy of the AMHPs report – Code of Practice Paragraph 4.94.

9. Untoward Incidents
There were 89 incidents during the year resulting from breaches of the Mental Health Act. This is an increase on the previous year when 76 were reported. 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 Mental Health Law Committee and more detailed analysis of these at the site MHA Fora. The number of breaches in 2014/15 represents a very small percentage (2%) against the number of Sections used in the Trust for the year, the breaches being identified on scrutiny by the Mental Health Act Co-ordination Team. The breaches that resulted in the most incidents were (a) Other MHA paperwork error - 33; (b) Other MHA Trust error – 31 and (c) non-rectifiable paperwork errors – 13 cases. There were five cases reported where the patient was admitted to a hospital which was not named on the Approved Mental Health Practitioner Application and seven cases where medication was administered without the authorisation of section 58 – this represented a small increase. Figure 1 displays the categories for the year.

10. Clinical Governance
During the year Trustwide audits were carried out on the following topics:

- Section 136 assessments, the causes of delays.
- Mental Capacity Act staff awareness audit.
- Mental Health Act renewals – AHM paper reviews
- Approved Mental Health Practitioner reports
- Section 132 rights

The recommendations and findings were presented to the quarterly meetings of the Trustwide Mental Health Law Committee.
The junior doctor, supported by an Associate Clinical Director, who had carried out an audit in 2013-14 on the quality of medical reports prepared for Associate Hospital Managers and Mental Health Tribunal hearings presented the findings to the Trustwide Mental Health Law Committee in June 2015. Once the template developed throughout the project had been in use for a period of six months the audit was repeated to assess if there was any difference in report quality. The findings of this repeat audit will be presented to a future meeting of the Trustwide Mental Health Law Committee during 2015-16.

11. Use of the Act
During the year 2014-15 the Trust had at total of 4430 admissions to all CAGs. 3783 of these were in Psychosis, Behaviour and Developmental, Psych Med, Mood and Anxiety, Mental Health Older Adults and Child and Adolescent Services. Of the 3783 admissions, 1720 were formal (45%). This represents an increase on 2013-14 when the percentage was 33%, and 2012-13 when the percentage was 27.45%.

The Trust has used the Act on 4135 occasions in 2014-15 (Table 1). This table includes both admissions direct under the MHA and the use of MHA while the patient was an in-patient. This was an increase on the past two years. The highest use of the MHA was seen in the Psychosis CAG (60%) followed by Psych Med (28%). 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 36% of the total use, with section 3 accounting for 23%. There was an increase in the use of sections 135, 17A, 2, 3, 4, 5(2), 5(4), 35 and 36. 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>
<thead>
<tr>
<th>Section</th>
<th>Psychosis</th>
<th>Behavioural and Developmental Psychiatry</th>
<th>Psychological Medicine</th>
<th>MAP</th>
<th>CAMHS</th>
<th>MHOA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>135(1)</td>
<td>10</td>
<td>0</td>
<td>26</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>Section 136</td>
<td>696</td>
<td>1</td>
<td>66</td>
<td>17</td>
<td>6</td>
<td>1</td>
<td>791</td>
</tr>
<tr>
<td>Section 17A (CTO/SCT)</td>
<td>179</td>
<td>35</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>236</td>
</tr>
<tr>
<td>Section 2</td>
<td>622</td>
<td>5</td>
<td>734</td>
<td>3</td>
<td>71</td>
<td>80</td>
<td>1517</td>
</tr>
<tr>
<td>Section 3</td>
<td>722</td>
<td>17</td>
<td>170</td>
<td>1</td>
<td>32</td>
<td>46</td>
<td>989</td>
</tr>
<tr>
<td>Section 35</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Section 36</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Section 37</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Section 37/41</td>
<td>3</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Section 37(Notional)</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Section 38</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Section 4</td>
<td>15</td>
<td>0</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>37</td>
</tr>
<tr>
<td>Section 41</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Section 47/49</td>
<td>4</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Section 48/49</td>
<td>5</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Section 5(2)</td>
<td>224</td>
<td>7</td>
<td>135</td>
<td>6</td>
<td>35</td>
<td>10</td>
<td>417</td>
</tr>
<tr>
<td>Section 5(4)</td>
<td>10</td>
<td>0</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>Section 45a</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 1: Use of Section by Directorate – 2014-15

<table>
<thead>
<tr>
<th></th>
<th>Psychosis</th>
<th>Behavioural and Developmental Psychiatry</th>
<th>Psychological Medicine</th>
<th>MAP</th>
<th>CAMHS</th>
<th>MHOA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2505</td>
<td>121</td>
<td>1170</td>
<td>34</td>
<td>147</td>
<td>151</td>
<td>4135</td>
</tr>
</tbody>
</table>

Figure 2 shows the percentage of MHA use across the Trust by CAG.
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. Section 136s are excluded as they are not a formal admission. This shows the number of MHA Admissions by CAG, compared to the total of all admissions for the CAG 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 four years when 1445, 1361, 1287 and 1242 were admitted direct respectively.

| Table 2 : Admission Direct to Hospital under MHA - 2014-15 |
|---------------------------------|--------------|-------------|-----------|---------|---------|---------|----------|
| Section 2 | 503 | 4 | 608 | 49 | 58 | 3 | 1226 |
| Section 3 | 138 | 5 | 99 | 5 | 4 | 0 | 251 |
| Section 4 | 14 | 0 | 16 | 0 | 4 | 1 | 35 |
| Section 37 | 5 | 1 | 1 | 0 | 0 | 0 | 7 |
| Section 37/41 | 3 | 4 | 1 | 0 | 0 | 0 | 8 |
| Section 48/49 | 5 | 10 | 0 | 0 | 0 | 0 | 15 |
| Section 47/49 | 4 | 7 | 0 | 0 | 0 | 0 | 11 |
| Total | 672 | 31 | 725 | 54 | 66 | 4 | 1553 |
| TOTAL ALL ADMISSIONS | 1262 | 47 | 1965 | 261 | 186 | 62 | 3783 |
| Percentage of MHA admissions | 53% | 66% | 37% | 21% | 35% | 6% | 41% |

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. 41% of admissions were under the MHA 1983. This represents an increase on the previous two years.
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 2014/15 can be seen in Figure 5. The use for the year was the highest since the Trust was formed.
12. **PAN London MHA Data**

Table 3 shows a comparison of MHA data across the nine London mental health trusts taking data submitted in their KP90 returns for 2014-15.

<table>
<thead>
<tr>
<th></th>
<th>BEHMT</th>
<th>CANDI</th>
<th>CNWL</th>
<th>NELFT</th>
<th>Oxleas</th>
<th>SLAM</th>
<th>SWLSTG</th>
<th>EL</th>
<th>WL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detained Admissions (No S136)</td>
<td>741</td>
<td>586</td>
<td>1215</td>
<td>542</td>
<td>298</td>
<td>1113</td>
<td>631</td>
<td>988</td>
<td>821</td>
</tr>
<tr>
<td>Informal Admissions</td>
<td>1261</td>
<td>1142</td>
<td>2619</td>
<td>867</td>
<td>2145</td>
<td>2292</td>
<td>1275</td>
<td>229</td>
<td>857</td>
</tr>
<tr>
<td>Total Admissions</td>
<td>2002</td>
<td>1728</td>
<td>4655</td>
<td>1409</td>
<td>2443</td>
<td>3405</td>
<td>1906</td>
<td>328</td>
<td>1678</td>
</tr>
<tr>
<td>% of detained admissions</td>
<td>37%</td>
<td>34%</td>
<td>26%</td>
<td>38%</td>
<td>14%</td>
<td>33%</td>
<td>33%</td>
<td>30%</td>
<td>49%</td>
</tr>
</tbody>
</table>

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Detained Admissions (Including section 136)</td>
<td>1078</td>
<td>586</td>
<td>2036</td>
<td>1111</td>
<td>706</td>
<td>1720</td>
<td>1168</td>
<td>148</td>
<td>1235</td>
</tr>
<tr>
<td>Changes from Informal to Detention</td>
<td>304</td>
<td>161</td>
<td>1025</td>
<td>326</td>
<td>355</td>
<td>786</td>
<td>186</td>
<td>506</td>
<td>254</td>
</tr>
<tr>
<td>Total MHA Activity</td>
<td>1382</td>
<td>747</td>
<td>3061</td>
<td>1437</td>
<td>1061</td>
<td>2506</td>
<td>1354</td>
<td>199</td>
<td>1489</td>
</tr>
</tbody>
</table>

13. **Ethnicity**

EPJ's MHA ethnicity data on use of sections 2, 3 and 136 in the Trust during 2014/15 compared with Census 2011 data on the ethnicity of residents in Croydon, Lambeth, Lewisham and Southwark.

The table and chart below show the ethnicity of all service users (of all ages) detained under section 2, 3 and 136 of the Mental Health Act during 2014/15 compared with the ethnicity of residents (of all ages) in Croydon, Lambeth, Lewisham and Southwark.

<table>
<thead>
<tr>
<th></th>
<th>Asian</th>
<th>Black</th>
<th>Mixed race</th>
<th>Other ethnic group</th>
<th>White</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity of Croydon residents (Census 2011)</td>
<td>16.4%</td>
<td>20.2%</td>
<td>6.6%</td>
<td>1.8%</td>
<td>55.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Ethnicity of Lambeth residents (Census 2011)</td>
<td>6.9%</td>
<td>25.9%</td>
<td>7.6%</td>
<td>2.4%</td>
<td>57.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Ethnicity of Lewisham residents (Census 2011)</td>
<td>9.3%</td>
<td>27.2%</td>
<td>7.4%</td>
<td>2.6%</td>
<td>53.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Ethnicity of Southwark residents (Census 2011)</td>
<td>9.4%</td>
<td>26.9%</td>
<td>6.2%</td>
<td>3.3%</td>
<td>54.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Percentage of uses of section 2 MHA in 14/15 (ePJS) (n=1651)</td>
<td>6.8%</td>
<td>44.5%</td>
<td>3.5%</td>
<td>6.7%</td>
<td>38.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Percentage of uses of section 3 MHA in 14/15 (ePJS) (n=1030)</td>
<td>5.5%</td>
<td>51.8%</td>
<td>3.4%</td>
<td>5.3%</td>
<td>33.6%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Percentage of uses of section 136 MHA in 14/15 (ePJS) (n=755)</td>
<td>4.0%</td>
<td>30.2%</td>
<td>2.8%</td>
<td>4.5%</td>
<td>51.9%</td>
<td>6.6%</td>
</tr>
</tbody>
</table>
This includes service users from 1) Behaviour Developmental Psychiatry CAG (n-28), 2) Child and Adolescent Mental Health Services CAG (n=122), 3) Mental Health of Older Adults and Dementia CAG (n=142), 4) Mood Anxiety and Personality CAG (n-25), 5) Psychological Medicine CAG (n-989), 5) Psychosis CAG (n=2123) and 7) No CAG (n-7).

The ethnicity of residents of all ages. Source: https://www.nomisweb.co.uk/census/2011/dc2101ew

This is the first time we have included this data benchmarked against the 2011 census in the Annual Report. Further work to understand it more fully in the context of National data and research is planned during 2015/16.

14. Proposed MHA Developments for 2015/16
- 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
- Revise Mental Health Law Policies in line with revised MHA Code of Practice.
- 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.
- Further develop better understanding of the use of the MHA across ethnic groups, reviewing same at the Trustwide Mental Health Law Committee.

Prepared by: Kay Burton
Assistant Director of Mental Health Legislation

17th November 2015
<table>
<thead>
<tr>
<th>Month</th>
<th>Item</th>
<th>Lead</th>
<th>Section</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec</td>
<td>R&amp;D Annual Report</td>
<td>Gill Dale/Tom Craig</td>
<td>Presentation</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Health &amp; Safety Policy</td>
<td>Paul Mitchell</td>
<td>Quality</td>
<td>Approval</td>
</tr>
<tr>
<td></td>
<td>Raising Concerns &amp; Freedom to Speak Up (action from Oct)</td>
<td>Al Beck/Martin Baggaley</td>
<td>Quality</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Simulation Training Opportunities and Update</td>
<td>Louise Hall/Sean Cross</td>
<td>Quality</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Complaints &amp; Incidents Integrated Report</td>
<td>Neil Brimblecombe</td>
<td>Quality</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Safer Staffing Review</td>
<td>Neil Brimblecombe</td>
<td>Quality</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>BRC Renewal (action from June)</td>
<td>Shitij Kapur/Matthew Hotopf</td>
<td>Strategy</td>
<td>Approval</td>
</tr>
<tr>
<td></td>
<td>HR Dashboard/Workforce/Staff Survey (action from May)</td>
<td>Louise Hall/Michael Kelly</td>
<td>Strategy</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Summary Service Change (CIPs) &amp; Quality Impact Assess</td>
<td>Neil Brimblecombe/Martin Black</td>
<td>Performance &amp; Activity</td>
<td>Approval</td>
</tr>
<tr>
<td></td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Contracting update</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>TOR – Review Annual timetable (action from Sept)</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>SLaM R&amp;D Committee Minutes</td>
<td>Carol Cooley</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Experiment on format of Board Meeting – Review after Board development Programme (action from March)</td>
<td>Roger Paffard/Paul Mitchell</td>
<td>Governance</td>
<td>Discussion</td>
</tr>
<tr>
<td>Jan</td>
<td>Suicide Thematic Review</td>
<td>Neil Brimblecombe</td>
<td>Quality</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Social Care Strategy – Update (action from April)</td>
<td>Cath Gormally</td>
<td>Quality</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Partnerships: with people who use our services, their friends, family, carers and communities – Progress Report (Action from Sept)</td>
<td>Zoe Reed/Kay Harwood/Julie Stephens</td>
<td>Strategy</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>HR Annual Plan</td>
<td>Louise Hall/Matthew Patrick</td>
<td>Strategy</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Briefing from BDIC Committee Meeting</td>
<td>Alan Downey/Emily Buttrum</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>Presenter(s)</td>
<td>Type</td>
<td>Session</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Feb</td>
<td>Medicines Management Presentation</td>
<td>David Taylor/Martin Baggaley</td>
<td>Presentation</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Trust Quality Strategy (action from Feb 15)</td>
<td>Neil Brimblecombe/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>Mar</td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Briefing from BDIC Committee Meeting</td>
<td>Alan Downey/Emily Buttrum</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>April</td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>May</td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Briefing from BDIC Committee Meeting</td>
<td>Alan Downey/Emily Buttrum</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>Month</td>
<td>Component</td>
<td>Presenter/Authors</td>
<td>Category</td>
<td>Topic</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------</td>
<td>---------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>June</td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>July</td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Briefing from BDIC Committee Meeting</td>
<td>Alan Downey/Emily Buttrum</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>Sept</td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Briefing from BDIC Committee Meeting</td>
<td>Alan Downey/Emily Buttrum</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>Oct</td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Revalidation Annual Report (action from Oct 15)</td>
<td>Dr K Valsraj</td>
<td>Performance &amp; Activity</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Nursing Annual Report (action from Oct 15)</td>
<td>Neil Brimblecombe</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>Month</td>
<td>Item</td>
<td>Presenter(s)</td>
<td>Category</td>
<td>Type</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Nov</td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Briefing from BDIC Committee Meeting</td>
<td>Alan Downey/Emily Buttrum</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td>Dec</td>
<td>Finance Report</td>
<td>Gus Heafield</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>Kristin Dominy</td>
<td>Performance &amp; Activity</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Council of Governors Update</td>
<td>Paul Mitchell</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Report</td>
<td>Paul Mitchell/Matthew Patrick</td>
<td>Governance</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>Briefing from the Quality Committee Meeting</td>
<td>Neil Brimblecombe/Lesley Calladine</td>
<td>Governance</td>
<td>Information</td>
</tr>
</tbody>
</table>
A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
WILL BE HELD ON TUESDAY 15TH DECEMBER 2015 AT 3:00PM
LEARNING CENTRE, MAUDSLEY HOSPITAL

AGENDA

1. APOLOGIES for absence:

2. Declarations of Interest

3. Minutes of the Board Meeting held on 24th November 2015

4. MATTERS ARISING/ACTION POINTS REVIEW

PRESENTATION
5. R&D Annual Report

QUALITY
6. Approval – Health & Safety Policy

7. Discuss – Simulation Training Opportunities & Update

8. Discuss – Safer Staffing Review

9. Discuss – Raising Concerns & Freedom to Speak Up (action from Oct)

10. Discuss - Complaints & Incidents Integrated Report

STRATEGY
11. Discuss – HR Dashboard/Workforce/Staff Survey – (action from May)

12. Approval – BRC Renewal (action from June)

PERFORMANCE AND ACTIVITY
13. Approve - Finance Report – Month 8

14. Approve - Performance Report – December

15. Approve – Summary Service Change (CIPs) & Quality Impact Assessment

16. Discuss – Contracting Update

GOVERNANCE
17. Information - Report from the Chief Executive

18. Information - Update from the Council of Governors

19. Information - Briefing from the Quality Sub Committee Meeting

20. Information – TOR – Review Annual timetable (action from Sept)

21. Information – SlaM R&D Committee Minutes

22. Discuss – Experiment on format of Board Meetings – Review after Board development Programme (action from March)

INFORMATION
23. Director’s Reports

24. Actions summary from today’s meeting

25. Reflections on today’s meeting

26. Forward Planner

27. Report from previous Month’s Part II

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

web site: www.slam.nhs.uk
Date of Next Meeting: Tuesday 26th January 2016 – 3:00pm, Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ. Please send apologies to Alison Baker 0203 228 4763 alison.baker@slam.nhs.uk
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 24 November 2015

Name of Report: Report from previous month’s Part 2 meeting

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

Author: Paul Mitchell, Trust Board Secretary

Approved by: Matthew Patrick, Chief Executive

Presented by: Roger Paffard, Chair

Purpose of the report:
To produce a summary report for consideration in the part of the Board meeting held in public which lists the items which were discussed in the P2 (private) meeting the previous month.

Action required:
To note.

Recommendations to the Board:
To agree whether this report should be produced for future Board meetings.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
No direct link but the report increases the transparency of the Board’s governance arrangements.

Summary of Financial and Legal Implications:
N/A.

Equality & Diversity and Public & Patient Involvement Implications:
N/A

Patient Quality Implications
N/A
### Part 2 report to Board

<table>
<thead>
<tr>
<th>Date of meeting</th>
<th>Ref</th>
<th>Item discussed</th>
<th>Summary of discussion</th>
<th>Lead Director</th>
<th>Reason for taking in P2</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 October</td>
<td>BOD PTII 47/15</td>
<td>Financial recovery plan</td>
<td>Detailed discussion of financial position prior to submission of Q2 return to Monitor.</td>
<td>Gus Heafield</td>
<td>Commercial in confidence.</td>
</tr>
<tr>
<td></td>
<td>BOD PTII 48/15</td>
<td>Capital projects</td>
<td>Agreement of process for award of contracts and review arrangements.</td>
<td>Gus Heafield</td>
<td>Commercial in confidence.</td>
</tr>
</tbody>
</table>